

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G394		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421			
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W0000	<p>This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00116647.</p> <p>Complaint #IN00116647 - Substantiated. Federal/state deficiencies related to the allegation are cited at W149, W154 and W249.</p> <p>Survey Dates: October 17, 18, 19 and 22, 2012.</p> <p>Facility Number: 000908 Provider Number: 15G394 AIM Number: 100244380</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/25/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on record review and interview for 1 of 3 clients in the sample who attended an outside services day program (D), the facility failed to ensure the day program's services met the need of the client.</p> <p>Findings include:</p> <p>A review of client D's record was conducted on 10/19/12 at 10:49 AM. The Nursing Quarterly, dated 2/27/12, indicated, "Staff reports that [client D] eats out of trash at day service." The June 2012 Monthly Health Review indicated, "Continued to eat out of the trash periodically at day service causing the BS (blood sugar) over 200." The September 2012 Monthly Health Review indicated, "Continues to periodically eat of out the trash." Client D's Behavior Support Plan, dated 10/7/11, indicated he had a targeted behavior of food seeking. Food seeking was defined as seeking and/or consuming food during non-meal times. The plan did not address eating out of the trash.</p> <p>An interview with the Home Manager (HM) was conducted on 10/19/12 at 12:07 PM. The HM indicated she did not have documentation for the targeted</p>	W0120	An IDT is scheduled for Client D at LARC on 11/11/2012 to discuss his behavior of attempting to eat out of the trash. Once this plan is approved by his guardian and HRC, this plan will be added to his ISP and staff at the home and day program will be trained. Observations will be completed by the Home Manager and/or Program Director weekly for four weeks and then will continue monthly to monitor the effectiveness of this plan and to determine if any changes need to be addressed. A tracking form will be implemented at the day program to monitor attempts of Client D to eat out of the trash cans. Responsible party: Home Manager, Program Director, and Area Director.	11/21/2012	

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	<p>behavior from the day program. The HM indicated client D may be eating out of the trash cans or out of other clients' lunches. The HM indicated the issue had been discussed during the group home's monthly meeting with the day program. On 10/22/12 at 11:43 AM, the HM indicated client D should not be eating out of the trash at day program. The HM indicated client D eating out of the trash was due to a lack of supervision and the day program needed to do something to address the issue. The HM indicated she did not know where the nurse received her information since the nurse did not attend the monthly meetings with the day program.</p> <p>An interview with the nurse was conducted on 10/19/12 at 2:21 PM. The nurse indicated she received the information regarding client D eating out of the trash from the staff at the day program while visiting the day program. The nurse indicated she also received information from the group home staff. The day program staff informed her it was hard for the day program staff to keep track of client D at the day program.</p> <p>An interview with the Area Director (AD) was conducted on 10/19/12 at 12:07 PM. The AD indicated he was not aware of the issue at day program. The AD indicated</p>			

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	<p>client D should receive increased supervision; the AD indicated the supervision level at the day program may not be adequate. The AD indicated client D's plan needed to be revised.</p> <p>9-3-1(a)</p>				

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W0125	<p>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.</p> <p>Based on observation, interview and record review for 4 of 4 clients in the sample (B, D, F and H), the facility failed to ensure the clients had the right to due process in regard to: 1) locking of linens and 2) client B's cigarettes being locked.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/17/12 from 3:38 PM to 6:01 PM and 10/18/12 from 5:56 AM to 7:33 AM.</p> <p>1) During the observations, the linens (flat and fitted sheets) were locked in a closet next to the office just inside the front door. The locked closet was accessible to staff using a key. Clients B, D, F and H did not have access to the closet.</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM. There was no documentation in client B's record indicating the linens were locked or needed to be locked. Client D's</p>	W0125	<p>An IDT is scheduled for 11/11/2012 to discuss the need for Client D's linens to be locked up due to "obsessively" changing his sheets if the sheets are readily available. (The 2567 states that this is for Client B, however, this is inaccurate and is actually for Client D).Once this plan is approved by his guardian and HRC, this plan will be added to his ISP and staff at the home will be trained.All other clients in the home will have their linens stored in their closets for their immediate access.A tracking form will be implemented in the home to monitor any attempts of Client D to get other clients linens inappropriately.An IDT will be completed for Client B on 11/11/2012 to address his need for a cigarette schedule and whether it is appropriate at this time for them to be locked up.Client B's ISP will be updated to include his cigarette schedule and what the team determined regarding the need for his cigarettes to be locked up. HRC approval will be obtained after this plan is updated.Staff in the home and at day program will be trained</p>	11/21/2012	

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	<p>Behavior Support Plan, dated 10/7/11, indicated he had a targeted behavior of stereotypical behavior defined as repetitive motor or verbal activity, including self-stimulation, which does not serve meaningful purpose. Resident is difficult to redirect to other activity and will often immediately return to original behavior.</p> <p>A review of client D's record was conducted on 10/19/12 at 10:49 AM. There was no documentation in client D's record indicating the linens were locked or needed to be locked.</p> <p>A review of client F's record was conducted on 10/18/12 at 12:27 PM. There was no documentation in client F's record indicating the linens were locked or needed to be locked.</p> <p>A review of client H's record was conducted on 10/18/12 at 12:17 PM. There was no documentation in client H's record indicating the linens were locked or needed to be locked.</p> <p>An interview with the Home Manager (HM) was conducted on 10/18/12 at 1:21 PM. The HM stated the linens were locked due to client B "obsessively" changing his sheets if the sheets were readily available. The HM indicated the</p>		<p>on the changes to Client B's plan. The Program Director will receive retraining on ensuring all ISPs include all restrictions and that guardian and HRC approvals are obtained before plans are implemented. Responsible Parties: Home Manager, Program Director, and Area Director.</p>				

