

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2014
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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W000000	<p>This visit was for the investigation of complaint #IN00159056.</p> <p>Complaint #IN00159056 - Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W156, W157 and W186.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: November 18, 19, 20, 21, and 24, 2014</p> <p>Facility Number: 001209 Provider Number: 15G634 AIM Number: 100240160</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/4/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p>			

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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	<p>Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise operating direction over the facility by failing to ensure its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B, C and D were implemented as written. The governing body failed to ensure thorough investigations were conducted. The governing body failed to ensure the results of investigations were reported to the administrator or designee within 5 working days. The governing body failed to ensure effective corrective actions were implemented to address staff failing to report abuse and neglect. The governing body failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to ensure there was sufficient staffing to meet the needs of the clients. The governing body failed to ensure the clients had the right to due process in regard to restricting the clients' access to the kitchen.</p> <p>Findings include:</p> <p>1. Please refer to W104. For 4 of 4</p>	W000102	<p>1. Plan of Correction: Fire alarm has been checked by Ryan's security earlier in the day and failed to reset the alarm. It was reset and it works. Couches were both replaced. Please see attached invoice from This End Up Furniture Company. (Attachment a). Plan of prevention: House manager has been trained on checking the alarm when it needs to be reset (attachment b). Plan of monitoring: Frequent observation by executive and program teams to ensure alarms are functioning and furniture is in good repair attachment c)</p>	12/01/2014			

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	<p>clients living in the group home (A, B, C and D), the governing body failed to exercise operating direction over the facility by failing to ensure its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B, C and D were implemented as written. The governing body failed to ensure thorough investigations were conducted. The governing body failed to ensure the results of investigations were reported to the administrator or designee within 5 working days. The governing body failed to ensure effective corrective actions were implemented to address staff failing to immediately report abuse and neglect of the clients. The governing body failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to ensure there was sufficient staffing to meet the needs of the clients. The governing body failed to ensure the clients' rights to due process in regard to restricting the clients' access to the kitchen. The governing body failed to exercise operating direction over the facility by failing to ensure the fire alarm system was operational and a couch in the living room was in good repair.</p> <p>2. Please refer to W122. For 9 of 13 incident/investigative reports reviewed</p>			

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W000104	<p>affecting clients A, B, C and D, the facility failed to meet the Condition of Participation: Client Protections. The governing body failed to implement its policies and procedures to prevent abuse and neglect of the clients, ensure staff immediately reported allegations of abuse and neglect to the administrator, report incidents of abuse and neglect to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, ensure appropriate corrective action was taken with staff for failing to immediately report abuse and neglect of the clients, report the results of investigations to the administrator within 5 working days, ensure the clients had the right to due process in regard to restricting the clients' access to the kitchen and provide sufficient staff during the overnight shift to manage and supervise the clients' program plans according to their individual program plans.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over</p>			

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	<p>the facility.</p> <p>Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the governing body failed to exercise operating direction over the facility by failing to ensure its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B, C and D were implemented as written. The governing body failed to ensure thorough investigations were conducted. The governing body failed to ensure the results of investigations were reported to the administrator or designee within 5 working days. The governing body failed to ensure effective corrective actions were implemented to address staff failing to immediately report abuse and neglect of the clients. The governing body failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to ensure there was sufficient staffing to meet the needs of the clients. The governing body failed to ensure the clients' rights to due process in regard to restricting the clients' access to the kitchen. The governing body failed to exercise operating direction over the facility by failing to ensure the fire alarm system was operational and a couch in the living room was in good repair.</p>	W000104	<p>1. Plan of correction: DSP who was restricting clients access to kitchen without due process, has been removed from the house schedule. He also received a performance review (attachment d). Plan of prevention: Active treatment and due process was covered at December Shiloh meeting/training (attachment e). Plan of monitoring: House manager /associate manager will conduct daily monitoring and training when needed (attachment f).</p> <p>2. Plan of correction: DSP who was founded as abusive and neglectful were terminated per Stone Belt policy. Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p> <p>3. Plan of correction: Investigation training was conducted with investigator responsible for the 5 out of 13 investigations that were not properly investigated. Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh</p>	12/05/2014

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	<p>Findings include:</p> <p>1. Please refer to W125. For 4 of 4 clients living in the group home (A, B, C and D), the governing body failed to ensure the clients had the right to due process in regard to restricting the clients' access to the kitchen.</p> <p>2. Please refer to W149. For 9 of 13 incident/investigative reports reviewed affecting clients A, B and C, the governing body neglected to implement its policies and procedures to prevent abuse and neglect of the clients, ensure staff immediately reported allegations of abuse and neglect to the administrator, report incidents of abuse and neglect to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, ensure appropriate corrective action was taken with staff for failing to immediately report abuse and neglect of the clients, report the results of investigations to the administrator within 5 working days, and provide sufficient staff during the overnight shift to manage and supervise the clients' program plans according to their individual program plans.</p> <p>3. Please refer to W153. For 6 of 13 incident/investigative reports reviewed affecting clients A, B and C, the</p>		<p>meeting and will bereviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director willprovide daily monitoring (attachment f). 4. Planof correction: Investigation training was conducted with investigatorresponsible for the 5 out of 13 investigations that were not properly investigated. Plan of prevention: Prevention andreporting abuse and neglect was trained at December Shiloh meeting and will bereviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director willprovide daily monitoring (attachment f). 5. Planof correction: Investigation training was conducted with investigatorresponsible for the 5 out of 13 investigations that were not properlyinvestigated. Plan of prevention: Prevention andreporting abuse and neglect was trained at December Shiloh meeting and will bereviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director willprovide daily monitoring (attachment f). 6. Planof correction: DSP who failed to immediately report abuse to the administrator, has been</p>				

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	<p>governing body failed to ensure staff immediately reported allegations of abuse and neglect to the administrator and submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>4. Please refer to W154. For 5 of 13 incident/investigative reports reviewed affecting clients A, B and C, the governing body failed to conduct thorough investigations of allegations of abuse and neglect.</p> <p>5. Please refer to W156. For 2 of 13 incident/investigative reports reviewed affecting clients B and C, the governing body failed to ensure the results of investigations were reported to the administrator within 5 working days of the incident.</p> <p>6. Please refer to W157. For 5 of 13 incident/investigative reports reviewed affecting clients A, B and C, the governing body failed to implement appropriate corrective action to address staff failing to immediately report abuse to the administrator and client A's elopement.</p> <p>7. Please refer to W186. For 4 of 4 clients living in the group home (A, B, C</p>		<p>removed from the house schedule. He also received a performance review for failure to report in a timely manner (attachment d).</p> <p>Plan of prevention: Preventing and reporting abuse and neglect was trained at December Shiloh meeting/training (attachment e).</p> <p>Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p> <p>7. Plan of correction: Staff schedule has been updated to reflect 2 staff to 4 client ratio from 10p-6a (attachment g).</p> <p>Plan of prevention: Facility staffing office is to prioritize open shifts for Deckard (attachment h).</p> <p>Plan of monitoring: Coordinator or director will provide daily monitoring and document that staff to client ratios are being followed (attachment f).</p> <p>8. Plan of Correction: Fire alarm has been checked by Ryan's security earlier in the day and failed to reset the alarm. It was reset and it works. Couches were both replaced. Please see attached invoice from This End Up Furniture Company. (Attachment a).</p> <p>Plan of prevention: House manager has been trained on checking the alarm when it needs to be reset (attachment b).</p> <p>Plan of monitoring: Frequent observation by executive and program teams to ensure alarms</p>	

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	<p>and D), the governing body failed to provide sufficient staff during the overnight shift (10:00 PM to 6:00 AM) to manage and supervise the clients in accordance with their individual program plans.</p> <p>8. An observation was conducted at the group home on 11/19/14 from 6:30 AM to 8:18 AM and indicated the following:</p> <p>a) At 7:27 AM, the fire alarm control panel's display indicated the following messages, "Fire sys normal. Alarm silenced. Frt smk/pulls. A1 1 Fire Alarm."</p> <p>An interview with the Maintenance Director (MD) was conducted on 11/19/14 at 12:29 PM. The MD indicated he was not aware and had not been contacted or received a maintenance request regarding the fire alarm system. The MD indicated the staff at the group home set the fire alarm off the other day and the staff did not know how to reset the system. The MD indicated he had left instructions on how to properly reset the system previously and the staff either lost them or did not implement the instructions. The MD stated regarding the issue with the fire alarm system, "First I've heard about it." On 11/19/14 at 1:17 PM, the MD contacted the</p>		are functioning and furniture is in good repair (attachment c).		

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	<p>surveyor indicating the fire alarm system was now functioning properly after a proper reset. This affected clients A, B, C and D.</p> <p>On 11/20/14 at 11:32 AM, the Group Home Director indicated she was not aware of there being an issue with the fire alarm system. The Group Home Director indicated the system was functioning properly on 11/17/14 when she was at the home.</p> <p>b) On 11/19/14 at 7:03 AM, the couch located near the dining room was noted to have a piece of the frame sticking out from underneath the couch. Upon inspection, the couch's frame was broken and the springs were exposed on the right hand side of the couch. The right front leg was missing causing the couch to sit crooked. This affected clients A, B, C and D.</p> <p>On 11/19/14 at 7:03 AM, staff #4 indicated the couch had been broken for several weeks and needed to be replaced.</p> <p>On 11/19/14 at 7:03 AM, staff #8 indicated the couch had been broken for one week and needed to be repaired or replaced. Staff #8 indicated the front leg was in the office area of the group home.</p>			

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W000122	<p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 9 of 13 incident/investigative reports reviewed affecting clients A, B, C and D, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent abuse and neglect of the clients, ensure staff immediately reported allegations of abuse and neglect to the administrator, report incidents of abuse and neglect to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, ensure appropriate corrective action was taken with staff for failing to immediately report abuse and neglect of the clients, report the results of investigations to the administrator within 5 working days, ensure the clients had the right to due process in regard to restricting the clients' access to the kitchen and provide</p>	W000122	<p>1. Plan of correction: DSP who was restricting clients access to kitchen without due process, has been removed from the house schedule. He also received a performance review (attachment d). Plan of prevention: Active treatment and due process was covered at December Shiloh meeting/training (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p> <p>2. Plan of correction: DSP who failed to immediately report abuse to the administrator, has been removed from the house schedule. He also received a performance review for failure to report in a timely manner (attachment d). Plan of prevention: Preventing</p>	12/05/2014	

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	<p>sufficient staff during the overnight shift to manage and supervise the clients according to their individual program plans.</p> <p>Findings include:</p> <p>1. Please refer to W125. For 4 of 4 clients living in the group home (A, B, C and D), the facility failed to ensure the clients had the right to due process in regard to restricting the clients' access to the kitchen.</p> <p>2. Please refer to W149. For 9 of 13 incident/investigative reports reviewed affecting clients A, B and C, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, ensure staff immediately reported allegations of abuse and neglect to the administrator, report incidents of abuse and neglect to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, ensure appropriate corrective action was taken with staff for failing to immediately report abuse and neglect of the clients, report the results of investigations to the administrator within 5 working days, and provide sufficient staff during the overnight shift to manage and supervise the clients' program plans according to their individual program plans.</p>		<p>and reporting abuse and neglect was trained at December Shiloh meeting/training (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p> <p>3. Plan of correction: DSP who failed to immediately report abuse to the administrator, has been removed from the house schedule. He also received a performance review for failure to report in a timely manner (attachment d).</p> <p>Plan of prevention: Preventing and reporting abuse and neglect was trained at December Shiloh meeting/training (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p> <p>4. Plan of correction: Investigation training was conducted with investigator responsible for the 5 out of 13 investigations that were not properly investigated. New investigation form created to assist in accurately documenting date and time of interviews (attachment k).</p> <p>Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will</p>	

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	<p>3. Please refer to W153. For 6 of 13 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to ensure staff immediately reported allegations of abuse and neglect to the administrator and submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>4. Please refer to W154. For 5 of 13 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to conduct thorough investigations of allegations of abuse and neglect.</p> <p>5. Please refer to W156. For 2 of 13 incident/investigative reports reviewed affecting clients B and C, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days of the incident.</p> <p>6. Please refer to W157. For 5 of 13 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to implement appropriate corrective action to address staff failing to immediately report abuse to the administrator and client A's elopement.</p> <p>7. Please refer to W186. For 4 of 4</p>		<p>conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p> <p>5. Plan of correction: Investigation training was conducted with investigator responsible for the 5 out of 13 investigations that were not properly investigated. Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e).</p> <p>Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p> <p>6. Plan of correction: Investigation training was conducted with investigator responsible for the 5 out of 13 investigations that were not properly investigated. This led to the ineffective implement corrective action to prevent abuse and neglect. Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e).</p> <p>Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p> <p>7. Plan of correction: Staff schedule has been updated to reflect 2 staff to 4 client ratio from 10p-6a (attachment g).</p>				

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W000125	<p>clients living in the group home (A, B, C and D), the facility failed to provide sufficient staff during the overnight shift (10:00 PM to 6:00 AM) to manage and supervise the clients in accordance with their individual program plans.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-2(a)</p> <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 living in the group home (A, B, C and D), the facility failed to ensure the clients had the right to due process in regard to restricting the clients' access to the kitchen.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/19/14 from 6:30 AM</p>	W000125	<p>Plan of prevention: Facility staffingoffice is to prioritize open shifts for Deckard (attachment h). Plan of monitoring: Coordinator ordirector will provide daily monitoring and document that staff to client ratiosare being followed (attachment f).</p> <p>1. Planof correction: Investigation training was conducted with investigatorresponsible for the 5 out of 13 investigations that were not properlyinvestigated. New investigation form created to assist in accuratelydocumenting date and time of interviews (attachmentk). Plan of prevention: Prevention andreporting abuse and neglect was trained at December Shiloh meeting and will bereviewed monthly (attachment e).</p>	12/05/2014

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	to 8:18 AM. At 7:06 AM, staff #8 was in the kitchen with the kitchen door closed. At 7:09 AM, staff #8 was cooking breakfast as clients A and D were watching through the window into the kitchen. At 7:11 AM, staff #8 gave client D a plate with eggs and a fork. Client D was not provided a drink. At 7:13 AM, client D put his plate and fork, through the pass through window, onto a counter in the kitchen. The door was closed. At 7:32 AM, client D attempted to enter the kitchen. Client D wanted to get some animal crackers. Staff #8 prompted client D out of the kitchen. Staff #8, in response to a question from a trainee, indicated the kitchen door needed to be closed and locked at all times when staff were cooking. Staff #8 informed the trainee the clients were not to be in the kitchen when staff were cooking. Staff #8 indicated clients A and C were allowed into the kitchen, at times, but did not indicate the circumstances when this was acceptable. Staff #8 stated it was a "trust issue" since he did not want the clients to get hurt. Staff #8 indicated the clients may not know if the burners were hot or not. At 7:48 AM, client A was given a plate with bacon and eggs and a cup of milk through the pass through window. At 7:50 AM when client C entered the kitchen, staff #8 was prompted to "step out" and staff #4		Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f). Plan of correction: DSP who was restricting clients access to kitchen without due process, has been removed from the house schedule. He also received a performance review (attachment d). Plan of prevention: Active treatment and due process was covered at December Shiloh meeting/training (attachment e). Plan of monitoring: House manager / associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).				

