STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING 00 B. WING	03/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the pre-determined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey. This visit was in conjunction with the investigation of complaints #IN00329141 and #IN00346364. Dates of survey: 2/17, 2/18, 2/19, 2/22, 2/23, 2/24, 2/26, and 3/1/2021. Facility Number: 012527 Provider Number: 15G802 AIM Number: 201024860 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/12/21.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H). -The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the facility implemented its abuse, neglect, and mistreatment policy and procedures to complete thorough investigations,	W 0102	Bona Vista implemented 15 minute checks for Client A in the home to ensure that staff know his whereabouts at all times for his safety. The House Manager will ensure that all staff are filling out the 15 minute check documentation daily. The House Manager put the 15 minute safety checks in Client A's programming book.	03/31/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	to develop and employ effective measures after client A's continued incidents of elopement, self harm and physical aggression, and to protect client A from staff neglect. -The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the facility's window alarms/bells, window locks, bedroom door frame, and the backyard wooden privacy fence were in good repair to protect client A from his continued elopement behaviors. -The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure clients A, B, C, D, E, F, G, and H were not restricted from unimpeded access to snack items and lunch box items without due process. Findings include: 1. Please refer to W104. The governing body failed for 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H), to exercise general policy, budget, and operating direction over the facility to ensure clients A, B, and E's bedroom closets had doors and to ensure client D had a closet available for his use, to ensure the facility implemented the agency's abuse, neglect, and mistreatment policy and procedure to protect client A from neglect, client A was supervised according to his identified behavioral needs, to complete thorough investigations into allegations of staff neglect, to develop and employ effective corrective measures regarding client A's continued aggression, threats of self harm, and elopement behaviors, and to ensure client A's window alarms/bells, window locks, bedroom door frame, and the backyard		The house manager has made sure that all clients have unimpeded access to their snacks and lunch boxes. They will be given choices for snacks. The House Manager will monitor staff daily to ensure that they are providing active treatment and redirection during lunch making.	

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	wooden privacy fence were in good repair to protect client A from his continued elopement behaviors. 2. Please refer to W122. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H). The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the facility implemented its abuse, neglect, and mistreatment policy and procedures to protect client A from staff neglect, to complete thorough investigations, and to develop and employ effective corrective measures regarding client A's continued elopements, self harm, and physical aggression. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure clients A, B, C, D, E, F, G, and H had unimpeded access to lunch box items and snack items. 9-3-1(a)			
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview for 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure: -Clients A, B, E's bedroom closets had doors and to ensure client D had a closet available for his	W 0104	/p> The House Manager will do monthly checks to ensure all window alarms are working properly and in good repair as well as the general condition of the home. The House Manager will report any unsafe conditions to the Assistant Director	03/31/2021

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	use. -The facility implemented the agency's abuse, neglect, and mistreatment policy and procedure to protect client A from neglect. -Client A was supervised according to his identified behavioral needs regarding elopement, self harm, and aggression. -To complete thorough investigations into allegations of staff neglect and client A's continued elopement, self harm, and aggression behavioral incidents. -To develop and employ effective corrective measures regarding client A's continued aggression, threats of self harm, and elopement behaviors. -To ensure client A's window alarms/bells, window locks, bedroom door frame, and the backyard wooden privacy fence were in good repair to protect client A from his continued elopement behaviors. Findings include: 1. On 2/17/2021 from 5:40am until 7:50am, on 2/17/2021 from 2:15pm until 2:55pm, and on 2/18/2021 from 2:55pm until 5:50pm, observation and interviews were conducted at the group home with clients A, B, D, and E. During the observation periods, clients A, B, and E did not have doors on their bedroom closets. During the observation periods, client D did not have a closet available for his use. On 2/18/2021 at 4:15pm, client D showed his basement bedroom. Client D had a rod extended		The House Manager trained all staff on the alarms installed in the home. The Clients have access to all lunch boxes and snack items and will be given choices of snacks and items to put in their lunches and will not be restricted from access to these items. A new armoire was purchased for Client D to use as an available closet. A barrier was placed in Client A, B, and E's bedroom giving them a closet as well. The bedroom door was repaired to where Client A's bedroom so that it would shut properly	

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	from the ceiling by cables with hanging clothes on the rod and client D indicated that was his closet and where he stored his hanging clothing. Client D stated "I never had a closet." No closet was inside client D's bedroom. 2. On 2/17/2021 from 5:40am until 7:50am, on 2/17/2021 from 2:15pm until 2:55pm, and on 2/18/2021 from 2:55pm until 5:50pm, observation and interviews were conducted at the group home with client A. During the observation periods, the backyard gates were locked, multiple pickets within the wooden fence around the backyard were missing, the side gate entrance to the group home was not locked and was opened without entering a key code, and two of two bedroom windows for client A's bedroom were not locked and no alarms were observed. During the observation periods, client A's bedroom door was able to be locked from the inside and client A's roommate was present inside the shared bedroom. The bedroom door had a half inch space around the door frame which showed light from the inside of the bedroom with the door securely shut. On 2/17/2021 at 7:30am, an interview was conducted with client A. Client A stated "They (the staff) think I don't know the codes for the doors, well I do. I can leave when I want." When asked how he left the group home, client A stated "I go out one of my windows." Client A then opened both of his bedroom windows repeatedly and stated "See, nobody comes." No staff responded to client A opening/closing the bedroom windows repeatedly. Client A stated "I get physical sometimes. I leave without staff knowing. It's my behavior." On 2/18/2021 at 9:15am, the facility's BDDS (Bureau of Developmental Disabilities Services)			

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	Reports and investigations were reviewed from 1/15/2020 through 2/18/2021 and indicated the following: -A 1/26/2021 BDDS report for an incident on 1/25/2021 at 10:30pm indicated client A "eloped from the [name of group home] at 10:30pm." -A 9/12/2020 BDDS report for an incident on 9/11/2020 at 9:25pm indicated client A "had a disagreement with staff in which led to [client A] locking himself into (his) room with roommate who was asleep. [Client A] threatened to hurt roommate in which staff called on call team lead, House Manager, and the QIDP. When staff were able to get into room, [client A] had already jumped out of the window and broke through fenced in backyard. Police were then called to help find [client A]. [Client A] was found by police and was transported to [name of hospital] emergency room for self harm/suicide idealization." -A 9/3/2020 BDDS report for an incident on 9/3/2020 at 10:30am indicated client A "eloped from day services in which staff maintained the sight while [client A] left day services with staff in pursuit. When [client A] was caught up with, [client A] then followed staff back to the day program then eloped again. They (the staff) followed again and police caught up to [client A] in which staff did not call. [Client A] willingly went with police and was taken to the house." -An 8/23/2020 BDDS report for an incident on 8/23/2020 at 12:00am indicated client A "had jumped out of another persons served bedroom window during the night. Staff were notified at 5:00am by the [name of city] police department that [client A] had been taken to [name of			

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	hospital] ER by EMS (Emergency Medical Services) and was admitted at 12:06am. [Client A] was picked up from the ER at 5:35am and taken back to the group home." -A 7/4/2020 BDDS report for an incident on 7/3/2020 at 4:30pm indicated client A "was having troubles working his new IPad and became very agitated according to staff at the house at the time. When [client A] returned to his room he jumped out of his bedroom (window) which is approximately 6 to 7 feet off the ground. When he jumped out the window he proceeded to break a way through the fence and eloped. Staff maintained visual while [client A] ran off the property in which staff pursued." -A 6/29/2020 BDDS report for an incident on 6/27/2020 at 8:00pm indicated client A "was feeling angry and upset all day and became very agitated when he was asked to not go outside while it was raining. [Client A] jumped out his bedroom window and broke part of the fence to elope from the group home." -A 2/18/2020 BDDS report for an incident on 2/17/2020 at 6:45pm indicated client A "was taking a nap and became agitated when prompted to wake up for dinner on 2/17/2020 around 6:35pm. He refused to wake up for dinner so the staff gave him space and then time to wake up. [Name of city] police called the House Manager on 2/17/2020 around 6:45pm and notified them [client A] called 9-1-1 and was at the gas station about 2/3 (two thirds) mile away from the home. [Client A] threatened to harm himself. [Client A] reported he jumped out his bedroom window, broke the fence behind the shed, and ran out the broken fence."			

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	Client A's record was reviewed on 2/23/2021 at 10:30am. Client A's 11/17/2020 ISP (Individual Support Plan) and 2/26/2020 BSP (Behavior Support Plan) indicated the targeted behaviors of elopement, self harm, and physical aggression. Client A's ISP and BSP indicated client A was to have been checked on "every 15 minutes" by his supervising staff. Client A's 11/17/2020 "Life Domain" assessment indicated "Level of Supervision: [Client A] does not display skills to be left alone for long periods of time, especially in new environments in the community. [Client A] could become a threat to others and himself if he was left out in the community alone...Staff will be aware of [client A's] whereabouts at all times in the group home, at day services, and in the community. Staff will complete 15 minute checks." The assessment indicated client A did not recognize dangers in the community and was not safe in the community without staff supervision. -Client A's 1/7/2020 "Elopement Plan" indicated client A "has a history of unsafe behavior, self-injurious behaviors, and poor judgement. He is at risk for elopement. He may run away as a way to escape if he feels he's in trouble or to redirect the attention from the original issue. [Client A] may not look or stop for cars before crossing a street when he's upset. He may not know how to get back home if he were to elope. He does not display skills to be left alone for long periods of time, especially in new environments in the community. He could become a threat to others and himself if he was left out in the community alone. Previous elopements out of the staff line of sight...1/3/2020, 1/5/2020. [Client A] has caused significant damage to the wooden privacy fence in the backyard of the group home which will be expensive and time consuming to repair...Implementation. Awake staff 24 hours a			

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	day supervision...There are door bells located throughout the group home to alert staff if [client A] leaves the home. The front window in [client A's] bedroom is locked/secured to prevent elopement into the front yard. The team may add a window bell/alarm to the side window in his bedroom and a window bell/alarm to the first story windows in shared areas. The front door and outdoor gate are kept locked at the group home to ensure safety...If the door bells/locks are not functioning correctly, [the staff] will notify the House Manager." -Client A's 2/26/2020 BSP indicated the restriction of "Locked Bedroom windows and Window bell" needed for his safety and to prevent elopement behaviors. On 2/17/2020 at 8:30am, an interview was conducted with the Director of Community Living (DCL) and the ADCL (Assistant Director of Community Living). The DCL stated the facility "was struggling to meet [Client A's] behavioral needs" when he elopes from the group home. The DCL indicated no maintenance and repairs were available for review of the fence, gates, and windows. On 2/18/2021 at 9:45am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated he was not aware client A's bedroom windows did not lock and did not have alarms/bells on the windows. The QIDP indicated client A needed the bells/alarms on his windows to alert the staff when client A eloped from the group home. The QIDP indicated client A's targeted behaviors included self harm, elopement, and physical aggression.			

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	On 2/26/2021 at 3:55pm, an interview was conducted with the DCL, the ADCL, the QIDP, and the LPN (Licensed Practical Nurse). The QIDP stated "there should be an alarm in place and there once was one, but the last time [client A] eloped he broke it and it has not been fixed since the last elopement." The QIDP and the LPN both indicated client A did not realize he can hurt himself and when he is upset he cannot make good choices" to practice street safety and pedestrian safety skills. The DCL and the QIDP both indicated client A's window alarms/bells, window locks, bedroom door frame, and the backyard wooden privacy fence needed to be in good repair to protect client A from his continued elopement behaviors. The DCL indicated no documented information was available for review to determine when the repairs would be completed. 3. Please refer to W149. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the facility implemented its abuse, neglect, and mistreatment policy and procedures to ensure their system protected clients from neglect, to ensure staff supervision during incidents, to thoroughly investigate to protect the clients from the potential for neglect, and to develop and employ effective corrective measures regarding client A's continued aggression, threats of self harm, and elopement behaviors. 4. Please refer to W154: The governing body failed to exercise general policy, budget, and operating direction over the facility to complete thorough investigations into allegations of staff neglect and client A's continued elopement, self harm, and aggression behavioral incidents.			

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	5. Please refer to W157. The governing body failed to exercise general policy, budget, and operating direction over the facility to develop and employ effective corrective measures regarding client A's continued aggression, threats of self harm, and elopement behaviors. 9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H). The facility failed to ensure its abuse, neglect, and mistreatment policy and procedures protected client A from staff neglect, to complete thorough investigations, and to develop and employ effective corrective measures regarding client A's continued elopements, self harm, and physical aggression. The facility failed to ensure clients A, B, C, D, E, F, G, and H had unimpeded access to lunch box items and snack items. Findings include: 1. Please refer to W149. For 1 of 3 sampled clients (client A), the facility neglected to implement their policy and procedure to prevent staff to client neglect, to ensure staff supervision during incidents, to thoroughly investigate, and to initiate and ensure effective corrective measures were employed regarding client A's continued aggression, threats of self harm, and elopement behaviors.	W 0122	/p> The house manager has made sure that all clients have unimpeded access to their snacks and lunch boxes. They will be given choices for snacks. The House Manager will monitor staff daily to ensure that they are providing active treatment and redirection during lunch making.	03/31/2021

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	2. Please refer to W154: For 1 of 3 sampled clients (client A), the facility failed to thoroughly investigate allegations of staff neglect and client A's continued elopement, self harm, and aggression behavioral incidents. 3. Please refer to W157. For 1 of 3 sampled clients (client A), the facility failed to initiate and ensure effective corrective measures were employed regarding client A's continued aggression, threats of self harm, and elopement behaviors. 4. Please refer to W125. For 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H), the facility failed to ensure clients A, B, C, D, E, F, G, and H had unimpeded access to the locked area which stored fruit juice drinks, chips, cookies, lunch box items, and snack items. 9-3-2(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H), the facility failed to ensure clients A, B, C, D, E, F, G, and H had unimpeded access to the locked area which stored fruit juice drinks, chips, cookies, lunch box items, and snack items. Findings include:	W 0125	The house manager has made sure that all clients have unimpeded access to their snacks and lunch boxes. The clients will be given choices for snacks and lunches. The House Manager will monitor staff daily to ensure that they are providing active treatment and choices during lunch making	03/31/2021

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	On 2/17/2021 from 5:40am until 7:50am and on 2/18/2021 from 2:55pm until 5:50pm, observation and interviews were conducted at the group home with clients A, B, C, D, E, F, G, and H. On 2/17/2021 from 5:40am until 6:55am, DSP (Direct Support Professional) #2 and DSP #6 walked back and forth from the kitchen to the locked office and medication room. Each time DSP #2 and DSP #6 returned to the kitchen they carried snack items, fruit juice packets for drinks, chips, and lunch box items. At 5:55am, DSP #2 and DSP #6 laid out eight lunches of chips, a bottle of water, fruit juice mix for the water, frozen chili dogs, prepackaged cookies, individual servings of crackers and fruit cups. DSP #2 stated "this is so the clients can pack their own lunches." When asked where the food was stored, DSP #2 stated "We keep it locked in the office and medication room." When asked why the food was locked, DSP #2 stated "the clients might eat it." During the observation periods, clients A, B, C, D, E, F, G, and H did not have unimpeded access to the locked fruit juice drinks, chips, cookies, lunch box items, and snack items. On 2/18/2021 at 6:00pm, clients A, B, C, D, E, F, G, and H indicated they did not have keys to access the locked fruit juice drinks, chips, cookies, lunch box items, and snack items. At 6:00pm, clients A and C indicated they had to ask a staff to retrieve the selected item and client C stated "sometimes we have it, sometimes staff say no." Client A's record was reviewed on 2/23/21 at 10:30am. Client A's 11/17/2020 ISP (Individual Support Plan) did not indicate an identified need to restrict fruit juice drinks, chips, cookies, lunch box items, and snack items. Client B's record was reviewed on 2/23/2021 at 1:45pm. Client B's 11/4/2020 ISP (Individual		and snack time.	