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	<p>restriction affected all the clients. The HM indicated the clients had access to the sheets by asking staff to open the locked closet. The HM stated, "All they have to do is ask."</p> <p>2) During the observations, client B's cigarettes were locked in the med closet. On 10/17/12 at 4:31 PM, client B asked for a cigarette. Staff #9 told client B he needed to get the key to the closet from staff #4 who was in the office passing medications. Staff #9 told client B he needed to wait for the med pass to be over. On 10/18/12 at 6:39 AM, client B asked staff #3 for a cigarette. Staff #3 used a key to access the locked closet to get client B a cigarette. At 7:09 AM, client B asked staff #2 if he could go smoke. Staff #2 told client B he had about 30 minutes until his next cigarette. Staff #2 told client B he could smoke every 45-60 minutes. At 7:19 AM, client B asked for his cigarette. Staff #2 told him he had about 10 minutes until it was time. At 7:27 AM, client B asked for his cigarette. Staff #2 went into the office to get the key, got client B's cigarette, and then went outside with client B while he smoked.</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM. There was no documentation in client B's</p>			

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	<p>record indicating client B's access to his cigarettes was restricted. There was no plan for client B's cigarette restriction.</p> <p>A review of a memo submitted by the current Program Director (PD) was received by email on 10/19/12 at 3:56 PM (this memo was not in client B's record). The memo, dated 4/6/12 and authored by client B's former PD at a different group home, indicated, "I would like to make the following clarifications regarding [Client B's] smoking schedule: [Client B] is allowed 1 cigarette per hour. It is [client B's] responsibility to request to smoke. Staff should not remind, encourage, or prompt him to smoke. [Client B] may choose what time to smoke. [Client B] must wait 1 hour from the time of his last cigarette before he can smoke again. For example: If [Client B] chooses to smoke at 6:15pm, he may do so, but he may not smoke again until 7:15pm. If [Client B] is preoccupied when his next cigarette is due at 7:15pm, staff will not take him to smoke until he requests it. If he then requests to smoke at 7:30pm, he would be able to smoke again at 8:30pm."</p>			

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	<p>An interview with the Home Manager (HM) was conducted on 10/22/12 at 11:25 AM. The HM indicated client B's cigarettes were locked in the medicine cabinet. The HM indicated there was no plan and no consent. The HM indicated client B was emancipated.</p> <p>An interview with the Area Director (AD) was conducted on 10/19/12 at 12:00 PM. The AD indicated he was not aware client B's cigarettes were being restricted. The AD indicated there should be a plan to address the restriction of locking client B's cigarettes.</p> <p>9-3-2(a)</p>			

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W0149	<p>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 record review and interview for 5 of 17 incident/investigative reports reviewed affecting clients B, E and H, the facility neglected to implement its policies and procedures to prevent client to client abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/17/12 at 12:35 PM and 10/18/12 at 11:11 AM.</p> <ol style="list-style-type: none"> On 7/22/12 at 12:30 PM, client H spit on client E's forearm. The investigative report, dated 7/27/12, indicated client H purposely spit on client E. On 7/23/12 at 6:45 PM, client H spit on client B's chest. The investigative report, dated 7/30/12, indicated client H purposely spit on client B. On 9/4/12 at 6:00 PM, client B eloped from the group home for "approximately 15 minutes" before being located by staff. Client B was walking toward the gas station to purchase a soda. The Bureau of Developmental Disabilities Services 	W0149	<p>The staff in the home will be retrained on the Abuse/Neglect Policy to prevent the possibility of future incidents of client to client abuse. The Program Director and/or Home Manager will complete random observations to monitor that staff are following client plans and being proactive to prevent incidents. The Program Director will be retrained on completing thorough and timely investigations. The Program Director will be retrained on completeing investigations of client to client incidents. Responsible Party: Home Manager, Program Director, and Area Director.</p>	11/21/2012

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	<p>report, dated 9/5/12, indicated, "Investigation will be completed and [client B] will remain within line of sight until further notice." Initially, the facility was unable to provide documentation indicating an investigation was conducted into the incident. On 10/19/12 the facility provided an investigation into the incident. The investigation was dated 10/19/12. The investigation indicated client B eloped from the group home for "approximately 30 minutes." The report indicated, "[Client B] moved from the [name of group home] due to elopement issues and had resided at the [name of current group home] since July 9th, 2012." The report indicated, "[Home Manager - HM] reported that [staff #9] called her at 6:00 PM to report that [client B] was not in the home and could not be located around the home. [HM] reported that [staff #9] was at the home with [client B] and two other clients (report did not identify the clients) at the time of this incident. [HM] reported that [staff #5] and [staff #4] were at Special Olympics Bowling with the other clients." The report indicated the HM contacted an off-duty staff (staff #3) to assist with locating client B. Staff #3 located client B at 6:15 PM walking toward "town." The report indicated the HM checked the doors and alarms and found that one of the alarms on one of the back doors of the</p>			