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	<p>would get his drink for him. Client C stood at the pass through window waiting for his drink. At 7:52 AM, client C was given a plate with eggs and bacon. At 7:58 AM, client C gave staff #8 his empty plate to clean and said, "Night night." Clients A, B, C and D were not allowed to go into the kitchen during the observation.</p> <p>A review of client A's record was conducted on 11/20/14 at 11:03 AM. Client A's Human Rights Approval form, dated 1/20/14, indicated, "Lock on kitchen door when staff is not present. Rationale: Two residents live at [name of group home] that display unsafe behavior in the kitchen, including touching hot stove or oven, putting hand in the garbage disposal, using knives and other appliances inappropriately, etc. This behavior could result in serious burns, cuts, and dismemberment to the residents if allowed in the kitchen without supervision. One of these residents also demonstrates Pica (ingestion of non-nutritive substances) behavior. These clients need to be directly supervised in the kitchen. Therefore, for the safety of residents the kitchen door is locked when staff is not present when at risk clients are present." There was no documentation in client A's record indicating the need for him to be</p>				

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	<p>prompted out of the kitchen when staff were present.</p> <p>A review of client B's record was conducted on 11/20/14 at 11:02 AM. Client B's Human Rights Approval form, dated 8/7/14, indicated, "Kitchen door locked when staff is not in kitchen and locks on kitchen cabinets. Rationale: Two residents live at [name of group home] that display unsafe behavior in the kitchen, including touching hot stove or oven, putting hand in the garbage disposal, using knives and other appliances inappropriately, etc. This behavior could result in serious burns, cuts, and dismemberment to the residents if allowed in the kitchen without supervision. One of these residents also demonstrates Pica (ingestion of non-nutritive substances) behavior." There was no documentation in client B's record indicating the need for him to be prompted out of the kitchen when staff were present.</p> <p>A review of client C's record was conducted on 11/20/14 at 11:00 AM. Client C's Human Rights Approval form, dated 8/7/14, indicated, "Kitchen door locked when staff is not in kitchen and locks on kitchen cabinets. Rationale: Two residents live at [name of group home] that display unsafe behavior in the</p>						

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	<p>kitchen, including touching hot stove or oven, putting hand in the garbage disposal, using knives and other appliances inappropriately, etc. This behavior could result in serious burns, cuts, and dismemberment to the residents if allowed in the kitchen without supervision. One of these residents also demonstrates Pica (ingestion of non-nutritive substances) behavior." There was no documentation in client C's record indicating the need for him to be prompted out of the kitchen when staff were present.</p> <p>A review of client D's record was conducted on 11/20/14 at 11:01 AM. Client D's Human Rights Approval form, dated 1/20/14, indicated, "Lock on kitchen door when staff is not present. Rationale: Two residents live at [name of group home] that display unsafe behavior in the kitchen, including touching hot stove or oven, putting hand in the garbage disposal, using knives and other appliances inappropriately, etc. This behavior could result in serious burns, cuts, and dismemberment to the residents if allowed in the kitchen without supervision. One of these residents also demonstrates Pica (ingestion of non-nutritive substances) behavior. These clients need to be directly supervised in the kitchen. Therefore, for</p>			

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	<p>the safety of residents the kitchen door is locked when staff is not present when at risk clients are present." There was no documentation in client D's record indicating the need for him to be prompted out of the kitchen when staff were present.</p> <p>On 11/20/14 at 11:21 AM, the Group Home Director (GHD) indicated there was no restriction in the group home to keep the clients out of the kitchen. The GHD indicated clients should not be in the kitchen unless staff was present. The GHD indicated staff #8 prompting the clients out of the kitchen was an unnecessary restriction.</p> <p>On 11/20/14 at 12:47 PM, staff #8 indicated client A, if allowed in the kitchen, stands too close to the stove. Staff #8 stated, "I prefer they stay out while cooking." Staff #8 indicated he was worried about the clients getting burned. Staff #8 indicated he was not sure if there was a plan to keep the clients out of the kitchen. Staff #8 indicated staff #2 told him to keep the clients out of the kitchen for their safety. Staff #8 indicated the clients would not become more independent with their cooking skills if they were not allowed to assist with cooking.</p>			

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W000149	<p>9-3-2(a)</p> <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 observation, record review and interview for 9 of 13 incident/investigative reports reviewed affecting clients A, B and C, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, ensure staff immediately reported allegations of abuse and neglect to the administrator, report incidents of abuse and neglect to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, ensure appropriate corrective action was taken with staff for failing to immediately report abuse and neglect of the clients, report the results of investigations to the administrator within 5 working days, and provide sufficient staff during the overnight shift to manage and supervise the clients' program plans according to their individual program plans.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 11/19/14 from 6:30 AM</p>	W000149	<p>1. Plan of correction: Investigation regarding unknown injury on client b's elbow indicated it was from a piece of trim in his restroom (attachment g). Plan of prevention: Trim in his restroom was repaired. Staff failing to report the incident in a timely manner received a training from his supervisor Eric Ford (attachment h). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring to ensure that all incidents and concerns are being documented (attachment f).</p> <p>2) Plan of correction: Staff schedule has been updated to reflect 2 staff to 4 client ratio from 10p-6a (attachment g). Client A has been served notice and will be discharge from the facility once he receives his CIH waiver. Plan of prevention: Facility staffing office is to prioritize open shifts for Deckard (attachment h). Plan of monitoring: Coordinator or director will provide daily</p>	12/05/2014

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	<p>to 8:18 AM. At 7:43 AM, client B was noted to have a 6 inch red scratch near his elbow on his right arm.</p> <p>On 11/18/14 at 11:53 AM, a review of the facility's incident/investigative reports was conducted. There was no incident report provided for review addressing the scratch on client B's arm. On 11/21/14 at 1:49 PM, the facility provided incident reports for review. The Stone Belt Arc, Inc. Incident Report, completed on 11/20/14 with an incident date of 11/17/14, indicated, "[Staff #13] was helping [client B] in the shower and reported no signs of injury at that time. As [staff #13] was helping [client B] get dressed after his shower, staff noticed a scratch on [client B's] right arm approximately 2 inches long." The BDDS report, dated 11/20/14, indicated, "On 11/17/2014 at 9:00 AM, [client B] was being helped in to the shower; staff reports no signs of injury at that time. As staff was helping [client B] get dressed after his shower, staff noticed a scratch on [client B's] right arm approximately 5-6 inches long. After staff finished helping [client B] get dressed, [client B] and staff went to the office and staff cleaned the scratch with an alcohol swab, and applied a bandage." The BDDS report and facility incident report were not completed in a timely manner.</p>		<p>monitoring and document that staff to client ratios are being followed (attachment f).</p> <p>3) Plan of correction: Staff schedule has been updated to reflect 2 staff to 4 client ratio from 10p-6a (attachment g). Client A has been served notice and will be discharge from the facility once he receives his CIH waiver. Investigation was completed and confirmed that staff #6 acted in good intentions and was attempting to keep others safe. Plan of prevention: Facility staffing office is to prioritize open shifts for Deckard (attachment h). Comprehensive training has been completed with facility staff by the CPI trainer and behavior consultant (attachment h). Plan of monitoring: Coordinator or director will provide daily monitoring and document that staff to client ratios are being followed (attachment f).</p> <p>4) Plan of correction: Investigation completed and it was determined that injury was self-inflicted (attachment i). Team is waiting client's follow up appointments with Theraplay and his pcp on 12/18 and 12/22 to discontinue the order for padded gloves or obtain an order to purchase a pair of gloves. Plan of prevention: Investigations will be completed and results will be reported to administrator within 5 days for review.</p>				

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	<p>On 11/19/14 at 7:43 AM, staff #3 indicated the scratch was from client B being unsteady in the bathroom near the kitchen. Staff #3 indicated staff #13 told him the information. Staff #3 indicated he thought client B scratched his arm on the wall to the left of the toilet on the hard, sharp plastic covering the wall during a fall.</p> <p>On 11/20/14 at 1:56 PM, staff #13 indicated he was preparing to document an incident report regarding the injury to client B's arm. Staff #13 indicated he had not completed an incident report for the injury. Staff #13 indicated he was going to process the incident report as an injury of unknown origin due to not observing what occurred to cause the injury. Staff #13 indicated client B did not have the scratch prior to taking a shower and when he got out and was seated on the toilet, client B had the scratch. Staff #13 indicated he did not know what happened to cause the scratch.</p> <p>On 11/20/14 at 11:10 AM, the Group Home Director (GHD) indicated there should be an incident report for the scratch on client B's arm. The GHD indicated whoever was providing supervision to client B at the time should have completed an incident report. The</p>		<p>Plan of monitoring: Housemanager or associate manager are schedule daily. Coordinator or director willprovide daily monitoring and document that staff to client ratios are beingfollowed (attachment f).</p> <p>5)Plan of correction: CPland client b's bsp were trained with staff #11 (attachment j).</p> <p>Plan of prevention: Client bhas been receiving ot/pt therapy from Theraplay. They are determining if he isappropriate for a harness instead of gait belt.</p> <p>Plan of monitoring: Housemanager or associate manager are schedule daily. Coordinator or director willprovide daily monitoring and document that staff to client ratios are beingfollowed (attachment f).</p> <p>1.Planof correction: Investigation completed and it was confirmed that staff #10 wasneglectful. Therefore he was terminated (attachmentk).</p> <p>Plan of prevention: Prevention andreporting abuse and neglect was trained at December Shiloh meeting and will bereviewed monthly (attachment e).</p> <p>Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director willprovide daily monitoring (attachment f).</p> <p>2.Planof correction: Investigation completed and it was confirmed that staff #7 wasneglectful. Therefore he was terminated (attachmentl). Staff</p>		

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	<p>GHD indicated the injury should have been reported to BDDS.</p> <p>On 11/20/14 at 11:14 AM, staff #1 indicated he thought staff #13 completed an incident report for client B's injury. Staff #1 indicated staff #9 reported that client B fell during the morning shift. Staff #1 indicated staff #13 was with client B at the time of the incident.</p> <p>On 11/18/14 at 11:53 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>2) On 11/17/14 at 3:00 AM, one of client A's housemates woke up and needed assistance with changing his clothes and bedding. Staff assisted client A's housemate for "approximately 7 minutes." Staff went to check on what he thought was the door alarm and noticed client A was not in his room. Client A was outside clearing the driveway of snow with a broom. Client A was prompted into the house several times. After less than 5 minutes, client A returned inside the house. Client A continued to "have behaviors" until 5:30 AM. A note, documented on the incident report from the Group Home Director indicated, "[Client A] did not leave</p>		<p>#10 was also terminated due to accusation of abuse mentioned in investigation and due to an unrelated neglect. Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f). 3. Plan of correction: Staff #10 admitted that he was both neglectful and abusive. Therefore he was terminated (attachment i). Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f). 4. Plan of correction: Staff #10 and staff #7 admitted that he was both neglectful and abusive. Therefore both were terminated (attachment i and j). Staff #8 was retrained on immediately preventing and reporting abuse and neglect. Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e). Plan of monitoring: House</p>				

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	<p>[name of group home] property. He had been obsessing over the snow and becoming snowed into their driveway." There was no documentation the incident was immediately reported to the administrator. There was no documentation of corrective actions taken to ensure a similar incident did not recur.</p> <p>On 11/20/14 at 11:19 PM, the Group Home Director (GHD) indicated an investigation was not being conducted. The GHD indicated the door alarm sounded, staff #14 went to check on the alarm and found client A outside sweeping snow with a broom. The GHD indicated client A returned inside the home within 5 minutes. Staff #1 went to the group home to assist staff #14 with calming client A down. The GHD indicated she interviewed staff #14 by phone regarding the incident but she was not going to conduct an investigation. The GHD indicated staff #14 responded to the alarm as soon as he heard it and client A was not outside for a prolonged period of time. The GHD indicated staff #14 reported he responded to alarm as soon as he heard it. On 11/20/14 at 12:19 PM, the GHD indicated the incident was reported to the administrator several hours after the incident occurred. The GHD indicated she submitted a BDDS report after she interviewed staff #14.</p>		<p>manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p>	

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	<p>Staff #14 notified the pager and the pager failed to notify the administrator. The GHD indicated there was one staff working at the group home at the time of the incident. The GHD indicated she did not initiate an investigation into the incident and was not planning on conducting an investigation. The GHD indicated client A needed to be within eyesight of the staff. On 11/18/14 at 12:31 PM, the GHD indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients. The GHD indicated the facility should prevent abuse and neglect of the clients.</p> <p>3) On 11/11/14 at 5:00 AM, client A was awake throughout the night and was attempting to wake up his housemates. Client A laid on the floor of client B's room and refused to leave. Client A was prompted several times to leave client B's room. Staff #6 followed client A's Behavior Support Plan (BSP) and a one person transport was used to lead client A to his room to calm down in exclusionary time out. Client A's door was held shut which was not part of his plan.</p> <p>The BDDS follow-up report, dated 11/16/14, indicated, in part, "[Client A] was checked for injuries the next morning when he was calm. He showed no signs of physical injuries or emotional</p>						

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	<p>distress. [Staff #6] is a sub (substitute), who was previously was (sic) a full time staff at [name of group home]. He was not scheduled shifts until following the investigation. He has choses (sic) to not work at [name of group home] following this incident. There was one staff scheduled until 6am. [Staff #3] was called in early and arrived approx. (approximately) 515a shortly after behavior started. Behavior had ended prior to his arrival. Behavior lasted less than 15 minutes. Transport was under 5 minutes. Exclusionary time was under 5 minutes. Investigation determined that [staff #6's] actions were ensuring the safety of clients and [client A]. Closing the door was used to block [client A] from hitting and throwing things at him, not to restrain him. [Client A's] BSP has been updated to include '[Client A] is to be in eyesight of staff at all times during exclusionary time.' Staff - [staff #6] - will be reinstated to work at other houses. Two staff will be scheduled to work with the four clients at the [name of group home]. New schedule started 11/12/14. All [name of group home] staff will receive competency based BSP training on [client A's] plan."</p> <p>The investigation, dated 11/13/14, indicated the incident occurred on 11/9/14. The investigation indicated the</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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	<p>allegation was staff #6 "held [client A's] door closed." Staff #6 indicated in the investigation he held client A's door closed for "Less than 5 minutes." The investigation indicated, "[Staff #6] closed [client A's] door and held it closed. Seclusion is against Stone Belt's BMAN (Behavior Management) policy." The investigation indicated the allegation was substantiated. The investigation indicated staff #6 "will be removed from the [name of group home] substitution list. Two staff will be scheduled to work at the house during overnight shift."</p> <p>On 11/18/14 at 12:31 PM, the GHD indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients. The GHD indicated the facility should prevent abuse and neglect of the clients.</p> <p>4) The BDDS report, dated 11/11/14, indicated, "Incident date 11/08/2014 unspecified time. On 11/10/2014 at 2:00 PM, [client B's] right hand was slightly swollen. On 11/08/2014, [client B] was experiencing tremors, and his hand had hit the wall and table numerous times. On 11/09/2014, it was noted that [client B's] right hand was swelling. On 11/10/2014, [client B] was transported to his PCP (Primary Care Physician) and sent for x-rays. It was determined that</p>			

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	<p>the bone on of the side of his right hand leading to his small finger was fractured. [Client B's] guardian stated that he has had numerous fractures due to his tremors, and possibly due to behaviors. [Client B's] hand was reset and placed in a brace. [Client B] was sent home with discharge orders to keep the brace on and return in three weeks." There was no documentation of an investigation.</p> <p>On 11/20/14 at 11:02 AM, a review of client B's record was conducted. A Stone Belt Outside Services Report, dated 11/10/14, indicated client B had a contusion on his right hand. Client B was sent for an x-ray of his right hand. Another Stone Belt Outside Services Report, dated 11/10/14, indicated, "Fracture right hand. Right 5F (pinky) metacarpal fx (fracture). Splint right hand." There was no documentation in record indicating how client B sustained the fracture. Client B's 4/29/14 Behavioral Intervention Plan indicated client B had a targeted behavior of head and hand banging (hitting his head or hand against an object such as a wall or table). The plan indicated, "If staff has attempted to redirect [client B] from hand banging and he persists, [client B] will be required to wear protective gear for his protection."</p>						

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	<p>On 11/20/14 at 11:10 AM, the GHD indicated a BDDS report was completed but not an investigation. The GHD indicated client B had a Behavior Support Plan addressing hitting his hand which was thought to be the cause of the injury. The GHD indicated a follow-up BDDS report was completed but not an investigation. There was no documentation of a BDDS follow-up report in the electronic incident report system.</p> <p>On 11/21/14 at 11:28 AM, the Nurse Manager (NM) indicated from what he understood, the fracture was caused by client B banging on table and walls causing his hand to swell. The NM indicated he thought the cause of the fracture was clear cut.</p> <p>On 11/21/14 at 12:55 PM, the Behavior Consultant (BC) indicated client B did not have protective equipment in the home to use. The BC indicated client B's plan included the use of protective equipment for his hands. The BC indicated hand banging had not been an issue until recently. The BC indicated from the reports he received from the staff, client B had been engaging in hand banging against walls and tables prior to his hand being fractured. The BC indicated he was not aware of an</p>						

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	<p>investigation being conducted.</p> <p>On 11/21/14 at 1:07 PM, the GHD responded to the question, "Does he have 'protective gear for his protection' for his hands?" The GHD indicated in her email, "No, not at this time. His guardian stated his PCP (primary care physician) said he didn't need them. We were waiting for the OT(Occupational Therapy)/PT (Physical Therapy) eval to obtain either an order for a replacement pair or an order to discontinue the gloves. At that point we would delete it from the BSP."</p> <p>5) On 11/3/14 at 5:05 PM, staff #1 and staff #11 were administering medications to client B. Social Worker was standing by the bathroom closest to the kitchen engaging with clients. Staff #11 exited from the office with his hands under client B's armpits and proceeded to transport him toward his room. Client B's feet were dragging along the ground and he was facing away from the direction he was being moved. Social Worker informed staff #11 the facility was not permitted to transport clients in that manner and he was not using an authorized transport method. Staff #11 indicated he understood and stopped using the non-authorized method. Client B was allowed to walk freely and did so.</p>						

