

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2606 H ST BEDFORD, IN 47421
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: July 29, 30, 31 and August 1, 2014</p> <p>Facility Number: 001166 Provider Number: 15G655 AIM Number: 100445440</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/7/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 9 of 62 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and former client #5, the facility neglected to implement its policies and procedures to prevent staff to client abuse and neglect, client to client abuse, conduct investigations of client to client</p>	W000149	<p>W149 483.420 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Corrective action for resident(s) found to have been affected (Plan of correction)</p>	08/01/2014

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>abuse, client #4's choking incident and an incident in which staff reported client #4 fell after passing out and ensure staff immediately reported suspected abuse to the administrator.</p> <p>Findings include:</p> <p>On 7/29/14 at 11:40 AM a review of the facility's incident/investigative reports indicated the following:</p> <p>1. On 2/26/14 (no time indicated), client #4 was injured (bruises on upper right arm and an abrasion above his right eye) during a behavioral incident at the facility-operated day program. The investigation, dated 3/3/14, indicated, "[Former staff #8] was not able to be interviewed. He was arrested by [name of city] police on 2/27/2014 on charges unrelated to this investigation. It was reported to this writer by staff who read the police blotter that charges included battery and sexual assault of a child. Fortunately, both [name], LLL (Life Long Learning) Director, and [name], Behavior Specialist, were able to interview [staff #8] on 2/26/2014. His account of events is contained in their reports along with the internal incident report that he completed."</p> <p>Staff #8's interview with the LLL</p>		<p>Staff accused of abuse was suspended following accusation of abuse and was terminated when investigation deemed it factual. Staff have been trained on Stone Belt policies and procedures that prohibit mistreatment, neglect or abuse of the client (Attachment W149A, Attachment W149B).</p> <p>How facility will identify other residents potentially affected & what measures taken – (Plan of identify and plan of correction) All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility coordinator and house manager will complete weekly observations of interactions between direct care staff and provide training of behavior plans as needed (Attachment W149C).</p> <p>How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility director will review online observations at LARC and home monthly. Facility director and behavior consultant will provide monthly observations and provide training as needed at LARC and home monthly.</p>				

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	<p>Director was as follows: "I spoke to [staff #8] on 2/26/14 at approximately 2:30 pm about a behavior incident that occurred earlier in the day with [client #4] that may have caused bruising. He relayed to me that he felt the bruising may have occurred when he was transporting [client #4] to the mat. He described the method he used with both of his hands on the upper portions of [client #4's] arms, either facing [client #4] or behind [client #4], with one hand on each upper arm. I let him know this was not a method we use or train, for escorting/transporting in a behavior situation, or at any time. He told me this is the method everyone uses with [client #4], both at day program and the house. Further, he made a statement that [staff #1] will just throw [client #4] onto the mat in the corner very quickly. I said wait a minute what do you mean? He retracted the statement quickly saying, oh no, that's not what I mean, I just mean [staff #1] will get [client #4] to the mat quickly when he's having a behavior. I asked [staff #8] for the sequence of events from the morning incident. He described that [client #4] became agitated and then started to grab at him. He and the other staff in the room used the blocking mats for about 30 minutes and then [client #4] began to bite his hand. Neither of them had ever seen [client #4] do this and were concerned he would</p>			

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	<p>really injure himself. [Staff #8] said that [staff #9] told him it was time to take him to the mat. [Staff #8] escorted [client #4] to the mat with the method described above and utilized a seated basket hold for about 5 minutes with [staff #9] observing [client #4's] breathing. [Client #4] then relaxed and the intervention was released. [Staff #8] stated he had never seen [client #4] bite himself or been trained that this was something to expect."</p> <p>The following was from the written statement given by the behavior specialist: "On 2/26/14 at approximately 2pm, [name] House manager (staff #1) asked to speak with me. He entered the conference room at [name of day program] and explained to me that a physical intervention had been used on [client #4]. I asked [staff #1] why the intervention was used and he said it was because [client #4] had been biting himself. I informed [staff #1] that I would go back to 'The Shop' room ([client #4's] classroom) and find out what had gone on. I proceeded to go back to the classroom where staff, (staff #10), was in there alone. I asked [staff #10] if he could tell me what had happened and he replied no, as he had just gotten in to work and the incident occurred prior to his arrival. [Staff #10]</p>			

