STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G353	A. BUILDING 00 B. WING	03/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	1012 PARKWAY DR ANDERSON, IN 46012

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W 0000 Bldg. 00	This visit was for investigation of complaint #IN00285354. Complaint #IN00285354: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W149, W154, W240 and W249. Unrelated deficiency cited. Survey dates: March 13, 14, 17 and 18, 2019. Facility Number: 000869 Provider Number: 15G353 AIM Number: 100244230 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed by #28194 and #09182 on 3/29/19.	W 0000		
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 1 of 3 sampled clients (client A), the facility neglected to monitor/supervise client A who had targeted behaviors of SIB (self-injurious behavior) and SI (suicidal ideation), prevent incidents of SIB and SI and to implement its written policy and procedures to conduct thorough investigations for 4 incidents of SIB for client A.	W 0149	·The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and meal observations. ·Staff training was completed on 4-8-19 by the Behavior Clinician regarding: Client A's BSP and restrictive measures that are in	04/17/2019

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

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	Findings include: On 3/13/19 from 3:50 PM to 6:50 PM and on 3/14/19 from 5:50 AM to 7:25 AM observations were conducted at the group home. At 3:50 PM, client A was taking out the trash and staff #3 gave the surveyor a tour of the home. There were multiple thumb tacks on bulletin boards and the walls throughout the group home. At 3:55 PM, client A was sitting in his bedroom on his bed. Client A's roommate had thumbtacks holding posters on the bedroom's walls and multiple video games in a tote (container) on the floor. Client A indicated he was doing great. There was an electrical receptacle cover missing on a receptacle next to client A's bed. At 4:40 PM, client A was preparing to eat dinner with his peers. There were 12 metal forks in an unlocked kitchen drawer. Staff #3 sat beside client A as he ate his dinner while using a metal fork. Client A went into his bedroom when he was done eating. The surveyor observed client A in his bedroom. There was a blue tote with a lid on it in the bottom of client A's closet under a blanket. The tote contained VCR (video cassette recorder) tapes, cords, a plastic mask, plastic hangers with metal clips, plastic bags and various other items that could be used for SIB. Client A stated, "I'm not supposed to have any of that stuff and they don't know I have it. I'm going to take it to [Program Supervisor]." Client A indicated the VCR tape he cut himself with at Day Service came out of the tote in his closet. At 5:28 PM, the surveyor left client A's room and notified the PS (Program Supervisor) about the items in client A's bedroom. The PS indicated client A was not supposed to have those items in his room. At 5:45 PM, the PS removed the blue tote and various other items from client A's bedroom. Client A was upset and yelling "I'm not going to hurt myself. G*d D*mn		place. ·The Behavior Clinician will review and monitor behavior documentation weekly. ·The Area Director will complete home observations at this home for 2 times per month for the next month to monitor the effectiveness of client BSP's and to monitor for restrictions utilized. ·The Behavior Department will complete weekly home observations in this home for the next 2 months to monitor the effectiveness of client BSP's and to monitor for restrictions utilized. ·The IDT met on 3-19-19 to discuss Client A's behavioral concerns and to determine the restrictive measures that need to be in place. ·A list of the restrictive measures for all individuals in the home has been created and is available in the home for all staff to review. ·The Behavior Clinician revised Client A's BSP on 3-20-19 and 4-4-19. ·Client A was seen by his psychiatrist on 4-2-19. ·HRC approval has been obtained for all restrictions put in place for Client A. ·Training will be completed with the Program Director on investigation requirements. ·The IDT has implemented monthly staffings to ensure that the team discusses the needs of	

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	you." The PS explained to client A he was not supposed to have those items in his room and their job was to keep him safe and he could have access to all of the items, he just had to ask staff first. Client A continued to yell obscenities towards the staff and the surveyor. At 5:55 PM, client A was calm in his bedroom talking with staff #4. At 5:15 PM (3/13/19), client A was interviewed in his bedroom. Client A showed the surveyor the scars on the tops of his hands and indicated they were from him cutting himself in the past with different things. Client A stated, "I signed a contract and I'm not going to do that (cut) anymore. I want to move to waiver (type of residential placement)." Client A indicated he had cut himself a couple times at day services. Now he's monitored when using a fork and has to turn it in to staff after he eats lunch. Client A indicated he stuck a thumb tack in his leg to make it bleed at the group home and he went to the hospital to be checked out. Client A stated, "I got the tack from my wall calendar in here (bedroom)." Client A indicated he wasn't able to have anything that he could use to hurt himself. Client A indicated he had something in his closet he wasn't supposed to have and gave permission for the surveyor to look. There was a blue tote (container) with a lid on it in the bottom of his closet under a blanket. The tote contained VCR (video cassette recorder) tapes, cords, a plastic mask, plastic hangers with metal clips, plastic bags and various other items that could be used for SIB. Client A stated, "I'm not supposed to have any of that staff and they don't know I have it. I'm going to take it to [Program Supervisor]." Client A indicated the VCR tape he cut himself with at Day Service came out of the tote in his closet.		the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. The AD will attend the meeting for the next 2 months. After the second month the Program Director will send a copy of the notes to the AD and Behavior Supervisor for review.	