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	<p>Social Worker consulted with Behavior Service Coordinator who recommended processing an incident report. Group Home Director and guardian were notified. Staff #11 was suspended.</p> <p>The investigation, dated 11/4/14, indicated, in part, "[Name of investigator] interviewed [staff #1] by telephone on 11/4/2014 at 10am regarding the incident report for [client B] from 11/3/2014. [Staff #1] indicated that [staff #11] appeared confused about how to get [client B] to move down the hall as [client B] had gone to 'dead weight', and wasn't standing up by himself, so he utilized this transport as described in the original IR (incident report). [Staff #1's] report of the transport was consistent with hooking under [client B's] arms and walking with him hanging from the waist down with his feet dragging the ground. When asked by [investigator] if it appeared that [staff #11] was mad or being abusive to [client B] he reported 'No, definitely not. He seemed just confused about what to do and how to get [client B] to his room.' [Staff #1] confirms that [staff #11] stopped the inappropriate transport as soon as [Social Worker] pointed out that it wasn't an approved hold/transport. [Investigator] asked [staff #1] whether this was a behavior or not on the part of [client B]</p>			

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	<p>refusing any task demand. He said he didn't know [client B] well enough to determine this.</p> <p>[Social Worker] who was interviewed in person on 11/4/2014 at 10:30am confirmed the above statements and account and reported that there was indeed confusion on the part of [staff #11] and that he stopped right away when informed of the inappropriateness of this hold. [Social Worker] reported that he seemed to want to do the right thing but wasn't sure what it was.</p> <p>An interview with [staff #11] took place on 11/4/2014 at 1pm. [Staff #11] was asked to relay the events of 11/3/2014 surrounding [client B] and 'dragging' [client B] from the med room. [Staff #11] indicated that he had hooked his arms under [client B's] and picked him up and began to carry, walk him down the hall. [Client B] had gone 'dead weight,' which was described as sagging to the side, tremoring, and inability to carry himself, or move his feet down the hall. [Staff #11] indicated when asked that he was unclear what else to do as he wanted to get [client B] to a place to rest comfortably as he was having a medical issue in that moment in his opinion. [Client B] had already complied with the medication administration and had no</p>						

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	<p>other task demands placed on him at the time of this event. So [staff #11's] assessment was that this was a medical event and not a behavioral incident. [Staff #11] did ask for further clarification about how to handle [client B] if he is refusing or is having a medical issue in the future. CPI (Crisis Prevention Institute) technique and use of restrictive interventions were reviewed with him. In addition, [behavior consultant] was present and clarified some strategies for using the gait belt, and/or wheelchair if [client B] is going to the floor or having an issue in the future. This allegation was not substantiated. [Staff #11] was reinstated 11/5. He will receive behavior plan training on 11/7 by behavioral consultant. [Client B] is going to be assessed for an OT/PT evaluation."</p> <p>6) On 11/2/14 at 10:15 PM, client B was in bed sleeping. Staff #10 took client B's medications to administer to him because he was sleeping. After his medications were administered, staff #8 noted client B had urinated on himself. As staff #8 went in to change client B's clothing, staff #8 was told by staff #10 to leave them on him and he would change client B's clothing in the morning. Client B slept with wet clothes on all night. When staff #8 returned at 6:30 AM on 11/3/14,</p>			

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	<p>client B had been changed into dry clothing.</p> <p>The investigation, dated 11/7/14, indicated, in part, "[Staff #8] reports he worked 4-12 and at 9:30 he went with [staff #10] to administer medication to [client B]. [Client B] was sleeping in his bed, in his bedroom. [Staff #8] noticed [client B] was wet from urine and [staff #8] reports he stated to [staff #10] 'lets (sic) change him' (into dry clothes) and [staff #10] stated 'don't worry about it.' [Staff #10] and [staff #8] then left the bedroom, [client B] remained wet. The next morning [staff #8] arrived at house for his next shift at 6am and noticed [client B] had been changed into dry clothes but that his bedding was not changed. [Staff #8] told [staff #3] and [staff #1] about what he stated above and they advised him to write an IR. [Staff #10] reports nothing out of the ordinary happening during medicine administration with any client on 11/2/14. He reports he was 'never med trained' for this house. [Staff #10] was interviewed again and remembered more about the incident. He reports he did tell another staff not to change [client B] after administering medication because 'I didn't want to shower him and he would be all awake.' He reports he does not know if anyone else changed him but he</p>			

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	<p>does report, [client B] got a shower in the morning. Additional Notes: statement by [Group Home Director] on 11/4/14 electronic IR, 'Interviewed the second staff [staff #1] working that evening. [Client B] was asleep when he got there at 10pm. [Client B] was changed along with his sheets a couple of times throughout the night.' Summary: [Staff #10] admits to choosing to leave a client, wet in his own urine with intent. [Staff #8] admits to not contacting proper supervision to report inappropriate staff behavior. [Staff #8] also admits to not interrupting neglectful behavior. Findings: Neglect substantiated."</p> <p>There was no documentation the results of the investigation were reported to the administrator within 5 working days. There was no documentation staff #8 immediately reported the allegation to the administrator.</p> <p>On 11/18/14 at 12:06 PM, the GHD indicated staff #10 allegedly told staff #8 to leave client B when he noticed he had been incontinent. Staff #10 allegedly said, "if we wake him up he'll be up all night." The GHD indicated staff #1 came in for his shift at midnight and changed client B during the overnight shift. The GHD indicated the allegation was substantiated neglect due to staff not</p>						

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	<p>changing client B when he was incontinent. The GHD indicated the allegation was not reported immediately. The GHD indicated the allegation was reported the next morning. The GHD indicated staff #10 refused to assist client B when his clothes and sheets were wet. The GHD stated staff #10 was terminated for "Neglect and abuse. Got him for both." On 11/18/14 at 12:31 PM, the GHD indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients. The GHD indicated the facility should prevent abuse and neglect of the clients.</p> <p>On 11/20/14 at 12:47 PM, staff #8 indicated he observed client B was incontinent. Staff #8 indicated he was going to change client B's clothing and staff #10 told him he would change him in the morning. Staff #8 indicated he told staff #10 they could not leave him that way and walked into the office. Staff #8 indicated staff #10 came into the office and told staff #8 "everything that has happened stays in this room." Staff #8 indicated staff #10 intimidated him by the statement.</p> <p>7) On 11/2/14 at 5:10 PM, client C was in the living room. Client C was "being aggressive" with staff #7 by chasing staff #7 around the living room. While</p>				

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	<p>chasing staff #7, client C acted like he was going to hit staff #7. Staff #7 took a pillow and hit client C "in the face as hard as he could," and client C hit the floor hard. Staff #7 acted like he was going to hit client C again and client C grabbed staff #7's wrist. Staff #7 put his arms on client C's throat "very hard," and told client C to let go of his arms and staff #7 would let go of client C's throat. After 20 seconds, client C let go. Staff #7 hit client C with a pillow a total of 13 times within 30 minutes. At times, staff #7 was being the aggressor toward client C because staff #7 could not watch TV and it was upsetting client C. Staff #8 asked client C to calm down and he sat down next to staff #8. Staff #8 checked client C for injuries but none were found. Client C was getting more aggressive over the hour. Staff #8 asked staff #7 for help to take client C to his room however staff #7 said no he was not going to get hurt.</p> <p>The investigation, not dated, indicated the following, "[Staff #8] reports he arrived at [name of group home] for his shift at 4. He reports he was sitting with another client (one on one support). He reports noticing [client C] acting agitated and turning off TV. [Staff #8] reports he heard [staff #7] tell [client C] 'No' and [client C] acting like he was going to hit</p>			

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	<p>[staff #7]. Around 5 he saw [client C] being aggressive towards staff (#7). [Staff #8] reports seeing [staff #7] hit [client C] with a throw pillow on the arm 'hard'. [Staff #8] reports at this point [client C] 'charged' at [staff #7]. [Staff #7] 'threatened' to hit [client C] with pillow several times (pretending like he was going to hit by raising pillow up) and [client C] became more agitated and aggressed towards [staff #7]. At this point [staff #8] observed [staff #7] hit [client C] in head with pillow one time 'very hard' and [client C] fell to floor. [Staff #8] saw [client C] get up from floor, start moving towards [staff #7], grabbed his wrist and [staff #7] used his arm on [client C's] throat to push him until he let go of his wrist (20 sec). [Staff #8] reports during the next 30 min (minutes), [staff #7] hit [client C] 'many times' (IR (incident report) states 13 times). [Staff #8] reports [client C] pulled down his pants and underwear, while aggressing towards staff. [Staff #8] reports seeing [staff #7] push [client C] on couch. [Staff #8] reports he asked [staff #7] to help him escort [client C] to his room but he refused stating 'I don't want to get hurt.' [Staff #8] reports [staff #9] reported that she called the pager and [Group Home Director] answered, responding 'What do you want me to do?' [Staff #8] then reports leaving the house</p>			

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	<p>to take another client for a ride because he had not been out all day.</p> <p>Later that evening around 9, [staff #8] reports [staff #10] 'dragged' [client C] to his room and closed the door and held (sic) door closed."</p> <p>[Staff #7] reports working at [name of group home] from 8am -9pm. He reports [client C] was agitated, stating he was 'out of control' and 'acting crazy.' [Staff #7] reports he was sitting with another client one-on-one, around 7pm when [client C] started 'attacking staff,' including himself. He reports [client C] 'flipping out on [staff #9]' by throwing cups and other objects at [staff #9]. [Staff #7] reports [client C] grabbed his neck from behind and scratched him. Interviewer noticed a scratch on [staff #7's] neck. [Staff #7] reports he 'forced [client C] to the ground' by 'grabbing him by the arms and pulling.' [Staff #7] reports 'blocking by hitting and pushing' [client C] away from him with a pillow. [Staff #7] denies hitting [client C] with malice with the intention to harm. He reports he hit [client C] with the pillow 'a couple times.' [Staff #7] denies hitting</p>						

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	<p>[client C] in the head. He denies [client C] falling to the ground as a result of being hit with pillow.</p> <p>Summary: [Staff #7] admitted to inappropriate use of blocking, including hitting the client with hands and pillow in response to an aggressive client. He stated he was in a defensive mode, due to the aggressive nature of the client. Moreover, he admitted to 'forcing' the client onto the ground. [Staff #10] admitted to inappropriate use of transporting, including 'dragging' client in response to aggressive behavior. [Staff #8] admitted to not contacting proper supervision in response to perceived inappropriate staff conduct. [Staff #8] also admits to not interrupting inappropriate behavior. [Staff #9] asked for further training to work with aggressive clients. Staff is consistent in reporting that [client C] was being aggressive on 11/2/14. They are consistent that it was handled appropriately, except for [staff #8], who filed the IR (incident report)." The investigation indicated physical abuse was defined as, "Physical abuse: Consists of any intentional and/or</p>			

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	<p>punitive physical action or motion by which physical harm or emotional trauma may occur. This includes, but is not limited to the following:</p> <ol style="list-style-type: none"> 1. Corporal/Physical punishment: hitting, slapping, punching, kicking, pinching and/or striking a consumer. 2. Willful infliction of injury. 3. Intentionally touching another person in a rude, insolent or angry manner with the potential to result in significant harm or injury. 4. Punitive withdrawal of food and other essentials for human living. 5. Unauthorized restraint or confinement resulting from physical or chemical intervention. 6. The placement of a consumer(s) alone and unattended in a locked room. 7. Rape. <p>Findings: abuse substantiated. Emotional support was provided by [staff #8] and the overnight staff - [staff #1]. No injuries or emotional distress was detected. Investigation completed moves were not intent to harm but were poor understanding of blocking and CPI</p>						

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	<p>(Crisis Prevention Institute) interventions. [Staff #7] (staff accused of abuse) was terminated. [Staff #8] (Staff failing to prevent or timely report alleged abuse) received a written warning. The other 2 staff present did not witness incident. 4:4 (4 clients to 4 staff) ratio the day of the incident. Team will continue to intensely train staff and provide a safe environment for the clients. Support team meeting held 11/4 with guardian and BC (behavior consultant) to discuss aggressive behavior. 'Dragging' of room mate mentioned in this report is due to his tremors and was investigated in a separate investigation. The issue is medical and behavioral related and is being reviewed by an OT/PT (Occupational Therapy/Physical Therapy) for recommendations." There was no documentation indicating when the results of the investigation were reported to the administrator.</p> <p>On 11/18/14 at 12:06 PM, the GHD stated staff #8 reported he was sitting with another client and observed client C "messaging" with the TV. Staff #7 told client C "no" and client C became</p>			

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	<p>physically aggressive toward staff #7. Staff #7 hit client C with a pillow and threatened to hit client C several times with the pillow. Staff #7 hit client C with the pillow knocking client C to the floor. Staff #8 observed client C grab staff #7's arms and staff #7 used his arm on client C's throat. Staff #7 pushed client C onto the couch and hit him several times with the pillow. Staff #8 asked staff #7 for assistance to transport client C to his bedroom and staff #7 refused to assist him. Staff #8 reported staff #9 told him to not call the pager because it would not help anyway. Staff #9 indicated she observed staff #7 use a pillow to block. The GHD indicated staff #7 admitted to hitting client C with a pillow. Staff #10 indicated he observed staff #7 hitting client C's arms down. Staff #10 held client C's arms and transported him to his room but denied holding the door closed. The GHD stated staff #7 indicated he "forced [client C] to the ground and blocked [client C's] physical aggression using blocking, hitting and pushing." The GHD indicated staff #7 was terminated for abuse. On 11/18/14 at 12:31 PM, the GHD indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients. The GHD indicated the facility should prevent abuse and neglect of the clients. On 11/18/14 at 12:06 PM, the GHD stated</p>						

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	<p>staff #10 was terminated for "Neglect and abuse. Got him for both." On 11/20/14 at 11:34 AM, the GHD indicated the investigator was told of the allegation client C was "dragged" to his room during her interview with staff #8. The GHD indicated she was not made aware of the allegation until she received the investigation results and read it in the report. The GHD indicated she should be made aware of allegations immediately.</p> <p>8) On 11/2/14 at 5:00 PM, staff #10 reported during an investigation he transported client C to his room due to client C's aggression toward staff and other clients. The BDDS report, submitted on 11/11/14, indicated the facility had knowledge of the incident on 11/6/14. The BDDS report indicated, "Incident date: 11/02/2014 unspecified time. Investigation regarding state incident 647655 was conducted. During a review of this incident it was reported that [staff #10], substitute staff, reported he did not see or hear about [staff #7] hitting [client C] with (sic) pillow. [Staff #10] reported to investigator concerning an unrelated accusation that he [staff #10] 'transported' [client C] to his room later on in the evening due to [client C's] aggression towards staff and other clients. [Staff #10] described the way he transported [client C] 'held him under his</p>			

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	<p>arms and dragged him on the floor.' [Staff #10] reports not knowing if the 'transporting' is part of the client's BSP, but [staff #10] felt that it was necessary to keep the other clients safe. On 11/10/2014, [staff #10], who had not worked a shift since 11/06/2014, was interviewed by [GHD]. [Staff #10] stated that he did admit to improperly transporting [client C] to his room on 11/02/2014. [Staff #10] requested additional training with [client C] and CPI (Crisis Prevention Institute). [Staff #10] was attempting to complete a one person escort to keep the other clients at [name of group home] safe. This transport lasted approximately 5 minutes. [Client C] pulled his legs out from under him, and this resulted in [staff #10] holding him under his arms and transporting him incorrectly to his room to calm down. [Client C] was checked for injuries, and spoke with his social worker the next day. No injuries (sic) or emotional distress was the result of the incorrect transport. [Staff #10] will receive a final written warning. [Client C's] psych (psychiatrist) and behavior consultant will be notified regarding the aggressive behavior. [Name of group home] staff will undergo competency based BSP training with behavior consultant. Guardian notified. Support team will review."</p>			

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	<p>There was no documentation of an investigation. The issue was mentioned by staff #8 during the investigation dated 11/2/14 at 5:10 PM. Staff #10 received an Employee Warning Notice for discharge on 11/11/14.</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated the investigator was told of the allegation client C was "dragged" to his room during her interview with staff #8. The GHD indicated she was not made aware of the allegation until she received the investigation results and read it in the report. The GHD indicated she should be made aware of allegations immediately. The GHD indicated a separate investigation was not conducted but should have been.</p> <p>9) On 11/1/14 at 4:30 PM, client B was sitting on the couch in the living room. Client B was trying to stand up and staff #7 told client B to sit down. On his fifth attempt to stand, staff #7 pushed client B down "very hard" causing client B to hit his head on the back of the couch "very hard." Client B started to cry. Staff #7 told client B not to be a "cry baby." Staff #8 told staff #7 not to do that again. Client B got up and staff #8 took him into the bathroom and checked him for injury. No injuries were found.</p>			