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	<p>house had been turned off. The HM indicated all the alarms were checked at 3:00 PM and were on and functional. The HM indicated staff #9 told her client B was in the living room listening to music and got up to use the restroom. The HM indicated staff #9 told her he was assisting another client in the kitchen when he noticed client B was still in the restroom. When staff #9 checked on client B, client B was not in the restroom or the home. The investigative report did not contain interviews with staff #9 or the two additional clients present at the time client B eloped.</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM. Client B's Individual Support Plan, dated 6/28/12, indicated "Per [client B's behavior plan, he requires a 1:1 (one on one) staffing ratio during waking hours." Client B's Behavior Support Plan (BSP), dated 6/28/12, indicated, "[client B] will have 1:1 staffing during waking hours. Staff will be right outside the door when he is in his bedroom or the bathroom."</p> <p>An interview with the Area Director (AD) was conducted on 10/19/12 at 11:07 AM. The AD indicated an investigation was not conducted for client B's elopement on 9/4/12. The AD indicated the incident should have been investigated. On</p>			

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	<p>10/22/12 at 9:29 AM, the AD indicated the staff could not implement 1:1 staffing when there were 3 clients and 1 staff. The AD indicated he did not think the BSP had been updated to reflect the current plan.</p> <p>4. On 9/13/12 at 6:00 PM, client B eloped from the group home. Client B was located "approximately 30 minutes later and was found approximately a mile and a half from the SGL (group home)." The investigative report, dated 9/18/12, indicated, "The factual findings do support that [client B] disarmed the front door alarm and eloped for approximately 30 minutes." The report indicated client B stated he wanted to "go for a walk." Client B indicated he was not supposed to go by himself. Client B's one on one (1:1) staff (#9) indicated he thought client B was in the restroom so he went to get something to drink. After approximately 10 minutes, staff #9 started to wonder what was taking client B so long and he checked the restroom. Client B was not in the restroom. Staff #9 indicated the alarms on the exit doors did not sound. Client B indicated when he was located he was going to get a soda. Staff #9 received a disciplinary action, "Due to [client B's] 1:1 staff, [staff #9], stepping into the kitchen hence allowing [client B] the opportunity to exit the restroom,</p>						

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	<p>disarm the front door alarm, and vacate from the house, he was given a Disciplinary Record of Discussion on 9/18/12 by the PD (Program Director) and Home Manager, [name of Home Manager]." The investigation did not contain interviews with staff #5 and staff #11 who were present at the time of the incident. There were no interviews with client B's seven housemates who may have witnessed the event.</p> <p>An addendum to the investigation, dated 10/19/12, indicated the following, "PD (Program Director) interviewed additional staff on duty, [staff #5 and #11] regarding the incident on 9/13/12. These staff all reiterated that [client B] had become somewhat irritable after he had spoken on the phone to his mother and had discussed with her wanting to 'go home.' Staff reported that although they couldn't hear the conversation from the mother, she sounded like she was very appropriate with redirection. Staff indicated they attempted to redirect [client B] to another activity but were unsuccessful. During the incident, [client B] had been able to exit through the front door which had initially been thought to have been left open by another client, however, staff indicate that they were unsure if this was the case as they couldn't recall whether the door had been open or closed."</p>						

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	<p>A review of client B's record was conducted on 10/18/12 at 12:44 PM. Client B's Individual Support Plan, dated 6/28/12, indicated "Per [client B's behavior plan, he requires a 1:1 (one on one) staffing ratio during waking hours." Client B's Behavior Support Plan (BSP), dated 6/28/12, indicated, "[client B] will have 1:1 staffing during waking hours. Staff will be right outside the door when he is in his bedroom or the bathroom."</p> <p>An interview with staff #9 was conducted on 10/22/12 at 9:46 AM. Staff #9 indicated he and staff #11 were sitting at the dining room table when client B eloped. Staff #9 indicated the front door was open so when client B exited the door, the alarm did not sound. Staff #9 indicated he did not recall being in the kitchen getting a drink when the elopement occurred but indicated it had been over 30 days since the incident. Staff #9 indicated he thought client B had been gone for approximately 5 minutes before the staff realized he was gone. Staff #9 indicated the staff did not stay outside of his bedroom or bathroom door when he was in there.</p> <p>An interview with the Area Director (AD) was conducted on 10/19/12 at 11:07 AM. The AD indicated the investigation was</p>			

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	<p>not thorough since two of the three staff present at the time client B eloped on 9/13/12 were not interviewed. On 10/22/12 at 9:29 AM, the AD indicated he did not believe client B's BSP had been updated to reflect changes in his plan. The AD indicated the staff did not position themselves outside the bedroom or bathroom door when client B was in there.</p> <p>5. On 9/16/12 at 2:15 PM, client A hit client E on the forearm with an open hand. Client E was not injured. The investigative report, dated 9/19/12, indicated client A did hit client E without causing injury.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 10/19/12 at 2:50 PM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure</p>			