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	The facility's BDDS (Bureau of Developmental Disabilities Services) reportable incidents were reviewed on 3/13/19 at 3:15 PM and on 3/14/19 at 10:00 AM and indicated the following: 1. On 1/3/19 at 4:00 PM, "[Client A] has been experiencing paranoia and anxiety at both the group home and the day program. On 1-3-19 [client A] was observed to be extremely upset, paranoid and experiencing high levels of anxiety. [Client A] went into his bedroom and destroyed several items of his personal belongings. [Client A] did try to self-harm twice yesterday. The first time was in the morning when he picked up a piece of glasses (sic) from his broken television. Staff was able to redirect him and he did hand over the piece of glass to staff. The second incident occurred later in the afternoon. [Client A] was observed to be breaking his game cases to try and use the plastic pieces to cut himself with. With both incidents there were no injuries reported. Since [client A] was still upset and not able to calm himself down, the police were called out to the group home. [Client A] was taken to [name of hospital] in [name of city] for a psych (psychiatric) evaluation. The psych evaluation was completed and the hospital team discharged [client A] with a safety plan and contact information to (sic) out patient services." There was no investigation completed for the above incident. 2. On 1/23/19 at 12:00 PM, "[Client A] has a behavior plan that addresses anxiety, agitation, property misuse, self-injurious behavior, physical aggression, depression, suicidal ideation, sexual aggression, and going AWOL (eloping). [Client A] was agitation (sic) all morning at day service, staff had attempted multiple times to deescalate			

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	him but he kept focusing on his past and was unable to be calmed down, While eating his lunch, [client A] threw his food on the ground and tore apart his pudding cup and began cutting his hand with the pudding cup. 911 was called and the EMT's (sic) (emergency medical technician's) were able to get the pudding cup away from [client A] and he was taken to the hospital." There was no investigation completed for the above incident. 3. On 1/25/19 at 8:15 AM, "[Client A] has a behavior plan that addresses anxiety, agitation, property misuse, self-injurious behavior, physical aggression, depression, suicidal ideation, sexual aggression, and going AWOL. [Client A] was extremely upset about being at [name of hospital] all day the day before this and not being admitted to the [name of psychiatric unit]. [Client A] walked into the PS/PD (Program Supervisor/Program Director) office at Day Service when he arrived in the building yelling about everyone lying to him. [Client A] got a VMS (sic) (video cassette recorder) tape out of his bag and broke a piece off and began cutting his hand open. He sliced his hand open several times before staff was able to get the plastic away from him. PD called the police and an ambulance came to take [client A] to [name of hospital]." There was no investigation completed for the above incident. 4. On 2/14/19 at 6:20 PM, "Staff had called the program supervisor and reported [client A] had found a push pin from somewhere and had broke off an electrical outlet cover yesterday evening. [Client A] had taken the push pin and used it to cause a vein in his leg to bleed. Staff reported			

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	[client A] was squeezing blood out of his vein onto the floor, [client A] was sent to the emergency room to have his leg evaluated to make sure there was no infection. The hospital monitored him and discharged him. Staff returned with [client A] back to the group home." There was no investigation completed for the above incident. On 3/14/19 at 12:15 PM, client A's record was reviewed. Client A's 11/13/18 BSP (Behavior Support Plan) indicated client A had targeted behaviors of SIB and SI. "...Self Injurious Behavior; skin picking- especially around his fingernails; cutting his anatomy with objects. ALL Sharps are to be locked to decrease incidents of harming self. Staff can ask [client A] to show them his hands, pockets, shoes etc. when needed (suspected of having sharp item) to ensure he does not have sharp items. 1. Offer 1 verbal prompt to stop. 2. Remove others present from the area to ensure their safety and to remove the audience. 3. Approach [client A] calmly. If he has an object he is attempting to cut himself with, maintain a distance in which you can safely monitor him. 4. Firmly tell [client A] to "stop" and ask him to give you the sharp item. 5. If [client A] refuses to give you the item and continues to threaten to harm himself, 911 should be called. 6. The PS/PD should then be called so they are aware that the police have been called. 7. PS/PD will request that the police take [client A] for a psychiatric evaluation. 8. All aggression towards self incidents should be documented...." "....Suicidal Ideation: threats of wanting to harm			

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	himself, statements about wanting to die. 1. Staff should listen without judgment. It might be helpful to engage [client A] in an activity at the same time he is expressing his SI thoughts (i.e., a walk, working on a hobby, playing cards, etc.). 2. Contact the PS/PD for further guidance while monitoring closely. 3. Document the Incident and intervention...." The 11/12/18 ISP (Individual Support Plan) indicated the following: "[Client A] is not appropriate around sharp objects. He will try to self-harm. The sharps are locked in the group home." The 1/3/19 Human Rights Committee/HRC Review notes indicated the following restriction for client A was approved: "Locked CDs (compact disks)/games- [Client A] had a recent attempt of self-harm on 1/3/19. [Client A] broke various XBox (type of gaming system) game disks in an attempt to self-harm." On 3/14/19 at 4:35 PM, staff #3 was interviewed and indicated the following. Client A doesn't have anything in his room to hurt himself. Client A should not have access to forks and thumb tacks. Staff #3 stated she was keeping client A safe by "making sure he doesn't have anything in his possession he can make a weapon out of and doing 15 minute checks." On 3/14/19 at 4:15 PM, the PS was interviewed and stated the following: "He (client A) has had 3-4 incidents of self harm since January 2019". The PS indicated client A was restricted from sharps and he shouldn't have access to thumb tacks and forks without supervision. The PS stated, "He (client A) was not to have access to game system games, VCR tapes or anything else he could use			