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	<p>The investigation, not dated, indicated the following, "[Staff #8] reports around 3:30 or 4:00pm he was starting his shift and was checking emails and talking to another client in the dining room. [Staff #8] reports he saw [staff #7] sitting on couch watching TV in living room. [Staff #7] was [client B's] one on one staff. [Client B] came into living room and [staff #7] sat him on couch. [Client B] was trying to get up from couch several times and [staff #7] kept putting him back down on the couch. [Staff #7] then put a chair in front of [client B] and sat on the chair to keep [client B] from getting up. [Client B] tried again to get up and [staff #8] reports seeing [staff #7] push [client B] back down to the couch and [client B] hit his head hard on the back of the couch. [Staff #7] reports [client B] starting to cry and [staff #7] responded by saying 'don't be a cry baby.' [Staff #8] reports checking the back of [client B's] head for injury and did not find any. He reports he told [staff #7] he would report this incident in an IR (incident report) and [staff #7] responded by telling [staff #8] he 'had no sleep.' [Staff #8] reports he told [staff #7] 'to be careful with [client B].' [Staff #8] reports no other staff saw the incident. Other staff working at the time of incident: [staff #9] 9-5 & [staff #10] 4-12.</p>			
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	<p>[Staff #7] reports he was working one-on-one with [client B]. He reports sitting on couch with [client B]. He denies pushing [client B] down on couch. He denies [client B] hitting head on couch. He denies any verbal abuse towards [client B] that day. He denies any behavior from any staff that was out of the ordinary or concerning to him. Additional Notes: [Nurse Manager] reports meeting with [client B] on 11/3/14 and observed no injury as a result of the incident. Summary: This is the case of one staff's word against another. No sustained injury was found on client. Client not able to verbalize about the incident. [Staff #8] admits to not interrupting neglectful behavior. Findings: Inconclusive. Staff accused [staff #7] was terminated for other concerns. [Staff #10] was terminated for neglect and abuse."</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated the results of the investigation should not have indicated staff #10 was terminated for neglect and abuse. The GHD stated, "It was an error on my part. Investigation should be more thorough. Should include the pertinent information."</p> <p>On 11/20/14 at 2:28 PM, the Manager of</p>			

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	<p>Clinical Services (MCS) indicated the GHD completed the Recommendations of Corrective Action section of the investigation. The MCS indicated the investigator did not complete the corrective actions section. The MCS indicated the GHD should document on the investigation when she received the results of the investigation.</p> <p>On 11/20/14 at 12:47 PM, staff #8 indicated client B tried to get up from the couch. Staff #7 was watching football and client B's attempts to get up started to "annoy" staff #7. Staff #7 took client B by his shoulders and threw him onto the couch. Client B hit his head and started to cry. Staff #7 told him not to be a cry baby. Staff #8 indicated he told staff #7 to be more gentle with client B about 10 minutes later.</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated it was determined staff #8 needed to receive retraining for failing to immediately report allegations of abuse and neglect.</p> <p>On 11/20/14 at 12:47 PM, staff #8 indicated he reported the incidents he observed to staff #3 and staff #1 on 11/3/14. Staff #8 indicated he reported his concerns on 11/3/14 to his supervisor. Staff #8 indicated he received a retraining</p>			

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	<p>to inform a staff observed to engage in abuse and neglect to clock out and go home and then call the pager. If that did not work, call 911. Staff #8 indicated he should immediately report his concerns regarding abuse and neglect.</p> <p>On 11/20/14 at 2:00 PM, the Human Resources Director (HRD) indicated staff #8 came into the main office on Monday (11/3/14) and reported to his supervisor he did not want to work at the facility anymore. When the supervisor asked staff #8 why he did not want to work here anymore, staff #8 reported his concerns. The HRD indicated staff #8 had not filled out incident reports or reported his concerns. The HRD stated staff #8, "Not followed any of the reporting procedures." The HRD indicated staff #7 was suspended and the investigation was substantiated. Staff #7 was terminated for abuse. The HRD indicated staff #10 was terminated for neglect. The HRD indicated the facility should conduct thorough investigations. The HRD indicated the facility should prevent abuse and neglect of the clients. The HRD indicated if staff #8 would have reported the first incident, the rest may have been avoided. The HRD indicated staff #8 should have immediately reported the allegations. The HRD indicated staff #8 had just been through</p>			

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	<p>employee orientation where he received training on reporting abuse and neglect. The HRD indicated staff #8 had an employee identification card with the phone number to call for reporting abuse and neglect.</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated the incidents over the weekend (11/1/14 to 11/2/14) were reported to her on 11/3/14 by staff #8's supervisor. The GHD indicated staff #8 was retrained on reporting abuse and neglect. The GHD indicated the results of the investigations were reported to her on 11/6/14. The GHD indicated staff #7 and #10 were terminated on 11/7/14.</p> <p>On 11/20/14 at 3:35 PM, a Staff Training Form, dated 11/3/14, indicated staff #8 received training on reporting/interrupting abuse, neglect and exploitation. On 11/20/14 at 12:01 PM, a review of staff #8's employee file indicated he received training on reporting abuse, neglect and exploitation on 10/23/14.</p> <p>On 11/20/14 at 3:35 PM, staff #7's employee file was reviewed. The Employee Warning Notice, dated 11/10/14, indicated, "Several allegations were made regarding [staff #7]. Summary: [Staff #7] admitted to</p>				

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	<p>inappropriate use of blocking, including hitting the client with hands and pillow in response to an aggressive client. He stated he was in a defensive mode, due to the aggressive nature of the client. Moreover, he admitted to 'forcing' the client onto the ground." Staff #7 was terminated on 11/10/14.</p> <p>On 11/20/14 at 3:35 PM, staff #10's employee file was reviewed. The Employee Warning Notice, dated 11/11/14, indicated, "[Staff #10] was accused of leaving a client who had an accident in his bed without changing him. He also admitted to the improper transport of a client during a behavior. Staff was terminated at approximately 4:30 pm on 11/11/14."</p> <p>On 11/19/14 at 9:46 AM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to</p>			

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	<p>employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law. Events Requiring Investigations. Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over client support; misuse of client or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct. This does not replace the obligation of employees to report immediately to supervisors, directors or to write incident reports. This provides for another level of notification beyond, and in addition to, incident reporting. The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must</p>						

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	<p>meet the ICF/MR regulations including completion of all investigations within 5 working days... Investigations must be started within 24 hours.</p> <p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events." The Human Rights Policy, dated 9/14, indicated, in part, "Emotional/Verbal abuse: Consists of the intentional use of actions, words, or activities where an individual suffers emotional/psychological harm or trauma."</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review and interview for 6 of 13 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to ensure staff immediately reported allegations of abuse and neglect to the administrator and submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 11/19/14 from 6:30 AM to 8:18 AM. At 7:43 AM, client B was noted to have a 6 inch red scratch near his elbow on his right arm.</p> <p>On 11/18/14 at 11:53 AM, a review of the facility's incident/investigative reports was conducted. There was no incident report provided for review addressing the scratch on client B's arm. On 11/21/14 at 1:49 PM, the facility provided incident reports for review. The Stone Belt Arc, Inc. Incident Report, completed on</p>	W000153	<p>1. Plan of correction: Investigation regarding unknown injury on client b's elbow indicated it was from a piece of trim in his restroom (attachment g). Plan of prevention: Trim in his restroom was repaired. Staff failing to report the incident in a timely manner received a training from his supervisor Eric Ford (attachment h). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring to ensure that all incidents and concerns are being documented (attachment f).</p> <p>2) Plan of correction: Staff schedule has been updated to reflect 2 staff to 4 client ratio from 10p-6a (attachment g). Client A has been served notice and will be discharge from the facility once he receives his CIH waiver. Plan of prevention: Facility staffing office is to prioritize open shifts for Deckard (attachment h). Plan of monitoring: Coordinator or director will provide daily monitoring and document that staff to client ratios are being</p>	12/05/2014			

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	<p>11/20/14 with an incident date of 11/17/14, indicated, "[Staff #13] was helping [client B] in the shower and reported no signs of injury at that time. As [staff #13] was helping [client B] get dressed after his shower, staff noticed a scratch on [client B's] right arm approximately 2 inches long." The BDDS report, dated 11/20/14, indicated, "On 11/17/2014 at 9:00 AM, [client B] was being helped in to the shower; staff reports no signs of injury at that time. As staff was helping [client B] get dressed after his shower, staff noticed a scratch on [client B's] right arm approximately 5-6 inches long. After staff finished helping [client B] get dressed, [client B] and staff went to the office and staff cleaned the scratch with an alcohol swab, and applied a bandage." The BDDS report and facility incident report were not completed in a timely manner.</p> <p>On 11/19/14 at 7:43 AM, staff #3 indicated the scratch was from client B being unsteady in the bathroom near the kitchen. Staff #3 indicated staff #13 told him the information. Staff #3 indicated he thought client B scratched his arm on the wall to the left of the toilet on the hard, sharp plastic covering the wall during a fall.</p> <p>On 11/20/14 at 1:56 PM, staff #13</p>		<p>followed (attachment f). 3)Plan of correction:Investigation completed and it was confirmed that staff #10 was neglectful.Therefore he was terminated (attachmentk). Plan of prevention: Prevention andreporting abuse and neglect was trained at December Shiloh meeting and will bereviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director willprovide daily monitoring (attachment f). 1.Planof correction: Investigation completed and it was confirmed that staff #7 wasneglectful. Therefore he was terminated (attachmentl). Staff #10 was also terminated due to accusation of abuse mentioned ininvestigation and due to an unrelated neglect. Plan of prevention: Prevention andreporting abuse and neglect was trained at December Shiloh meeting and will bereviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director willprovide daily monitoring (attachment f). 2.Planof correction: Investigation completed and it was confirmed that staff #7 wasneglectful. Therefore he was terminated (attachmentl). Staff #10 was also terminated due to accusation of abuse mentioned</p>	

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	<p>indicated he was preparing to document an incident report regarding the injury to client B's arm. Staff #13 indicated he had not completed an incident report for the injury. Staff #13 indicated he was going to process the incident report as an injury of unknown origin due to not observing what occurred to cause the injury. Staff #13 indicated client B did not have the scratch prior to taking a shower and when he got out and was seated on the toilet, client B had the scratch. Staff #13 indicated he did not know what happened to cause the scratch.</p> <p>On 11/20/14 at 11:10 AM, the Group Home Director (GHD) indicated there should be an incident report for the scratch on client B's arm. The GHD indicated whoever was providing supervision to client B at the time should have completed an incident report. The GHD indicated the injury should have been reported to BDDS.</p> <p>On 11/18/14 at 11:53 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>2) On 11/17/14 at 3:00 AM, one of client A's housemates woke up and needed assistance with changing his clothes and</p>		<p>ininvestigation and due to an unrelated neglect. Plan of prevention: Prevention andreporting abuse and neglect was trained at December Shiloh meeting and will bereviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director willprovide daily monitoring (attachment f). 3. Planof correction: Investigation completed and it was confirmed that staff #7 wasneglectful. Therefore he was terminated (attachmentl). Staff #10 was also terminated due to accusation of abuse mentioned ininvestigation and due to an unrelated neglect. Plan of prevention: Prevention andreporting abuse and neglect was trained at December Shiloh meeting and will bereviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director willprovide daily monitoring (attachment f).</p>				

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	<p>bedding. Staff assisted client A's housemate for "approximately 7 minutes." Staff went to check on what he thought was the door alarm and noticed client A was not in his room. Client A was outside clearing the driveway of snow with a broom. Client A was prompted into the house several times. After less than 5 minutes, client A returned inside the house. Client A continued to "have behaviors" until 5:30 AM. A note, documented on the incident report from the Group Home Director indicated, "[Client A] did not leave [name of group home] property. He had been obsessing over the snow and becoming snowed into their driveway." There was no documentation the incident was immediately reported to the administrator.</p> <p>On 11/20/14 at 11:19 PM, the Group Home Director (GHD) the door alarm sounded, staff #14 went to check on the alarm and found client A outside sweeping snow with a broom. The GHD indicated client A returned inside the home within 5 minutes. Staff #1 went to the group home to assist staff #14 with calming client A down. The GHD indicated staff #14 responded to the alarm as soon as he heard it and client A was not outside for a prolonged period of time. The GHD indicated staff #14</p>			

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	<p>reported he responded to alarm as soon as he heard it. On 11/20/14 at 12:19 PM, the GHD indicated the incident was reported to the administrator several hours after the incident occurred. The GHD indicated she submitted a BDDS report after she interviewed staff #14. Staff #14 notified the pager and the pager failed to notify the administrator. The GHD indicated there was one staff working at the group home at the time of the incident.</p> <p>3) On 11/2/14 at 10:15 PM, client B was in bed sleeping. Staff #10 took client B's medications to administer to him because he was sleeping. After his medications were administered, staff #8 noted client B had urinated on himself. As staff #8 went in to change client B's clothing, staff #8 was told by staff #10 to leave them on him and he would change client B's clothing in the morning. Client B slept with wet clothes on all night. When staff #8 returned at 6:30 AM on 11/3/14, client B had been changed into dry clothing.</p> <p>The investigation, dated 11/7/14, indicated, in part, "[Staff #8] reports he worked 4-12 and at 9:30 he went with [staff #10] to administer medication to [client B]. [Client B] was sleeping in his bed, in his bedroom. [Staff #8] noticed</p>						

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	[client B] was wet from urine and [staff #8] reports he stated to [staff #10] 'lets (sic) change him' (into dry clothes) and [staff #10] stated 'don't worry about it.' [Staff #10] and [staff #8] then left the bedroom, [client B] remained wet. The next morning [staff #8] arrived at house for his next shift at 6am and noticed [client B] had been changed into dry clothes but that his bedding was not changed. [Staff #8] told [staff #3] and [staff #1] about what he stated above and they advised him to write an IR. [Staff #10] reports nothing out of the ordinary happening during medicine administration with any client on 11/2/14. He reports he was 'never med trained' for this house. [Staff #10] was interviewed again and remembered more about the incident. He reports he did tell another staff not to change [client B] after administering medication because 'I didn't want to shower him and he would be all awake.' He reports he does not know if anyone else changed him but he does report, [client B] got a shower in the morning. Additional Notes: statement by [Group Home Director] on 11/4/14 electronic IR, 'Interviewed the second staff [staff #1] working that evening. [Client B] was asleep when he got there at 10pm. [Client B] was changed along with his sheets a couple of times throughout the night.' Summary: [Staff			

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	<p>#10] admits to choosing to leave a client, wet in his own urine with intent. [Staff #8] admits to not contacting proper supervision to report inappropriate staff behavior. [Staff #8] also admits to not interrupting neglectful behavior. Findings: Neglect substantiated." There was no documentation staff #8 immediately reported the allegation to the administrator.</p> <p>On 11/18/14 at 12:06 PM, the GHD indicated the allegation was not reported immediately. The GHD indicated the allegation was reported the next morning. The GHD indicated allegations of abuse and neglect should be reported immediately.</p> <p>4) On 11/2/14 at 5:10 PM, client C was in the living room. Client C was "being aggressive" with staff #7 by chasing staff #7 around the living room. While chasing staff #7, client C acted like he was going to hit staff #7. Staff #7 took a pillow and hit client C "in the face as hard as he could," and client C hit the floor hard. Staff #7 acted like he was going to hit client C again and client C grabbed staff #7's wrist. Staff #7 put his arms on client C's throat "very hard," and told client C to let go of his arms and staff #7 would let go of client C's throat. After 20 seconds, client C let go. Staff</p>			

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	<p>#7 hit client C with a pillow a total of 13 times within 30 minutes. At times, staff #7 was being the aggressor toward client C because staff #7 could not watch TV and it was upsetting client C. Staff #8 asked client C to calm down and he sat down next to staff #8. Staff #8 checked client C for injuries but none were found. Client C was getting more aggressive over the house. Staff #8 asked staff #7 for help to take client C to his room however staff #7 said no he was not going to get hurt.</p> <p>The investigation, not dated, indicated the following, "[Staff #8] reports he arrived at [name of group home] for his shift at 4. He reports he was sitting with another client (one on one support). He reports noticing [client C] acting agitated and turning off TV. [Staff #8] reports he heard [staff #7] tell [client C] 'No' and [client C] acting like he was going to hit [staff #7]. Around 5 he saw [client C] being aggressive towards staff (#7). [Staff #8] reports seeing [staff #7] hit [client C] with a throw pillow on the arm 'hard'. [Staff #8] reports at this point [client C] 'charged' at [staff #7]. [Staff #7] 'threatened' to hit [client C] with pillow several times (pretending like he was going to hit by raising pillow up) and [client C] became more agitated and aggressed towards [staff #7]. At this</p>			