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	<p>the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights."</p> <p>This federal tag relates to complaint #IN00116647.</p> <p>9-3-2(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 17 incident/investigative reports reviewed affecting client B, the facility failed to conduct thorough investigations of elopement on 9/4/12 and 9/13/12.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/17/12 at 12:35 PM and 10/18/12 at 11:11 AM.</p> <p>1) On 9/4/12 at 6:00 PM, client B eloped from the group home for "approximately 15 minutes" before being located by staff. Client B was walking toward the gas station to purchase a soda. The Bureau of Developmental Disabilities Services report, dated 9/5/12, indicated, "Investigation will be completed and [client B] will remain within line of sight until further notice." Initially, the facility was unable to provide documentation indicating an investigation was conducted into the incident. On 10/19/12 the facility provided an investigation into the incident. The investigation was dated 10/19/12. The investigation indicated client B eloped from the group home for</p>	W0154	The staff in the home will be retrained on the Abuse/Neglect Policy to prevent the possibility of future incidents of client to client abuse. The Program Director and/or Home Manager will complete random observations to monitor that staff are following client plans and being proactive to prevent incidents. The Program Director will be retrained on completing thorough and timely investigations. The Program Director will be retrained on completing investigations of client to client incidents. Repponsible Party: Home Manager, Program Director, and Area Director.	11/21/2012			

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	"approximately 30 minutes." The report indicated, "[Client B] moved from the [name of group home] due to elopement issues and had resided at the [name of current group home] since July 9th, 2012." The report indicated, "[Home Manager - HM] reported that [staff #9] called her at 6:00 PM to report that [client B] was not in the home and could not be located around the home. [HM] reported that [staff #9] was at the home with [client B] and two other clients (report did not identify the clients) at the time of this incident. [HM] reported that [staff #5] and [staff #4] were at Special Olympics Bowling with the other clients." The report indicated the HM contacted an off-duty staff (staff #3) to assist with locating client B. Staff #3 located client B at 6:15 PM walking toward "town." The report indicated the HM checked the doors and alarms and found that one of the alarms on one of the back doors of the house had been turned off. The HM indicated all the alarms were checked at 3:00 PM and were on and functional. The HM indicated staff #9 told her client B was in the living room listening to music and got up to use the restroom. The HM indicated staff #9 told her he was assisting another client in the kitchen when he noticed client B was still in the restroom. When staff #9 checked on client B, client B was not in the restroom or the home.			

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	<p>The investigative report did not contain interviews with staff #9 or the two additional clients present at the time client B eloped.</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM. Client B's Individual Support Plan, dated 6/28/12, indicated "Per [client B's behavior plan, he requires a 1:1 (one on one) staffing ratio during waking hours." Client B's Behavior Support Plan (BSP), dated 6/28/12, indicated, "[client B] will have 1:1 staffing during waking hours. Staff will be right outside the door when he is in his bedroom or the bathroom."</p> <p>An interview with the Area Director (AD) was conducted on 10/19/12 at 11:07 AM. The AD indicated an investigation was not conducted for client B's elopement on 9/4/12. The AD indicated the incident should have been investigated.</p> <p>2) On 9/13/12 at 6:00 PM, client B eloped from the group home. Client B was located "approximately 30 minutes later and was found approximately a mile and a half from the SGL (group home)." The investigative report, dated 9/18/12, indicated, "The factual findings do support that [client B] disarmed the front door alarm and eloped for approximately 30 minutes." The report indicated client</p>						

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	<p>B stated he wanted to "go for a walk." Client B indicated he was not supposed to go by himself. Client B's one on one (1:1) staff (#9) indicated he thought client B was in the restroom so he went to get something to drink. After approximately 10 minutes, staff #9 started to wonder what was taking client B so long and he checked the restroom. Client B was not in the restroom. Staff #9 indicated the alarms on the exit doors did not sound. Client B indicated when he was located he was going to get a soda. Staff #9 received a disciplinary action, "Due to [client B's] 1:1 staff, [staff #9], stepping into the kitchen hence allowing [client B] the opportunity to exit the restroom, disarm the front door alarm, and vacate from the house, he was given a Disciplinary Record of Discussion on 9/18/12 by the PD (Program Director) and Home Manager, [name of Home Manager]." The investigation did not contain interviews with staff #5 and staff #11 who were present at the time of the incident. There were no interviews with client B's seven housemates who may have witnessed the event.</p> <p>An addendum to the investigation, dated 10/19/12, indicated the following, "PD (Program Director) interviewed additional staff on duty, [staff #5 and #11] regarding the incident on 9/13/12. These staff all</p>				

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	<p>reiterated that [client B] had become somewhat irritable after he had spoken on the phone to his mother and had discussed with her wanting to 'go home.' Staff reported that although they couldn't hear the conversation from the mother, she sounded like she was very appropriate with redirection. Staff indicated they attempted to redirect [client B] to another activity but were unsuccessful. During the incident, [client B] had been able to exit through the front door which had initially been thought to have been left open by another client, however, staff indicate that they were unsure if this was the case as they couldn't recall whether the door had been open or closed."</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM. Client B's Individual Support Plan, dated 6/28/12, indicated "Per [client B's behavior plan, he requires a 1:1 (one on one) staffing ratio during waking hours." Client B's Behavior Support Plan (BSP), dated 6/28/12, indicated, "[client B] will have 1:1 staffing during waking hours. Staff will be right outside the door when he is in his bedroom or the bathroom."</p> <p>An interview with staff #9 was conducted on 10/22/12 at 9:46 AM. Staff #9 indicated he and staff #11 were sitting at the dining room table when client B</p>				