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	15G802	A. BUILDING 00 B. WING	03/01/2021

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	Support Plan) did not indicate an identified need to restrict fruit juice drinks, chips, cookies, lunch box items, and snack items. Client C's record was reviewed on 2/23/2021 at 1:00pm. Client C's 9/17/2020 ISP (Individual Support Plan) did not indicate an identified need to restrict fruit juice drinks, chips, cookies, lunch box items, and snack items. On 2/26/2021 at 3:30pm, an interview was conducted with the Director of Community Living (DCL), the Assistant Director of Community Living (ADCL), the QIDP (Qualified Intellectual Disabilities Professional), and the LPN (Licensed Practical Nurse). The DCL, the QIDP, and the LPN indicated they were not aware fruit juice drinks, chips, cookies, lunch box items, and snack items were kept locked inside the office and medication room. The DCL, the QIDP, and the LPN indicated clients A, B, C, D, E, F, G, and H did not have an identified need. 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 9 of 25 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 1 of 3 sampled clients (client A), the facility neglected to implement their policy and procedure to prevent staff to client neglect, to ensure staff supervision during incidents, to thoroughly investigate, and to initiate and ensure effective corrective measures were employed regarding client A's continued aggression, threats	W 0149	Bona Vista completed a staff training on the window alarms and keeping the doors and windows to the home locked at all time to ensure the safety of all clients. Bona Vista repaired Client A's door frame on 3/3/21. Alarms were installed on the targeted windows of the home to ensure Client A's safety and elopement	03/31/2021

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	of self harm, and elopement behaviors. Findings include: On 2/17/2021 from 5:40am until 7:50am, on 2/17/2021 from 2:15pm until 2:55pm, and on 2/18/2021 from 2:55pm until 5:50pm, observation and interviews were conducted at the group home with client A. During the observation periods, the backyard gates were locked, multiple pickets within the wooden fence around the backyard were missing, the side gate entrance to the group home was not locked and was opened without entering a key code, and two of two bedroom windows for client A's bedroom were not locked and no alarms were observed. During the observation periods, client A's bedroom door was able to be locked from the inside and client A's roommate was present inside the shared bedroom. The bedroom door had a half inch space around the door frame which showed light from the inside of the bedroom with the door securely shut. On 2/17/2021 from 5:40am until 6:55am, client A was inside his bedroom, lay in his bed, and was reading the screen on his IPad which glowed in the dark. From 5:40am until 6:55am, DSP (Direct Support Professional) #2 and DSP #6 did not check and/or open client A's bedroom door. On 2/17/2021 at 7:30am, an interview was conducted with client A. Client A stated "They (the staff) think I don't know the codes for the doors, well I do. I can leave when I want." When asked how he left the group home, client A stated "I go out one of my windows." Client A then opened both of his bedroom windows repeatedly and stated "See, nobody comes." No staff responded to client A opening/closing the bedroom windows repeatedly and no alarms sounded. Client A stated "I'm in trouble right		plan were followed. Fifteen minute safety checks were implemented for Client A's safety. All staff in the home were trained on his BSP and the fifteen minute checks. The House Manager will ensure and monitor that staff are documenting on Client A's safety checks daily. Staff will know the whereabouts of Client A at all times. Staff will listen for the newly installed window alarms and check on Client A every 15 minutes. Staff will ensure that they are using the code to the gate and that all doors and gates are locked at all times. Bona Vista requires that two staff be on shift at all times. Bona Vista usually has more and will try to staff this home with 3 at all times.	

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	now. I'm not supposed to have my IPad because I stalked a girl on the phone and my IPad about a week ago. I downloaded an app (from the Internet) that redials constantly the same number. I can go do other things when this app is on, it just keeps calling that number. I made some threats to the girl and to the girl's mom when her mom answered the phone. That scared me. So I got off of it (the app). Well her mom about two or three days later called the IPad or the phone of my housemate, I can't remember. Well anyway, her mom said Hey you didn't think I would find you, did you. Stop this now." Client A stated "My staff said I could have been arrested for stuff like this. So I don't do that no more." Client A refused to identify the staff who took the call on the housemate's phone or the housemate's phone which was used during his recall incident. Client A stated "I get physical sometimes. I leave without staff knowing. It's my behavior." On 2/17/2021 at 5:40am, an interview with DSP (Direct Support Professional) #2 and DSP #6 was conducted. DSP #2 and DSP #6 both stated "We only check on clients about every half hour or forty-five minutes." When asked if staff check on clients more often, both staff stated "We check on [client A] every 15 minutes but only if he is on suicide watch. That's the only time." On 2/17/2021 at 2:30pm, an interview with DSP #1 and DSP #3 was conducted. DSP #1 and DSP #3 both stated they check on clients out of their eye sight "about every 20-30 minutes" to allow private time in their bedrooms. DSP #2 and DSP #3 stated "We only check on clients every 15 minutes like [client A] when he is on suicide watch." On 2/18/2021 at 9:15am, the facility's BDDS (Bureau of Developmental Disabilities Services)			

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	Reports and investigations were reviewed from 1/15/2020 through 2/18/2021 and indicated the following: 1. A 1/26/2021 BDDS report for an incident on 1/25/2021 at 10:30pm indicated client A "eloped from the [name of group home] at 10:30pm due to being upset about having (his) IPad (an Internet device to listen and view information) confiscated due to HRC (Human Rights Committee) approved restriction past 10:00pm. Police were called and they took [client A] to [name of hospital] room under his own reconnaissance to be evaluated for feet soreness. Talked [client A] down (sic) and redirected [client A] to want to go back home. [Client A] went to bed...Staff called House Manager and then House Manager called QIDP (Qualified Intellectual Disabilities Professional)." No investigation was available for review. 2. A 9/12/2020 BDDS report for an incident on 9/11/2020 at 9:25pm indicated client A "had a disagreement with staff which led to [client A] locking himself in (his) room with roommate who was asleep. [Client A] threatened to hurt roommate in which staff called on call team lead, House Manager, and the QIDP. When staff were able to get into room, [client A] had already jumped out of the window and broke through fenced in backyard. Police were then called to help find [client A]. [Client A] was found by police and was transported to [name of hospital] emergency room for self harm/suicide idealization. Due to frequent behaviors of self harm and permission of his psychiatrist nurse of counseling center [client A] will be recommended for neuropsych admission in [name of town] for evaluation and care." The 9/11/2020 "Investigation" indicated "Why			

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	[client A] eloped from the home and what]occurred when he eloped from the home." The 9/11/2020 investigation indicated "Findings: [Client A] had eloped from the home. [Client A] at the time due to there only being 2 staff on shift at the time of the incident (sic). The staff contacted police. [Client A] was then found by the police and taken to the hospital due to self harm/suicide idealization. The staff that were working at the time of the incident...both stated [client A] got upset with them because they informed him that he could not be in one of his housemate's bedrooms. [Client A] then got upset and went outside. They stated that when [client A] was outside he was throwing things at the van. He then tried to break the fence to get out of the yard. The staff stated that they were talking to [client A] and trying to get him to go back into the house. They stated that he then broke a cologne bottle that he had found and tried to cut himself with the glass. The staff stated that they were able to get the glass away from [client A]. They stated that [client A] then started yelling at the staff and went back into the house. They stated that he then went into his bedroom and put things in front of the door so that staff could not get into the room. They stated that he was then saying that he was going to hurt his roommate that was asleep in the room at the time. The staff stated that when they were finally able to get the door pushed open to his bedroom they noticed that he had jumped out of the window, broke some of the fence where he had made a hole, and had run from the home. They immediately called the House Manager, who then instructed them to call the police. The police then found [client A] and took him to the hospital due to him trying to hurt himself. [Client A] stated that he got mad at the staff because he wanted to go in a housemate's bedroom and play a game, but they told him that			

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	he couldn't go in the room. He stated that he then went outside and was trying to calm down, but the staff followed him and made him more upset. He stated that he then picked up a piece of glass to try and cut himself because he wanted to scare the staff and make them leave him alone. He stated that he then went inside to his bedroom and decided to try to leave the house to get away from everyone. He stated he does not want to be at the home anymore and wants to move. He stated that he knew he shouldn't have done what he did. He stated that he was sorry and didn't want to get anyone in trouble. He also stated that he didn't really want to hurt himself, but that he just wanted to scare the staff so they would leave him alone. He stated that he knew he needed to stop leaving the house because he wants to move and he is not helping himself by running away all the time. He stated that he left the house because he knew the staff couldn't follow him and he would be able to be by himself for a while to calm down. It is recommended that the staff continue to follow the Behavior Support Plan (BSP) that is in place for [client A]." The investigation did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. 3. A 9/3/2020 BDDS report for an incident on 9/3/2020 at 10:30am indicated client A "eloped from day services in which staff maintained the sight while [client A] left day services with staff in pursuit. When [client A] was caught up with, [client A] then followed staff back to the day program then eloped again. They (the staff) followed again and police caught up to [client A] in which staff did not call. [Client A] willingly went with police and was taken to the house (group home) in which he decided to take PRN (as			

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	needed medication for behaviors) and rest in his bedroom to calm down...[Client A] got into a disagreement with another person served in which [client A] became upset." No investigation was available for review. 4. An 8/23/2020 BDDS report for an incident on 8/23/2020 at 12:00am indicated client A "had jumped out of another persons served bedroom window during the night. Staff were notified at 5:00am by the [name of city] police department that [client A] had been taken to [name of hospital] ER by EMS (Emergency Medical Services) and was admitted at 12:06am. [Client A] was picked up from the ER at 5:35am and taken back to the group home. Both staff were suspended pending investigation. All staff are trained on midnight duties and check lists. All staff are trained on [client A's] BSP and risk plans before working with him." The 8/25/2020 "Investigation" indicated "On Sunday 8/23/2020 at 5:00am the police arrived at the group home and informed staff that [client A] was in the hospital after he had eloped from the home, and was picked up by the police and taken to the hospital." The investigation indicated both staff were suspended. The investigation indicated "On Saturday 8/22/2020 at 10:00pm both staff went into [client A's] bedroom and told him that it was time for him to turn his IPad into the staff for the evening. The staff stated that this had been HRC approved for every night. However, it was only HRC approved for staff to take the IPad from [client A] during the weeks at 10pm not on the weekends. They stated that [client A] got upset with staff and refused to turn the IPad in. Staff then left his room for a while. The staff then went and helped another housemate clean himself up after he had an			

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	accident. After staff helped the other housemate they went back to [client A] and informed him it was time to give staff the IPad, he again refused. Staff stated that [client A] then went into the kitchen and got a drink and went back to his bedroom. They stated that he then entered the living room, didn't say anything to him, nothing was said to him by staff, and then he went back into his bedroom again. Staff stated that she was walking in the hallway when she saw [client A] in the dark with his combat gloves on, his mouthpiece in, and his shoes on. Staff stated that she didn't say anything to him because he looked like he was ready to fight her. Staff checked on [client A] at 10:45pm and 11pm, and he was just sitting on his bed in his bedroom. [DSP (Direct Support Professional) #10] stated that she dozed off from 11:30 or 12am to about 2:00am. She stated that when she opened her eyes she started to clean the house again...They stated that then at 5:00am the police knocked on the door and informed them that they had a person served that had left the house and had been picked up at 12:06am by the police and taken to the hospital...Both the staff admitted to not doing the 15 minute checks on the persons served throughout the entire night...[Client A] stated that after the staff checked on him a few times he went into his housemates bedroom and moved his bed and chair around in his room and then jumped out the bedroom window and started running. He stated that after he had been gone from the house for a while his legs started to hurt so he fell in the middle of the road and rolled to the side of the road because he didn't want to get run over. He stated that the police showed up and took him to the hospital. He stated that when he woke up at the hospital the house manager was there and took him home...Due to the staff admitting to not completing the 15 minute checks on the persons			

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	served throughout the night causing them not to know that [client A] had eloped from the home, the allegations of neglect are substantiated. Due to the allegation of neglect being substantiated both of the staff will be put on a last chance agreement." The investigation was not thorough in that it did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. 5. A 7/4/2020 BDDS report for an incident on 7/3/2020 at 4:30pm indicated client A "was having troubles working his new IPad and became very agitated according to staff at the house at the time. When [client A] returned to his room he jumped out of his bedroom (window) which is approximately 6 to 7 feet off the ground. When he jumped out the window he proceeded to break a way through the fence and eloped. Staff maintained visual while [client A] ran off the property in which staff pursued. Team lead was called also with Director on call in which then was relayed to the author of the circumstances. While in pursuit, authorities spotted [client A] and pulled over and arrested him due to self injury idealization. Police took [client A] to the hospital in which he was later admitted to neuropsych hospital...[Client A] receives 24/7 (twenty-four hours a day/seven days a week) staff supervision at the group home. There is HRC and guardian approval for all sharp knives and sharp utensils to be kept in a locked box at the group home for the safety of all persons served. There is HRC approved for the gates to be locked to ensure safety." No investigation was available for review. 6. A 6/29/2020 BDDS report for an incident on 6/27/2020 at 8:00pm indicated client A "was			