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	<p>point [staff #8] observed [staff #7] hit [client C] in head with pillow one time 'very hard' and [client C] fell to floor. [Staff #8] saw [client C] get up from floor, start moving towards [staff #7], grabbed his wrist and [staff #7] used his arm on [client C's] throat to push him until he let go of his wrist (20 sec). [Staff #8] reports during the next 30 min (minutes), [staff #7] hit [client C] 'many times' (IR (incident report) states 13 times). [Staff #8] reports [client C] pulled down his pants and underwear, while aggressing towards staff. [Staff #8] reports seeing [staff #7] push [client C] on couch. [Staff #8] reports he asked [staff #7] to help him escort [client C] to his room but he refused stating 'I don't want to get hurt.' [Staff #8] reports [staff #9] reported that she called the pager and [Group Home Director] answered, responding 'What do you want me to do?' [Staff #8] then reports leaving the house to take another client for a ride because he had not been out all day.</p> <p>Later that evening around 9, [staff #8] reports [staff #10] 'dragged' [client C] to his room and closed the door and held (sic) door closed."</p> <p>[Staff #7] reports working at [name of group home] from 8am -9pm. He reports</p>			

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	<p>[client C] was agitated, stating he was 'out of control' and 'acting crazy.' [Staff #7] reports he was sitting with another client one-on-one, around 7pm when [client C] started 'attacking staff,' including himself. He reports [client C] 'flipping out on [staff #9]' by throwing cups and other objects at [staff #9]. [Staff #7] reports [client C] grabbed his neck from behind and scratched him. Interviewer noticed a scratch on [staff #7's] neck. [Staff #7] reports he 'forced [client C] to the ground' by 'grabbing him by the arms and pulling.' [Staff #7] reports 'blocking by hitting and pushing' [client C] away from him with a pillow. [Staff #7] denies hitting [client C] with malice with the intention to harm. He reports he hit [client C] with the pillow 'a couple times.' [Staff #7] denies hitting [client C] in the head. He denies [client C] falling to the ground as a result of being hit with pillow.</p> <p>Summary: [Staff #7] admitted to inappropriate use of blocking, including hitting the client with hands and pillow in response to an aggressive client. He stated he was in a defensive mode, due to the aggressive nature of the client.</p>			

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	<p>Moreover, he admitted to 'forcing' the client onto the ground. [Staff #10] admitted to inappropriate use of transporting, including 'dragging' client in response to aggressive behavior. [Staff #8] admitted to not contacting proper supervision in response to perceived inappropriate staff conduct. [Staff #8] also admits to not interrupting inappropriate behavior. [Staff #9] asked for further training to work with aggressive clients. Staff is consistent in reporting the [client C] was being aggressive on 11/2/14. They are consistent that it was handled appropriately, except for [staff #8], who filed the IR (incident report)." The investigation indicated physical abuse was defined as, "Physical abuse: Consists of any intentional and/or punitive physical action or motion by which physical harm or emotional trauma may occur. This includes, but is not limited to the following:</p> <ol style="list-style-type: none"> 1. Corporal/Physical punishment: hitting, slapping, punching, kicking, pinching and/or striking a consumer. 2. Willful infliction of injury. 3. Intentionally touching another 			

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	<p>person in a rude, insolent or angry manner with the potential to result in significant harm or injury.</p> <p>4. Punitive withdrawal of food and other essentials for human living.</p> <p>5. Unauthorized restraint or confinement resulting from physical or chemical intervention.</p> <p>6. The placement of a consumer(s) alone and unattended in a locked room.</p> <p>7. Rape.</p> <p>Findings: abuse substantiated. Emotional support was provided by [staff #8] and the overnight staff - [staff #1]. No injuries or emotional distress was detected. Investigation completed moves were not intent to harm but were poor understanding of blocking and CPI (Crisis Prevention Institute) interventions. [Staff #7] (staff accused of abuse) was terminated. [Staff #8] (Staff failing to prevent or timely report alleged abuse) received a written warning. The other 2 staff present did not witness incident. 4:4 (4 clients to 4 staff) ratio the day of the incident. Team will continue to intensely train staff and</p>			

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	<p>provide a safe environment for the clients. Support team meeting held 11/4 with guardian and BC (behavior consultant) to discuss aggressive behavior. "Dragging" of room mate mentioned in this report is due to his tremors and was investigated in a separate investigation. The issue is medical and behavioral related and is being reviewed by an OT/PT (Occupational Therapy/Physical Therapy) for recommendations."</p> <p>On 11/18/14 at 12:06 PM, the GHD stated staff #8 reported he was sitting with another client and observed client C "messaging" with the TV. Staff #7 told client C "no" and client C became physically aggressive toward staff #7. Staff #7 hit client C with a pillow and threatened to hit client C several times with the pillow. Staff #7 hit client C with the pillow knocking client C to the floor. Staff #8 observed client C grab staff #7's arms and staff #7 used his arm on client C's throat. Staff #7 pushed client C onto the couch and hit him several times with the pillow. Staff #8 asked staff #7 for assistance to transport client C to his bedroom and staff #7 refused to assist him. Staff #8 reported staff #9 told him to not call the pager because it would not</p>			

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	<p>help anyway. Staff #9 indicated she observed staff #7 use a pillow to block. The GHD indicated staff #7 admitted to hitting client C with a pillow. Staff #10 indicated he observed staff #7 hitting client C's arms down. Staff #10 held client C's arms and transported him to his room but denied holding the door closed. The GHD stated staff #7 indicated he "forced [client C] to the ground and blocked [client C's] physical aggression using blocking, hitting and pushing." The GHD indicated staff #7 was terminated for abuse. On 11/20/14 at 11:34 AM, the GHD indicated the investigator was told of the allegation client C was "dragged" to his room during her interview with staff #8. The GHD indicated she was not made aware of the allegation until she received the investigation results and read it in the report. The GHD indicated she should be made aware of allegations immediately.</p> <p>5) On 11/2/14 at 5:00 PM, staff #10 reported during an investigation he transported client C to his room due to client C's aggression toward staff and other clients. The BDDS report, submitted on 11/11/14, indicated the facility had knowledge of the incident on 11/6/14. The BDDS report indicated, "Incident date: 11/02/2014 unspecified time. Investigation regarding state</p>						

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	<p>incident 647655 was conducted. During a review of this incident it was reported that [staff #10], substitute staff, reported he did not see or hear about [staff #7] hitting [client C] with (sic) pillow. [Staff #10] reported to investigator concerning an unrelated accusation that he [staff #10] 'transported' [client C] to his room later on in the evening due to [client C's] aggression towards staff and other clients. [Staff #10] described the way he transported [client C] 'held him under his arms and dragged him on the floor.' [Staff #10] reports not knowing if the 'transporting' is part of the client's BSP, but [staff #10] felt that it was necessary to keep the other clients safe. On 11/10/2014, [staff #10], who had not worked a shift since 11/06/2014, was interviewed by [GHD]. [Staff #10] stated that he did admit to improperly transporting [client C] to his room on 11/02/2014. [Staff #10] requested additional training with [client C] and CPI (Crisis Prevention Institute). [Staff #10] was attempting to complete a one person escort to keep the other clients at [name of group home] safe. This transport lasted approximately 5 minutes. [Client C] pulled his legs out from under him, and this resulted in [staff #10] holding him under his arms and transporting him incorrectly to his room to calm down. [Client C] was checked</p>			

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	<p>for injuries, and spoke with his social worker the next day. No injuries (sic) or emotional distress was the result of the incorrect transport. [Staff #10] will receive a final written warning. [Client C's] psych (psychiatrist) and behavior consultant will be notified regarding the aggressive behavior. [Name of group home] staff will undergo competency based BSP training with behavior consultant. Guardian notified. Support team will review."</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated the investigator was told of the allegation client C was "dragged" to his room during her interview with staff #8. The GHD indicated she was not made aware of the allegation until she received the investigation results and read it in the report. The GHD indicated she should be made aware of allegations immediately.</p> <p>6) On 11/1/14 at 4:30 PM, client B was sitting on the couch in the living room. Client B was trying to stand up and staff #7 told client B to sit down. On his fifth attempt to stand, staff #7 pushed client B down "very hard" causing client B to hit his head on the back of the couch "very hard." Client B started to cry. Staff #7 told client B not to be a "cry baby." Staff #8 told staff #7 not to do that again. Client B got up and staff #8 took him into</p>			

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	<p>the bathroom and checked him for injury. No injuries were found.</p> <p>The investigation, not dated, indicated the following, "[Staff #8] reports around 3:30 or 4:00pm he was starting his shift and was checking emails and talking to another client in the dining room. [Staff #8] reports he saw [staff #7] sitting on couch watching TV in living room. [Staff #7] was [client B's] one on one staff. [Client B] came into living room and [staff #7] sat him on couch. [Client B] was trying to get up from couch several times and [staff #7] kept putting him back down on the couch. [Staff #7] then put a chair in front of [client B] and sat on the chair to keep [client B] from getting up. [Client B] tried again to get up and [staff #8] reports seeing [staff #7] push [client B] back down to the couch and [client B] hit his head hard on the back of the couch. [Staff #7] reports [client B] starting to cry and [staff #7] responded by saying 'don't be a cry baby.' [Staff #8] reports checking the back of [client B's] head for injury and did not find any. He reports he told [staff #7] he would report this incident in an IR (incident report) and [staff #7] responded by telling [staff #8] he 'had no sleep.' [Staff #8] reports he told [staff #7] 'to be careful with [client B].' [Staff #8] reports no other staff saw the incident. Other</p>			

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	<p>staff working at the time of incident: [staff #9] 9-5 & [staff #10] 4-12.</p> <p>[Staff #7] reports he was working one-on-one with [client B]. He reports sitting on couch with [client B]. He denies pushing [client B] down on couch. He denies [client B] hitting head on couch. He denies any verbal abuse towards [client B] that day. He denies any behavior from any staff that was out of the ordinary or concerning to him. Additional Notes: [Nurse Manager] reports meeting with [client B] on 11/3/14 and observed no injury as a result of the incident. Summary: This is the case of one staff's word against another. No sustained injury was found on client. Client not able to verbalize about the incident. [Staff #8] admits to not interrupting neglectful behavior. Findings: Inconclusive. Staff accused [staff #7] was terminated for other concerns. [Staff #10] was terminated for neglect and abuse."</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated staff #8 should have reported the allegation immediately.</p> <p>On 11/20/14 at 12:47 PM, staff #8 indicated client B tried to get up from the couch. Staff #7 was watching football and client B's attempts to get up started to</p>			

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	<p>"annoy" staff #7. Staff #7 took client B by his shoulders and threw him onto the couch. Client B hit his head and started to cry. Staff #7 told him not to be a cry baby. Staff #8 indicated he told staff #7 to be more gentle with client B about 10 minutes later.</p> <p>On 11/20/14 at 12:47 PM, staff #8 indicated he reported the incidents he observed to staff #3 and staff #1 on 11/3/14. Staff #8 indicated he reported his concerns on 11/3/14 to his supervisor. Staff #8 indicated he received a retraining to inform a staff observed to engage in abuse and neglect to clock out and go home and then call the pager. If that did not work, call 911. Staff #8 indicated he should immediately report his concerns regarding abuse and neglect.</p> <p>On 11/20/14 at 2:00 PM, the Human Resources Director (HRD) indicated staff #8 came into the main office on Monday (11/3/14) and reported to his supervisor he did not want to work at the facility anymore. When the supervisor asked staff #8 why he did not want to work here anymore, staff #8 reported his concerns. The HRD indicated staff #8 had not filled out incident reports or reported his concerns. The HRD stated staff #8, "Not followed any of the reporting procedures." The HRD indicated if staff</p>						

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W000154	<p>#8 would have reported the first incident, the rest may have been avoided. The HRD indicated staff #8 should have immediately reported the allegations. The HRD indicated staff #8 had just been through employee orientation where he received training on reporting abuse and neglect. The HRD indicated staff #8 had an employee identification card with the phone number to call for reporting abuse and neglect.</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated the incidents over the weekend (11/1/14 to 11/2/14) were reported to her on 11/3/14 by staff #8's supervisor. The GHD indicated staff #8 was retrained on reporting abuse and neglect. The GHD indicated the results of the investigations were reported to her on 11/6/14. The GHD indicated staff #7 and #10 were terminated on 11/7/14.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly</p>						

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	<p>investigated.</p> <p>Based on record review and interview for 5 of 13 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to conduct thorough investigations of allegations of abuse and neglect.</p> <p>Findings include:</p> <p>1) On 11/17/14 at 3:00 AM, one of client A's housemates woke up and needed assistance with changing his clothes and bedding. Staff assisted client A's housemate for "approximately 7 minutes." Staff went to check on what he thought was the door alarm and noticed client A was not in his room. Client A was outside clearing the driveway of snow with a broom. Client A was prompted into the house several times. After less than 5 minutes, client A returned inside the house. Client A continued to "have behaviors" until 5:30 AM. A note, documented on the incident report from the Group Home Director indicated, "[Client A] did not leave [name of group home] property. He had been obsessing over the snow and becoming snowed into their driveway."</p> <p>On 11/20/14 at 11:19 PM, the Group Home Director (GHD) indicated an investigation was not being conducted.</p>	W000154	<p>1. Plan of correction: Investigation training was conducted with investigator responsible for the 5 out of 13 investigations that were not properly investigated. New investigation form created to assist in accurately documenting date and time of interviews (attachment k). Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e). Plan of monitoring: House manager / associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p>	12/05/2014			

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	<p>The GHD indicated the door alarm sounded, staff #14 went to check on the alarm and found client A outside sweeping snow with a broom. The GHD indicated client A returned inside the home within 5 minutes. Staff #1 went to the group home to assist staff #14 with calming client A down. The GHD indicated she interviewed staff #14 by phone regarding the incident but she was not going to conduct an investigation. The GHD indicated staff #14 responded to the alarm as soon as he heard it and client A was not outside for a prolonged period of time. The GHD indicated staff #14 reported he responded to alarm as soon as he heard it. The GHD indicated there was one staff working at the group home at the time of the incident. The GHD indicated she did not initiate an investigation into the incident and was not planning on conducting an investigation. The GHD indicated client A needed to be within eyesight of the staff.</p> <p>2) The BDDS report and the investigation did not indicate the same incident date. On 11/11/14 at 5:00 AM, client A was awake throughout the night and was attempting to wake up his housemates. Client A laid on the floor of client B's room and refused to leave. Client A was prompted several times to</p>						

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	<p>leave client B's room. Staff #6 followed client A's Behavior Support Plan (BSP) and a one person transport was used to lead client A to his room to calm down in exclusionary time out. Client A's door was held shut which was not part of his plan.</p> <p>The BDDS follow-up report, dated 11/16/14, indicated, in part, "[Client A] was checked for injuries the next morning when he was calm. He showed no signs of physical injuries or emotional distress. [Staff #6] is a sub (substitute), who was previously was (sic) a full time staff at [name of group home]. He was not scheduled shifts until following the investigation. He has choses (sic) to not work at [name of group home] following this incident. There was one staff scheduled until 6am. [Staff #3] was called in early and arrived approx. (approximately) 515a shortly after behavior started. Behavior had ended prior to his arrival. Behavior lasted less than 15 minutes. Transport was under 5 minutes. Exclusionary time was under 5 minutes. Investigation determined that [staff #6's] actions were ensuring the safety of clients and [client A]. Closing the door was used to block [client A] from hitting and throwing things at him, not to restrain him. [Client A's] BSP has been updated to include '[Client A] is to</p>			

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	<p>be in eyesight of staff at all times during exclusionary time.' Staff - [staff #6] - will be reinstated to work at other houses. Two staff will be scheduled to work with the four clients at the [name of group home]. New schedule started 11/12/14. All [name of group home] staff will receive competency based BSP training on [client A's] plan."</p> <p>The investigation, dated 11/13/14, indicated the incident occurred on 11/9/14. The investigation indicated the allegation was staff #6 "held [client A's] door closed." Staff #6 indicated in the investigation he held client A's door closed for "Less than 5 minutes." The investigation indicated, "[Staff #6] closed [client A's] door and held it closed. Seclusion is against Stone Belt's BMAN (Behavior Management) policy." The investigation indicated the allegation was substantiated. The investigation indicated staff #6 "will be removed from the [name of group home] substitution list. Two staff will be scheduled to work at the house during overnight shift."</p> <p>On 11/20/14 at 2:00 PM, the Human Resources Director indicated the facility should conduct thorough investigations.</p> <p>On 11/18/14 at 12:31 PM, the GHD indicated the facility should conduct</p>				