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	<p>then stated that [client #4] had bruises on the back of his right arm. At this time, [client #4] was sitting on the couch. I sat next to him and asked him if I could see his arm, he obliged and raised his arm up. On the backside of his right arm were four bruises that were purple and red in color. I asked [client #4] if his arm hurt and replied no. I then asked [staff #10] if he knew where the bruises came from and he replied that he thought the bruises were a result of the incident that had occurred earlier in the day. He also noted that [name] house staff had to use the blocking pads on [client #4] the night before (2/25) as he was attempting to be aggressive, and once [client #4] had calmed down house staff did a body check and no bruises were discovered. At this point, staff (#8), entered the classroom. I asked [staff #8] if he could tell me what happened and he said yes.</p> <p>[Staff #8] and I went into the [name] office at [name of day program] and discussed the incident. [Staff #8] informed me that this was the most aggressive he had ever seen [client #4] and was visibly shaken (as evidenced by rapid speech and flushed cheeks). [Staff #8] explained that [client #4] had made comments about [name of city] and [name of a person] (these, historically, have been statements that have preceded</p>			

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	<p>aggressive behavior from [client #4]). [Staff #8] said he became nervous that a behavioral outburst would follow. He stated that [client #4] began to become aggressive with staff by attempting to strike and grab at them. [Staff #8] said he and staff (#9), got [client #4] to the mat (his calming area) and began using the blocking pads to keep [client #4] safe from injury. [Staff #8] said during the use of the blocking pads he looked down and saw [client #4] biting his hand between his thumb and forefinger. [Staff #8] stated that he looked at [staff #9] and said, 'I am going to restrain him' and [staff #9] replied, 'Ok.' At that time, [staff #8] said he put [client #4] in a seated baskethold and 'almost immediately' [client #4] began to calm down. [Staff #8] also said that he thought [client #4] calmed down because he wanted attention and sensory input and the hold provided that. [Staff #8] said he and [staff #9] monitored [client #4] on the mat while he calmed down.</p> <p>I then explained to [staff #8] that using physical interventions with a client is a very restrictive measure and should only be used as a last resort. [Staff #8] informed me that he was scared [client #4] was hurting himself and didn't know what else to do. [Staff #8] and I then discussed agency policy and state</p>			

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	<p>regulations that require staff to use least restrictive techniques before moving on to most restrictive. I provided [staff #8] with some examples of least restrictive techniques that should have been used prior to implementing a seated baskethold, such as prompting, redirection and/or a brief physical hold. [Staff #8] understood. I told him that I did not feel as though this was an incident which required the use of a seated baskethold and that we need to continue to follow the behavior plan, which emphasizes the use of least restrictive interventions first. [Staff #8] then said, 'So you're saying I should never put him in a hold?' I replied no, that the hold is in the plan for the rare occasion in which other least restrictive techniques have been utilized unsuccessfully and staff are unable to keep themselves, others or [client #4] safe. [Staff #8] understood.</p> <p>I then spoke with [staff #11 - day program supervisor] about the incident. We discussed the need for BSP (behavior support plan) re-training for staff. [Staff #11] agreed that both [staff #9] and [staff #8] should be re-trained on the BSP and the hierarchy of interventions. I also informed her that there were visible bruises on [client #4].</p>			