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	feeling angry and upset all day and became very agitated when he was asked to not go outside while it was raining. [Client A] jumped out his bedroom window and broke part of the fence to elope from the group home. Staff notified [House Manager]. Staff were instructed to call police to notify them of the elopement from the group home. The House Manager found [client A] at the [name of gas station]. [Client A] was still upset...[Client A] did have a scrape on his right forearm about 3 inches by 1 inch and on his right chin about 2 inches by 1 inch from jumping out his bedroom window." The 7/6/2020 "Investigation" indicated "On 6/27/2020 it was brought to the attention of the House Manager...[client A] had eloped from the home and was out of the line of sight. The House Manger instructed staff to call 9-1-1 and report that [client A] had left the home and then informed the staff that she was leaving her home to start looking for [client A]. There were two staff working when [client A] eloped...They both stated that [client A] had been wrestling/horseplay with another one of his housemates. The staff then stated that [client A] became irritated and upset when they asked him to stop wrestling/horseplay...They stated that [client A] then asked if he could go outside to play basketball for a while. They stated that when they informed [client A] that he needed to stay in the home due to it raining outside he became even more upset and agitated. They stated that [client A] went into his bedroom and called his grandmother. They stated that when he got off of the phone with his grandmother, he jumped out of his bedroom window, broke the fence, and eloped from the home. They stated that before [client A] jumped out of his bedroom window he informed staff from his bedroom that he was going to go			

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	live with his grandmother. They stated that when they contacted the [name of house manager] they informed her of everything that had happened. They also stated that when they contacted the house manager she informed them that they needed to call 9-1-1. They stated they stated that when they got off of the phone with the house manager, they then called 9-1-1 and reported that [client A] had eloped from the home. They both stated another client was having behaviors at the same time and that neither of the staff followed [client A] when he eloped due to it only being the two of them and one of the other persons served in the home was a two staff at all times staff supervision...The staff stated that from the time that [client A] left the home until he returned to the home he was gone for about 17 minutes. They stated that the house manager was the one that found [client A] at [name of gas station] and then brought him back to the house." The investigation was not thorough in that it did not include how many staff should have been scheduled for seven clients based on their identified supervision needs. 7. A 5/12/2020 BDDS report for an incident on 5/11/2020 at 6:00pm indicated client H "became upset and was threatening the staff to hit them. [Client A] came into the kitchen and asked what was going on and [client H] ran outside into the back yard. [Client A] followed [client H] outside. [Client H] tried to break the fence and [client A] pulled [client H] off the fence and hit [client H] in the head. Staff separated the two of them and [client A] went back into the house...[Client H] had a small scratch and bruise on his left upper forehead area. Scratches and bruise measure 2cm (centimeters) in length." The 5/11/2020 "Investigation" indicated "Results			

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	of Investigation: It was determined through a thorough investigation that this was a simple peer to peer aggression due to [client A] responding to [client H] in a negative manner. [Client H] was arguing with staff in the kitchen. The staff was attempting to talk to [client H] and get him to calm down. The staff stated that [client H] was yelling at staff for apparent reason. [Client H] then got even more upset with staff and ran out the door into the backyard and attempted to elope through the fence. [Client A] was in his bedroom when [client H] was yelling at the staff...[Client A] went into the kitchen to see what was going on. [Client A] then went outside where [client H] was. Staff member then went outside behind [client A] . The staff attempted to talk to [client A] and tell him to let him handle [client H] to get him to go back in the home. [Client A] then grabbed [client H] by the back and pulled him to the ground. [Client H] started kicking [client A] and then [client A] started hitting [client H] in the head. The staff was able to get them separated." The investigation was not thorough in that it did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. 8. A 3/15/2020 BDDS report for an incident on 3/14/2020 at 12:50pm indicated client A "became agitated at lunch over the way staff was having the guys rinse their dishes off. [Client A] tied a shoestring around his neck and went outside. Staff talked to him and he immediately took it off. He was trying to calm down and asked for a PRN (as needed behavior medication) to help him." The 3/14/2020 "Investigation of Significant Injury" indicated client A "got upset with staff and went outside the home and wrapped his			

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	shoestring around his neck. [Client A] did not receive any injury from the shoestring." The investigation did not address how client A had shoestrings available for his use. The investigation was not thorough in that it did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. A 4/28/2020 BDDS report for an incident on 4/22/2020 at 5:00pm indicated client A "is still a patient at [name of behavioral hospital] There is no known date of discharge at this time. [Client A] sees a licensed clinical social worker for routine counseling...All behaviors are documented...[Client A's] front bedroom windows locked with HRC approval to prevent elopement by him and his roommate. [Client A's] rear bedroom window leads to the backyard, which is fenced in with locked gates to reduce risk of elopement. The front door and outdoor gates are locked to ensure safety." The BDDS report indicated client A's hospitalization was because of increased behaviors of self harm, elopement, and aggression. 9. A 2/18/2020 BDDS report for an incident on 2/17/2020 at 6:45pm indicated client A "was taking a nap and became agitated when prompted to wake up for dinner on 2/17/2020 around 6:35pm. He refused to wake up for dinner so the staff gave him space and then time to wake up. [Name of city] police called the House Manager on 2/17/2020 around 6:45pm and notified them [client A] called 9-1-1 and was at the gas station about 2/3 (two thirds) mile away from the home. [Client A] threatened to harm himself. [Client A] reported he jumped out his bedroom window, broke the fence behind the shed, and ran out the broken			

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	fence. The House Manager notified the IDT (Interdisciplinary Team) around 6:50pm. Police officers transported [client A] to [name of hospital] emergency room. [Client A] was assessed by a crisis therapist. [Client A] reported he was depressed and having suicidal and homicidal ideation. [Client A] waited in the ER (Emergency Room) until a bed became available...No known discharge date...Client A] sees a licensed clinical social worker for routine counseling...All behaviors are documented... [Client A's] front bedroom windows locked with HRC approval to prevent elopement by him and his roommate. [Client A's] rear bedroom window leads to the backyard, which is fenced in with locked gates to reduce risk of elopement. The front door and outdoor gates are locked to ensure safety." The 2/18/2020 "Investigation" indicated "On Monday 2/17/2020 at 6:35pm, the House Manager was contacted by the [name of city] police department that they had [client A] at the [name of gas station] and he was telling them that he was going to hurt himself and that he was off all of his medications. [Name of house manager] contacted the staff at the home and asked them where [client A] was and they told her that he was sin his bedroom asleep. She instructed them to go in [client A's] room and check on him. The staff then realized that [client A] was gone. They stated that he had pushed his television over by the window to use as a step to jump out of the bedroom window. The staff then went outside and looked around...found a hole in the fence behind the shed where [client A] had escaped through...[Client A] was admitted to the hospital...The staff that were working at the home stated that one staff had gotten home with groceries prior to [client A] leaving and they			

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	asked [client A] to help carry the groceries and he refused. They stated that they then asked him to go to the dining room to eat dinner and he refused to eat saying that he wasn't hungry and just wanted to sleep. The staff stated that it was only 10 to 15 minutes later and [name of house manager] was calling saying that [client A] wasn't at the home and had eloped to the gas station....They (the staff) stated that they normally check on them (the clients) every 15 to 20 minutes...The staff that were working at the time of the incident were asked if they are supposed to check on [client A] every 15 minutes while they are on shift, and they all said that they don't have to check on him every 15 minutes unless he is on suicide watch, however, they stated that they do check on him even through they don't have to. However, [client A's] Behavior Support Plan stated that staff will check on him every 15 minutes to make sure that he is okay. Due to the staff stating that they do not have to check on [client A] every 15 minutes while they are on shift, all of the staff in the home will be retrained on [client A's] Behavior Support Plan." The investigation was not thorough in that it did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. Client A's record was reviewed on 2/23/2021 at 10:30am. Client A's 11/17/2020 ISP (Individual Support Plan) and 2/26/2020 BSP (Behavior Support Plan) indicated the targeted behaviors of elopement, self harm, and physical aggression. Client A's ISP and BSP indicated client A was to have been checked on "every 15 minutes" by his supervising staff. Client A's 11/17/2020 "Life Domain" assessment indicated "Level of Supervision: [Client A] does not display skills to			

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	be left alone for long periods of time, especially in new environments in the community. [Client A] could become a threat to others and himself if he was left out in the community alone...Staff will be aware of [client A's] whereabouts at all times in the group home, at day services, and in the community. Staff will complete 15 minute checks." The assessment indicated client A did not recognize dangers in the community and was not safe in the community without staff supervision. -Client A's 1/7/2020 "Elopement Plan" indicated client A "has a history of unsafe behavior, self-injurious behaviors, and poor judgement. He is at risk for elopement. He may run away as a way to escape if he feels he's in trouble or to redirect the attention from the original issue. [Client A] may not look or stop for cars before crossing a street when he's upset. He may not know how to get back home if he were to elope. He does not display skills to be left alone for long periods of time, especially in new environments in the community. He could become a threat to others and himself if he was left out in the community alone. Previous elopements out of the staff line of sight...1/3/2020, 1/5/2020. [Client A] has caused significant damage to the wooden privacy fence in the backyard of the group home which will be expensive and time consuming to repair...Implementation. Awake staff 24 hours a day supervision...There are door bells located throughout the group home to alert staff if [client A] leaves the home. The front window in [client A's] bedroom is locked/secured to prevent elopement into the front yard. The team may add a window bell/alarm to the side window in his bedroom and a window bell/alarm to the first story windows in shared areas. The front door and outdoor gate are kept locked at the group home to ensure safety...If the door bells/locks are not			

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	functioning correctly, [the staff] will notify the House Manager...If [client A] starts to elope...the staff will keep him within line of sight to ensure [client A's] safety then notify the on call, House Manager, or QIDP immediately...A staff will drive or walk to follow him...If out of line of sight, call 9-1-1, then the QIDP, and keep looking for [client A]." No plan revisions were available for review. -Client A's 2/26/2020 BSP indicated the restriction of "Locked Bedroom windows and Window bell" needed for his safety and to prevent elopement behaviors. Client A's BSP indicated the restriction from his IPad after not sleeping at night. The restriction indicated staff will ask for client A's IPad Sunday through Thursday nights at 10:00pm to lock client A's IPad in the office until the next morning when client A wakes for the day. The restriction was the result of client A's lack of sleep and rest at night. -Client A's record did not indicate IDT (Interdisciplinary Team) meetings to determine the team had met to review client A's continued behaviors and plans. Client A's record indicated his ISP and BSP were not revised from 1/2020 through 11/17/2020 after each elopement behavior to add effective corrective measures. Client A's BSP did not include the behavior of stalking his girlfriends over the telephone and no plan was in place. On 2/17/2020 at 8:30am, an interview was conducted with the Director of Community Living (DCL) and the ADCL (Assistant Director of Community Living). The DCL and the ADCL both indicated the facility followed the BDDS reporting and investigating policy and procedure to complete reporting for each incident, to thoroughly investigate allegations of abuse,			

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	neglect, and/or mistreatment, and to initiate effective corrective action to prevent a future incident from occurring. The DCL and the ADCL both indicated the BDDS reports and the investigation summaries into the allegations and client A's continued behaviors of self harm, elopement, and aggression substantiated staff neglect of client A. The DCL stated the facility "was struggling to meet [Client A's] behavioral needs" when he elopes from the group home. The DCL indicated neglect was the failure to ensure staff provided and clients received supervision and supports which each client needed. The DCL indicated neglect was the failure to provide appropriate care, food, medical care, or staff supervision. On 2/18/2021 at 9:45am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the staff failed to implement client A's plans correctly when client A eloped from the group home. The QIDP indicated he was not aware client A's bedroom windows did not lock and did not have alarms/bells on the windows. The QIDP indicated client A needed the bells/alarms on his windows to alert the staff when client A eloped from the group home. The QIDP indicated client A's targeted behaviors included self harm, elopement, and physical aggression. The QIDP indicated there were no IDT (Interdisciplinary Team) meetings available for review to determine the team had met to reviewed client A's continued behaviors. The QIDP stated the staff "have to know where [client A] was all the time." The QIDP indicated client A's ISP and BSP had not been revised since 11/17/2020. The QIDP indicated client A's ISP and BSP were not revised from 1/2020 through 11/17/2020 after each elopement behavior to add effective corrective			

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	measures. The QIDP indicated he did not determine staffing ratios for how many staff were scheduled at the group home. The QIDP stated clients A and H had the identified need of having two staff in the home "at all times" because of their history of physical aggression and client H's falls with significant injuries. The QIDP indicated when there were two staff on duty in the home and no behaviors taking place the home was meeting the staffing ratios. The QIDP stated when client A eloped from the home and "If a staff followed [client A]" that would leave one staff in the home with 6 clients including client H who needed two staff on duty at the home "at all times." The QIDP stated the staff should be checking and "laying eyes on [client A] every 15 minutes." The QIDP indicated neglect was the failure to provide appropriate care, food, medical care, or supervision. On 2/26/2021 at 3:55pm, an interview was con ducted with the DCL, the ADCL, the QIDP, and the LPN (Licensed Practical Nurse). The QIDP stated "We have talked about" client A's behavior of stalking his girlfriends over the telephone and no plan was in place. The QIDP stated "there should be an alarm in place and there once was one, but the last time [client A] eloped he broke it and it has not been fixed since the last elopement." The QIDP and the LPN both indicated client A did not realize he can hurt himself and when he is upset he cannot make good choices" to practice street safety and pedestrian safety skills. The DCL, the ADCL, and the QIDP			

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	indicated there were not additional investigations regarding client A's elopements documented on BDDS reports on 1/25/21, 9/3/2020, and 7/4/2020. The DCL indicated the agency should have documented effective corrective action and completed thorough investigations regarding allegations of staff to client neglect.On 2/17/2021 at 8:30am, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." The policy and procedure indicated allegations of abuse, neglect, and mistreatment should be immediately reported to the agency's administrator and to BDDS in accordance			

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	with State Law and thoroughly investigated.On 2/17/2021 at 8:30am, a record review of the facility's undated policy and procedures for Abuse, Neglect, and Exploitation indicated "Abuse, Neglect, Exploitation" neglect was defined as "failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to (sic) an individual's psychological and social wellbeing. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment...." The policy and procedure indicated allegations of abuse, neglect, and mistreatment should be thoroughly investigated. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 9 of 25 BDDS (Bureau of Developmental Disabilities reports and investigations reviewed for 1 of 3 sampled clients (client A), the facility failed to thoroughly investigate allegations of staff neglect and client A's continued elopement, self harm, and aggression behavioral incidents. Findings include: On 2/18/2021 at 9:15am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 1/15/2020 through 2/18/2021 and indicated the following:	W 0154	Bona Vista will ensure that all investigations are done correctly and thoroughly. The Quality Assurance Coordinator will document and investigate each investigation for Abuse, Neglect, and Exploitation completely. The Quality Assurance Coordinator will submit all investigations to the Vice President of Community Living and Residential Services, Director of Community living, and the Assistant Director of Community Living for review and signatures. All four persons of management will review the	03/31/2021

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	1. A 1/26/2021 BDDS report for an incident on 1/25/2021 at 10:30pm indicated client A "eloped from the [name of group home] at 10:30pm due to being upset about having (his) IPad confiscated due to HRC (Human Rights Committee) approved restriction past 10:00pm. Police were called and they took [client A] to [name of hospital] room under his own reconnaissance to be evaluated for feet soreness. Talked [client A] down (sic) and redirected [client A] to want to go back home. [Client A] went to bed...Staff called House Manager and then House Manager called QIDP (Qualified Intellectual Disabilities Professional)." No investigation was available for review. 2. A 9/12/2020 BDDS report for an incident on 9/11/2020 at 9:25pm indicated client A "had a disagreement with staff which led to [client A] locking himself in (his) room with roommate who was asleep. [Client A] threatened to hurt roommate in which staff called on call team lead, House Manager, and the QIDP. When staff were able to get into room, [client A] had already jumped out of the window and broke through fenced in backyard. Police were then called to help find [client A]. [Client A] was found by police and was transported to [name of hospital] emergency room for self harm/suicide idealization. Due to frequent behaviors of self harm and permission of his psychiatrist nurse of counseling center [client A] will be recommended for neuropsych admission in [name of town] for evaluation and care." The 9/11/2020 "Investigation" indicated reason for investigation "Why [client A] eloped from the home and what occurred when he eloped from the home." The 9/11/2020 investigation indicated "Findings: Substantiated...Not substantiated. [Client A] had eloped from the home. [Client A] at		investigations for thoroughness and accuracy and make sure it pertains all pertinent information.	