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	<p>thorough investigations.</p> <p>3) The BDDS report, dated 11/11/14, indicated, "Incident date 11/08/2014 unspecified time. On 11/10/2014 at 2:00 PM, [client B's] right hand was slightly swollen. On 11/08/2014, [client B] was experiencing tremors, and his hand had hit the wall and table numerous time. On 11/09/2014, it was noted that [client B's] right hand was swelling. On 11/10/2014, [client B] was transported to his PCP (Primary Care Physician) and sent for x-rays. It was determined that the bone on of the side of his right hand leading to his small finger was fractured. [Client B's] guardian stated that he has had numerous fractures due to his tremors, and possibly due to behaviors. [Client B's] hand was reset and placed in a brace. [Client B] was sent home with discharge orders to keep the brace on and return in three weeks." There was no documentation of an investigation.</p> <p>On 11/20/14 at 11:02 AM, a review of client B's record was conducted. A Stone Belt Outside Services Report, dated 11/10/14, indicated client B had a contusion on his right hand. Client B was sent for an x-ray of his right hand. Another Stone Belt Outside Services Report, dated 11/10/14, indicated, "Fracture right hand. Right 5F (pinky)</p>			

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	<p>metacarpal fx (fracture). Splint right hand." There was no documentation in record indicating how client B sustained the fracture. Client B's 4/29/14 Behavioral Intervention Plan indicated client B had a targeted behavior of head and hand banging (hitting his head or hand against an object such as a wall or table). The plan indicated, "If staff has attempted to redirect [client B] from hand banging and he persists, [client B] will be required to wear protective gear for his protection."</p> <p>On 11/20/14 at 11:10 AM, the GHD indicated a BDDS report was completed but not an investigation. The GHD indicated client B had a Behavior Support Plan addressing hitting his hand which was thought to be the cause of the injury. The GHD indicated a follow-up BDDS report was completed but not an investigation.</p> <p>On 11/21/14 at 11:28 AM, the Nurse Manager (NM) indicated from what he understood, the fracture was caused by client B banging on table and walls causing his hand to swell. The NM indicated he thought the cause of the fracture was clear cut.</p> <p>On 11/21/14 at 12:55 PM, the Behavior Consultant (BC) indicated client B did</p>			

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	<p>not have protective equipment in the home to use. The BC indicated client B's plan included the use of protective equipment for his hands. The BC indicated hand banging had not been an issue until recently. The BC indicated from the reports he received from the staff, client B had been engaging in hand banging against walls and tables prior to his hand being fractured. The BC indicated he was not aware of an investigation being conducted.</p> <p>4) On 11/2/14 at 5:00 PM, staff #10 reported during an investigation he transported client C to his room due to client C's aggression toward staff and other clients. The BDDS report, submitted on 11/11/14, indicated the facility had knowledge of the incident on 11/6/14. The BDDS report indicated, "Incident date: 11/02/2014 unspecified time. Investigation regarding state incident 647655 was conducted. During a review of this incident it was reported that [staff #10], substitute staff, reported he did not see or hear about [staff #7] hitting [client C] with (sic) pillow. [Staff #10] reported to investigator concerning an unrelated accusation that he [staff #10] 'transported' [client C] to his room later on in the evening due to [client C's] aggression towards staff and other clients. [Staff #10] described the way he</p>			

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	<p>transported [client C] 'held him under his arms and dragged him on the floor.' [Staff #10] reports not knowing if the 'transporting' is part of the client's BSP, but [staff #10] felt that it was necessary to keep the other clients safe. On 11/10/2014, [staff #10], who had not worked a shift since 11/06/2014, was interviewed by [GHD]. [Staff #10] stated that he did admit to improperly transporting [client C] to his room on 11/02/2014. [Staff #10] requested additional training with [client C] and CPI (Crisis Prevention Institute). [Staff #10] was attempting to complete a one person escort to keep the other clients at [name of group home] safe. This transport lasted approximately 5 minutes. [Client C] pulled his legs out from under him, and this resulted in [staff #10] holding him under his arms and transporting him incorrectly to his room to calm down. [Client C] was checked for injuries, and spoke with his social worker the next day. No injuries (sic) or emotional distress was the result of the incorrect transport. [Staff #10] will receive a final written warning. [Client C's] psych (psychiatrist) and behavior consultant will be notified regarding the aggressive behavior. [Name of group home] staff will undergo competency based BSP training with behavior consultant. Guardian notified. Support</p>			

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	<p>team will review."</p> <p>There was no documentation of an investigation. The issue was mentioned by staff #8 during the investigation dated 11/2/14 at 5:10 PM. Staff #10 received an Employee Warning Notice for discharge on 11/11/14.</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated the investigator was told of the allegation client C was "dragged" to his room during her interview with staff #8. The GHD indicated a separate investigation was not conducted but should have been.</p> <p>5) On 11/1/14 at 4:30 PM, client B was sitting on the couch in the living room. Client B was trying to stand up and staff #7 told client B to sit down. On his fifth attempt to stand, staff #7 pushed client B down "very hard" causing client B to hit his head on the back of the couch "very hard." Client B started to cry. Staff #7 told client B not to be a "cry baby." Staff #8 told staff #7 not to do that again. Client B got up and staff #8 took him into the bathroom and checked him for injury. No injuries were found.</p> <p>The investigation, not dated, indicated the following, "[Staff #8] reports around 3:30 or 4:00pm he was starting his shift</p>						

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	<p>and was checking emails and talking to another client in the dining room. [Staff #8] reports he saw [staff #7] sitting on couch watching TV in living room. [Staff #7] was [client B's] one on one staff. [Client B] came into living room and [staff #7] sat him on couch. [Client B] was trying to get up from couch several times and [staff #7] kept putting him back down on the couch. [Staff #7] then put a chair in front of [client B] and sat on the chair to keep [client B] from getting up. [Client B] tried again to get up and [staff #8] reports seeing [staff #7] push [client B] back down to the couch and [client B] hit his head hard on the back of the couch. [Staff #7] reports [client B] starting to cry and [staff #7] responded by saying 'don't be a cry baby.' [Staff #8] reports checking the back of [client B's] head for injury and did not find any. He reports he told [staff #7] he would report this incident in an IR (incident report) and [staff #7] responded by telling [staff #8] he 'had no sleep.' [Staff #8] reports he told [staff #7] 'to be careful with [client B].' [Staff #8] reports no other staff saw the incident. Other staff working at the time of incident: [staff #9] 9-5 & [staff #10] 4-12.</p> <p>[Staff #7] reports he was working one-on-one with [client B]. He reports sitting on couch with [client B]. He</p>			

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	<p>denies pushing [client B] down on couch. He denies [client B] hitting head on couch. He denies any verbal abuse towards [client B] that day. He denies any behavior from any staff that was out of the ordinary or concerning to him. Additional Notes: [Nurse Manager] reports meeting with [client B] on 11/3/14 and observed no injury as a result of the incident. Summary: This is the case of one staff's word against another. No sustained injury was found on client. Client not able to verbalize about the incident. [Staff #8] admits to not interrupting neglectful behavior. Findings: Inconclusive. Staff accused [staff #7] was terminated for other concerns. [Staff #10] was terminated for neglect and abuse."</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated the results of the investigation should not have indicated staff #10 was terminated for neglect and abuse. The GHD indicated staff #10 was not involved in the incident and the investigation should not have included information about staff #10 being terminated. The GHD stated, "It was an error on my part. Investigation should be more thorough. Should include the pertinent information."</p> <p>On 11/20/14 at 12:47 PM, staff #8</p>			

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	<p>indicated client B tried to get up from the couch. Staff #7 was watching football and client B's attempts to get up started to "annoy" staff #7. Staff #7 took client B by his shoulders and threw him onto the couch. Client B hit his head and started to cry. Staff #7 told him not to be a cry baby. Staff #8 indicated he told staff #7 to be more gentle with client B about 10 minutes later.</p> <p>On 11/20/14 at 2:00 PM, the Human Resources Director (HRD) indicated staff #8 came into the main office on Monday (11/3/14) and reported to his supervisor he did not want to work at the facility anymore. When the supervisor asked staff #8 why he did not want to work here anymore, staff #8 reported his concerns. The HRD indicated staff #8 had not filled out incident reports or reported his concerns. The HRD stated staff #8, "Not followed any of the reporting procedures." The HRD indicated staff #7 was suspended and the investigation was substantiated. Staff #7 was terminated for abuse. The HRD indicated staff #10 was terminated for neglect. The HRD indicated the facility should conduct thorough investigations. The HRD indicated if staff #8 would have reported the first incident, the rest may have been avoided. The HRD indicated staff #8 had just been through employee orientation</p>						

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W000156	<p>where he received training on reporting abuse and neglect. The HRD indicated staff #8 had an employee identification card with the phone number to call for reporting abuse and neglect.</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated the incidents over the weekend (11/1/14 to 11/2/14) were reported to her on 11/3/14 by staff #8's supervisor. The GHD indicated staff #8 was retrained on reporting abuse and neglect. The GHD indicated the results of the investigations were reported to her on 11/6/14. The GHD indicated staff #7 and #10 were terminated on 11/7/14.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 2 of 13 incident/investigative reports reviewed affecting clients B and C, the facility failed to ensure the results of</p>	W000156	1. Plan of correction: Investigation training was conducted with investigator responsible for the 2 out of 13 investigations that were	12/05/2014			

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	<p>investigations were reported to the administrator within 5 working days of the incident.</p> <p>Findings include:</p> <p>On 11/18/14 at 11:53 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 11/2/14 at 10:15 PM, client B was in bed sleeping. Staff #10 took client B's medications to administer to him because he was sleeping. After his medications were administered, staff #8 noted client B had urinated on himself. As staff #8 went in to change client B's clothing, staff #8 was told by staff #10 to leave them on him and he would change client B's clothing in the morning. Client B slept with wet clothes on all night. When staff #8 returned at 6:30 AM on 11/3/14, client B had been changed into dry clothing.</p> <p>The investigation, dated 11/7/14, indicated, in part, "[Staff #8] reports he worked 4-12 and at 9:30 he went with [staff #10] to administer medication to [client B]. [Client B] was sleeping in his bed, in his bedroom. [Staff #8] noticed [client B] was wet from urine and [staff #8] reports he stated to [staff #10] 'lets</p>		<p>not properly investigated. New investigation form created to assist in accurately documenting date and time of interviews (attachment k).</p> <p>Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e).</p> <p>Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p>				

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	(sic) change him' (into dry clothes) and [staff #10] stated 'don't worry about it.' [Staff #10] and [staff #8] then left the bedroom, [client B] remained wet. The next morning [staff #8] arrived at house for his next shift at 6am and noticed [client B] had been changed into dry clothes but that his bedding was not changed. [Staff #8] told [staff #3] and [staff #1] about what he stated above and they advised him to write an IR. [Staff #10] reports nothing out of the ordinary happening during medicine administration with any client on 11/2/14. He reports he was 'never med trained' for this house. [Staff #10] was interviewed again and remembered more about the incident. He reports he did tell another staff not to change [client B] after administering medication because 'I didn't want to shower him and he would be all awake.' He reports he does not know if anyone else changed him but he does report, [client B] got a shower in the morning. Additional Notes: statement by [Group Home Director] on 11/4/14 electronic IR, 'Interviewed the second staff [staff #1] working that evening. [Client B] was asleep when he got there at 10pm. [Client B] was changed along with his sheets a couple of times throughout the night.' Summary: [Staff #10] admits to choosing to leave a client, wet in his own urine with intent. [Staff			

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	<p>#8] admits to not contacting proper supervision to report inappropriate staff behavior. [Staff #8] also admits to not interrupting neglectful behavior. Findings: Neglect substantiated." There was no documentation the results of the investigation were reported to the administrator within 5 working days.</p> <p>On 11/18/14 at 12:06 PM, the GHD indicated staff #10 allegedly told staff #8 to leave client B when he noticed he had been incontinent. Staff #10 allegedly said, "if we wake him up he'll be up all night." The GHD indicated staff #1 came in for his shift at midnight and changed client B during the overnight shift. The GHD indicated the allegation was substantiated neglect due to staff not changing client B when he was incontinent. The GHD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The GHD indicated she reviewed the results of the investigation on 11/6/14 but did not have documentation to indicate her review.</p> <p>2) On 11/2/14 at 5:10 PM, client C was in the living room. Client C was "being aggressive" with staff #7 by chasing staff #7 around the living room. While chasing staff #7, client C acted like he was going to hit staff #7. Staff #7 took a</p>			

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	<p>pillow and hit client C "in the face as hard as he could," and client C hit the floor hard. Staff #7 acted like he was going to hit client C again and client C grabbed staff #7's wrist. Staff #7 put his arms on client C's throat "very hard," and told client C to let go of his arms and staff #7 would let go of client C's throat. After 20 seconds, client C let go. Staff #7 hit client C with a pillow a total of 13 times within 30 minutes. At times, staff #7 was being the aggressor toward client C because staff #7 could not watch TV and it was upsetting client C. Staff #8 asked client C to calm down and he sat down next to staff #8. Staff #8 checked client C for injuries but none were found. Client C was getting more aggressive over the house. Staff #8 asked staff #7 for help to take client C to his room however staff #7 said no he was not going to get hurt.</p> <p>The investigation, not dated, indicated the following, "[Staff #8] reports he arrived at [name of group home] for his shift at 4. He reports he was sitting with another client (one on one support). He reports noticing [client C] acting agitated and turning off TV. [Staff #8] reports he heard [staff #7] tell [client C] 'No' and [client C] acting like he was going to hit [staff #7]. Around 5 he saw [client C] being aggressive towards staff (#7).</p>			

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	<p>[Staff #8] reports seeing [staff #7] hit [client C] with a throw pillow on the arm 'hard'. [Staff #8] reports at this point [client C] 'charged' at [staff #7]. [Staff #7] 'threatened' to hit [client C] with pillow several times (pretending like he was going to hit by raising pillow up) and [client C] became more agitated and aggressed towards [staff #7]. At this point [staff #8] observed [staff #7] hit [client C] in head with pillow one time 'very hard' and [client C] fell to floor. [Staff #8] saw [client C] get up from floor, start moving towards [staff #7], grabbed his wrist and [staff #7] used his arm on [client C's] throat to push him until he let go of his wrist (20 sec). [Staff #8] reports during the next 30 min (minutes), [staff #7] hit [client C] 'many times' (IR (incident report) states 13 times). [Staff #8] reports [client C] pulled down his pants and underwear, while aggressing towards staff. [Staff #8] reports seeing [staff #7] push [client C] on couch. [Staff #8] reports he asked [staff #7] to help him escort [client C] to his room but he refused stating 'I don't want to get hurt.' [Staff #8] reports [staff #9] reported that she called the pager and [Group Home Director] answered, responding 'What do you want me to do?' [Staff #8] then reports leaving the house to take another client for a ride because he had not been out all day.</p>			

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	<p>Later that evening around 9, [staff #8] reports [staff #10] 'dragged' [client C] to his room and closed the door and held (sic) door closed."</p> <p>[Staff #7] reports working at [name of group home] from 8am -9pm. He reports [client C] was agitated, stating he was 'out of control' and 'acting crazy.' [Staff #7] reports he was sitting with another client one-on-one, around 7pm when [client C] started 'attacking staff,' including himself. He reports [client C] 'flipping out on [staff #9]' by throwing cups and other objects at [staff #9]. [Staff #7] reports [client C] grabbed his neck from behind and scratched him. Interviewer noticed a scratch on [staff #7's] neck. [Staff #7] reports he 'forced [client C] to the ground' by 'grabbing him by the arms and pulling.' [Staff #7] reports 'blocking by hitting and pushing' [client C] away from him with a pillow. [Staff #7] denies hitting [client C] with malice with the intention to harm. He reports he hit [client C] with the pillow 'a couple times.' [Staff #7] denies hitting [client C] in the head. He denies [client C] falling to the ground as a result of</p>			

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	<p>being hit with pillow.</p> <p>Summary: [Staff #7] admitted to inappropriate use of blocking, including hitting the client with hands and pillow in response to an aggressive client. He stated he was in a defensive mode, due to the aggressive nature of the client.</p> <p>Moreover, he admitted to 'forcing' the client onto the ground. [Staff #10] admitted to inappropriate use of transporting, including 'dragging' client in response to aggressive behavior. [Staff #8] admitted to not contacting proper supervision in response to perceived inappropriate staff conduct. [Staff #8] also admits to not interrupting inappropriate behavior. [Staff #9] asked for further training to work with aggressive clients. Staff is consistent in reporting the [client C] was being aggressive on 11/2/14. They are consistent that it was handled appropriately, except for [staff #8], who filed the IR (incident report)." The investigation indicated physical abuse was defined as, "Physical abuse: Consists of any intentional and/or punitive physical action or motion by which physical harm or emotional trauma</p>						