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	<p>I left [staff #11's] office and returned to [client #4's] classroom to gather information about how [staff #8] and [staff #9] transported [client #4] to the mat. I asked [staff #8] to demonstrate (on staff [#10]) how he was transported. At first, [staff #8] placed [staff #10] in front of him, grabbed his upper arms (around his biceps) and pushed/guided him to the mat. [Staff #8] then said no, that actually wasn't how it happened. I then asked him to show me again what actually happened. He then had his back to the mat, with [staff #10] in front of him, and placed his elbows under [staff #10's] armpits and pulled him backwards towards the mat. I asked him if, at any point, he was facing [client #4], grabbed his upper arms and pushed him backwards and [staff #8] replied, 'Yea, maybe, I think that happened.' [Staff #8] also mentioned that his methods of transport were methods that he, 'was taught by house staff and that's what they do at the house.' I asked [staff #8] if he noticed the bruises on [client #4's] arm. He said yes but was unsure of where they could have come from. He mentioned that he believed that [client #4] may have given himself the bruises by reaching one arm over the other.</p> <p>I then spoke with [LLL Director] and expressed my concerns about the</p>						

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	<p>incident. Primarily the bruises on [client #4], but also the lack of following the BSP and using least restrictive interventions first. [LLL Director] agreed and noted that she had a conversation with [staff #8] about the incident in which she noted he was both scared and honest. She also expressed her concern that physical interventions were used inappropriately.</p> <p>After leaving [name of day program] I went to [name] house for a visit. I spoke with staff [staff #1] and [staff #2] about how they transport [client #4] to the mat/calming area when he is having behavioral difficulties at home. They stated that often times asking [client #4] to go to the mat to calm down is sufficient, but if it is not they will hold their hands out and [client #4] will put his wrists in their hands and they will lead him to the mat. I asked if they ever escorted him by his upper arms and both individuals replied no.</p> <p>This afternoon, I received the IR (incident report) for electronic review and the narrative on the IR does not match the story that was told to me by staff ([#8]) who was present. [Behavior Specialist]."</p> <p>The interview with staff #9 indicated, "[Staff #9] stated that he began work at</p>						

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	<p>8am at [name of day program] on 2/26 in the area called 'the shop.' There were 5 clients present: [client #4], [names of four clients] and two DSPs (Direct Support Professionals): [staff #9] and [staff #8]. [Staff #9] reported that [client #4] was having a normal morning, nothing out of the ordinary. At approximately 10:15am, [staff #9] left the room to assist another client with the restroom. When asked who was in the room when he left, [staff #9] said [names of three clients], [client #4] were with [staff #8]. (I asked [staff #9] if he insured that when he left the room, the adjoining door was open. [Staff #9] said he did not open the door and did not notice if the door was opened at any time that day). [Staff #9] said that it took about 15 minutes to clean and change the male client and when he returned to the room, [client #4] was sitting on the mat. [Staff #9] said that [client #4] was not having any behaviors or saying anything but he did not look right. When asked for more details - [staff #9] said [client #4] looked kind of in a daze. When asked if [staff #9] noticed any marks or bruises at that time, [staff #9] responded that he did not notice any marks or bruises on [client #4]. [Staff #9] reported that when [staff #9] came in and noticed [client #4] on the mat, [staff #8] offered an explanation saying that [client #4] 'had</p>			

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	<p>behaviors.' [Staff #9] asked [client #4] if he wanted to get up and [client #4] said yes. [Client #4] then sat on the couch next to [staff #9] and [client #4] then said '[staff #8] hurt [client #4]' a few times. [Staff #9] asked [staff #8] 'what did you do to him?' and [staff #8] said 'nothing' he was talking about being a baby and being upset...</p> <p>[Staff #9] reported observing several things that morning that disturbed him. I asked him to describe what he observed. [Staff #9] reported that [client #4's] attitude and mood got progressively worse during the rest of the morning because [staff #8] started doing some strange things like bouncing the basketball on the walls and floor right next to [client #4], squeezing [client #4's] head to the point that [client #4] yelled out and these things were obviously bothering [client #4]. [Staff #9] then reported that [staff #8] often 'rough-housed' with [client #4] but he thought it had gone too far. I asked him what 'rough-housing' looked like. He said you know 'rough-housing.' I said - no I don't know. Describe it. He said [staff #8] would grab [client #4] by his upper body and lift him up in the air, would tickle, would sit next to him on the couch and they would alternate leaning/pushing on each other. [Staff #9]</p>			