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	to harm himself." On 3/13/19 at 5:05 PM, staff #4 was interviewed and indicated client A was restricted from sharps which included, knives, forks and any other items that could be used for self harm. Staff #4 indicated client A should also not have access to thumb tacks. On 3/13/19 at 5:30 PM, DSS (Day Service Staff) #1 was interviewed and indicated she was full time staff at the facility operated day service, but she also worked at the group home. DSS #1 indicated client A should not have access to anything he could use to harm himself, including, forks, thumb tacks, VCR tapes, CDs and video games. The DSS #1 stated, "We need to do a better job protecting him." On 3/14/19 at 8:05 AM, the PD (Program Director) and PS at the facility operated day program were interviewed and they indicated client A should not have access to anything he could use to hurt himself. The PD indicated these items included sharps, tacks, forks, VCR tapes and video games. On 3/14/19 at 12:00 PM and 1:50 PM, the AD (Area Director) was interviewed. The AD stated former PD #1 told staff on 1/3/19 client A was not to have access to anything "that could be used to harm himself and it needed to be removed from his room." The AD indicated the following: HRC approval was obtained for locked CDs and games due to an incident where client A attempted self harm with a broken video game disk. The staff were never told client A could not have access to thumb tacks. Client A's BSP needed to be updated to include a detailed list of what items were considered sharps and how the staff should monitor client A's bedroom to ensure client A was			

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	not hoarding harmful items in his bedroom. There was an IDT (Interdisciplinary team) meeting on 3/19/19 to discuss client A's BSP. Incidents of self harm and attempted self harm should be investigated and she did not have investigations for client A's incidents of self harm. The facility's policy and procedures were reviewed on 3/13/19 at 2:15 PM. The facility's Quality and Risk Management Policy dated September 2017 indicated the following: -"Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." -"Indiana Mentor is committed to ensuring the individuals we serve are provided with a safe and quality living environment." -"Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee." -"1. Investigations will be completed for all deaths, allegations of abuse, neglect, exploitation or mistreatment. Additional investigations will be completed for incidents with significant injuries of unknown origin and incidents that may be requested by outside entities." -"4. A service delivery site that compromises the health and safety of an individual while the individual is receiving services from the following causes:"			

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	-"f. Event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual receiving services;" This federal tag relates to complaint #IN00285354. 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 4 of 10 incident reports reviewed affecting client A, the facility failed to conduct thorough investigations for 4 incidents of SIB (self-injurious behavior) for client A. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reportable incidents were reviewed on 3/13/19 at 3:15 PM and on 3/14/19 at 10:00 AM and indicated the following: 1. On 1/3/19 at 4:00 PM, "[Client A] has been experiencing paranoia and anxiety at both the group home and the day program. On 1-3-19 [client A] was observed to be extremely upset, paranoid and experiencing high levels of anxiety. [Client A] went into his bedroom and destroyed several items of his personal belongings. [Client A] did try to self-harm twice yesterday. The first time was in the morning when he picked up a piece of glasses (sic) from his broken television. Staff was able to redirect him and he did hand over the piece of glass to staff. The second incident occurred later in the afternoon. [Client A]	W 0154	·The Program Director will be retrained on investigation expectations and components of a thorough investigations. ·The Program Director will be retrained on what requires an investigation The Quality Improvement Department and the Area Director will monitor incidents as they are reported to ensure that required investigations are completed. ·Area Director and/or Quality Assurance will monitor and assist the Program Director as needed during the investigation process to help ensure investigation thoroughness.	04/17/2019

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	was observed to be breaking his game cases to try and use the plastic pieces to cut himself with. With both incidents there were no injuries reported. Since [client A] was still upset and not able to calm himself down, the police were called out to the group home. [Client A] was taken to [name of hospital] in [name of city] for a psych (psychiatric) evaluation. The psych evaluation was completed and the hospital team discharged [client A] with a safety plan and contact information to (sic) out patient services." There was no investigation completed for the above incident. 2. On 1/23/19 at 12:00 PM, "[Client A] has a behavior plan that addresses anxiety, agitation, property misuse, self-injurious behavior, physical aggression, depression, suicidal ideation, sexual aggression, and going AWOL (eloping). [Client A] was agitation (sic) all morning at day service, staff had attempted multiple times to deescalate him but he kept focusing on his past and was unable to be calmed down, While eating his lunch, [client A] threw his food on the ground and tore apart his pudding cup and began cutting his hand with the pudding cup. 911 was called and the EMT's (emergency medical technician's) were able to get the pudding cup away from [client A] and he was taken to the hospital." There was no investigation completed for the above incident. 3. On 1/25/19 at 8:15 AM, "[Client A] has a behavior plan that addresses anxiety, agitation, property misuse, self-injurious behavior, physical aggression, depression, suicidal ideation, sexual aggression, and going AWOL. [Client A] was extremely upset about being at [name of hospital]			

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	all day the day before this and not being admitted to the [name of psychiatric unit]. [Client A] walked into the PS/PD (Program Supervisor/Program Director) office at Day Service when he arrived in the building yelling about everyone lying to him. [Client A] got a VMS (sic) (video cassette recorder) tape out of his bag and broke a piece off and began cutting his hand open. He sliced his hand open several times before staff was able to get the plastic away from him. PD called the police and an ambulance came to take [client A] to [name of hospital]." There was no investigation completed for the above incident. 4. On 2/14/19 at 6:20 PM, "Staff had called the program supervisor and reported [client A] had found a push pin from somewhere and had broke off an electrical outlet cover yesterday evening. [Client A] had taken the push pin and used it to cause a vein in his leg to bleed. Staff reported [client A] was squeezing blood out of his vein onto the floor, [client A] was sent to the emergency room to have his leg evaluated to make sure there was no infection. The hospital monitored him and discharged him. Staff returned with [client A] back to the group home." There was no investigation completed for the above incident. On 3/14/19 at 12:00 PM and 1:50 PM, the AD (Area Director) was interviewed and indicated incidents of self harm and attempted self hard should be investigated and she did not have investigations for client A's incidents of self harm. This federal tag relates to complaint #IN00285354.			