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	<p>may occur. This includes, but is not limited to the following:</p> <ol style="list-style-type: none"> 1. Corporal/Physical punishment: hitting, slapping, punching, kicking, pinching and/or striking a consumer. 2. Willful infliction of injury. 3. Intentionally touching another person in a rude, insolent or angry manner with the potential to result in significant harm or injury. 4. Punitive withdrawal of food and other essentials for human living. 5. Unauthorized restraint or confinement resulting from physical or chemical intervention. 6. The placement of a consumer(s) alone and unattended in a locked room. 7. Rape. <p>Findings: abuse substantiated. Emotional support was provided by [staff #8] and the overnight staff - [staff #1]. No injuries or emotional distress was detected. Investigation completed moves were not intent to harm but were poor understanding of blocking and CPI (Crisis Prevention Institute) interventions. [Staff #7] (staff accused of</p>			

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	<p>abuse) was terminated. [Staff #8] (Staff failing to prevent or timely report alleged abuse) received a written warning. The other 2 staff present did not witness incident. 4:4 (4 clients to 4 staff) ratio the day of the incident. Team will continue to intensely train staff and provide a safe environment for the clients. Support team meeting held 11/4 with guardian and BC (behavior consultant) to discuss aggressive behavior. "Dragging' of room mate mentioned in this report is due to his tremors and was investigated in a separate investigation. The issue is medical and behavioral related and is being reviewed by an OT/PT (Occupational Therapy/Physical Therapy) for recommendations." There was no documentation indicating when the results of the investigation were reported to the administrator.</p> <p>On 11/18/14 at 12:06 PM, the GHD stated staff #8 reported he was sitting with another client and observed client C "messaging" with the TV. Staff #7 told client C "no" and client C became physically aggressive toward staff #7. Staff #7 hit client C with a pillow and</p>			

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	<p>threatened to hit client C several times with the pillow. Staff #7 hit client C with the pillow knocking client C to the floor. Staff #8 observed client C grab staff #7's arms and staff #7 used his arm on client C's throat. Staff #7 pushed client C onto the couch and hit him several times with the pillow. Staff #8 asked staff #7 for assistance to transport client C to his bedroom and staff #7 refused to assist him. Staff #8 reported staff #9 told him to not call the pager because it would not help anyway. Staff #9 indicated she observed staff #7 use a pillow to block. The GHD indicated staff #7 admitted to hitting client C with a pillow. Staff #10 indicated he observed staff #7 hitting client C's arms down. Staff #10 held client C's arms and transported him to his room but denied holding the door closed. The GHD stated staff #7 indicated he "forced [client C] to the ground and blocked [client C's] physical aggression using blocking, hitting and pushing." The GHD indicated staff #7 was terminated for abuse. The GHD indicated she reviewed the results of the investigation on 11/6/14 but did not have documentation to indicate her review.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-2(a)</p>						

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 5 of 13 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to implement appropriate corrective action to address staff failing to immediately report abuse to the administrator and client A's elopement.</p> <p>Findings include:</p> <p>1) On 11/17/14 at 3:00 AM, one of client A's housemates woke up and needed assistance with changing his clothes and bedding. Staff assisted client A's housemate for "approximately 7 minutes." Staff went to check on what he thought was the door alarm and noticed client A was not in his room. Client A was outside clearing the driveway of snow with a broom. Client A was prompted into the house several times. After less than 5 minutes, client A returned inside the house. Client A continued to "have behaviors" until 5:30 AM. A note, documented on the incident report from the Group Home Director indicated, "[Client A] did not leave [name of group home] property. He had</p>	W000157	<p>1. Plan of correction: Immediately reporting suspicion of abuse to administrator was conducted with staff #8 who was responsible for the 4 out of 13 investigations that were not timely reported. Plan of prevention: Prevention and reporting abuse and neglect was trained at December Shiloh meeting and will be reviewed monthly (attachment e). Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f).</p>	12/05/2014

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	<p>been obsessing over the snow and becoming snowed into their driveway." There was no documentation of corrective actions taken to ensure a similar incident did not recur.</p> <p>On 11/20/14 at 12:19 PM, the GHD indicated the incident was reported to the administrator several hours after the incident occurred. The GHD indicated she submitted a BDDS report after she interviewed staff #14. Staff #14 notified the pager and the pager failed to notify the administrator. The GHD indicated there was one staff working at the group home at the time of the incident. The GHD indicated she did not initiate an investigation into the incident and was not planning on conducting an investigation. The GHD indicated client A needed to be within eyesight of the staff.</p> <p>2) On 11/2/14 at 10:15 PM, client B was in bed sleeping. Staff #10 took client B's medications to administer to him because he was sleeping. After his medications were administered, staff #8 noted client B had urinated on himself. As staff #8 went in to change client B's clothing, staff #8 was told by staff #10 to leave them on him and he would change client B's clothing in the morning. Client B slept with wet clothes on all night. When</p>			

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	<p>staff #8 returned at 6:30 AM on 11/3/14, client B had been changed into dry clothing.</p> <p>The investigation, dated 11/7/14, indicated, in part, "[Staff #8] reports he worked 4-12 and at 9:30 he went with [staff #10] to administer medication to [client B]. [Client B] was sleeping in his bed, in his bedroom. [Staff #8] noticed [client B] was wet from urine and [staff #8] reports he stated to [staff #10] 'lets (sic) change him' (into dry clothes) and [staff #10] stated 'don't worry about it.' [Staff #10] and [staff #8] then left the bedroom, [client B] remained wet. The next morning [staff #8] arrived at house for his next shift at 6am and noticed [client B] had been changed into dry clothes but that his bedding was not changed. [Staff #8] told [staff #3] and [staff #1] about what he stated above and they advised him to write an IR. [Staff #10] reports nothing out of the ordinary happening during medicine administration with any client on 11/2/14. He reports he was 'never med trained' for this house. [Staff #10] was interviewed again and remembered more about the incident. He reports he did tell another staff not to change [client B] after administering medication because 'I didn't want to shower him and he would be all awake.' He reports he does not</p>			

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	<p>know if anyone else changed him but he does report, [client B] got a shower in the morning. Additional Notes: statement by [Group Home Director] on 11/4/14 electronic IR, 'Interviewed the second staff [staff #1] working that evening. [Client B] was asleep when he got there at 10pm. [Client B] was changed along with his sheets a couple of times throughout the night.' Summary: [Staff #10] admits to choosing to leave a client, wet in his own urine with intent. [Staff #8] admits to not contacting proper supervision to report inappropriate staff behavior. [Staff #8] also admits to not interrupting neglectful behavior. Findings: Neglect substantiated."</p> <p>There was no documentation staff #8 received disciplinary action for failing to immediately report abuse.</p> <p>On 11/18/14 at 12:06 PM, the GHD indicated staff #8 received a retraining on reporting abuse and neglect.</p> <p>3) On 11/2/14 at 5:10 PM, client C was in the living room. Client C was "being aggressive" with staff #7 by chasing staff #7 around the living room. While chasing staff #7, client C acted like he was going to hit staff #7. Staff #7 took a pillow and hit client C "in the face as hard as he could," and client C hit the</p>						

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	<p>floor hard. Staff #7 acted like he was going to hit client C again and client C grabbed staff #7's wrist. Staff #7 put his arms on client C's throat "very hard," and told client C to let go of his arms and staff #7 would let go of client C's throat. After 20 seconds, client C let go. Staff #7 hit client C with a pillow a total of 13 times within 30 minutes. At times, staff #7 was being the aggressor toward client C because staff #7 could not watch TV and it was upsetting client C. Staff #8 asked client C to calm down and he sat down next to staff #8. Staff #8 checked client C for injuries but none were found. Client C was getting more aggressive over the house. Staff #8 asked staff #7 for help to take client C to his room however staff #7 said no he was not going to get hurt.</p> <p>The investigation, not dated, indicated the following, "[Staff #8] reports he arrived at [name of group home] for his shift at 4. He reports he was sitting with another client (one on one support). He reports noticing [client C] acting agitated and turning off TV. [Staff #8] reports he heard [staff #7] tell [client C] 'No' and [client C] acting like he was going to hit [staff #7]. Around 5 he saw [client C] being aggressive towards staff (#7). [Staff #8] reports seeing [staff #7] hit [client C] with a throw pillow on the arm</p>						

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	<p>'hard'. [Staff #8] reports at this point [client C] 'charged' at [staff #7]. [Staff #7] 'threatened' to hit [client C] with pillow several times (pretending like he was going to hit by raising pillow up) and [client C] became more agitated and aggressed towards [staff #7]. At this point [staff #8] observed [staff #7] hit [client C] in head with pillow one time 'very hard' and [client C] fell to floor. [Staff #8] saw [client C] get up from floor, start moving towards [staff #7], grabbed his wrist and [staff #7] used his arm on [client C's] throat to push him until he let go of his wrist (20 sec). [Staff #8] reports during the next 30 min (minutes), [staff #7] hit [client C] 'many times' (IR (incident report) states 13 times). [Staff #8] reports [client C] pulled down his pants and underwear, while aggressing towards staff. [Staff #8] reports seeing [staff #7] push [client C] on couch. [Staff #8] reports he asked [staff #7] to help him escort [client C] to his room but he refused stating 'I don't want to get hurt.' [Staff #8] reports [staff #9] reported that she called the pager and [Group Home Director] answered, responding 'What do you want me to do?' [Staff #8] then reports leaving the house to take another client for a ride because he had not been out all day.</p> <p>Later that evening around 9, [staff #8]</p>			

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	<p>reports [staff #10] 'dragged' [client C] to his room and closed the door and held (sic) door closed."</p> <p>[Staff #7] reports working at [name of group home] from 8am -9pm. He reports [client C] was agitated, stating he was 'out of control' and 'acting crazy.' [Staff #7] reports he was sitting with another client one-on-one, around 7pm when [client C] started 'attacking staff,' including himself. He reports [client C] 'flipping out on [staff #9]' by throwing cups and other objects at [staff #9]. [Staff #7] reports [client C] grabbed his neck from behind and scratched him. Interviewer noticed a scratch on [staff #7's] neck. [Staff #7] reports he 'forced [client C] to the ground' by 'grabbing him by the arms and pulling.' [Staff #7] reports 'blocking by hitting and pushing' [client C] away from him with a pillow. [Staff #7] denies hitting [client C] with malice with the intention to harm. He reports he hit [client C] with the pillow 'a couple times.' [Staff #7] denies hitting [client C] in the head. He denies [client C] falling to the ground as a result of being hit with pillow.</p> <p>Summary: [Staff #7] admitted to</p>			

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	<p>inappropriate use of blocking, including hitting the client with hands and pillow in response to an aggressive client. He stated he was in a defensive mode, due to the aggressive nature of the client. Moreover, he admitted to 'forcing' the client onto the ground. [Staff #10] admitted to inappropriate use of transporting, including 'dragging' client in response to aggressive behavior. [Staff #8] admitted to not contacting proper supervision in response to perceived inappropriate staff conduct. [Staff #8] also admits to not interrupting inappropriate behavior. [Staff #9] asked for further training to work with aggressive clients. Staff is consistent in reporting the [client C] was being aggressive on 11/2/14. They are consistent that it was handled appropriately, except for [staff #8], who filed the IR (incident report)." The investigation indicated physical abuse was defined as, "Physical abuse: Consists of any intentional and/or punitive physical action or motion by which physical harm or emotional trauma may occur. This includes, but is not limited to the following:</p>						

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	<ol style="list-style-type: none"> 1. Corporal/Physical punishment: hitting, slapping, punching, kicking, pinching and/or striking a consumer. 2. Willful infliction of injury. 3. Intentionally touching another person in a rude, insolent or angry manner with the potential to result in significant harm or injury. 4. Punitive withdrawal of food and other essentials for human living. 5. Unauthorized restraint or confinement resulting from physical or chemical intervention. 6. The placement of a consumer(s) alone and unattended in a locked room. 7. Rape. <p>Findings: abuse substantiated. Emotional support was provided by [staff #8] and the overnight staff - [staff #1]. No injuries or emotional distress was detected. Investigation completed moves were not intent to harm but were poor understanding of blocking and CPI (Crisis Prevention Institute) interventions. [Staff #7] (staff accused of abuse) was terminated. [Staff #8] (Staff failing to prevent or timely report alleged</p>			

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	<p>abuse) received a written warning. The other 2 staff present did not witness incident. 4:4 (4 clients to 4 staff) ratio the day of the incident. Team will continue to intensely train staff and provide a safe environment for the clients. Support team meeting held 11/4 with guardian and BC (behavior consultant) to discuss aggressive behavior. "Dragging" of room mate mentioned in this report is due to his tremors and was investigated in a separate investigation. The issue is medical and behavioral related and is being reviewed by an OT/PT (Occupational Therapy/Physical Therapy) for recommendations." There was no documentation staff #8 received a written warning as indicated in the investigation.</p> <p>On 11/18/14 at 12:06 PM, the GHD stated staff #8 reported he was sitting with another client and observed client C "messaging" with the TV. Staff #7 told client C "no" and client C became physically aggressive toward staff #7. Staff #7 hit client C with a pillow and threatened to hit client C several times with the pillow. Staff #7 hit client C with</p>			

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	<p>the pillow knocking client C to the floor. Staff #8 observed client C grab staff #7's arms and staff #7 used his arm on client C's throat. Staff #7 pushed client C onto the couch and hit him several times with the pillow. Staff #8 asked staff #7 for assistance to transport client C to his bedroom and staff #7 refused to assist him. Staff #8 reported staff #9 told him to not call the pager because it would not help anyway. Staff #9 indicated she observed staff #7 use a pillow to block. The GHD indicated staff #7 admitted to hitting client C with a pillow. Staff #10 indicated he observed staff #7 hitting client C's arms down. Staff #10 held client C's arms and transported him to his room but denied holding the door closed. The GHD stated staff #7 indicated he "forced [client C] to the ground and blocked [client C's] physical aggression using blocking, hitting and pushing."</p> <p>4) On 11/2/14 at 5:00 PM, staff #10 reported during an investigation he transported client C to his room due to client C's aggression toward staff and other clients. The BDDS report, submitted on 11/11/14, indicated the facility had knowledge of the incident on 11/6/14. The BDDS report indicated,</p>						

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	"Incident date: 11/02/2014 unspecified time. Investigation regarding state incident 647655 was conducted. During a review of this incident it was reported that [staff #10], substitute staff, reported he did not see or hear about [staff #7] hitting [client C] with (sic) pillow. [Staff #10] reported to investigator concerning an unrelated accusation that he [staff #10] 'transported' [client C] to his room later on in the evening due to [client C's] aggression towards staff and other clients. [Staff #10] described the way he transported [client C] 'held him under his arms and dragged him on the floor.' [Staff #10] reports not knowing if the 'transporting' is part of the client's BSP, but [staff #10] felt that it was necessary to keep the other clients safe. On 11/10/2014, [staff #10], who had not worked a shift since 11/06/2014, was interviewed by [GHD]. [Staff #10] stated that he did admit to improperly transporting [client C] to his room on 11/02/2014. [Staff #10] requested additional training with [client C] and CPI (Crisis Prevention Institute). [Staff #10] was attempting to complete a one person escort to keep the other clients at [name of group home] safe. This transport lasted approximately 5 minutes. [Client C] pulled his legs out from under him, and this resulted in [staff #10] holding him under his arms and			

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	<p>transporting him incorrectly to his room to calm down. [Client C] was checked for injuries, and spoke with his social worker the next day. No injuries (sic) or emotional distress was the result of the incorrect transport. [Staff #10] will receive a final written warning. [Client C's] psych (psychiatrist) and behavior consultant will be notified regarding the aggressive behavior. [Name of group home] staff will undergo competency based BSP training with behavior consultant. Guardian notified. Support team will review."</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated the investigator was told of the allegation client C was "dragged" to his room during her interview with staff #8. The GHD indicated she was not made aware of the allegation until she received the investigation results and read it in the report. The GHD indicated she should be made aware of allegations immediately. The GHD indicated a separate investigation was not conducted but should have been. The GHD indicated staff #8 received a retraining on immediately reporting abuse and neglect. The GHD indicated she was not sure if staff #8 received disciplinary action.</p> <p>5) On 11/1/14 at 4:30 PM, client B was sitting on the couch in the living room.</p>						