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	<p>reported that that morning he had stepped out of the room for something and walked by the 'shop' and when he looked in the room he observed [staff #8] 'straddling [client #4]' on the couch. I asked him to demonstrate. He described [client #4] prone on his side on the couch and it appeared that [staff #8] was laying stretched out on top of [client #4's] hands up/out with one leg on the couch and one leg hanging by the floor. He said he didn't think [staff #8] saw him. I asked him if what he saw was sexual, he said no it was more vulgar. It bothered him. I asked him if he reported any of these actions that [staff #8] was doing to anyone. He said he reported it to [staff #11] on Thursday 2/27 because it had gotten 'out of hand' on Wednesday. On 2/26 around noon, [client #4's] behavior started to escalate, he started talking about being a baby, lunging/kicking at staff, screaming, grabbed [staff #9's] sweatshirt and pulled the zipper down (it had been reported that [client #4] ripped [staff #9's] shirt. [Staff #9] said no, he just pulled the zipper down). It was at that time that [staff #9] and [staff #8] decided to move [client #4] to the mat. [Staff #9] said he was on medical restrictions and could not do any physical interventions. [Staff #9] got on one side of [client #4] and [staff #8] was on the other side and they walked [client #4] to</p>			

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	<p>the mat. [Client #4] got to the mat and flailed and squirmed as is his custom and continued to lunge and kick. [Staff #9] and [staff #8] got the pads and used them to block. At some point, [staff #8] said '[client #4's] biting himself we can't let him do that.' [Staff #9] said he was above [client #4] and couldn't see but that [staff #8] tried to pull [client #4's] hand away and then decided to put him in a basket-hold. [Staff #9] again explained he was on restriction and could not do any physical intervention so [staff #8] had to do it. The basket-hold lasted 30 seconds and then [client #4] calmed and the incident was over. I asked [staff #9] if he was familiar with [client #4's] behavior plan. He said yes. I asked him if he knew what interventions to use with a bite, what staff were supposed to do if [client #4] was getting upset, or started hurting himself. He said he didn't see what [staff #8] did about the biting and couldn't have helped with a release anyway. I asked [staff #9] to show me how he and [staff #8] escorted [client #4] to the mat. I asked him several times if he saw [staff #8] hold or grab [client #4] by his upper arms or move him toward the mat by pushing or pulling him by his upper arms, he said no. I asked him if he saw the bruises on Wednesday, he said no. I asked him if he had any idea how [client #4] got bruises. He said no. Then</p>			

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	<p>he said maybe he got them the night before at the house. I told him the nurse examined [client #4] on Wednesday afternoon and described the color of the bruises as blue and that they looked fresh. [Staff #9] said he did not know how [client #4] received bruises. He said he thought maybe the mark above his eye came from the mat because [client #4] would thrash face down and turn back and forth on quickly. I then told him that [staff #8] admitted to grabbing [client #4] by his upper arms and moving him toward the mat that way. He said that is not what happened when he was in the room...</p> <p>Follow Up Interview: After speaking with clients [Day Program (DP) client #1] and [DP client #2], this writer had concerns about [staff #9's] knowledge of [staff #8's] mistreatment of [client #4] prior to Wednesday. I shared my concerns with [LLL Director] and she suspended [staff #9]. [Staff #9] was concerned about the suspension. I told him that we received information during the day that needed follow up and it was part of our procedure to suspend. I reviewed/summarized the information that I had received from him in the morning. He agreed to the information as I presented it and as written above. This writer and [name of social worker] asked</p>						