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W 0240 Bldg. 00	9-3-2(a) 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 3 sampled clients (client A), the facility failed to include specific written guidelines in client A's BSP (Behavior Support Plan) for SIB (self injurious behavior) including what items were considered sharps and how the staff should monitor client A's bedroom to ensure he does not have access to items which could be used for self injury. Findings include: On 3/13/19 from 3:50 PM to 6:50 PM and on 3/14/19 from 5:50 AM to 7:25 AM observations were conducted at the group home. At 3:50 PM, client A was taking out the trash and staff #3 gave the surveyor a tour of the home. There were multiple thumb tacks on bulletin boards and the walls throughout the group home. At 3:55 PM, client A was sitting in his bedroom on his bed. Client A's roommate had thumbtacks holding posters on their bedroom walls and multiple video games in a tote (container) on the floor. Client A indicated he was doing great. There was an electrical receptacle cover missing on a receptacle next to client A's bed. At 4:40 PM, client A was preparing to eat dinner with his peers. There were 12 metal forks in an unlocked kitchen drawer. Staff #3 sat beside client A as he ate his dinner while using a metal fork. Client A went to his bedroom when he was done eating. The surveyor observed client A in his bedroom. There was a blue tote with a lid on it in the bottom of client A's	W 0240	·The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and meal observations. ·Staff training was completed on 4-8-19 by the Behavior Clinician regarding: Client A's BSP and restrictive measures that are in place. ·The Behavior Clinician will review and monitor behavior documentation weekly. ·The Area Director will complete home observations at this home for 2 times per month for the next month to monitor the effectiveness of client BSP's and to monitor for restrictions utilized. ·The Behavior Department will complete weekly home observations in this home for the next 2 months to monitor the effectiveness of client BSP's and to monitor for restrictions utilized. ·The IDT met on 3-19-19 to discuss Client A's behavioral concerns and to determine the restrictive measures that need to be in place. ·A list of the restrictive measures for all individuals in the	04/17/2019

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	closet under a blanket. The tote contained VCR (video cassette recorder) tapes, cords, a plastic mask, plastic hangers with metal clips, plastic bags and various other items that could be used for SIB. Client A stated, "I'm not supposed to have any of that stuff and they don't know I have it. I'm going to take it to [Program Supervisor]." Client A indicated the VCR tape he cut himself with at Day Service came out of the tote in his closet. At 5:28 PM, the surveyor left client A's room and notified the PS (Program Supervisor) about the items in client A's bedroom. The PS indicated client A was not supposed to have those items in his room. At 5:45 PM, the PS removed the blue tote and various other items from client A's bedroom. Client A was upset and yelling "I'm not going to hurt myself. G*d D*mn you." The PS explained to client A he was not supposed to have those items in his room and their job was to keep him safe and he could have access to all of the items, he just had to ask staff first. Client A continued to yell obscenities towards the staff and the surveyor. At 5:55 PM, client A was calm in his bedroom talking with staff #4. At 5:15 PM, client A was interviewed in his bedroom. Client A showed the surveyor the scars on the tops of his hands and indicated they were from him cutting himself in the past with different things. Client A stated, "I signed a contract and I'm not going to do that (cut) anymore. I want to move to waiver (type of residential placement)." Client A indicated he had cut himself a couple times at day services. Now he's monitored while using a fork and has to turn it in to staff after he eats lunch. Client A indicated he stuck a thumb tack in his leg to make it bleed at the group home and he went to the hospital to be checked out. Client A stated, "I got the tack from my wall		home has been created and is available in the home for all staff to review. ·The Behavior Clinician revised Client A's BSP on 3-20-19 and 4-4-19. ·Client A's BSP now includes room checks and personal searches. ·HRC approval has been obtained for all restrictions put in place for Client A. ·New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, BSP's, programming, and medication review. ·The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. ·Oversight of the behavior documentation will be completed by the Program Coordinator, QIDP, Behavior Clinician. ·Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of	

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	calendar in here (bedroom)." Client A indicated he wasn't able to have anything that he could use to hurt himself. Client A indicated he had something in his closet he wasn't supposed to have and gave permission for the surveyor to look. There was a blue tote with a lid on it in the bottom of his closet under a blanket. The tote contained VCR (video cassette recorder) tapes, cords, a plastic mask, plastic hangers with metal clips, plastic bags and various other items that could be used for SIB. Client A stated, "I'm not supposed to have any of that stuff and they don't know I have it. I'm going to take it to [Program Supervisor]." Client A indicated the VCR tape he cut himself with at Day Service came out of the tote in his closet. The facility's BDDS (Bureau of Developmental Disabilities Services) reportable incidents were reviewed on 3/13/19 at 3:15 PM and on 3/14/19 at 10:00 AM and indicated the following: 1. On 1/3/19 at 4:00 PM, "[Client A] has been experiencing paranoia and anxiety at both the group home and the day program. On 1-3-19 [client A] was observed to be extremely upset, paranoid and experiencing high levels of anxiety. [Client A] went into his bedroom and destroyed several items of his personal belongings. [Client A] did try to self-harm twice yesterday. The first time was in the morning when he picked up a piece of glasses (sic) from his broken television. Staff was able to redirect him and he did hand over the piece of glass to staff. The second incident occurred later in the afternoon. [Client A] was observed to be breaking his game cases to try and use the plastic pieces to cut himself with. With both incidents there were no injuries reported. Since [client A] was still upset and not able to calm himself down, the police were called		the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document, how to report incidents and understanding of BSP's. ·On-going the Area Director will review Program Director's weekly supervisory visits forms and will follow up with the appropriate individual to ensure the concerns are addressed.	