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	<p>eloped. Staff #9 indicated the front door was open so when client B exited the door, the alarm did not sound. Staff #9 indicated he did not recall being in the kitchen getting a drink when the elopement occurred but indicated it had been over 30 days since the incident. Staff #9 indicated he thought client B had been gone for approximately 5 minutes before the staff realized he was gone. Staff #9 indicated the staff did not stay outside of his bedroom or bathroom door when he was in there.</p> <p>An interview with the Area Director (AD) was conducted on 10/19/12 at 11:07 AM. The AD indicated the investigation was not thorough since two of the three staff present at the time client B eloped on 9/13/12 were not interviewed. On 10/22/12 at 9:29 AM, the AD indicated he did not believe client B's BSP had been updated to reflect changes in his plan. The AD indicated the staff did not position themselves outside the bedroom or bathroom door when client B was in there.</p> <p>This federal tag relates to complaint #IN00116647.</p> <p>9-3-2(a)</p>						

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 1 of 4 non-sampled clients (E), the Qualified Mental Retardation Professional (called Program Director - PD) failed to convene the interdisciplinary team to review and discuss recommendations by the speech language pathologist.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/17/12 from 3:38 PM to 6:01 PM. At 5:30 PM, dinner started. Client E was being given one tablespoon of his food at a time on a separate plate from his dinner plate. Client E attempted numerous times throughout dinner to grab and take his plate from staff #4. At 5:40 PM, client E attempted to eat out of the serving bowl of rice. Client E bit his wrist when staff #4 redirected him. Client E attempted to eat biscuits out of the serving bowl. At 5:42 PM, client E attempted to grab his plate with all his food on it. At 5:45 PM, client E struggled with staff attempting to get the plate with all his food on it. Staff #4 and the Home Manager (HM) tried to keep client E from</p>	W0159	<p>The Program Director will be retrained on completing IDTs to review and discuss recommendations made by medical professionals. Client E's doctor was contacted on 10/23/2012 and recommended the diet plan she wants followed for Client E during mealtimes. An IDT will be completed on 11/11/12 to determine interaction guidelines to assist Client E during mealtimes to ensure his safety and to decrease his frustration during mealtimes. Staff at home will be trained on Client E's updated dining plan. The Program Director and/or Home Manager will complete various observations to ensure Client E's dining plan is being implemented correctly. Responsible Party: Home Manager, Program Director, and Area Director.</p>	11/21/2012

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	<p>eating bite after bite off of the plate with his food on it. At 5:47 PM, the HM prompted client E to put down his spoon between bites.</p> <p>An interview with the Home Manager (HM) was conducted on 10/17/12 at 5:42 PM. The HM indicated client E's plan changed to get a spoonful of food at a time.</p> <p>A review of client E's record was conducted on 10/18/12 at 11:31 AM. Client E's Speech evaluation, dated 4/9/12, indicated, "Pt (patient) consumed several boluses of thin liquid, puree food, mech soft and hard solid. No signs of aspiration were observed, but moderate oral residue was noted (with) hard solids. Recommend: continue thin liquids. Consider slow flow cup to modulate drink side. Mech soft diet, small amounts of regular food with supervision. Closely monitor during meals, small bites and drinks, only one at a time." A fax, dated 4/16/12, to client E's doctor from the nurse indicated, "At [client E's] speech eval the therapist recommends mech soft chopped diet with thin liquids. She also would like staff to only provide him with 1 tbsp (tablespoon) of food at a time due to overstuffing. She also states he can occasionally have hard solids (crackers, chips) as long as he is give (sic) one at a</p>			

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	time with staff supervision." The physician signed the fax on 4/20/12. On 6/12/12, the Program Director (PD) sent an email to the nurse. The PD's email indicated, "I am working on [client E's] updated ISP (Individual Support Plan) and it was brought to my attention that [client E's] diet was changed to be 'Mech Soft, chopped, 1 tbs at a time, hard solids 1 at a time w/ (with) supervision.' [Client E's] plan has always been 'Mech. soft, cut food into bite size pieces, may have 2nds and snacks' and this has been working great. I think that the 1tbs at a time and hard solids 1 at a time, is a bit of an overkill, not to mention setting staff up for failure considering how difficult it would be to monitor this AND monitor the rest of the guys who also need supervision, and allowing [client E] to continue eating at the table with the rest of the guys at dinner. The HM and staff are in agreement with me on this, can we change this back to the way it read before?" The nurse's response, also dated 6/12/12, indicated, "It is based on a recommendation from the ST (Speech Therapist). Staff where (sic) concerned regarding over stuffing and rapid eating so he was evaluated. This is her recommendation. She said when she gave him a handful of crackers he really struggled eating them. I asked staff about it when the dietician recommended			

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	<p>transitioning to 1/2 portions, staff reported that there was no change in his rapid eating so they felt it was better to keep it the way it was for now." The nurse, in a separate email dated 6/12/12, indicated, "I talked with the ST on the phone to clarify her initial vague recommendations. I tried to get her to agree to 1/2 portions, initially she want (sic) staff to feed him 1 tsp (teaspoon) at a time but I convinced her that it was not practical and got her to agree on the 1 tbsp with him feeding himself. So unless we get a 2nd option that differs we need to go with her recommendation." There was no documentation regarding client E's diet order in his record since 6/12/12.</p> <p>An interview with the Home Manager (HM) was conducted on 10/22/12 at 11:28 AM. The HM indicated the dietician recommended a change to client E's plan. The nurse recommended a swallow study. The swallow study recommendations indicated the change to his plan. The nurse wrote up the recommendations and sent to the physician, who signed off on the order. The HM indicated it was not an ideal plan for him. The HM indicated she spoke to the nurse about the plan in May 2012. The HM indicated the plan was not working.</p>						