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	<p>in depth questions about [staff #8's] 'straddling' of [client #4] by [staff #8]. He again described it and said it did not seem sexual in nature but 'vulgar.' Asked if he had seen anything like that before Wednesday, he said no. Asked [staff #9] if clients had ever reported to him that [staff #8] mistreated [client #4], [staff #9] said Wednesday was the first time. He said that [name of client] told him on 2/27 that [staff #8] pulled [client #4's] legs and pushed them up in the air when he sat on the couch. [Name of client] said he bounced the ball against the wall to bother him and squeezed [client #4's] head til (sic) he yelled. When asked what did you do when [name of client] told you, [staff #9] replied that he told [staff #11]. We asked if [staff #11] had written an incident report, [staff #9] said I don't know. [Staff #9] reported that he and [staff #8] had been working together for about a month. We asked if [staff #9] noticed anything before Wednesday. He said he noticed that [client #4] would scoot away from [staff #8] if he could and that [client #4] was acting more strange lately. [Staff #9] said he asked [staff #8] 'what did you do to him?' [Staff #8] replied 'nothing.' [Staff #9] also noticed that [client #4] wanted him ([staff #9]) to sit beside him on the couch more than usual. We asked [staff #9] if there were clients in the 'shop' that would</p>			

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	<p>recognize inappropriate staff behavior? [Staff #9] said yes. We asked would those clients report bad staff behavior? [Staff #9] replied - yes. We asked have clients told you about staff bad behavior? [Staff #9]: not until Thursday. We asked looking back, is it possible that clients have tried to tell you about staff bad behavior? [Staff #9]: 'It's possible. We all make mistakes. Maybe I didn't want to see it.' [Staff #9] said that he recalls reporting to [staff #11] that he thought [staff #8] needed to learn to work better with [client #4]. He said he told her about the rough housing. He said he probably told her two or three times in the past two weeks that [staff #8] was not working well with [client #4]. We asked - what was her response? [Staff #9]: her response was that [staff #8] is new and was still learning. [Staff #9] said he did not know what else to do except tell [staff #11]...</p> <p>This writer introduced herself to [client #4]. He settled into a chair and seemed calm and friendly. We said we heard he had an injury on his arm and asked if we could see. [Client #4] was very cooperative and lifted up his arm. He had bruises on his upper right arm/tricep area; and a small abrasion above his right eyebrow. This writer asked [client #4] if she could take pictures and he indicated</p>			

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	<p>that it was ok. This writer then asked [client #4] what happened to his arm. He said 'mat.' This writer asked what happened to his eye? [Client #4] said 'mat.' This writer asked who took hold of his arm and [client #4] said 'mat.' [Client #4] was calm and at ease during these questions. This writer thanked [client #4] and [staff #11] took him back to his program.</p> <p>[A client who attended the day program (DP) - DP client #1] dictated a note to [staff #11] on 2/26/2014: "[Staff #9] was outside on his phone. [Staff #8] squeezed [client #4's] head. [Client #4] said Stop. [DP client #1] said [staff #8] did it a second time and [client #4] said Stop. [Staff #8] stopped after the second time.</p> <p>This writer told [DP client #1] that I had read the note he dictated to [staff #11] on Wednesday. [DP client #1] said '[staff #8] tormented [client #4].' We asked him what did [staff #8] do to torment [client #4]? [DP Client #1] reported that [staff #8] would squeeze [client #4's] head until he yelled. He would put paint on his finger and put it up to [client #4's] face like he was going to paint him; he would pull [client #4's] legs down or raise them up when [client #4] was sitting on the couch. ([DP client #1] demonstrated these actions on [staff #12]). [Staff #8]</p>			

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	would get a ball and bounce it near [client #4] and make a lot of noise and sometimes bounce a ball off [client #4's] head. When [client #4] cries, [staff #8] yells at him. [DP client #1] said this mostly happens every time [staff #9] goes out of the room. When asked, this happened Wednesday or before Wednesday. He said before Wednesday and Wednesday. [DP client #1] reported that he feels protective of [client #4] and does not like it when [staff #8] bothers [client #4]. When asked, have you told anyone? [DP client #1] said I tell [staff #9] when [staff #8] does this stuff. When asked if he was in the 'shop' on Wednesday when [client #4] was upset, [DP client #1] said yes. [DP client #1] said that [client #4] was on the couch and [staff #8] was bouncing the ball near [client #4], squeezing his head, [client #4] was getting upset and [DP client #1] said [staff #8] grabbed [client #4] off the couch and put him on the mat. We asked, was [staff #9] in the room? [DP client #1] said no - [staff #9] was gone. We asked [DP client #1] to demonstrate what he saw. He indicated that [staff #8] had grabbed [client #4] by the arm and pulled him off the couch and then had his hands on his upper arms and marched him backwards and put him on the mat. [DP client #1] said he tries 'to be the bigger person' that [staff #12] taught him			