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	the time due to there only being 2 staff on shift at the time of the incident (sic). The staff contacted police. [Client A] was then found by the police and taken to the hospital due to self harm/suicide idealization. The staff that were working at the time of the incident...both stated [client A] got upset with them because they informed him that he could not be in one of his housemate's bedrooms. [Client A] then got upset and went outside. They stated that when [client A] was outside he was throwing things at the van. He then tried to break the fence to get out of the yard. The staff stated that they were talking to [client A] and trying to get him to go back into the house. They stated that he then broke a cologne bottle that he had found and tried to cut himself with the glass. The staff stated that they were able to get the glass away from [client A] They stated that [client A] then started yelling at the staff and went back into the house. They stated that he then went into his bedroom and put things in front of the door so that staff could not get into the room. They stated that he was then saying that he was going to hurt his roommate that was asleep in the room at the time. The staff stated that when they were finally able to get the door pushed open to his bedroom they noticed that he had jumped out of the window, broke some of the fence where he had made a hole, and had run from the home. They immediately called the House Manager, who then instructed them to call the police. The police then found [client A] and took him to the hospital due to him trying to hurt himself. [Client A] stated that he got mad at the staff because he wanted to go in a housemate's bedroom and play a game, but they told him that he couldn't go in the room. He stated that he then went outside and was trying to calm down, but the staff followed him and made him more upset. He stated that he then picked up a piece of glass			

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	to try and cut himself because he wanted to scare the staff and make them leave him alone. He stated that he then went inside to his bedroom and decided to try to leave the house to get away from everyone. He stated he does not want to be at the home anymore and wants to move. He stated that he knew he shouldn't have done what he did. He stated that he was sorry and didn't want to get anyone in trouble. He also stated that he didn't really want to hurt himself, but that he just wanted to scare the staff so they would leave him alone. He stated that he knew he needed to stop leaving the house because he wants to move and he is not helping himself by running away all the time. He stated that he left the house because he knew the staff couldn't follow him and he would be able to be by himself for a while to calm down. It is recommended that the staff continue to follow the Behavior Support Plan (BSP) that is in place for [client A]." The investigation was not thorough in that it did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. The investigation did not include whether the alarms in place functioned. 3. A 9/3/2020 BDDS report for an incident on 9/3/2020 at 10:30am indicated client A "eloped from day services in which staff maintained the sight while [client A] left day services with staff in pursuit. When [client A] was caught up with, [client A] then followed staff back to the day program then eloped again. They (the staff) followed again and police caught up to [client A] in which staff did not call. [Client A] willingly went with police and was taken to the house (group home) in which he decided to take PRN (as needed medication for behaviors) and rest in his bedroom to calm down...[Client A] got into a			

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	disagreement with another person served in which [client A] became upset." No investigation was available for review. 4. An 8/23/2020 BDDS report for an incident on 8/23/2020 at 12:00am indicated client A "had jumped out of another persons served bedroom window during the night. Staff were notified at 5:00am by the [name of city] police department that [client A] had been taken to [name of hospital] ER by EMS (Emergency Medical Services) and was admitted at 12:06am. [Client A] was picked up from the ER at 5:35am and taken back to the group home. Both staff were suspended pending investigation. All staff are trained on midnight duties and check lists. All staff are trained on [client A's] BSP and risk plans before working with him." The 8/25/2020 "Investigation" indicated "On Sunday 8/23/2020 at 5:00am the police arrived at the group home and informed staff that [client A] was in the hospital after he had eloped from the home, and was picked up by the police and taken to the hospital." The investigation indicated both staff were suspended. The investigation indicated "On Saturday 8/22/2020 at 10:00pm both staff went into [client A's] bedroom and told him that it was time for him to turn his IPad into the staff for the evening. The staff stated that this had been HRC approved for every night. However, it was only HRC approved for staff to take the IPad from [client A] during the weeks at 10pm not on the weekends. They stated that [client A] got upset with staff and refused to turn the IPad in. Staff then left his room for a while. The staff then went and helped another housemate clean himself up after he had an accident. After staff helped the other housemate they went back to [client A] and informed him it			

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	was time to give staff the IPad, he again refused. Staff stated that [client A] then went into the kitchen and got a drink and went back to his bedroom. They stated that he then entered the living room, didn't say anything to him, nothing was said to him by staff, and then he went back into his bedroom again. Staff stated that she was walking in the hallway when she saw [client A] in the dark with his combat gloves on, his mouthpiece in, and his shoes on. Staff stated that she didn't say anything to him because he looked like he was ready to fight her. Staff checked on [client A] at 10:45pm and 11pm, and he was just sitting on his bed in his bedroom. [DSP (Direct Support Professional) #10] stated that she dozed off from 11:30 or 12am to about 2:00am. She stated that when she opened her eyes she started to clean the house again...They stated that then at 5:00am the police knocked on the door and informed them that they had a person served that had left the house and had been picked up at 12:06am by the police and taken to the hospital...Both the staff admitted to not doing the 15 minute checks on the persons served throughout the entire night...[Client A] stated that after the staff checked on him a few times he went into his housemates bedroom and moved his bed and chair around in his room and then jumped out the bedroom window and started running. He stated that after he had been gone from the house for a while his legs started to hurt so he fell in the middle of the road and rolled to the side of the road because he didn't want to get run over. He stated that the police showed up and took him to the hospital. He stated that when he woke up at the hospital the house manager was there and took him home...Due to the staff admitting to not completing the 15 minute checks on the persons served throughout the night causing them not to know that [client A] had eloped from the home,			

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	the allegations of neglect are substantiated. Due to the allegation of neglect being substantiated both of the staff will be put on a last chance agreement." The investigation was not thorough in that it did not include how many staff should have been scheduled for seven clients based on their identified supervision needs. The investigation did not include whether the alarms in place functioned. 5. A 7/4/2020 BDDS report for an incident on 7/3/2020 at 4:30pm indicated client A "was having troubles working his new IPad and became very agitated according to staff at the house at the time. When [client A] returned to his room he jumped out of his bedroom (window) which is approximately 6 to 7 feet off the ground. When he jumped out the window he proceeded to break a way through the fence and eloped. Staff maintained visual while [client A] ran off the property in which staff pursued. Team lead was called also with Director on call in which then was relayed to the author of the circumstances. While in pursuit, authorities spotted [client A] and pulled over and arrested him due to self injury idealization. Police took [client A] to the hospital in which he was later admitted to neuropsych hospital...[Client A] receives 24/7 (twenty-four hours a day/seven days a week) staff supervision at the group home. There is HRC and guardian approval for all sharp knives and sharp utensils to be kept in a locked box at the group home for the safety of all persons served. There is HRC approved for the gates to be locked to ensure safety." No investigation was available for review. 6. A 6/29/2020 BDDS report for an incident on 6/27/2020 at 8:00pm indicated client A "was feeling angry and upset all day and became very			

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	agitated when he was asked to not go outside while it was raining. [Client A] jumped out his bedroom window and broke part of the fence to elope from the group home. Staff notified [House Manager]. Staff were instructed to call police to notify them of the elopement from the group home. The House Manager found [client A] at the [name of gas station]. [Client A] was still upset...[Client A] did have a scrape on his right forearm about 3 inches by 1 inch and on his right chin about 2 inches by 1 inch from jumping out his bedroom window." The 7/6/2020 "Investigation" indicated "On 6/27/2020 it was brought to the attention of the House Manager...[client A] had eloped from the home and was out of the line of sight. The House Manger instructed staff to call 9-1-1 and report that [client A] had left the home and then informed the staff that she was leaving her home to start looking for [client A]. There were two staff working when [client A] eloped...They both stated that [client A] had been wrestling/horseplay with another one of his housemates. The staff then stated that [client A] became irritated and upset when they asked him to stop wrestling/horseplay...They stated that [client A] then asked if he could go outside to play basketball for a while. They stated that when they informed [client A] that he needed to stay in the home due to it raining outside he became even more upset and agitated. They stated that [client A] went into his bedroom and called his grandmother. They stated that when he got off of the phone with his grandmother, he jumped out of his bedroom window, broke the fence, and eloped from the home. They stated that before [client A] jumped out of his bedroom window he informed staff from his bedroom that he was going to go live with his grandmother. They stated that when			

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	they contacted the [name of house manager] they informed her of everything that had happened. They also stated that when they contacted the house manager she informed them that they needed to call 9-1-1. They stated they stated that when they got off of the phone with the house manager, they then called 9-1-1 and reported that [client A] had eloped from the home. They both stated another client was having behaviors at the same time and that neither of the staff followed [client A] when he eloped due to it only being the two of them and one of the other persons served in the home was a two staff at all times staff supervision...The staff stated that from the time that [client A] left the home until he returned to the home he was gone for about 17 minutes. They stated that the house manager was the one that found [client A] at [name of gas station] and then brought him back to the house." The investigation was not thorough in that it did not include how many staff should have been scheduled for seven clients based on their identified supervision needs. The investigation did not include whether the alarms in place functioned. 7. A 5/12/2020 BDDS report for an incident on 5/11/2020 at 6:00pm indicated client H "became upset and was threatening the staff to hit them. [Client A] came into the kitchen and asked what was going on and [client H] ran outside into the back yard. [Client A] followed [client H] outside. [Client H] tried to break the fence and [client A] pulled [client H] off the fence and hit [client H] in the head. Staff separated the two of them and [client A] went back into the house...[Client H] had a small scratch and bruise on his left upper forehead area. Scratches and bruise measure 2cm (centimeters) in length."			

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	The 5/11/2020 "Investigation" indicated "Results of Investigation: It was determined through a thorough investigation that this was a simple peer to peer aggression due to [client A] responding to [client H] in a negative manner. [Client H] was arguing with staff in the kitchen. The staff was attempting to talk to [client H] and get him to calm down. The staff stated that [client H] was yelling at staff for apparent reason. [Client H] then got even more upset with staff and ran out the door into the backyard and attempted to elope through the fence. [Client A] was in his bedroom when [client H] was yelling at the staff...[Client A] went into the kitchen to see what was going on. [Client A] then went outside where [client H] was. Staff member then went outside behind [client A] . The staff attempted to talk to [client A] and tell him to let him handle [client H] to get him to go back in the home. [Client A] then grabbed [client H] by the back and pulled him to the ground. [Client H] started kicking [client A] and then [client A] started hitting [client H] in the head. The staff was able to get them separated." The investigation was not thorough in that it did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. 8. A 3/15/2020 BDDS report for an incident on 3/14/2020 at 12:50pm indicated client A "became agitated at lunch over the way staff was having the guys rinse their dishes off. [Client A] tied a shoestring around his neck and went outside. Staff talked to him and he immediately took it off. He was trying to calm down and asked for a PRN (as needed behavior medication) to help him." No effective corrective measures were available for review.			

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	The 3/14/2020 "Investigation of Significant Injury" indicated client A "got upset with staff and went outside the home and wrapped his shoestring around his neck. [Client A] did not receive any injury from the shoestring." The investigation did not address how client A had shoestrings available for his use. The investigation was not thorough in that it did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. A 4/28/2020 BDDS report for an incident on 4/22/2020 at 5:00pm indicated client A "is still a patient at [name of behavioral hospital] There is no known date of discharge at this time. [Client A] sees a licensed clinical social worker for routine counseling...All behaviors are documented...[Client A's] front bedroom windows locked with HRC approval to prevent elopement by him and his roommate. [Client A's] rear bedroom window leads to the backyard, which is fenced in with locked gates to reduce risk of elopement. The front door and outdoor gates are locked to ensure safety." The BDDS report indicated client A's hospitalization was because of increased behaviors of self harm, elopement, and aggression. 9. A 2/18/2020 BDDS report for an incident on 2/17/2020 at 6:45pm indicated client A "was taking a nap and became agitated when prompted to wake up for dinner on 2/17/2020 around 6:35pm. He refused to wake up for dinner so the staff gave him space and then time to wake up. [Name of city] police called the House Manager on 2/17/2020 around 6:45pm and notified them [client A] called 9-1-1 and was at the gas station about 2/3 (two thirds) mile away from the home. [Client			

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	A] threatened to harm himself. [Client A] reported he jumped out his bedroom window, broke the fence behind the shed, and ran out the broken fence. The House Manager notified the IDT (Interdisciplinary Team) around 6:50pm. Police officers transported [client A] to [name of hospital] emergency room. [Client A] was assessed by a crisis therapist. [Client A] reported he was depressed and having suicidal and homicidal ideation. [Client A] waited in the ER (Emergency Room) until a bed became available...No known discharge date...Client A] sees a licensed clinical social worker for routine counseling...All behaviors are documented... [Client A's] front bedroom windows locked with HRC approval to prevent elopement by him and his roommate. [Client A's] rear bedroom window leads to the backyard, which is fenced in with locked gates to reduce risk of elopement. The front door and outdoor gates are locked to ensure safety." The 2/18/2020 "Investigation" indicated "On Monday 2/17/2020 at 6:35pm, the House Manager was contacted by the [name of city] police department that they had [client A] at the [name of gas station] and he was telling them that he was going to hurt himself and that he was off all of his medications. [Name of house manager] contacted the staff at the home and asked them where [client A] was and they told her that he was sin his bedroom asleep. She instructed them to go in [client A's] room and check on him. The staff then realized that [client A] was gone. They stated that he had pushed his television over by the window to use as a step to jump out of the bedroom window. The staff then went outside and looked around...found a hole in the fence behind the shed where [client A] had escaped through...[Client A] was admitted to the			

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	hospital...The staff that were working at the home stated that one staff had gotten home with groceries prior to [client A] leaving and they asked [client A] to help carry the groceries and he refused. They stated that they then asked him to go to the dining room to eat dinner and he refused to eat saying that he wasn't hungry and just wanted to sleep. The staff stated that it was only 10 to 15 minutes later and [name of house manager] was calling saying that [client A] wasn't at the home and had eloped to the gas station....They (the staff) stated that they normally check on them (the clients) every 15 to 20 minutes...The staff that were working at the time of the incident were asked if they are supposed to check on [client A] every 15 minutes while they are on shift, and they all said that they don't have to check on him every 15 minutes unless he is on suicide watch, however, they stated that they do check on him even through they don't have to. However, [client A's] Behavior Support Plan stated that staff will check on him every 15 minutes to make sure that he is okay. Due to the staff stating that they do not have to check on [client A] every 15 minutes while they are on shift, all of the staff in the home will be retrained on [client A's] Behavior Support Plan." The investigation was not thorough in that it did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. The investigation did not include whether the alarms in place functioned. Client A's record was reviewed on 2/23/2021 at 10:30am. Client A's 11/17/2020 ISP (Individual Support Plan) and 2/26/2020 BSP (Behavior Support Plan) indicated the targeted behaviors of elopement, self harm, and physical aggression.			