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	<p>An interview with the Area Director (AD) was conducted on 10/19/12 at 11:40 AM. The AD indicated the issue regarding client E's diet order was it had not been addressed since 6/12/12. The AD indicated the plan should have been changed since client E was struggling with staff during meals. At 11:46 AM, the AD indicated the team should have convened to discuss client E's struggling with staff to get his full plate, come up with recommendations, and taken the recommendations to the ST. The AD indicated this issue was noted in June 2012 and had not been addressed since then. The AD indicated the nurse and ST could have gone to the home to observe client E's meals. The plan could have been changed to address his agitation during meals since since noted in June 2012. The AD indicated there had to be another option so client E did not get agitated during meals. The AD indicated the issue was the amount of time that had passed without the issue being addressed.</p> <p>9-3-3(a)</p>				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review and interview for 2 of 4 clients in the sample (B and D), the facility failed to implement: 1) client B's plan for elopement and 2) client D's Behavior Support Plan for food seeking and having a picture schedule.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 10/17/12 from 3:38 PM to 6:01 PM and 10/18/12 from 5:56 AM to 7:33 AM. During the observations, client B entered his bedroom numerous times. The staff present during the evening observation (#4, #6 and #9) and morning observation (#2, #3 and #7) did not sit or stand outside his bedroom door.</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM. Client B's Individual Support Plan, dated 6/28/12, indicated "Per [client B's] behavior plan, he requires a 1:1 (one on one) staffing ratio during waking hours."</p>	W0249	<p>An IDT will be completed on 11/11/2012 to determine Client B's current supervision needs in the community and at home. Client B's ISP will be updated to include the IDT's recommendations. Staff in the home and at the day program will be retrained on Client B's elopement plan. Staff will be retrained on Client D's dining plan and appropriate serving or redirection. An IDT will be completed on 11/11/2012 to review Client D's Visual Picture schedule. Staff will be trained on the visual picture schedule for Client D. The Program Director and/or Home Manager will complete various observations to ensure Client D's dining plan and Visual Schedule are being implemented correctly. Responsible Party: Home Manager, Program Director, and Area Director</p>	11/21/2012			

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	<p>Client B's Behavior Support Plan (BSP), dated 6/28/12, indicated, "[client B] will have 1:1 staffing during waking hours. Staff will be right outside the door when he is in his bedroom or the bathroom."</p> <p>A review of the facility's incident/investigative reports was conducted on 10/17/12 at 12:35 PM and 10/18/12 at 11:11 AM. On 9/4/12 at 6:00 PM, client B eloped from the group home for "approximately 15 minutes" before being located by staff. Client B was walking toward the gas station to purchase a soda. The Bureau of Developmental Disabilities Services report, dated 9/5/12, indicated, "Investigation will be completed and [client B] will remain within line of sight until further notice." The investigation, dated 10/19/12, indicated client B eloped from the group home for "approximately 30 minutes." The report indicated, "[Client B] moved from the [name of group home] due to elopement issues and had resided at the [name of current group home] since July 9th, 2012." The report indicated, "[Home Manager - HM] reported that [staff #9] called her at 6:00 PM to report that [client B] was not in the home and could not be located around the home. [HM] reported that [staff #9] was at the home with [client B] and two other clients (report did not identify the clients)</p>			

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	<p>at the time of this incident. [HM] reported that [staff #5] and [staff #4] were at Special Olympics Bowling with the other clients." The report indicated the HM contacted an off-duty staff (staff #3) to assist with locating client B. Staff #3 located client B at 6:15 PM walking toward "town." The report indicated the HM checked the doors and alarms and found that one of the alarms on one of the back doors of the house had been turned off. The HM indicated all the alarms were checked at 3:00 PM and were on and functional. The HM indicated staff #9 told her client B was in the living room listening to music and got up to use the restroom. The HM indicated staff #9 told her he was assisting another client in the kitchen when he noticed client B was still in the restroom. When staff #9 checked on client B, client B was not in the restroom or the home.</p> <p>An interview with the Area Director (AD) was conducted on 10/22/12 at 9:29 AM, the AD indicated the staff could not implement 1:1 staffing when there were 3 clients and 1 staff. The AD indicated he did not think the BSP had been updated to reflect the current plan.</p> <p>2) An observation was conducted at the group home on 10/17/12 from 3:38 PM to 6:01 PM. At 5:42 PM, client D attempted</p>				