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	<p>that. He likes [client #4] and doesn't think it's right what [staff #8] does to him. When asked if he saw [staff #8] pick on other clients, [DP client #1] replied no, just [client #4]...</p> <p>[DP client #2] said that [staff #8] doesn't help him much. [Staff #8] opens the paint for him. He said he mostly helps other clients in the room more than him. When asked to talk about how [staff #8] and [client #4] get along. [DP client #2] reported that [client #4] sits on the couch and [staff #8] talks to him especially when he has behaviors. He said sometimes when [client #4] sits on the couch [staff #8] squeezes his head and sometimes he bounces the ball on [client #4's] head. We asked, who is in the room when he does this? [DP client #2] replied clients. He said [staff #9] is outside talking on his cell phone. [Staff #8] waits til (sic) [staff #9] goes outside. When asked if he tells anyone what [staff #8] does, he said yes I tell [staff #9]. We asked if he remembers Wednesday when [client #4] was upset. He said [staff #8] took [client #4] off the couch and put him on the mat. He said I saw bruises on [client #4's] arm when I came back from work. When asked if he has seen [staff #8] bother other clients, [DP client #2] said no."</p>			

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	<p>The Statement of Findings section of the investigation indicated, "Testimony provided by LLL clients and staff revealed that [staff #8] targeted [client #4] by initiating a number of actions that were deliberately irritating, annoying, bullying, incendiary and/or outright physically abusive. It is not clear how long or how frequent this pattern of behavior was conducted since [staff #8] preferred to initiate these actions when other staff left the area and clients could not give details about dates and times and frequency. This writer did not have the opportunity to interview [staff #8] to ascertain the scope and severity of his actions.</p> <p>There is a confusion concerning the behavior that occurred at 12:15 (PM) when both [staff #9] and [staff #8] escorted [client #4] to the mat area. [Staff #8] describes that event on the internal IR (incident report) as the one where he grabbed [client #4] by his upper arms to move him. [Staff #9] reports that [client #4] went to the mat of his own power and was not physically assisted there. LLL clients reported that when [staff #9] left the room (10:15am) [staff #8] started to 'torment' [client #4] and caused him to become very upset resulting in [staff #8] grabbing [client #4] by his upper arm(s) from the couch,</p>			

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	<p>moving him to the mat where he thrashed and flailed, apparently receiving the abrasion above his right eye. When [staff #9] returned to the room and sat beside [client #4], [client #4] told him that [staff #8] hurt him. It is this writer's conclusion that there were two incidents on the morning of 2/26 involving [client #4] being moved to the mat. One occurred when [staff #9] was out of the room which resulted in [client #4's] injuries and one occurred when [staff #9] was in the room.</p> <p>It is the conclusion of this investigation that [staff #8] physically abused [client #4] on 2/26/2014 by forcibly pulling him off of the couch causing injury. It is also a finding from reports and interviews that it is likely that [staff #9] witnessed a number of abusive interactions between [client #4] and [staff #8] prior to 2/26/2014 without reporting them. Even if he did not recognize them as abusive, he did admit that the interactions between [staff #8] and [client #4] troubled him. It is also likely that [staff #9] was aware of mistreatment taking place in his absence per client testimony that they reported [staff #8] to [staff #9]. It is a great concern to this writer that [staff #9] received a text message from [staff #8] eight days prior to the incident of this investigation that described detailed</p>			