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	Client A's ISP and BSP indicated client A was to have been checked on "every 15 minutes" by his supervising staff. Client A's 11/17/2020 "Life Domain" assessment indicated "Level of Supervision: [Client A] does not display skills to be left alone for long periods of time, especially in new environments in the community. [Client A] could become a threat to others and himself if he was left out in the community alone...Staff will be aware of [client A's] whereabouts at all times in the group home, at day services, and in the community. Staff will complete 15 minute checks." The assessment indicated client A did not recognize dangers in the community and was not safe in the community without staff supervision. -Client A's 1/7/2020 "Elopement Plan" indicated client A "has a history of unsafe behavior, self-injurious behaviors, and poor judgement. He is at risk for elopement. He may run away as a way to escape if he feels he's in trouble or to redirect the attention from the original issue. [Client A] may not look or stop for cars before crossing a street when he's upset. He may not know how to get back home if he were to elope. He does not display skills to be left alone for long periods of time, especially in new environments in the community. He could become a threat to others and himself if he was left out in the community alone. Previous elopements out of the staff line of sight...1/3/2020, 1/5/2020. [Client A] has caused significant damage to the wooden privacy fence in the backyard of the group home which will be expensive and time consuming to repair...Implementation. Awake staff 24 hours a day supervision...There are door bells located throughout the group home to alert staff if [client A] leaves the home. The front window in [client A's] bedroom is locked/secured to prevent elopement into the front yard. The team may add			

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	a window bell/alarm to the side window in his bedroom and a window bell/alarm to the first story windows in shared areas. The front door and outdoor gate are kept locked at the group home to ensure safety...If the door bells/locks are not functioning correctly, [the staff] will notify the House Manager...If [client A] starts to elope...the staff will keep him within line of sight to ensure [client A's] safety then notify the on call, House Manager, or QIDP immediately...A staff will drive or walk to follow him...If out of line of sight, call 9-1-1, then the QIDP, and keep looking for [client A]." -Client A's 2/26/2020 BSP indicated the restriction of "Locked Bedroom windows and Window bell" needed for his safety and to prevent elopement behaviors. Client A's BSP indicated the restriction from his IPad after not sleeping at night. The restriction indicated staff will ask for client A's IPad Sunday through Thursday nights at 10:00pm to lock client A's IPad in the office until the next morning when client A wakes for the day. The restriction was the result of client A's lack of sleep and rest at night. On 2/17/2020 at 8:30am, an interview was conducted with the Director of Community Living (DCL) and the ADCL (Assistant Director of Community Living). The DCL and the ADCL both indicated the facility followed the BDDS investigating policy and procedure to thoroughly investigate allegations of abuse, neglect, and/or mistreatment. The DCL and the ADCL both indicated the BDDS reports and the investigation summaries into the allegations and client A's continued behaviors of self harm, elopement, and aggression substantiated staff neglect of client A. The DCL stated the facility "was struggling to meet [Client A's] behavioral needs" when he			

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	elopes from the group home. On 2/18/2021 at 9:45am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the staff failed to implement client A's plans correctly when client A eloped from the group home. The QIDP indicated he was not aware client A's bedroom windows did not lock and did not have alarms/bells on the windows. The QIDP indicated client A needed the bells/alarms on his windows to alert the staff when client A eloped from the group home. The QIDP indicated client A's targeted behaviors included self harm, elopement, and physical aggression. The QIDP stated the staff "have to know where [client A] was all the time." The QIDP indicated client A's ISP and BSP had not been revised since 11/17/2020. The QIDP indicated he did not determine staffing ratios for how many staff were scheduled at the group home. The QIDP stated clients A and H had the identified need of having two staff in the home "at all times" because of their history of physical aggression and client H's falls which resulted in significant injuries. The QIDP indicated during the periods of time when there were two staff on duty in the home and no behaviors taking place the home was meeting the staffing ratios. The QIDP stated when client A eloped from the home and "If a staff followed [client A]" that would leave one staff in the home with 6 clients including client H who needed two staff on duty at the home "at all times." The QIDP stated the staff should be checking and "laying eyes on [client A] every 15 minutes." On 2/26/2021 at 3:55pm, an interview was conducted with the DCL, the ADCL, the QIDP, and the LPN (Licensed Practical Nurse). The DCL, the ADCL, and the QIDP indicated there were not			

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	additional investigations regarding client A's elopements documented on BDDS reports on 1/25/21, 9/3/2020, and 7/4/2020. The DCL indicated the agency should have completed thorough investigations regarding allegations of staff to client neglect. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview, for 9 of 25 BDDS (Bureau of Developmental Disabilities Services) reports and investigations reviewed for 1 of 3 sampled clients (client A), the facility failed to initiate and ensure effective corrective measures were employed regarding client A's continued aggression, threats of self harm, and elopement behaviors. Findings include: On 2/17/2021 from 5:40am until 7:50am, on 2/17/2021 from 2:15pm until 2:55pm, and on 2/18/2021 from 2:55pm until 5:50pm, observation and interviews were conducted at the group home with client A. During the observation periods, the backyard gates were locked, multiple pickets within the wooden fence around the backyard were missing, the side gate entrance to the group home was not locked and was opened without entering a key code, and two of two bedroom windows for client A's bedroom were not locked and no alarms were observed. During the observation periods, client A's bedroom door was able to be locked from the inside and client A's roommate was present inside the shared bedroom. The bedroom door had a half inch space around	W 0157	Bona Vista will ensure that corrective measures are taken regarding Client A's continuous eloping, self harm, aggression, and threats. The QIDP will ensure that all staff are following Client A's BSP, Risk Plans, and ISP. This will get monitored monthly. The QIDP will update all BSP, Risk Plans, and ISP's to include corrections based on any and all incidents that Client A may have. There are HRC approvals in place for Client A's safety which include locked gates, doors, windows, alarms and sharps. The QIDP will retrain all staff on current BSP and behaviors for Client A. . If Behaviors continue to still happen on a regular basis the QIDP will conduct regular IDT meeting with Client A's team to discuss solutions and options	03/31/2021

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	the door frame which showed light from the inside of the bedroom with the door securely shut. On 2/17/2021 from 5:40am until 6:55am, client A was inside his bedroom, lay in his bed, and was reading the screen on his IPad which glowed in the dark. From 5:40am until 6:55am, DSP (Direct Support Professional) #2 and DSP #6 did not check and/or open client A's bedroom door. On 2/17/2021 at 7:30am, an interview was conducted with client A. Client A stated "They (the staff) think I don't know the codes for the doors, well I do. I can leave when I want." When asked how he left the group home, client A stated "I go out one of my windows." Client A then opened both of his bedroom windows repeatedly and stated "See, nobody comes." No staff responded to client A opening/closing the bedroom windows repeatedly and no alarms sounded. Client A stated "I'm in trouble right now. I'm not supposed to have my IPad because I stalked a girl on the phone and my IPad about a week ago. I downloaded an app (from the Internet) that redials constantly the same number. I can go do other things when this app is on, it just keeps calling that number. I made some threats to the girl and to the girl's mom when her mom answered the phone. That scared me. So I got off of it (the app). Well her mom about two or three days later called the IPad or the phone of my housemate, I can't remember. Well anyway, her mom said Hey you didn't think I would find you, did you. Stop this now." Client A stated "My staff said I could have been arrested for stuff like this. So I don't do that no more." Client A refused to identify the staff who took the call on the housemate's phone or the housemate's phone which was used during his recall incident. Client A stated "I get physical sometimes. I leave without staff knowing. It's my behavior."			

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	On 2/17/2021 at 5:40am, an interview with DSP (Direct Support Professional) #2 and DSP #6 was conducted. DSP #2 and DSP #6 both stated "We only check on clients about every half hour or forty-five minutes." When asked if staff check on clients more often, both staff stated "We check on [client A] every 15 minutes but only if he is on suicide watch. That's the only time." On 2/17/2021 at 2:30pm, an interview with DSP #1 and DSP #3 was conducted. DSP #1 and DSP #3 both stated they check on clients out of their eye sight "about every 20-30 minutes" to allow private time in their bedrooms. DSP #2 and DSP #3 stated "We only check on clients every 15 minutes like [client A] when he is on suicide watch." On 2/18/2021 at 9:15am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 1/15/2020 through 2/18/2021 and indicated the following: 1. A 1/26/2021 BDDS report for an incident on 1/25/2021 at 10:30pm indicated client A "eloped from the [name of group home] at 10:30pm due to being upset about having (his) IPad (an Internet device to listen and view information) confiscated due to HRC (Human Rights Committee) approved restriction past 10:00pm. Police were called and they took [client A] to [name of hospital] room under his own reconnaissance to be evaluated for feet soreness. Talked [client A] down (sic) and redirected [client A] to want to go back home. [Client A] went to bed...Staff called House Manager and then House Manager called QIDP (Qualified Intellectual Disabilities Professional)." 2. A 9/12/2020 BDDS report for an incident on			

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	9/11/2020 at 9:25pm indicated client A "had a disagreement with staff which led to [client A] locking himself in (his) room with roommate who was asleep. [Client A] threatened to hurt roommate in which staff called on call team lead, House Manager, and the QIDP. When staff were able to get into room, [client A] had already jumped out of the window and broke through fenced in backyard. Police were then called to help find [client A]. [Client A] was found by police and was transported to [name of hospital] emergency room for self harm/suicide idealization. Due to frequent behaviors of self harm and permission of his psychiatrist nurse of counseling center [client A] will be recommended for neuropsych admission in [name of town] for evaluation and care." The 9/11/2020 "Investigation" indicated "Why [client A] eloped from the home and what]occurred when he eloped from the home." The 9/11/2020 investigation indicated "Findings: Substantiated...Not substantiated. [Client A] had eloped from the home. [Client A] at the time due to there only being 2 staff on shift at the time of the incident (sic). The staff contacted police. [Client A] was then found by the police and taken to the hospital due to self harm/suicide idealization. The staff that were working at the time of the incident...both stated [client A] got upset with them because they informed him that he could not be in one of his housemate's bedrooms. [Client A] then got upset and went outside. They stated that when [client A] was outside he was throwing things at the van. He then tried to break the fence to get out of the yard. The staff stated that they were talking to [client A] and trying to get him to go back into the house. They stated that he then broke a cologne bottle that he had found and tried to cut himself			

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	with the glass. The staff stated that they were able to get the glass away from [client A]. They stated that [client A] then started yelling at the staff and went back into the house. They stated that he then went into his bedroom and put things in front of the door so that staff could not get into the room. They stated that he was then saying that he was going to hurt his roommate that was asleep in the room at the time. The staff stated that when they were finally able to get the door pushed open to his bedroom they noticed that he had jumped out of the window, broke some of the fence where he had made a hole, and had run from the home. They immediately called the House Manager, who then instructed them to call the police. The police then found [client A] and took him to the hospital due to him trying to hurt himself. [Client A] stated that he got mad at the staff because he wanted to go in a housemate's bedroom and play a game, but they told him that he couldn't go in the room. He stated that he then went outside and was trying to calm down, but the staff followed him and made him more upset. He stated that he then picked up a piece of glass to try and cut himself because he wanted to scare the staff and make them leave him alone. He stated that he then went inside to his bedroom and decided to try to leave the house to get away from everyone. He stated he does not want to be at the home anymore and wants to move. He stated that he knew he shouldn't have done what he did. He stated that he was sorry and didn't want to get anyone in trouble. He also stated that he didn't really want to hurt himself, but that he just wanted to scare the staff so they would leave him alone. He stated that he knew he needed to stop leaving the house because he wants to move and he is not helping himself by running away all the time. He stated that he left the house because he knew the staff couldn't follow him and he			

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	would be able to be by himself for a while to calm down. It is recommended that the staff continue to follow the Behavior Support Plan (BSP) that is in place for [client A]." The investigation did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. 3. A 9/3/2020 BDDS report for an incident on 9/3/2020 at 10:30am indicated client A "eloped from day services in which staff maintained the sight while [client A] left day services with staff in pursuit. When [client A] was caught up with, [client A] then followed staff back to the day program then eloped again. They (the staff) followed again and police caught up to [client A] in which staff did not call. [Client A] willingly went with police and was taken to the house (group home) in which he decided to take PRN (as needed medication for behaviors) and rest in his bedroom to calm down...[Client A] got into a disagreement with another person served in which [client A] became upset." 4. An 8/23/2020 BDDS report for an incident on 8/23/2020 at 12:00am indicated client A "had jumped out of another persons served bedroom window during the night. Staff were notified at 5:00am by the [name of city] police department that [client A] had been taken to [name of hospital] ER by EMS (Emergency Medical Services) and was admitted at 12:06am. [Client A] was picked up from the ER at 5:35am and taken back to the group home. Both staff were suspended pending investigation. All staff are trained on midnight duties and check lists. All staff are trained on [client A's] BSP and risk plans before working with him."			