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	out to the group home. [Client A] was taken to [name of hospital] in [name of city] for a psych (psychiatric) evaluation. The psych evaluation was completed and the hospital team discharged [client A] with a safety plan and contact information to (sic) out patient services." 2. On 1/23/19 at 12:00 PM, "[Client A] has a behavior plan that addresses anxiety, agitation, property misuse, self-injurious behavior, physical aggression, depression, suicidal ideation, sexual aggression, and going AWOL (eloping). [Client A] was agitation (sic) all morning at day service, staff had attempted multiple times to deescalate him but he kept focusing on his past and was unable to be calmed down, While eating his lunch, [client A] threw his food on the ground and tore apart his pudding cup and began cutting his hand with the pudding cup (container). 911 was called and the EMT's (sic) (emergency medical technician's) were able to get the pudding cup away from [client A] and he was taken to the hospital." 3. On 1/25/19 at 8:15 AM, "[Client A] has a behavior plan that addresses anxiety, agitation, property misuse, self-injurious behavior, physical aggression, depression, suicidal ideation, sexual aggression, and going AWOL. [Client A] was extremely upset about being at [name of hospital] all day the day before this and not being admitted to the [name of psychiatric unit]. [Client A] walked into the PS/PD (Program Supervisor/Program Director) office at Day Service when he arrived in the building yelling about everyone lying to him. [Client A] got a VMS (sic) (video cassette recorder) tape out of his bag and broke a piece off and began cutting his hand open. He sliced his hand open several times before staff was able to get the plastic away from him. PD called the police			

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	and an ambulance came to take [client A] to [name of hospital]." 4. On 2/14/19 at 6:20 PM, "Staff had called the program supervisor and reported [client A] had found a push pin from somewhere and had broke off an electrical outlet cover yesterday evening. [Client A] had taken the push pin and used it to cause a vein in his leg to bleed. Staff reported [client A] was squeezing blood out of his vein onto the floor, [client A] was sent to the emergency room to have his leg evaluated to make sure there was no infection. The hospital monitored him and discharged him. Staff returned with [client A] back to the group home." On 3/14/19 at 12:15 PM, client A's record was reviewed. Client A's 11/13/18 BSP (Behavior Support Plan) indicated client A had targeted behaviors of SIB and SI. "...Self Injurious Behavior; skin picking- especially around his fingernails; cutting his anatomy with objects. ALL Sharps are to be locked to decrease incidents of harming self. Staff can ask [client A] to show them his hands, pockets, shoes etc. when needed (suspected of having sharp item) to ensure he does not have sharp items. 1. Offer 1 verbal prompt to stop. 2. Remove others present from the area to ensure their safety and to remove the audience. 3. Approach [client A] calmly. If he has an object he is attempting to cut himself with, maintain a distance in which you can safely monitor him. 4. Firmly tell [client A] to 'stop' and ask him to give you the sharp item. 5. If [client A] refuses to give you the item and continues to threaten to harm himself, 911 should be called. 6. The PS/PD should then be called so they are aware that the police have been called.			

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	7. PS/PD will request that the police take [client A] for a psychiatric evaluation. 8. All aggression towards self incidents should be documented...." "....Suicidal Ideation: threats of wanting to harm himself, statements about wanting to die. 1. Staff should listen without judgment. It might be helpful to engage [client A] in an activity at the same time he is expressing his SI thoughts (i.e., a walk, working on a hobby, playing cards, etc.). 2. Contact the PS/PD for further guidance while monitoring closely. 3. Document the Incident and intervention...." A review of client A's 11/13/18 BSP indicated the BSP did not include a detailed list of items considered sharps and how the staff should monitor client A's bedroom to ensure he does not have access to those items. The 11/12/18 ISP (Individual Support Plan) indicated the following: "[Client A] is not appropriate around sharp objects. He will try to self-harm. The sharps are locked in the group home." The 1/3/19 Human Rights Committee Review notes indicated the following restriction for client A was approved: "Locked CD's (sic) (compact disks)/games- [Client A] had a recent attempt of self-harm on 1/3/19. [Client A] broke various XBox game disks in an attempt to self-harm." On 3/14/19 at 4:35 PM, staff #3 was interviewed and indicated the following. Client A doesn't have anything in his room to hurt himself. Client A should not have access to forks and thumb tacks. Staff #3 stated she was keeping client A safe by "making sure he doesn't have anything in			

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	his possession he can make a weapon out of and doing 15 minute checks." On 3/14/19 at 4:15 PM, the PS was interviewed and stated the following: "He (client A) has had 3-4 incidents of self harm since January 2019." The PS indicated client A was restricted from sharps and he shouldn't have access to thumb tacks and forks without supervision. The PS stated, "He (client A) was not to have access to game system games, VCR tapes or anything else he could use to harm himself." On 3/13/19 at 5:05 PM, staff #4 was interviewed and indicated client A was restricted from sharps which included, knives, forks and any other items that could be used for self harm. Staff #4 indicated client A should also not have access to thumb tacks. On 3/13/19 at 5:30 PM, DSS (Day Service Staff) #1 was interviewed and indicated she was full time staff at the facility operated day service, but she also worked at the group home. The DSS #1 indicated client A should not have access to anything he could use to harm himself, including, forks, thumb tacks, VCR tapes, CDs and video games. The DSS #1 stated, "We need to do a better job protecting him." On 3/14/19 at 8:05 AM, the PD (Program Director) and PS at the facility operated day program were interviewed and they indicated client A should not have access to anything he could use to hurt himself. The PD indicated these items included sharps, tacks, forks, VCR tapes and video games. On 3/14/19 at 12:00 PM and 1:50 PM, the AD (Area Director) was interviewed. The AD stated the former PD told staff on 1/3/19 client A was not			