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	<p>to serve himself a second piece of fish from the serving bowl on the table. Staff #9 verbally redirected client D and then staff #9 took the fish away from client D. Staff #4 informed staff #9 that client D could have the fish. Client D was then allowed to serve himself a second piece of fish. Observations were also conducted at the group home on 10/18/12 from 5:56 AM to 7:33 AM. During the observations at the group home, there was no visual picture schedule posted for client D to review.</p> <p>A review of client D's record was conducted on 10/19/12 at 10:49 AM. Client D's BSP, dated 10/7/11, indicated he had a targeted behavior of food seeking. Food seeking was defined as "seeking and/or consuming food during non-meal times." The plan indicated, "If [client D] refuses to surrender a small amount of food, do not try to remove it from his possession." Client D's plan indicated, "[Client D] will be provided with a visual picture schedule. Verbally go through the pictures with [client D] daily. Discuss any changes that are going to occur with [client D] 24 hours in advance, when possible. Post the picture schedule somewhere in the house that is accessible to [client D]."</p> <p>An interview with the Home Manager</p>						

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	<p>(HM) was conducted on 10/19/12 at 12:07 PM. The HM indicated client D did not have a visual picture schedule. The HM indicated the recommendation in the BSP was appropriate however the group home was not implementing the recommendation. The HM indicated staff #9 should not have taken the fish away from client D.</p> <p>An interview with the Area Director (AD) was conducted on 10/19/12 at 12:07 PM. The AD indicated staff #9 should not have taken the piece of fish away from client D. The AD indicated the only time food should be removed from a client was if the client's health was in danger from consuming the food.</p> <p>This federal tag relates to complaint #IN00116647.</p> <p>9-3-4(a)</p>				

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W0262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, interview and record review for 4 of 4 clients in the sample (B, D, F and H), the facility failed to ensure the specially constituted committee (HRC) reviewed, approved and monitored the following restrictive interventions: 1) locking of linens affecting clients B, D, F and H, and 2) client B's cigarettes being locked.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/17/12 from 3:38 PM to 6:01 PM and 10/18/12 from 5:56 AM to 7:33 AM.</p> <p>1) During the observations, the linens (flat and fitted sheets) were locked in a closet next to the office just inside the front door. The locked closet was accessible to staff using a key. Clients B, D, F and H did not have access to the closet.</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM.</p>	W0262	The Program Director will receive retraining on ensuring all ISPs include all restrictions and that guardian and HRC approvals are obtained before plans are implemented. The Program Director will be retrained on ensuring clients plans are updated to include restrictions. Responsible Party: Home Manager, Program Director, and Area Director	11/21/2012	

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	<p>There was no documentation in client B's record indicating the linens were locked or needed to be locked. There was no documentation the HRC reviewed, approved and monitored the locking of the linens.</p> <p>A review of client D's record was conducted on 10/19/12 at 10:49 AM. There was no documentation in client D's record indicating the linens were locked or needed to be locked. There was no documentation the HRC reviewed, approved and monitored the locking of the linens.</p> <p>A review of client F's record was conducted on 10/18/12 at 12:27 PM. There was no documentation in client F's record indicating the linens were locked or needed to be locked. There was no documentation the HRC reviewed, approved and monitored the locking of the linens.</p> <p>A review of client H's record was conducted on 10/18/12 at 12:17 PM. There was no documentation in client H's record indicating the linens were locked or needed to be locked. There was no documentation the HRC reviewed, approved and monitored the locking of the linens.</p>			

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	<p>An interview with the Home Manager (HM) was conducted on 10/18/12 at 1:21 PM. The HM stated the linens were locked due to client B "obsessively" changing his sheets if the sheets were readily available. The HM indicated the restriction affected all the clients. The HM indicated the clients had access to the sheets by asking staff to open the locked closet. The HM stated, "All they have to do is ask."</p> <p>2) During the observations, client B's cigarettes were locked in the med closet. On 10/17/12 at 4:31 PM, client B asked for a cigarette. Staff #9 told client B he needed to get the key to the closet from staff #4 who was in the office passing medications. Staff #9 told client B he needed to wait for the med pass to be over. On 10/18/12 at 6:39 AM, client B asked staff #3 for a cigarette. Staff #3 used a key to access the locked closet to get client B a cigarette. At 7:09 AM, client B asked staff #2 if he could go smoke. Staff #2 told client B he had about 30 minutes until his next cigarette. Staff #2 told client B he could smoke every 45-60 minutes. At 7:19 AM, client B asked for his cigarette. Staff #2 told him he had about 10 minutes until it was time. At 7:27 AM, client B asked for his cigarette. Staff #2 went into the office to get the key, got client B's cigarette, and</p>			

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	<p>then went outside with client B while he smoked.</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM. There was no documentation in client B's record indicating client B's access to his cigarettes was restricted. There was no plan for client B's cigarette restriction. There was no documentation in client B's record indicating his cigarettes needed to be locked.</p> <p>A review of a memo submitted by the current Program Director (PD) was received by email on 10/19/12 at 3:56 PM (this memo was not in client B's record). The memo, dated 4/6/12 and authored by client B's former PD at a different group home, indicated, "I would like to make the following clarifications regarding [Client B's] smoking schedule: [Client B] is allowed cigarette per hour. It is [client B's] responsibility to request to smoke. Staff should not remind, encourage, or prompt him to smoke. [Client B] may choose what time to smoke. [Client B] must wait 1 hour from the time of his last cigarette before he can smoke again. For example: If [Client B] chooses to smoke at 6:15pm, he may do so, but he may not</p>			