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	The 8/25/2020 "Investigation" indicated "On Sunday 8/23/2020 at 5:00am the police arrived at the group home and informed staff that [client A] was in the hospital after he had eloped from the home, and was picked up by the police and taken to the hospital." The investigation indicated both staff were suspended. The investigation indicated "On Saturday 8/22/2020 at 10:00pm both staff went into [client A's] bedroom and told him that it was time for him to turn his IPad into the staff for the evening. The staff stated that this had been HRC approved for every night. However, it was only HRC approved for staff to take the IPad from [client A] during the weeks at 10pm not on the weekends. They stated that [client A] got upset with staff and refused to turn the IPad in. Staff then left his room for a while. The staff then went and helped another housemate clean himself up after he had an accident. After staff helped the other housemate they went back to [client A] and informed him it was time to give staff the IPad, he again refused. Staff stated that [client A] then went into the kitchen and got a drink and went back to his bedroom. They stated that he then entered the living room, didn't say anything to him, nothing was said to him by staff, and then he went back into his bedroom again. Staff stated that she was walking in the hallway when she saw [client A] in the dark with his combat gloves on, his mouthpiece in, and his shoes on. Staff stated that she didn't say anything to him because he looked like he was ready to fight her. Staff checked on [client A] at 10:45pm and 11pm, and he was just sitting on his bed in his bedroom. [DSP (Direct Support Professional) #10] stated that she dozed off from 11:30 or 12am to about 2:00am. She stated that when she opened her eyes she started to clean the house again...They stated that then at 5:00am the police knocked on the door and			

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	informed them that they had a person served that had left the house and had been picked up at 12:06am by the police and taken to the hospital...Both the staff admitted to not doing the 15 minute checks on the persons served throughout the entire night...[Client A] stated that after the staff checked on him a few times he went into his housemates bedroom and moved his bed and chair around in his room and then jumped out the bedroom window and started running. He stated that after he had been gone from the house for a while his legs started to hurt so he fell in the middle of the road and rolled to the side of the road because he didn't want to get run over. He stated that the police showed up and took him to the hospital. He stated that when he woke up at the hospital the house manager was there and took him home...Due to the staff admitting to not completing the 15 minute checks on the persons served throughout the night causing them not to know that [client A] had eloped from the home, the allegations of neglect are substantiated. Due to the allegation of neglect being substantiated both of the staff will be put on a last chance agreement." 5. A 7/4/2020 BDDS report for an incident on 7/3/2020 at 4:30pm indicated client A "was having troubles working his new IPad and became very agitated according to staff at the house at the time. When [client A] returned to his room he jumped out of his bedroom (window) which is approximately 6 to 7 feet off the ground. When he jumped out the window he proceeded to break a way through the fence and eloped. Staff maintained visual while [client A] ran off the property in which staff pursued. Team lead was called also with Director on call in which then was relayed to the author of the circumstances. While in pursuit, authorities spotted [client A] and			

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	pulled over and arrested him due to self injury idealization. Police took [client A] to the hospital in which he was later admitted to neuropsych hospital...[Client A] receives 24/7 (twenty-four hours a day/seven days a week) staff supervision at the group home. There is HRC and guardian approval for all sharp knives and sharp utensils to be kept in a locked box at the group home for the safety of all persons served. There is HRC approved for the gates to be locked to ensure safety." 6. A 6/29/2020 BDDS report for an incident on 6/27/2020 at 8:00pm indicated client A "was feeling angry and upset all day and became very agitated when he was asked to not go outside while it was raining. [Client A] jumped out his bedroom window and broke part of the fence to elope from the group home. Staff notified [House Manager]. Staff were instructed to call police to notify them of the elopement from the group home. The House Manager found [client A] at the [name of gas station]. [Client A] was still upset...[Client A] did have a scrape on his right forearm about 3 inches by 1 inch and on his right chin about 2 inches by 1 inch from jumping out his bedroom window." The 7/6/2020 "Investigation" indicated "On 6/27/2020 it was brought to the attention of the House Manager...[client A] had eloped from the home and was out of the line of sight. The House Manger instructed staff to call 9-1-1 and report that [client A] had left the home and then informed the staff that she was leaving her home to start looking for [client A]. There were two staff working when [client A] eloped...They both stated that [client A] had been wrestling/horseplay with another one of his housemates. The staff then stated that [client A]			

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	became irritated and upset when they asked him to stop wrestling/horseplay...They stated that [client A] then asked if he could go outside to play basketball for a while. They stated that when they informed [client A] that he needed to stay in the home due to it raining outside he became even more upset and agitated. They stated that [client A] went into his bedroom and called his grandmother. They stated that when he got off of the phone with his grandmother, he jumped out of his bedroom window, broke the fence, and eloped from the home. They stated that before [client A] jumped out of his bedroom window he informed staff from his bedroom that he was going to go live with his grandmother. They stated that when they contacted the [name of house manager] they informed her of everything that had happened. They also stated that when they contacted the house manager she informed them that they needed to call 9-1-1. They stated they stated that when they got off of the phone with the house manager, they then called 9-1-1 and reported that [client A] had eloped from the home. They both stated another client was having behaviors at the same time and that neither of the staff followed [client A] when he eloped due to it only being the two of them and one of the other persons served in the home was a two staff at all times staff supervision...The staff stated that from the time that [client A] left the home until he returned to the home he was gone for about 17 minutes. They stated that the house manager was the one that found [client A] at [name of gas station] and then brought him back to the house." 7. A 5/12/2020 BDDS report for an incident on 5/11/2020 at 6:00pm indicated client H "became upset and was threatening the staff to hit them. [Client A] came into the kitchen and asked what was going on and [client H] ran outside into the			

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BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

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	back yard. [Client A] followed [client H] outside. [Client H] tried to break the fence and [client A] pulled [client H] off the fence and hit [client H] in the head. Staff separated the two of them and [client A] went back into the house...[Client H] had a small scratch and bruise on his left upper forehead area. Scratches and bruise measure 2cm (centimeters) in length." The 5/11/2020 "Investigation" indicated "Results of Investigation: It was determined through a thorough investigation that this was a simple peer to peer aggression due to [client A] responding to [client H] in a negative manner. [Client H] was arguing with staff in the kitchen. The staff was attempting to talk to [client H] and get him to calm down. The staff stated that [client H] was yelling at staff for apparent reason. [Client H] then got even more upset with staff and ran out the door into the backyard and attempted to elope through the fence. [Client A] was in his bedroom when [client H] was yelling at the staff...[Client A] went into the kitchen to see what was going on. [Client A] then went outside where [client H] was. Staff member then went outside behind [client A] . The staff attempted to talk to [client A] and tell him to let him handle [client H] to get him to go back in the home. [Client A] then grabbed [client H] by the back and pulled him to the ground. [Client H] started kicking [client A] and then [client A] started hitting [client H] in the head. The staff was able to get them separated." 8. A 3/15/2020 BDDS report for an incident on 3/14/2020 at 12:50pm indicated client A "became agitated at lunch over the way staff was having the guys rinse their dishes off. [Client A] tied a shoestring around his neck and went outside. Staff talked to him and he immediately took it off. He was trying to calm down and asked for a PRN			

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	(as needed behavior medication) to help him." The 3/14/2020 "Investigation of Significant Injury" indicated client A "got upset with staff and went outside the home and wrapped his shoestring around his neck. [Client A] did not receive any injury from the shoestring." The investigation did not address how client A had shoestrings available for his use. The investigation was not thorough in that it did not include how many staff were at the home during the incident and how many staff should have been scheduled for seven clients based on their identified supervision needs. A 4/28/2020 BDDS report for an incident on 4/22/2020 at 5:00pm indicated client A "is still a patient at [name of behavioral hospital] There is no known date of discharge at this time. [Client A] sees a licensed clinical social worker for routine counseling...All behaviors are documented...[Client A's] front bedroom windows locked with HRC approval to prevent elopement by him and his roommate. [Client A's] rear bedroom window leads to the backyard, which is fenced in with locked gates to reduce risk of elopement. The front door and outdoor gates are locked to ensure safety." The BDDS report indicated client A's hospitalization was because of increased behaviors of self harm, elopement, and aggression. 9. A 2/18/2020 BDDS report for an incident on 2/17/2020 at 6:45pm indicated client A "was taking a nap and became agitated when prompted to wake up for dinner on 2/17/2020 around 6:35pm. He refused to wake up for dinner so the staff gave him space and then time to wake up. [Name of city] police called the House Manager on 2/17/2020 around 6:45pm and notified them [client			

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	A] called 9-1-1 and was at the gas station about 2/3 (two thirds) mile away from the home. [Client A] threatened to harm himself. [Client A] reported he jumped out his bedroom window, broke the fence behind the shed, and ran out the broken fence. The House Manager notified the IDT (Interdisciplinary Team) around 6:50pm. Police officers transported [client A] to [name of hospital] emergency room. [Client A] was assessed by a crisis therapist. [Client A] reported he was depressed and having suicidal and homicidal ideation. [Client A] waited in the ER (Emergency Room) until a bed became available...No known discharge date...Client A] sees a licensed clinical social worker for routine counseling...All behaviors are documented... [Client A's] front bedroom windows locked with HRC approval to prevent elopement by him and his roommate. [Client A's] rear bedroom window leads to the backyard, which is fenced in with locked gates to reduce risk of elopement. The front door and outdoor gates are locked to ensure safety." The 2/18/2020 "Investigation" indicated "On Monday 2/17/2020 at 6:35pm, the House Manager was contacted by the [name of city] police department that they had [client A] at the [name of gas station] and he was telling them that he was going to hurt himself and that he was off all of his medications. [Name of house manager] contacted the staff at the home and asked them where [client A] was and they told her that he was sin his bedroom asleep. She instructed them to go in [client A's] room and check on him. The staff then realized that [client A] was gone. They stated that he had pushed his television over by the window to use as a step to jump out of the bedroom window. The staff then went outside and looked around...found a hole in the fence			

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	behind the shed where [client A] had escaped through...[Client A] was admitted to the hospital...The staff that were working at the home stated that one staff had gotten home with groceries prior to [client A] leaving and they asked [client A] to help carry the groceries and he refused. They stated that they then asked him to go to the dining room to eat dinner and he refused to eat saying that he wasn't hungry and just wanted to sleep. The staff stated that it was only 10 to 15 minutes later and [name of house manager] was calling saying that [client A] wasn't at the home and had eloped to the gas station....They (the staff) stated that they normally check on them (the clients) every 15 to 20 minutes...The staff that were working at the time of the incident were asked if they are supposed to check on [client A] every 15 minutes while they are on shift, and they all said that they don't have to check on him every 15 minutes unless he is on suicide watch, however, they stated that they do check on him even through they don't have to. However, [client A's] Behavior Support Plan stated that staff will check on him every 15 minutes to make sure that he is okay. Due to the staff stating that they do not have to check on [client A] every 15 minutes while they are on shift, all of the staff in the home will be retrained on [client A's] Behavior Support Plan." Client A's record was reviewed on 2/23/2021 at 10:30am. Client A's 11/17/2020 ISP (Individual Support Plan) and 2/26/2020 BSP (Behavior Support Plan) indicated the targeted behaviors of elopement, self harm, and physical aggression. Client A's ISP and BSP indicated client A was to have been checked on "every 15 minutes" by his supervising staff. Client A's 11/17/2020 "Life Domain" assessment indicated "Level of Supervision: [Client A] does not display skills to			

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	be left alone for long periods of time, especially in new environments in the community. [Client A] could become a threat to others and himself if he was left out in the community alone...Staff will be aware of [client A's] whereabouts at all times in the group home, at day services, and in the community. Staff will complete 15 minute checks." The assessment indicated client A did not recognize dangers in the community and was not safe in the community without staff supervision. -Client A's 1/7/2020 "Elopement Plan" indicated client A "has a history of unsafe behavior, self-injurious behaviors, and poor judgement. He is at risk for elopement. He may run away as a way to escape if he feels he's in trouble or to redirect the attention from the original issue. [Client A] may not look or stop for cars before crossing a street when he's upset. He may not know how to get back home if he were to elope. He does not display skills to be left alone for long periods of time, especially in new environments in the community. He could become a threat to others and himself if he was left out in the community alone. Previous elopements out of the staff line of sight...1/3/2020, 1/5/2020. [Client A] has caused significant damage to the wooden privacy fence in the backyard of the group home which will be expensive and time consuming to repair...Implementation. Awake staff 24 hours a day supervision...There are door bells located throughout the group home to alert staff if [client A] leaves the home. The front window in [client A's] bedroom is locked/secured to prevent elopement into the front yard. The team may add a window bell/alarm to the side window in his bedroom and a window bell/alarm to the first story windows in shared areas. The front door and outdoor gate are kept locked at the group home to ensure safety...If the door bells/locks are not			

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	functioning correctly, [the staff] will notify the House Manager...If [client A] starts to elope...the staff will keep him within line of sight to ensure [client A's] safety then notify the on call, House Manager, or QIDP immediately...A staff will drive or walk to follow him...If out of line of sight, call 9-1-1, then the QIDP, and keep looking for [client A]." No plan revisions were available for review. -Client A's 2/26/2020 BSP indicated the restriction of "Locked Bedroom windows and Window bell" needed for his safety and to prevent elopement behaviors. Client A's BSP indicated the restriction from his IPad after not sleeping at night. The restriction indicated staff will ask for client A's IPad Sunday through Thursday nights at 10:00pm to lock client A's IPad in the office until the next morning when client A wakes for the day. The restriction was the result of client A's lack of sleep and rest at night. -Client A's record did not indicate IDT (Interdisciplinary Team) meetings to determine the team had met to review client A's continued behaviors and plans. Client A's record indicated his ISP and BSP were not revised from 1/2020 through 11/17/2020 after each elopement behavior to add effective corrective measures. Client A's BSP did not include the behavior of stalking his girlfriends over the telephone and no plan was in place. On 2/17/2020 at 8:30am, an interview was conducted with the Director of Community Living (DCL) and the ADCL (Assistant Director of Community Living). The DCL and the ADCL both indicated the facility failed to initiate and document effective corrective action after each of client A's incidents to prevent a future incident from occurring. The DCL and the ADCL both			

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	indicated the BDDS reports and the investigation summaries into the allegations and client A's continued behaviors of self harm, elopement, and aggression substantiated staff neglect of client A. The DCL stated the facility "was struggling to meet [Client A's] behavioral needs" when he elopes from the group home. The DCL indicated neglect was the failure to ensure staff provided and clients received supervision and supports which each client needed. The DCL indicated neglect was the failure to provide appropriate care, food, medical care, or staff supervision. On 2/18/2021 at 9:45am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the staff failed to implement client A's plans correctly when client A eloped from the group home. The QIDP indicated he was not aware client A's bedroom windows did not lock and did not have alarms/bells on the windows. The QIDP indicated client A needed the bells/alarms on his windows to alert the staff when client A eloped from the group home. The QIDP indicated client A's targeted behaviors included self harm, elopement, and physical aggression. The QIDP indicated there were no IDT (Interdisciplinary Team) meetings available for review to determine the team had met to reviewed client A's continued behaviors. The QIDP stated the staff "have to know where [client A] was all the time." The QIDP indicated client A's ISP and BSP had not been revised since 11/17/2020. The QIDP indicated client A's ISP and BSP were not revised from 1/2020 through 11/17/2020 after each elopement behavior to add effective corrective measures. The QIDP indicated the staff was spoken to regarding client A's continued behaviors and elopements and stated "no documented" staff training documents were			