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	to have access to anything "that could be used to harm himself and it needed to be removed from his room." The AD indicated the following: HRC approval was obtained for locked CDs and games due to an incident where client A attempted self harm with a broken video game disk. The staff were never told client A could not have access to thumb tacks. Client A's BSP needed to be updated to include a detailed list of what items are considered sharps and how the staff should monitor client A's bedroom to ensure client A is not hoarding harmful items in his bedroom. The interview indicated an IDT (Interdisciplinary team) meeting was scheduled on 3/19/19 to discuss client A's BSP. This federal tag relates to complaint #IN00285354. 9-3-4(a)			
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 ensure client A's ISP (Individual Support Plan) and BSP (Behavior Support Plan) objectives were implemented as written. Findings include: On 3/13/19 from 3:50 PM to 6:50 PM and on 3/14/19 from 5:50 AM to 7:25 AM observations	W 0249	·The Program Supervisor will do home observations weekly to ensure staff are implementing the plans of clients, the client's needs are being met and meal observations. ·Staff training was completed on 4-8-19 by the Behavior Clinician regarding: Client A's BSP and restrictive measures that are in	04/17/2019

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	were conducted at the group home. At 3:50 PM, client A was taking out the trash and staff #3 gave the surveyor a tour of the home. There were multiple thumb tacks on bulletin boards and the walls throughout the group home. At 3:55 PM, client A was sitting in his bedroom on his bed. Client A's roommate had thumbtacks holding posters on the walls and multiple video games in a tote (container) on the floor. Client A indicated he was doing great. There was a cover missing from an electrical receptacle next to client A's bed. At 4:40 PM, client A was preparing to eat dinner with his peers. There were 12 metal forks in an unlocked kitchen drawer. Staff #3 sat beside client A as he ate his dinner while using a metal fork. Client A went to his bedroom when he was done eating. The surveyor observed client A in his bedroom. There was a blue tote with a lid on it in the bottom of client A's closet under a blanket. The tote contained VCR (video cassette recorder) tapes, cords, a plastic mask, plastic hangers with metal clips, plastic bags and various other items that could be used for SIB. Client A stated, "I'm not supposed to have any of that stuff and they don't know I have it. I'm going to take it to [Program Supervisor]." Client A indicated the VCR tape he cut himself with at Day Service came out of the tote in his closet. At 5:28 PM, the surveyor left client A's room and notified the PS (Program Supervisor) about the items in client A's bedroom. The PS indicated client A was not supposed to have those items in his room. At 5:45 PM, the PS removed the blue tote and various other items from client A's bedroom. Client A was upset and yelling "I'm not going to hurt myself. G*d D*mn you." The PS explained to client A he was not supposed to have those items in his room and their job was to keep him safe. He could have access to all of the items, he just had to ask staff		place. ·The Behavior Clinician will review and monitor behavior documentation weekly. ·The Area Director will complete home observations at this home for 2 times per month for the next month to monitor the effectiveness of client BSP's and to monitor for restrictions utilized. ·The Behavior Department will complete weekly home observations in this home for the next 2 months to monitor the effectiveness of client BSP's and to monitor for restrictions utilized. ·The IDT met on 3-19-19 to discuss Client A's behavioral concerns and to determine the restrictive measures that need to be in place. ·A list of the restrictive measures for all individuals in the home has been created and is available in the home for all staff to review. ·The Behavior Clinician revised Client A's BSP on 3-20-19 and 4-4-19. ·Client A's BSP now includes room checks and personal searches. ·HRC approval has been obtained for all restrictions put in place for Client A. ·New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training	

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	first. Client A continued to yell obscenities towards the staff and the surveyor. At 5:55 PM, client A was in his bedroom calm, talking with staff #4. At 5:15 PM, client A was interviewed in his bedroom. Client A showed the surveyor the scars on the tops of his hands and indicated they were from him cutting himself in the past with different things. Client A stated, "I signed a contract and I'm not going to do that (cut) anymore. I want to move to waiver (type of residential placement)." Client A indicated he had cut himself a couple times at day services. Now he's monitored when using a fork and has to turn it in to staff after he eats lunch. Client A indicated he stuck a thumb tack in his leg to make it bleed at the group home and he went to the hospital to be checked out. Client A stated, "I got the tack from my wall calendar in here (bedroom)." Client A indicated he wasn't able to have anything that he could use to hurt himself. Client A indicated he had something in his closet he wasn't supposed to have and gave permission for the surveyor to look. There was a blue tote with a lid on it in the bottom of his closet under a blanket. The tote contained VCR (video cassette recorder) tapes, cords, a plastic mask, plastic hangers with metal clips, plastic bags and various other items that could be used for SIB. Client A stated, "I'm not supposed to have any of that stuff and they don't know I have it. I'm going to take it to [Program Supervisor]." Client A indicated the VCR tape he cut himself with at Day Service came out of the tote in his closet. The facility's BDDS (Bureau of Developmental Disabilities Services) reportable incidents were reviewed on 3/13/19 at 3:15 PM and on 3/14/19 at 10:00 AM and indicated the following:		includes items such as: client's diets, risk plans, ISP's, BSP's, programming, and medication review. ·The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. ·Oversight of the behavior documentation will be completed by the Program Coordinator, QIDP, Behavior Clinician. ·Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document, how to report incidents and understanding of BSP's. ·On-going the Area Director will review Program Director's weekly supervisory visits forms and will follow up with the appropriate individual to ensure the concerns are addressed.	