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	<p>Client B was trying to stand up and staff #7 told client B to sit down. On his fifth attempt to stand, staff #7 pushed client B down "very hard" causing client B to hit his head on the back of the couch "very hard." Client B started to cry. Staff #7 told client B not to be a "cry baby." Staff #8 told staff #7 not to do that again. Client B got up and staff #8 took him into the bathroom and checked him for injury. No injuries were found.</p> <p>The investigation, not dated, indicated the following, "[Staff #8] reports around 3:30 or 4:00pm he was starting his shift and was checking emails and talking to another client in the dining room. [Staff #8] reports he saw [staff #7] sitting on couch watching TV in living room. [Staff #7] was [client B's] one on one staff. [Client B] came into living room and [staff #7] sat him on couch. [Client B] was trying to get up from couch several times and [staff #7] kept putting him back down on the couch. [Staff #7] then put a chair in front of [client B] and sat on the chair to keep [client B] from getting up. [Client B] tried again to get up and [staff #8] reports seeing [staff #7] push [client B] back down to the couch and [client B] hit his head hard on the back of the couch. [Staff #7] reports [client B] starting to cry and [staff #7] responded by saying 'don't be a cry baby.'</p>			

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	<p>[Staff #8] reports checking the back of [client B's] head for injury and did not find any. He reports he told [staff #7] he would report this incident in an IR (incident report) and [staff #7] responded by telling [staff #8] he 'had no sleep.' [Staff #8] reports he told [staff #7] 'to be careful with [client B].' [Staff #8] reports no other staff saw the incident. Other staff working at the time of incident: [staff #9] 9-5 & [staff #10] 4-12.</p> <p>[Staff #7] reports he was working one-on-one with [client B]. He reports sitting on couch with [client B]. He denies pushing [client B] down on couch. He denies [client B] hitting head on couch. He denies any verbal abuse towards [client B] that day. He denies any behavior from any staff that was out of the ordinary or concerning to him. Additional Notes: [Nurse Manager] reports meeting with [client B] on 11/3/14 and observed no injury as a result of the incident. Summary: This is the case of one staff's word against another. No sustained injury was found on client. Client not able to verbalize about the incident. [Staff #8] admits to not interrupting neglectful behavior. Findings: Inconclusive. Staff accused [staff #7] was terminated for other concerns. [Staff #10] was terminated for neglect and abuse."</p>			

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	<p>On 11/20/14 at 12:47 PM, staff #8 indicated client B tried to get up from the couch. Staff #7 was watching football and client B's attempts to get up started to "annoy" staff #7. Staff #7 took client B by his shoulders and threw him onto the couch. Client B hit his head and started to cry. Staff #7 told him not to be a cry baby. Staff #8 indicated he told staff #7 to be more gentle with client B about 10 minutes later.</p> <p>On 11/20/14 at 11:34 AM, the GHD indicated it was determined staff #8 needed to receive retraining for failing to immediately report allegations of abuse and neglect.</p> <p>On 11/20/14 at 12:47 PM, staff #8 indicated he reported the incidents he observed to staff #3 and staff #1 on 11/3/14. Staff #8 indicated he reported his concerns on 11/3/14 to his supervisor. Staff #8 indicated he received a retraining to inform a staff observed to engage in abuse and neglect to clock out and go home and then call the pager. If that did not work, call 911. Staff #8 indicated he should immediately report his concerns regarding abuse and neglect.</p> <p>On 11/20/14 at 2:00 PM, the Human Resources Director (HRD) indicated staff</p>						

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	<p>#8 came into the main office on Monday (11/3/14) and reported to his supervisor he did not want to work at the facility anymore. When the supervisor asked staff #8 why he did not want to work here anymore, staff #8 reported his concerns. The HRD indicated staff #8 had not filled out incident reports or reported his concerns. The HRD stated staff #8, "Not followed any of the reporting procedures." The HRD indicated staff #7 was suspended and the investigation was substantiated. Staff #7 was terminated for abuse. The HRD indicated staff #10 was terminated for neglect. The HRD indicated the facility should conduct thorough investigations. The HRD indicated the facility should prevent abuse and neglect of the clients. The HRD indicated if staff #8 would have reported the first incident, the rest may have been avoided. The HRD indicated staff #8 should have immediately reported the allegations. The HRD indicated staff #8 had just been through employee orientation where he received training on reporting abuse and neglect. The HRD indicated staff #8 had an employee identification card with the phone number to call for reporting abuse and neglect.</p> <p>On 11/20/14 at 3:35 PM, a Staff Training Form, dated 11/3/14, indicated staff #8</p>				

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W000186	<p>received training on reporting/interrupting abuse, neglect and exploitation. On 11/20/14 at 12:01 PM, a review of staff #8's employee file indicated he received training on reporting abuse, neglect and exploitation on 10/23/14. There was no documentation staff #8 received a written warning or disciplinary action for failing to immediately report allegations of abuse and neglect.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to provide sufficient staff during the overnight shift (10:00 PM to 6:00 AM) to manage and supervise the clients in</p>	W000186	<p>Plan of correction: Staff schedule has been updated to reflect 2 staff to 4 client ratio from 10p-6a (attachment g). Client A has been served notice and will be discharged from the facility once he receives his CIH waiver.</p> <p>Plan of prevention: Facility</p>	12/05/2014

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	<p>accordance with their individual program plans.</p> <p>Findings include:</p> <p>On 11/18/14 at 11:53 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 11/17/14 at 3:00 AM, one of client A's housemates woke up and needed assistance with changing his clothes and bedding. Staff assisted client A's housemate for "approximately 7 minutes." Staff went to check on what he thought was the door alarm and noticed client A was not in his room. Client A was outside clearing the driveway of snow with a broom. Client A was prompted into the house several times. After less than 5 minutes, client A returned inside the house. Client A continued to "have behaviors" until 5:30 AM. A note, documented on the incident report from the Group Home Director indicated, "[Client A] did not leave [name of group home] property. He had been obsessing over the snow and becoming snowed into their driveway."</p> <p>On 11/20/14 at 11:19 PM, the Group Home Director (GHD) indicated the door alarm sounded, staff #14 went to check</p>		<p>staffing office is to prioritize open shifts for Deckard. Comprehensive training has been completed with facility staff by the CPI trainer and behavior consultant (attachment h). Plan of monitoring: Coordinator or director will provide daily monitoring and document that staff to client ratios are being followed (attachment f).</p>				

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	<p>on the alarm and found client A outside sweeping snow with a broom. The GHD indicated client A returned inside the home within 5 minutes. Staff #1 went to the group home to assist staff #14 with calming client A down. The GHD indicated she interviewed staff #14 by phone regarding the incident but she was not going to conduct an investigation. The GHD indicated staff #14 responded to the alarm as soon as he heard it and client A was not outside for a prolonged period of time. The GHD indicated staff #14 reported he responded to alarm as soon as he heard it. The GHD indicated there was one staff working at the group home at the time of the incident.</p> <p>2) On 11/11/14 at 5:00 AM, client A was awake throughout the night and was attempting to wake up his housemates. Client A laid on the floor of client B's room and refused to leave. Client A was prompted several times to leave client B's room. Staff #6 followed client A's Behavior Support Plan (BSP) and a one person transport was used to lead client A to his room to calm down in exclusionary time out. Client A's door was held shut which was not part of his plan.</p> <p>The BDDS follow-up report, dated 11/16/14, indicated, in part, "[Client A] was checked for injuries the next</p>						

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	<p>morning when he was calm. He showed no signs of physical injuries or emotional distress. [Staff #6] is a sub (substitute), who was previously was (sic) a full time staff at [name of group home]. He was not scheduled shifts until following the investigation. He has choses (sic) to not work at [name of group home] following this incident. There was one staff scheduled until 6am. [Staff #3] was called in early and arrived approx. (approximately) 515a shortly after behavior started. Behavior had ended prior to his arrival. Behavior lasted less than 15 minutes. Transport was under 5 minutes. Exclusionary time was under 5 minutes. Investigation determined that [staff #6's] actions were ensuring the safety of clients and [client A]. Closing the door was used to block [client A] from hitting and throwing things at him, not to restrain him. [Client A's] BSP has been updated to include '[Client A] is to be in eyesight of staff at all times during exclusionary time.' Staff - [staff #6] - will be reinstated to work at other houses. Two staff will be scheduled to work with the four clients at the [name of group home]. New schedule started 11/12/14. All [name of group home] staff will receive competency based BSP training on [client A's] plan."</p> <p>The investigation, dated 11/13/14,</p>			

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	<p>indicated the incident occurred on 11/9/14. The investigation indicated the allegation was staff #6 "held [client A's] door closed." Staff #6 indicated in the investigation he held client A's door closed for "Less than 5 minutes." The investigation indicated, "[Staff #6] closed [client A's] door and held it closed. Seclusion is against Stone Belt's BMAN (Behavior Management) policy." The investigation indicated the allegation was substantiated. The investigation indicated staff #6 "will be removed from the [name of group home] substitution list. Two staff will be scheduled to work at the house during overnight shift."</p> <p>On 11/20/14 at 11:03 AM, client A's Behavioral Support Plan, dated 8/6/14, indicated he had the following maladaptive behaviors targeted in his plan: disruptive behaviors, physical aggression, stealing, inappropriate refusals, self-injurious behaviors, and elopement.</p> <p>On 11/20/14 at 11:02 AM, client B's Behavioral Support Plan, dated 4/29/14, indicated he had the following maladaptive behaviors targeted in his plan: physical aggression, PICA (ingestion of non-nutritive items), task avoidance, out of bounds and head and hand banging.</p>						

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	<p>On 11/20/14 at 11:00 AM, client C's Behavioral Support Plan, dated 7/25/14, indicated he had the following maladaptive behaviors targeted in his plan: refusals, tantrums, physical aggression, out of bounds/inappropriate touch, skin picking, and symptoms of depression.</p> <p>On 11/20/14 at 11:01 AM, client D's Behavioral Support Plan, dated 7/21/14, indicated he had the following maladaptive behaviors targeted in his plan: physical aggression, property destruction, inappropriate sexual behavior, compulsive behavior, and symptoms of bi-polar disorder.</p> <p>On 11/19/14 at 6:30 AM, staff #4 indicated one staff during the overnight shift was not sufficient to provide adequate supervision to the clients. Staff #4 indicated the overnight shift staffing had increased recently to two staff which made it possible to provide sufficient staffing during the overnight shift.</p> <p>On 11/21/14 at 12:55 PM, the Behavior Consultant (BC) indicated the home's staffing level had recently increased to include two overnight staff. The BC indicated two staff were needed to provide supervision to clients A, B, C</p>						

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W000436	<p>and D.</p> <p>On 11/20/14 at 11:55 AM, the Group Home Director (GHD) indicated the incidents on 11/11/14 and 11/17/14 occurred when there was one staff working at the group home. The GHD indicated the staffing level had increased since the incidents to two staff.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-3(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on record review and interview for 1 of 1 clients in the sample (B) with adaptive equipment, the facility failed to ensure client B had protective equipment available to him to protect his hands from hand banging.</p> <p>Findings include:</p> <p>On 11/18/14 at 11:53 AM, a review of</p>	W000436	<p>Plan of correction: Investigation completed and it was determined that injury was self-inflicted (attachment i). Team is waiting client's follow up appointments with Theraplay and his pcp on 12/18 and 12/22 to discontinue the order for padded gloves or obtain an order to purchase a pair of gloves.</p> <p>Plan of prevention: Facility day aid is to review all plans and ensure</p>	12/05/2014			

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	<p>the facility's incident/investigative reports was conducted and indicated the following: A Bureau of Developmental Disabilities Services (BDDS) report, dated 11/11/14, indicated, "Incident date 11/08/2014 unspecified time. On 11/10/2014 at 2:00 PM, [client B's] right hand was slightly swollen. On 11/08/2014, [client B] was experiencing tremors, and his hand had hit the wall and table numerous time. On 11/09/2014, it was noted that [client B's] right hand was swelling. On 11/10/2014, [client B] was transported to his PCP (Primary Care Physician) and sent for x-rays. It was determined that the bone on the side of his right hand leading to his small finger was fractured. [Client B's] guardian stated that he has had numerous fractures due to his tremors, and possibly due to behaviors. [Client B's] hand was reset and placed in a brace. [Client B] was sent home with discharge orders to keep the brace on and return in three weeks."</p> <p>On 11/20/14 at 11:02 AM, a review of client B's record was conducted. A Stone Belt Outside Services Report, dated 11/10/14, indicated client B had a contusion on his right hand. Client B was sent for an x-ray of his right hand. Another Stone Belt Outside Services Report, dated 11/10/14, indicated, "Fracture right hand. Right 5F (pinky)</p>		<p>that adaptive equipment are in thehome and in working order. Training will be provided by them to DSPs. An emailwas sent out to each SGL staff reviewing this and it will be trained at thenext Shiloh meeting (attachment m). Plan of monitoring: Housemanager or associate manager are schedule daily. Coordinator or director willprovide daily monitoring and document that day aid duties are being completed (attachment f).</p>	

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	<p>metacarpal fx (fracture). Splint right hand." There was no documentation in record indicating how client B sustained the fracture. Client B's 4/29/14 Behavioral Intervention Plan indicated client B had a targeted behavior of head and hand banging (hitting his head or hand against an object such as a wall or table). The plan indicated, "If staff has attempted to redirect [client B] from hand banging and he persists, [client B] will be required to wear protective gear for his protection."</p> <p>On 11/20/14 at 11:10 AM, the GHD indicated client B had a Behavior Support Plan addressing hitting his hand which was thought to be the cause of the injury.</p> <p>On 11/21/14 at 11:28 AM, the Nurse Manager (NM) indicated from what he understood, the fracture was caused by client B banging on table and walls causing his hand to swell. The NM indicated he thought the cause of the fracture was clear cut.</p> <p>On 11/21/14 at 12:55 PM, the Behavior Consultant (BC) indicated client B did not have protective equipment in the home to use. The BC indicated client B's plan included the use of protective equipment for his hands. The BC indicated hand banging had not been an</p>				

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W000488	<p>issue until recently. The BC indicated from the reports he received from the staff, client B had been engaging in hand banging against walls and tables prior to his hand being fractured.</p> <p>On 11/21/14 at 1:07 PM, the GHD responded to the question, "Does he have 'protective gear for his protection' for his hands?" The GHD indicated in her email, "No, not at this time. His guardian stated his PCP (primary care physician) said he didn't need them. We were waiting for the OT(Occupational Therapy)/PT (Physical Therapy) eval to obtain either an order for a replacement pair or an order to discontinue the gloves. At that point we would delete it from the BSP."</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 4 of 4 clients living at the group home (A, B, C and D), the facility failed to ensure the clients were involved with preparing and serving themselves breakfast.</p>	W000488	Plan of correction: DSP who was restricting clients access to kitchen without due process, has been removed from the houseschedule. He also received a performance review (attachment d).	12/05/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Findings include:</p> <p>An observation was conducted at the group home on 11/19/14 from 6:30 AM to 8:18 AM. At 7:06 AM, staff #8 was in the kitchen cooking eggs and making toast while client D stood at the pass through opening looking into the kitchen. At 7:09 AM, staff #8 cooked eggs and made toast while clients A and D stood at the pass through window. At 7:11 AM, client D was handed a plate through the pass through window with eggs and a fork. Client D was not provided a drink. At 7:13 AM, client D finished his eggs and put his plate on the counter in the kitchen through the pass through window. Staff #8 was washing the skillet. At 7:27 AM, staff #8 made client B's grilled turkey sandwiches for his lunch later in the day. Client B was in the office receiving his medications. At 7:48 AM, client A was given a cup of milk and a plate with bacon and eggs. At 7:50 AM when client C went into the kitchen to get a cup of milk, staff #8 prompted him out of the kitchen and poured client C's milk and gave it to him. At 7:52 AM, client C was given a plate with bacon and eggs on the plate. At 7:58 AM, client C gave staff #8 his empty plate and stated, "Night night" and went to his bedroom. At 8:13 AM, client</p>		<p>Plan of prevention: Active treatment and due process wascovered at December Shiloh meeting/training (attachment e). Plan of monitoring: House manager / associate managerwill conduct daily observations. Coordinator or director will provide daily monitoring(attachment f).</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/24/2014
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408		
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	<p>B was given a plate with eggs, bacon and a piece of toast by staff #12. Staff #12 poured milk into a cup with a lid and a straw for client B. Clients A, B, C and D were not involved with preparing their breakfast, serving themselves and cleaning up after breakfast.</p> <p>On 11/20/14 at 11:21 AM, the Group Home Director indicated the clients should be involved with preparing and serving themselves during meals.</p> <p>On 11/20/14 at 12:47 PM, staff #8 indicated the clients were able to participate with meal preparation. Staff #8 indicated the clients would not learn to become more independent with meal preparation and serving themselves if the staff do it for them.</p> <p>9-3-8(a)</p>				