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	available for review. The QIDP indicated he did not determine staffing ratios for how many staff were scheduled at the group home. The QIDP stated clients A and H had the identified need of having two staff in the home "at all times" because of their history of physical aggression and client H's falls with significant injuries. The QIDP indicated when there were two staff on duty in the home and no behaviors taking place the home was meeting the staffing ratios. The QIDP stated when client A eloped from the home and "If a staff followed [client A]" that would leave one staff in the home with 6 clients including client H who needed two staff on duty at the home "at all times." The QIDP stated the staff should be checking and "laying eyes on [client A] every 15 minutes." The QIDP indicated neglect was the failure to provide appropriate care, food, medical care, or supervision. On 2/26/2021 at 3:55pm, an interview was conducted with the DCL, the ADCL, the QIDP, and the LPN (Licensed Practical Nurse). The QIDP stated "We have talked about" client A's behavior of stalking his girlfriends over the telephone and no plan was in place. The QIDP stated "there should be an alarm in place and there once was one, but the last time [client A] eloped he broke it and it has not been fixed since the last elopement." The QIDP and the LPN both indicated client A did not realize he can hurt himself and when he is upset he cannot make good choices" to practice street safety and pedestrian safety skills. The DCL indicated the agency did not document effective corrective action and staff retraining regarding client A's continued elopements and behaviors. 9-3-2(a)			

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W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, for 1 of 3 sampled clients (client A), the facility failed to implement client A's ISP (Individual Support Plan), BSP (Behavior Support Plan), and risk plans when formal and informal opportunities existed. Findings include: On 2/17/2021 from 5:40am until 7:50am, on 2/17/2021 from 2:15pm until 2:55pm, and on 2/18/2021 from 2:55pm until 5:50pm, observation and interviews were conducted at the group home with client A. During the observation periods, the backyard gates were locked, multiple pickets within the wooden fence around the backyard were missing, the side gate entrance to the group home was not locked and was opened without entering a key code, and two of two bedroom windows for client A's bedroom were not locked and no alarms were observed. During the observation periods, client A's bedroom door was able to be locked from the inside and client A's roommate was present inside the shared bedroom. The bedroom door had a half inch space around the door frame which showed light from the inside of the bedroom with the door securely shut. On 2/17/2021 from 5:40am until 6:55am, client A was inside his bedroom, lay in his bed, and was reading the screen on his IPad which glowed in	W 0249	The Residential QIDP will retrain all staff on Client A's BSP, Risk Plans, and ISP. The QIDP will do monthly checks to ensure that all staff are following and implementing Client A's plans that are in place. The QIDP will update and revise Client A's plans as needed. The House Manager will make sure that all alarms are working and all doors and windows remain locked for Client A's safety. Staff will document and do fifteen minute checks in the home to ensure Client A is safe.	03/31/2021

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	the dark. From 5:40am until 6:55am, DSP (Direct Support Professional) #2 and DSP #6 did not check and/or open client A's bedroom door. On 2/17/2021 at 7:30am, an interview was conducted with client A. Client A stated "They (the staff) think I don't know the codes for the doors, well I do. I can leave when I want." When asked how he left the group home, client A stated "I go out one of my windows." Client A then opened both of his bedroom windows repeatedly and stated "See, nobody comes." No staff responded and no alarms sounded when client A opened/closed the bedroom windows repeatedly. Client A stated "I'm in trouble right now. I'm not supposed to have my IPad because I stalked a girl on the phone and my IPad about a week ago. I downloaded an app (from the Internet) that redials constantly the same number. I can go do other things when this app is on, it just keeps calling that number. I made some threats to the girl and to the girl's mom when her mom answered the phone. That scared me. So I got off of it (the app). Well her mom about two or three days later called the IPad or the phone of my housemate, I can't remember. Well anyway, her mom said Hey you didn't think I would find you, did you. Stop this now." Client A stated "My staff said I could have been arrested for stuff like this. So I don't do that no more." Client A refused to identify the staff who took the call on the housemate's phone or the housemates phone which was used during his recall incident. Client A stated "I get physical sometimes. I leave without staff knowing. It's my behavior." On 2/17/2021 at 5:40am, an interview with DSP (Direct Support Professional) #2 and DSP #6 was conducted. DSP #2 and DSP #6 both stated "We only check on clients about every half hour or			

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	forty-five minutes." When asked if staff check on clients more often, both staff stated "We check on [client A] every 15 minutes but only if he is on suicide watch. That's the only time." On 2/17/2021 at 2:30pm, an interview with DSP #1 and DSP #3 was conducted. DSP #1 and DSP #3 both stated they check on clients out of their eye sight "about every 20-30 minutes" to allow private time in their bedrooms. DSP #2 and DSP #3 stated "We only check on clients every 15 minutes like [client A] when he is on suicide watch." On 2/18/2021 at 9:15am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 1/15/2020 through 2/18/2021 and indicated the following: 1. A 1/26/2021 BDDS report for an incident on 1/25/2021 at 10:30pm indicated client A "eloped from the [name of group home] at 10:30pm due to being upset about having (his) IPad confiscated due to HRC (Human Rights Committee) approved restriction past 10:00pm. Police were called and they took [client A] to [name of hospital] room under his own reconnaissance to be evaluated for feet soreness. Talked [client A] down (sic) and redirected [client A] to want to go back home. [Client A] went to bed...Staff called House Manager and then House Manager called QIDP (Qualified Intellectual Disabilities Professional)." 2. A 9/12/2020 BDDS report for an incident on 9/11/2020 at 9:25pm indicated client A "had a disagreement with staff which led to [client A] locking himself in (his) room with roommate who was asleep. [Client A] threatened to hurt roommate in which staff called on call team lead, House Manager, and the QIDP. When staff were			

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	able to get into room, [client A] had already jumped out of the window and broke through fenced in backyard. Police were then called to help find [client A]. [Client A] was found by police and was transported to [name of hospital] emergency room for self harm/suicide idealization. Due to frequent behaviors of self harm and permission of his psychiatrist nurse of counseling center [client A] will be recommended for neuropsych admission in [name of town] for evaluation and care." The 9/11/2020 "Investigation" indicated "Why [client A] eloped from the home and what occurred when he eloped from the home." The 9/11/2020 investigation indicated "Findings: Substantiated...Not substantiated. [Client A] had eloped from the home. [Client A] at the time due to there only being 2 staff on shift at the time of the incident (sic). The staff contacted police. [Client A] was then found by the police and taken to the hospital due to self harm/suicide idealization. The staff that were working at the time of the incident...both stated [client A] got upset with them because they informed him that he could not be in one of his housemate's bedrooms. [Client A] then got upset and went outside. They stated that when [client A] was outside he was throwing things at the van. He then tried to break the fence to get out of the yard. The staff stated that they were talking to [client A] and trying to get him to go back into the house. They stated that he then broke a cologne bottle that he had found and tried to cut himself with the glass. The staff stated that they were able to get the glass away from [client A]. They stated that [client A] then started yelling at the staff and went back into the house. They stated that he then went into his bedroom and put things in front of the door so that staff could not get into			

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	the room. They stated that he was then saying that he was going to hurt his roommate that was asleep in the room at the time. The staff stated that when they were finally able to get the door pushed open to his bedroom they noticed that he had jumped out of the window, broke some of the fence where he had made a hole, and had run from the home. They immediately called the House Manager, who then instructed them to call the police. The police then found [client A] and took him to the hospital due to him trying to hurt himself. [Client A] stated that he got mad at the staff because he wanted to go in a housemate's bedroom and play a game, but they told him that he couldn't go in the room. He stated that he then went outside and was trying to calm down, but the staff followed him and made him more upset. He stated that he then picked up a piece of glass to try and cut himself because he wanted to scare the staff and make them leave him alone. He stated that he then went inside to his bedroom and decided to try to leave the house to get away from everyone. He stated he does not want to be at the home anymore and wants to move. He stated that he knew he shouldn't have done what he did. He stated that he was sorry and didn't want to get anyone in trouble. He also stated that he didn't really want to hurt himself, but that he just wanted to scare the staff so they would leave him alone. He stated that he knew he needed to stop leaving the house because he wants to move and he is not helping himself by running away all the time. He stated that he left the house because he knew the staff couldn't follow him and he would be able to be by himself for a while to calm down. It is recommended that the staff continue to follow the Behavior Support Plan (BSP) that is in place for [client A]." 3. A 9/3/2020 BDDS report for an incident on			

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	9/3/2020 at 10:30am indicated client A "eloped from day services in which staff maintained the sight while [client A] left day services with staff in pursuit. When [client A] was caught up with, [client A] then followed staff back to the day program then eloped again. They (the staff) followed again and police caught up to [client A] in which staff did not call. [Client A] willingly went with police and was taken to the house (group home) in which he decided to take PRN (as needed medication for behaviors) and rest in his bedroom to calm down...[Client A] got into a disagreement with another person served in which [client A] became upset." 4. A 8/23/2020 BDDS report for an incident on 8/23/2020 at 12:00am indicated client A "had jumped out of another persons served bedroom window during the night. Staff were notified at 5:00am by the [name of city] police department that [client A] had been taken to [name of hospital] ER by EMS (Emergency Medical Services) and was admitted at 12:06am. [Client A] was picked up from the ER at 5:35am and taken back to the group home. Both staff were suspended pending investigation. All staff are trained on midnight duties and check lists. All staff are trained on [client A's] BSP and risk plans before working with him." The 8/25/2020 "Investigation" indicated "On Sunday 8/23/2020 at 5:00am the police arrived at the group home and informed staff that [client A] was in the hospital after he had eloped from the home, and was picked up by the police and taken to the hospital." The investigation indicated both staff were suspended. The investigation indicated "On Saturday 8/22/2020 at 10:00pm both staff went into [client A's] bedroom and told him that it was time for him to turn his IPad into the			

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	staff for the evening. The staff stated that this had been HRC approved for every night. However, it was only HRC approved for staff to take the IPad from [client A] during the weeks at 10pm not on the weekends. They stated that [client A] got upset with staff and refused to turn the IPad in. Staff then left his room for a while. The staff then went and helped another housemate clean himself up after he had an accident. After staff helped the other housemate they went back to [client A] and informed him it was time to give staff the IPad, he again refused. Staff stated that [client A] then went into the kitchen and got a drink and went back to his bedroom. They stated that he then entered the living room, didn't say anything to him, nothing was said to him by staff, and then he went back into his bedroom again. Staff stated that she was walking in the hallway when she saw [client A] in the dark with his combat gloves on, his mouthpiece in, and his shoes on. Staff stated that she didn't say anything to him because he looked like he was ready to fight her. Staff checked on [client A] at 10:45pm and 11pm, and he was just sitting on his bed in his bedroom. [DSP (Direct Support Professional) #10] stated that she dozed off from 11:30 or 12am to about 2:00am. She stated that when she opened her eyes she started to clean the house again...They stated that then at 5:00am the police knocked on the door and informed them that they had a person served that had left the house and had been picked up at 12:06am by the police and taken to the hospital...Both the staff admitted to not doing the 15 minute checks on the persons served throughout the entire night...[Client A] stated that after the staff checked on him a few times he went into his housemates bedroom and moved his bed and chair around in his room and then jumped out the bedroom window and started running. He			

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	stated that after he had been gone from the house for a while his legs started to hurt so he fell in the middle of the road and rolled to the side of the road because he didn't want to get run over. He stated that the police showed up and took him to the hospital. He stated that when he woke up at the hospital the house manager was there and took him home...Due to the staff admitting to not completing the 15 minute checks on the persons served throughout the night causing them not to know that [client A] had eloped from the home, the allegations of neglect are substantiated. Due to the allegation of neglect being substantiated both of the staff will be put on a last chance agreement." 5. A 7/4/2020 BDDS report for an incident on 7/3/2020 at 4:30pm indicated client A "was having troubles working his new IPad and became very agitated according to staff at the house at the time. When [client A] returned to his room he jumped out of his bedroom (window) which is approximately 6 to 7 feet off the ground. When he jumped out the window he proceeded to break a way through the fence and eloped. Staff maintained visual while [client A] ran off the property in which staff pursued. Team lead was called also with Director on call in which then was relayed to the author of the circumstances. While in pursuit, authorities spotted [client A] and pulled over and arrested him due to self injury idealization. Police took [client A] to the hospital in which he was later admitted to neuropsych hospital...[Client A] receives 24/7 (twenty-four hours a day/seven days a week) staff supervision at the group home. There is HRC and guardian approval for all sharp knives and sharp utensils to be kept in a locked box at the group home for the safety of all persons served. There is HRC approved for the gates to be locked to ensure			

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	safety." 6. A 6/29/2020 BDDS report for an incident on 6/27/2020 at 8:00pm indicated client A "was feeling angry and upset all day and became very agitated when he was asked to not go outside while it was raining. [Client A] jumped out his bedroom window and broke part of the fence to elope from the group home. Staff notified [House Manager]. Staff were instructed to call police to notify them of the elopement from the group home. The House Manager found [client A] at the [name of gas station]. [Client A] was still upset...[Client A] did have a scrape on his right forearm about 3 inches by 1 inch and on his right chin about 2 inches by 1 inch from jumping out his bedroom window." The 7/6/2020 "Investigation" indicated "On 6/27/2020 it was brought to the attention of the House Manager...[client A] had eloped from the home and was out of the line of sight. The House Manger instructed staff to call 9-1-1 and report that [client A] had left the home and then informed the staff that she was leaving her home to start looking for [client A]. There were two staff working when [client A] eloped...They both stated that [client A] had been wrestling/horseplay with another one of his housemates. The staff then stated that [client A] became irritated and upset when they asked him to stop wrestling/horseplay...They stated that [client A] then asked if he could go outside to play basketball for a while. They stated that when they informed [client A] that he needed to stay in the home due to it raining outside he became even more upset and agitated. They stated that [client A] went into his bedroom and called his grandmother. They stated that when he got off of the phone with his grandmother, he jumped out of			

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	his bedroom window, broke the fence, and eloped from the home. They stated that before [client A] jumped out of his bedroom window he informed staff from his bedroom that he was going to go live with his grandmother. They stated that when they contacted the [name of house manager] they informed her of everything that had happened. They also stated that when they contacted the house manager she informed them that they needed to call 9-1-1. They stated they stated that when they got off of the phone with the house manager, they then called 9-1-1 and reported that [client A] had eloped from the home. They both stated another client was having behaviors at the same time and that neither of the staff followed [client A] when he eloped due to it only being the two of them and one of the other persons served in the home was a two staff at all times staff supervision...The staff stated that from the time that [client A] left the home until he returned to the home he was gone for about 17 minutes. They stated that the house manager was the one that found [client A] at [name of gas station] and then brought him back to the house." 7. A 5/12/2020 BDDS report for an incident on 5/11/2020 at 6:00pm indicated client H "became upset and was threatening the staff to hit them. [Client A] came into the kitchen and asked what was going on and [client H] ran outside into the back yard. [Client A] followed [client H] outside. [Client H] tried to break the fence and [client A] pulled [client H] off the fence and hit [client H] in the head. Staff separated the two of them and [client A] went back into the house...[Client H] had a small scratch and bruise on his left upper forehead area. Scratches and bruise measure 2cm (centimeters) in length." The 5/11/2020 "Investigation" indicated "Results			

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	of Investigation: It was determined through a thorough investigation that this was a simple peer to peer aggression due to [client A] responding to [client H] in a negative manner. [Client H] was arguing with staff in the kitchen. The staff was attempting to talk to [client H] and get him to calm down. The staff stated that [client H] was yelling at staff for apparent reason. [Client H] then got even more upset with staff and ran out the door into the backyard and attempted to elope through the fence. [Client A] was in his bedroom when [client H] was yelling at the staff...[Client A] went into the kitchen to see what was going on. [Client A] then went outside where [client H] was. Staff member then went outside behind [client A] . The staff attempted to talk to [client A] and tell him to let him handle [client H] to get him to go back in the home. [Client A] then grabbed [client H] by the back and pulled him to the ground. [Client H] started kicking [client A] and then [client A] started hitting [client H] in the head. The staff was able to get them separated." 8. A 3/15/2020 BDDS report for an incident on 3/14/2020 at 12:50pm indicated client A "became agitated at lunch over the way staff was having the guys rinse their dishes off. [Client A] tied a shoestring around his neck and went outside. Staff talked to him and he immediately took it off. He was trying to calm down and asked for a PRN (as needed behavior medication) to help him." The 3/14/2020 "Investigation of Significant Injury" indicated client A "got upset with staff and went outside the home and wrapped his shoestring around his neck. [Client A] did not receive any injury from the shoestring." The investigation did not address how client A had shoestrings available for his use.			