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	1. On 1/3/19 at 4:00 PM, "[Client A] has been experiencing paranoia and anxiety at both the group home and the day program. On 1-3-19 [client A] was observed to be extremely upset, paranoid and experiencing high levels of anxiety. [Client A] went into his bedroom and destroyed several items of his personal belongings. [Client A] did try to self-harm twice yesterday. The first time was in the morning when he picked up a piece of glasses (sic) from his broken television. Staff was able to redirect him and he did hand over the piece of glass to staff. The second incident occurred later in the afternoon. [Client A] was observed to be breaking his game cases to try and use the plastic pieces to cut himself with. With both incidents there were no injuries reported. Since [client A] was still upset and not able to calm himself down, the police were called out to the group home. [Client A] was taken to [name of hospital] in [name of city] for a psych (psychiatric) evaluation. The psych evaluation was completed and the hospital team discharged [client A] with a safety plan and contact information to (sic) out patient services." 2. On 1/23/19 at 12:00 PM, "[Client A] has a behavior plan that addresses anxiety, agitation, property misuse, self-injurious behavior, physical aggression, depression, suicidal ideation, sexual aggression, and going AWOL (eloping). [Client A] was agitation (sic) all morning at day service, staff had attempted multiple times to deescalate him but he kept focusing on his past and was unable to be calmed down. While eating his lunch, [client A] threw his food on the ground and tore apart his pudding cup and began cutting his hand with the pudding cup (container). 911 was called and the EMT's (sic) (emergency medical technician's) were able to get the pudding cup			

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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
	away from [client A] and he was taken to the hospital." 3. On 1/25/19 at 8:15 AM, "[Client A] has a behavior plan that addresses anxiety, agitation, property misuse, self-injurious behavior, physical aggression, depression, suicidal ideation, sexual aggression, and going AWOL. [Client A] was extremely upset about being at [name of hospital] all day the day before this and not being admitted to the [name of psychiatric unit]. [Client A] walked into the PS/PD (Program Supervisor/Program Director) office at Day Service when he arrived in the building yelling about everyone lying to him. [Client A] got a VMS (sic) (video cassette recorder) tape out of his bag and broke a piece off and began cutting his hand open. He sliced his hand open several times before staff was able to get the plastic away from him. PD called the police and an ambulance came to take [client A] to [name of hospital]." 4. On 2/14/19 at 6:20 PM, "Staff had called the program supervisor and reported [client A] had found a push pin from somewhere and had broke off an electrical outlet cover yesterday evening. [Client A] had taken the push pin and used it to cause a vein in his leg to bleed. Staff reported [client A] was squeezing blood out of his vein onto the floor, [client A] was sent to the emergency room to have his leg evaluated to make sure there was no infection. The hospital monitored him and discharged him. Staff returned with [client A] back to the group home." On 3/14/19 at 12:15 PM, client A's record was reviewed. Client A's 11/13/18 BSP (Behavior Support Plan) indicated client A had targeted behaviors of SIB and SI. "...Self Injurious Behavior; skin picking- especially			

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	15G353	A. BUILDING 00 B. WING	03/18/2019

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	around his fingernails; cutting his anatomy with objects. ALL Sharps are to be locked to decrease incidents of harming self. Staff can ask [client A] to show them his hands, pockets, shoes etc. when needed (suspected of having sharp item) to ensure he does not have sharp items. 1. Offer 1 verbal prompt to stop. 2. Remove others present from the area to ensure their safety and to remove the audience. 3. Approach [client A] calmly. If he has an object he is attempting to cut himself with, maintain a distance in which you can safely monitor him. 4. Firmly tell [client A] to 'stop' and ask him to give you the sharp item. 5. If [client A] refuses to give you the item and continues to threaten to harm himself, 911 should be called. 6. The PS/PD should then be called so they are aware that the police have been called. 7. PS/PD will request that the police take [client A] for a psychiatric evaluation. 8. All aggression towards self incidents should be documented...." "....Suicidal Ideation: threats of wanting to harm himself, statements about wanting to die. 1. Staff should listen without judgment. It might be helpful to engage [client A] in an activity at the same time he is expressing his SI thoughts (i.e., a walk, working on a hobby, playing cards, etc.). 2. Contact the PS/PD for further guidance while monitoring closely. 3. Document the Incident and intervention...." Client A's 3/14/19 at 12:15 PM record review indicated a 11/13/18 BSP (Behavior Support Plan). The review indicated facility staff failed to implement client A's BSP by not ensuring client A did not have access to the sharps he used to injure himself.			

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The 11/12/18 ISP (Individual Support Plan) indicated the following: "[Client A] is not appropriate around sharp objects. He will try to self-harm. The sharps are locked in the group home."

The review of the 11/12/18 ISP indicated facility staff failed to implement client A's ISP by not ensuring client A did not have access to the sharps he used to injure himself.

The 1/3/19 Human Rights Committee Review notes indicated the following restriction for client A was approved: "Locked CD's (sic) (compact disks)/games- [Client A] had a recent attempt of self-harm on 1/3/19. [Client A] broke various XBox game disks in an attempt to self-harm."

On 3/14/19 at 4:35 PM, staff #3 was interviewed and indicated the following. Client A doesn't have anything in his room to hurt himself. Client A should not have access to forks and thumb tacks. Staff #3 stated she was keeping client A safe by "making sure he doesn't have anything in his possession he can make a weapon out of and doing 15 minute checks."