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	<p>smoke again until 7:15pm. If [Client B] is preoccupied when his next cigarette is due at 7:15pm, staff will not take him to smoke until he requests it. If he then requests to smoke at 7:30pm, he would be able to smoke again at 8:30pm."</p> <p>An interview with the Home Manager (HM) was conducted on 10/22/12 at 11:25 AM. The HM indicated client B's cigarettes were locked in the medicine cabinet. The HM indicated there was no consent from the HRC for client B's cigarettes being locked. The HM indicated client B was emancipated.</p> <p>An interview with the Area Director (AD) was conducted on 10/19/12 at 12:00 PM. The AD indicated he was not aware client B's cigarettes were being restricted. The AD indicated there should be a plan to address the restriction of locking client B's cigarettes.</p> <p>9-3-4(a)</p>				

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, interview and record review for 4 of 4 clients in the sample (B, D, F and H), the facility failed to ensure the specially constituted committee (HRC) obtained consent for the following restrictive interventions: 1) locking of linens affecting clients B, D, F and H, and 2) client B's cigarettes being locked.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/17/12 from 3:38 PM to 6:01 PM and 10/18/12 from 5:56 AM to 7:33 AM.</p> <p>1) During the observations, the linens (flat and fitted sheets) were locked in a closet next to the office just inside the front door. The locked closet was accessible to staff using a key. Clients B, D, F and H did not have access to the closet.</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM. There was no documentation in client B's</p>	W0263	<p>The Program Director will receive retraining on ensuring all ISP's include all restrictions and that guardian and HRC approvals are obtained before plans are implemented. The Program Director will be retrained on ensuring clients plans are updated to include restrictions. Responsible Party: Home Manager, Program Director, and Area Director</p>	11/21/2012

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	<p>record indicating the linens were locked or needed to be locked. There was no documentation client B consented to the linens being locked.</p> <p>A review of client D's record was conducted on 10/19/12 at 10:49 AM. There was no documentation in client D's record indicating the linens were locked or needed to be locked. There was no documentation client D's guardian consented to the linens being locked.</p> <p>A review of client F's record was conducted on 10/18/12 at 12:27 PM. There was no documentation in client F's record indicating the linens were locked or needed to be locked. There was no documentation client F consented to the linens being locked.</p> <p>A review of client H's record was conducted on 10/18/12 at 12:17 PM. There was no documentation in client H's record indicating the linens were locked or needed to be locked. There was no documentation client H's guardian consented to the linens being locked.</p> <p>An interview with the Home Manager (HM) was conducted on 10/18/12 at 1:21 PM. The HM stated the linens were locked due to client B "obsessively" changing his sheets if the sheets were</p>			

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	<p>readily available. The HM indicated the restriction affected all the clients. The HM indicated the clients had access to the sheets by asking staff to open the locked closet. The HM stated, "All they have to do is ask."</p> <p>2) During the observations, client B's cigarettes were locked in the med closet. On 10/17/12 at 4:31 PM, client B asked for a cigarette. Staff #9 told client B he needed to get the key to the closet from #4 who was in the office passing medications. Staff #9 told client B he needed to wait for the med pass to be over. On 10/18/12 at 6:39 AM, client B asked staff #3 for a cigarette. Staff #3 used a key to access the locked closet to get client B a cigarette. At 7:09 AM, client B asked staff #2 if he could go smoke. Staff #2 told client B he had about 30 minutes until his next cigarette. Staff #2 told client B he could smoke every 45-60 minutes. At 7:19 AM, client B asked for his cigarette. Staff #2 told him he had about 10 minutes until it was time. At 7:27 AM, client B asked for his cigarette. Staff #2 went into the office to get the key, got client B's cigarette, and then went outside with client B while he smoked.</p> <p>A review of client B's record was conducted on 10/18/12 at 12:44 PM.</p>				

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	<p>There was no documentation in client B's record indicating client B's access to his cigarettes was restricted. There was no plan for client B's cigarette restriction. There was no documentation in client B's record indicating his cigarettes needed to be locked.</p> <p>A review of a memo submitted by the current Program Director (PD) was received by email on 10/19/12 at 3:56 PM (this memo was not in client B's record). The memo, dated 4/6/12 and authored by client B's former PD at a different group home, indicated, "I would like to make the following clarifications regarding [Client B's] smoking schedule: [Client B] is allowed cigarette per hour. It is [client B's] responsibility to request to smoke. Staff should not remind, encourage, or prompt him to smoke. [Client B] may choose what time to smoke. [Client B] must wait 1 hour from the time of his last cigarette before he can smoke again. For example: If [Client B] chooses to smoke at 6:15pm, he may do so, but he may not smoke again until 7:15pm. If [Client B] is preoccupied when his next cigarette is due at 7:15pm, staff will not take him to smoke until he requests it. If he then</p>						

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	<p>requests to smoke at 7:30pm, he would be able to smoke again at 8:30pm."</p> <p>An interview with the Home Manager (HM) was conducted on 10/22/12 at 11:25 AM. The HM indicated client B's cigarettes were locked in the medicine cabinet. The HM indicated client B did not consent to his cigarettes being locked. The HM indicated client B was emancipated.</p> <p>An interview with the Area Director (AD) was conducted on 10/19/12 at 12:00 PM. The AD indicated he was not aware client B's cigarettes were being restricted. The AD indicated there should be a plan to address the restriction of locking client B's cigarettes.</p> <p>9-3-4(a)</p>						