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	9. A 2/18/2020 BDDS report for an incident on 2/17/2020 at 6:45pm indicated client A "was taking a nap and became agitated when prompted to wake up for dinner on 2/17/2020 around 6:35pm. He refused to wake up for dinner so the staff gave him space and then time to wake up. [Name of city] police called the House Manager on 2/17/2020 around 6:45pm and notified them [client A] called 9-1-1 and was at the gas station about 2/3 (two thirds) mile away from the home. [Client A] threatened to harm himself. [Client A] reported he jumped out his bedroom window, broke the fence behind the shed, and ran out the broken fence. The House Manager notified the IDT (Interdisciplinary Team) around 6:50pm. Police officers transported [client A] to [name of hospital] emergency room. [Client A] was assessed by a crisis therapist. [Client A] reported he was depressed and having suicidal and homicidal ideation. [Client A] waited in the ER (Emergency Room) until a bed became available...No known discharge date...Client A] sees a licensed clinical social worker for routine counseling...All behaviors are documented... [Client A's] front bedroom windows locked with HRC approval to prevent elopement by him and his roommate. [Client A's] rear bedroom window leads to the backyard, which is fenced in with locked gates to reduce risk of elopement. The front door and outdoor gates are locked to ensure safety." The 2/18/2020 "Investigation" indicated "On Monday 2/17/2020 at 6:35pm, the House Manager was contacted by the [name of city] police department that they had [client A] at the [name of gas station] and he was telling them that he was going to hurt himself and that he was off all of his medications. [Name of house manager] contacted the staff at the home and asked them			

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	where [client A] was and they told her that he was sin his bedroom asleep. She instructed them to go in [client A's] room and check on him. The staff then realized that [client A] was gone. They stated that he had pushed his television over by the window to use as a step to jump out of the bedroom window. The staff then went outside and looked around...found a hole in the fence behind the shed where [client A] had escaped through...[Client A] was admitted to the hospital...The staff that were working at the home stated that one staff had gotten home with groceries prior to [client A] leaving and they asked [client A] to help carry the groceries and he refused. They stated that they then asked him to go to the dining room to eat dinner and he refused to eat saying that he wasn't hungry and just wanted to sleep. The staff stated that it was only 10 to 15 minutes later and [name of house manager] was calling saying that [client A] wasn't at the home and had eloped to the gas station....They (the staff) stated that they normally check on them (the clients) every 15 to 20 minutes...The staff that were working at the time of the incident were asked if they are supposed to check on [client A] every 15 minutes while they are on shift, and they all said that they don't have to check on him every 15 minutes unless he is on suicide watch, however, they stated that they do check on him even through they don't have to. However, [client A's] Behavior Support Plan stated that staff will check on him every 15 minutes to make sure that he is okay. Due to the staff stating that they do not have to check on [client A] every 15 minutes while they are on shift, all of the staff in the home will be retrained on [client A's] Behavior Support Plan." Client A's record was reviewed on 2/23/2021 at 10:30am. Client A's 11/17/2020 ISP (Individual			

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	Support Plan) and 2/26/2020 BSP (Behavior Support Plan) indicated the targeted behaviors of elopement, self harm, and physical aggression. Client A's ISP and BSP indicated client A was to have been checked on "every 15 minutes" by his supervising staff. Client A's 11/17/2020 "Life Domain" assessment indicated "Level of Supervision: [Client A] does not display skills to be left alone for long periods of time, especially in new environments in the community. [Client A] could become a threat to others and himself if he was left out in the community alone...Staff will be aware of [client A's] whereabouts at all times in the group home, at day services, and in the community. Staff will complete 15 minute checks." The assessment indicated client A did not recognize dangers in the community and was not safe in the community without staff supervision. -Client A's 1/7/2020 "Elopement Plan" indicated client A "has a history of unsafe behavior, self-injurious behaviors, and poor judgement. He is at risk for elopement. He may run away as a way to escape if he feels he's in trouble or to redirect the attention from the original issue. [Client A] may not look or stop for cars before crossing a street when he's upset. He may not know how to get back home if he were to elope. He does not display skills to be left alone for long periods of time, especially in new environments in the community. He could become a threat to others and himself if he was left out in the community alone. Previous elopements out of the staff line of sight...1/3/2020, 1/5/2020. [Client A] has caused significant damage to the wooden privacy fence in the backyard of the group home which will be expensive and time consuming to repair...Implementation. Awake staff 24 hours a day supervision...There are door bells located throughout the group home to alert staff if [client			

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	A] leaves the home. The front window in [client A's] bedroom is locked/secured to prevent elopement into the front yard. The team may add a window bell/alarm to the side window in his bedroom and a window bell/alarm to the first story windows in shared areas. The front door and outdoor gate are kept locked at the group home to ensure safety...If the door bells/locks are not functioning correctly, [the staff] will notify the House Manager...If [client A] starts to elope...the staff will keep him within line of sight to ensure [client A's] safety then notify the on call, House Manager, or QIDP immediately...A staff will drive or walk to follow him...If out of line of sight, call 9-1-1, then the QIDP, and keep looking for [client A]. -Client A's 2/26/2020 BSP indicated the restriction of "Locked Bedroom windows and Window bell" needed for his safety and to prevent elopement behaviors. Client A's BSP indicated the restriction from his IPad after not sleeping at night. The restriction indicated staff will ask for client A's IPad Sunday through Thursday nights at 10:00pm to lock client A's IPad in the office until the next morning when client A wakes for the day. The restriction was the]result of client A's lack of sleep and rest at night. On 2/17/2020 at 8:30am, an interview was conducted with the Director of Community Living (DCL) and the ADCL (Assistant Director of Community Living). The DCL stated the facility "was struggling to meet [Client A's] behavioral needs" when he elopes from the group home. On 2/18/2021 at 9:45am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the staff failed to implement client A's plans correctly			

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	when client A eloped from the group home. The QIDP indicated he was not aware client A's bedroom windows did not lock and did not have alarms/bells on the windows. The QIDP indicated client A needed the bells/alarms on his windows to alert the staff when client A eloped from the group home. The QIDP indicated client A's targeted behaviors included self harm, elopement, and physical aggression. The QIDP stated the staff "have to know where [client A] was all the time." The QIDP indicated client A's ISP and BSP had not been revised since 11/17/2020. The QIDP indicated client A's ISP and BSP were not revised from 1/2020 through 11/17/2020 after each elopement behavior. The QIDP stated the staff should be checking and "laying eyes on [client A] every 15 minutes." On 2/26/2021 at 3:55pm, an interview was conducted with the DCL, the ADCL, the QIDP, and the LPN (Licensed Practical Nurse). The QIDP stated "We have talked about" client A's behavior of stalking his girlfriends over the telephone and no plan was in place. The QIDP stated "there should be an alarm in place and there once was one, but the last time [client A] eloped he broke it and it has not been fixed since the last elopement." The QIDP and the LPN both indicated client A did not realize he can hurt himself and when he is upset he cannot make good choices" to practice street safety and pedestrian safety skills. The QIDP indicated the staff failed to correctly implement and use formal and informal opportunities regarding client A's ISP, BSP, and risk plans when client A continued to elope, self harm, and be physically aggressive. 9-3-4(a)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview for 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H), the facility failed to ensure the staff implemented the agency's written policy/guidelines to screen visitors to the group home to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic. Findings include: On 2/17/2021 from 5:40am until 7:50am, on 2/17/2021 from 2:15pm until 2:55pm, and on 2/18/2021 from 2:55pm until 5:50pm, observation and interviews were conducted at the group home with clients A, B, C, D, E, F, G, and H. During the observation periods, no signs and/or written guidelines were posted on the entry/exit doors of the group home regarding visitation to the group home, restrictions for visitors such as face mask requirements, screening requirements for temperature and travel, and emphasis to ensure visitors washed their hands while at the group home related to preventing the spread of Covid-19. On 2/17/2021 from 2:15pm until 2:55pm, observation and record reviews were conducted at the group home with DSP (Direct Support Professional) #1, DSP #3, DSP #6, and DSP #7. When the surveyor entered the home at 2:15pm, no screening requirements and temperature checks were completed. The surveyor was not asked to wash her hands. At 2:30pm, the Life	W 0455	The Residential Nurse retrained all staff on infection control, prevention, and screening all visitors in the home. The House Manager will ensure that all visitors are screened for temperature when entering the home and make sure that they are wearing masks. This will be done every time someone enters the home. This is to be done for the safety of all clients as well as staff to prevent the spread of disease.	03/31/2021

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	15G802	A. BUILDING 00 B. WING	03/01/2021

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	Safety Code surveyor, the Vice President (VP), and the maintenance person entered the home and no screening requirements, no temperature checks, and no hand washing were completed. At 2:55pm, the VP indicated she, the Life Safety Code surveyor, and the maintenance person had not completed screening questions, temperature checks, and hand washing upon entry to the group home. The VP indicated the agency followed a pandemic plan and the CDC guidelines regarding posting of signs on the entrances/exits of the group home to alert visitors of the screening requirements, questions asked, temperature checks, to wear a face mask, and hand washing to be completed to prevent the spread of Covid-19. On 2/18/2021 at 9:30am, the agency's 3/2020 "Covid-19 Procedures" related to the agency's policies and procedures during a pandemic indicated the agency followed CDC (Centers for Disease Control) guidelines, education for staff to refer to the CDC website for information, how to work remotely from home when possible, guidelines for employees to follow with their work day, and monitoring staff and clients regarding their body temperatures. The policy and procedure included written guidelines related to Covid-19 for the restriction of visitors at the group home, to monitor "all" temperatures for those who enter the group home, and screening questions to ask related to Covid-19 for the staff to implement to assist with preventing the spread of Covid-19 during a pandemic for clients and visitors. On 2/18/2021 at 9:30am, the article "Coronavirus Disease 2019 (COVID-19): Protect Yourself" was reviewed from the website www.cdc.gov. The article indicated: "Everyone should: Wash your hands often: Wash your hands often with soap			

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	and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing. If soap and water are not readily available, use a hand sanitizer that contains at least 60% (percent) alcohol. Cover all surfaces of your hands and rub them together until they feel dry. Avoid touching your eyes, nose, and mouth with unwashed hands. Avoid close contact: Avoid close contact with people who are sick, even if inside your home. If possible, maintain 6 feet between the person who is sick and other household members. Put distance between yourself and other people outside of your home. Remember that some people without symptoms may be able to spread virus. Stay at least 6 feet from other people. Do not gather in groups. Stay out of crowded places and avoid mass gatherings. Keeping distance from others is especially important for people who are at higher risk of getting very sick. Cover your mouth and nose with a cloth face cover when around others: You could spread COVID-19 to others even if you do not feel sick. Everyone should wear a cloth face cover when they have to go out in public, for example if they have to go to the grocery store or to pick up other necessities .... The cloth face cover is meant to protect other people in case you are infected .... Continue to keep about 6 feet distance between yourself and others. The cloth face cover is not a substitute for social distancing. Cover coughs and sneezes: If you are in a private setting and do not have on your cloth face covering, remember to always cover your mouth and nose with a tissue when you cough or sneeze or use the inside of your elbow. Throw used tissues in the trash. Immediately wash your hands with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol.			

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	Clean and disinfect: Clean and disinfect frequently touched surfaces daily. This includes tables, door knobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets and sinks. If surfaces are dirty, clean them. Use detergent or soap and water prior to disinfection. Then, use a household disinfectant. Monitor your health: Be alert for symptoms. Watch for fever, cough, shortness of breath, or other symptoms of COVID-19. Especially important if you are running essential errands, going into the office or workplace, and in setting where it may be difficult to keep a physical distance of 6 feet. Take your temperature if symptoms develop .... Follow CDC guidance if symptoms develop." On 2/18/2021 at 9:30am, a review of the agency's undated "Covid-19 Training" attendance record indicated DSP #2 completed a review of the agency's 3/2020 policy and procedure for Covid-19 regarding the requirements to screen visitors to the group home and to post signs/written guidelines on the entrances and exits of the group home. On 2/26/2021 at 3:30pm, an interview was conducted with the DCL (Director of Community Living) and the LPN (Licensed Practical Nurse). The LPN and the DCL both stated staff, visitors, and clients "should be screened before entering the group home each time" and the staff on duty were responsible for ensuring the screening was completed. The LPN and the DCL both indicated the agency followed the CDC guidelines and developed written guidelines indicating staff were to ensure visitors were screened by asking Covid-19 questions and recording the person's temperature before entering the group home. The LPN stated signs/written guidelines should be posted on "all entries/exits" to the group home to			

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	alert staff and visitors of the requirements to visit including wearing a facemask, screening questions, temperature checks, and washing their hands to prevent the spread of infection during a pandemic. 9-3-7(a)			