On 3/14/19 at 4:15 PM, the PS was interviewed and stated the following: "He (client A) has had 3-4 incidents of self harm since January 2019." The PS indicated client A was restricted from sharps and he shouldn't have access to thumb tacks and forks without supervision. The PS stated, "He (client A) was not to have access to game system games, VCR tapes or anything else he could use to harm himself."

On 3/13/19 at 5:05 PM, staff #4 was interviewed and indicated client A was restricted from sharps

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which included, knives, forks and any other items that could be used for self harm. Staff #4 indicated client A should also not have access to thumb tacks.

On 3/13/19 at 5:30 PM, DSS #1 was interviewed and indicated she was full time staff at the facility operated day service, but she also worked at the group home. The DSS #1 indicated client A should not have access to anything he could use to harm himself, including, forks, thumb tacks, VCR tapes, CDs and video games. The DSS #1 stated, "We need to do a better job protecting him."

On 3/14/19 at 8:05 AM, the PD (Program Director) and PS at the facility operated day program were interviewed and they indicated client A should not have access to anything he could use to hurt himself. The PD indicated these items included sharps, tacks, forks, VCR tapes and video games.

On 3/14/19 at 12:00 PM and 1:50 PM, the AD (Area Director) was interviewed. The AD stated the former PD (Program Director) told staff on 1/3/19 client A was not to have access to anything "that could be used to harm himself and it needed to be removed from his room." The AD indicated the following: HRC approval was obtained for locked CDs and games due to an incident where client A attempted self harm with a broken video game disk. The staff were never told client A could not have access to thumb tacks. Client A's ISP and BSP should be implemented as written.

This federal tag relates to complaint #IN00285354.

9-3-4(a)

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W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 sampled clients (A), the facility's nursing services failed to ensure client A's lab (laboratory blood tests) work was completed as ordered by the physician which resulted in client A missing his prescribed psychotropic medication. Findings Include: The facility's BDDS (Bureau of Developmental Disabilities Services) reportable incidents were reviewed on 3/13/19 at 3:15 PM and on 3/14/19 at 10:00 AM and indicated the following: On 3/12/19 at 8:00 AM, "....On 3/2/19 [client A] started taking Clozapine (anti-psychotic medication for behavior) as prescribed by his psychiatrist. He was ordered to take 25 mg (milligrams) 3 days, then 25 mg BID (twice daily) for 3 days and then 25 mg TID (three times daily). He was ordered to get weekly lab draws so the pharmacy could release the next ordered round (dosage) of medication. On 3/12/19 IN (Indiana) Mentor's nurse was informed that [client A] did not have the medication for his 25 mg TID dose. After looking into the concern the nurse was able to determine the [client A] did not complete his lab work last week and consequently the pharmacy was unable to release to (sic) medication as prescribed. [Client A] completed the lab work on 3/11/19. It was determined that [client A] missed his prescribed doses for the 12p and 7p dose on the 8th, 9th, 10th, 11th and 12th (March 2019). He also missed his 7am dose on the 12th...."	W 0331	·The labs for Client A have now been set up on a weekly lab draw schedule. The labs are now forwarded to the pharmacy so the Clozapine medication will be released timely. ·Client A's psychiatrist forwarded a new titration schedule for his Clozapine medication to the pharmacy on 3-14-19. ·Client A's new titration schedule for his Clozapine started on 3-15-19. ·Training will be completed with the Program Supervisor by the nurse regarding: ·Expectations regarding following physicians orders ·Completing lab work timely ·Ensuring labs are forwarded to the pharmacy timely as required ·Client A was seen by his psychiatrist again on 4-2-19. ·The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. ·The nurse will monitor medical needs when she is in the home and/or day services at least	04/17/2019

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	On 3/14/19 at 12:15 PM, client A's record was reviewed. Client A's MAR (Medication Administration Record) for March 2019 indicated client A missed his prescribed Clozapine 25 mg on the following dates and times: 3/8/19 at 12:00 PM and 7:00 PM, 3/9/19 at 12:00 PM and 7:00 PM, 3/10/19 at 12:00 PM and 7:00 PM, 3/11/19 at 12:00 PM and 7:00 PM, 3/12/19 at 7:00 AM, 12:00 PM and 7:00 PM, 3/13/19 at 7:00 AM, 12:00 PM and 7:00 PM and, 3/14/19 at 7:00 AM. A 2/19/19 prescription from [name of psychiatrist] indicated client A was to have lab work completed weekly due being prescribed Clozapine. On 3/13/19 at 4:15 PM, the PS (Program Supervisor) was interviewed and indicated she was responsible for ensuring client A's lab work was completed as scheduled. The PS indicated client A did not have lab work completed as scheduled which resulted in him missing his prescribed medication for multiple days. On 3/14/19 at 1:30 PM, the RN (Registered Nurse) was interviewed. The RN indicated clients' medications should be administered as ordered by the Physician. The RN indicated client A did not have his lab work completed as scheduled so the pharmacy would not fill the medication (prescription/s). The RN indicated client A had the lab work completed on 3/11/19 and the pharmacy received the order for the medication today (3/14/19). The RN stated, "he (client A) will start back over at 25 mg once a day. Labs are scheduled weekly through [name of lab] and they come to the house." The RN indicated the Program Supervisor was responsible for ensuring client A's labs were completed as scheduled.		weekly. ·The nurse will monitor lab work to ensure that it is completed as ordered.	

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	9-3-6(a)			