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	<p>abuse of a two year old child and [staff #9] did not report this to authorities even though he was aware that [staff #8] was a person of interest to law enforcement. It is the conclusion of this investigation that [staff #9] was neglectful in that he minimized [client #4's] mistreatment by [staff #8] (calling it rough housing, understating in his reports to supervisors that [staff #8] needs more training with [client #4]) and failed to report the true nature of the interactions he witnessed to supervisors. Further, there was a plan in place to open the door between the 'shop' and the adjoining room when one staff had to leave the area. This was to ensure immediate assistance if additional staff was needed. [Staff #9] failed to ensure that this happened when he left the room which according to client testimony happened several times during the day to talk on his phone. It is this writer's understanding that cell phone reception is poor at [name of day program] and there are only certain areas of the building where the signal gets through. It makes sense that [staff #9] would leave the 'shop' area to make/receive calls."</p> <p>The Statement of Substantiation section of the investigation indicated both abuse and neglect were substantiated. The investigation indicated, "Abuse: The findings go beyond the original concern</p>						

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	<p>which was that improper escort techniques were used. Neglect: The findings indicate staff failed to report client mistreatment. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual . Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma."</p> <p>The investigation indicated, "The reports of the LLL clients are consistent with [staff #8's] report that he had [client #4] by his upper arms and moved him toward the mat area. However there were two incidents during the morning where [client #4] was transported to the mat area. The conclusion is that [staff #8] initiated a series of actions including bouncing a ball on the wall near and/or on [client #4], squeezing [client #4's] head, straddling him on the couch (tormenting him according to a client witness) when staff left the room at 10:15am - that caused great distress and escalated [client #4's] behavior to the point that [staff #8] grabbed [client #4]</p>			

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	<p>by his upper arm (s) and pulled him from the couch and moved him to the mat. The kind, number and location of the bruises are consistent with unnecessary force being applied during an action of this nature. Two clients gave consistent and similar accounts that [staff #8] often provoked and picked on [client #4], often when staff left the room and both said they told [staff #9] what [staff #8] was doing when he left the room. They could not say when or how many times they reported this to [staff #9] but both said it was not just this week.</p> <p>Agency policy was followed to suspended (sic) staff for suspected abuse and neglect. Agency policy was not followed in failing to ensure client protections. Agency policy was not followed when client reports of mistreatment went unreported. Agency policy was not followed in that least restrictive measures were not implemented and unauthorized physical interventions were used resulting in client injury." The investigation indicated staff #8 and #9 were terminated and the facility-operated day program staff were retrained on preventing abuse, neglect and exploitation.</p> <p>2. The facility conducted an investigation, dated 3/12/14, "To</p>				

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	<p>determine if there was an event of abuse or neglect concerning [client #2] following a staff observation concerning [client #2] appearing agitated or upset after having contact with staff, [staff #8], who has had substantiated abuse of another Stone Belt client, and is under investigation for child abuse in an unrelated situation." The investigation indicated, in part, "[Staff #8] was suspended pending investigation on 2-27-14, for another incident which had occurred on 2-26-14. At the time of this incident report, he had already been suspended for the other incident at Day Program, unfortunately he did work at [name of group home] House the morning of 2-27-14 before being suspended later in the day, when this incident was reported to have occurred."</p> <p>The Nature of the Event/Alleged event section indicated, "[Staff #8] worked the morning shift at [name of group home] House on 2-27-14 and [staff #9] also worked at [name of group home] House that morning. After, [staff #8 and #9] and the [name of group home] clients came to day program and [staff #8] left and went home, at some point law enforcement officers came to [name of day program] looking for [staff #8] to arrest him. At this point staff were talking about the allegations against [staff</p>				

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	<p>#8], and [staff #13] said to [staff #9] that he hoped that [staff #8] had not done anything to [client #2]. [Staff #13] stated that he had been concerned how [client #2] seemed agitated that morning, and other mornings and seemed to be avoidant of [staff #8]. [Staff #9] told [staff #13] that he had observed [staff #8] hold [client #2's] arms down against his sides, and tease [client #2] about 'show me how strong you are' wanting [client #2] to resist the pressure/restraint that [staff #8] was holding on [client #2's] arms.</p> <p>I asked [staff #13] why he did not report this to [Director of Health and Clinical Resources], or [staff #11], or [Director of Supervised Group Living]. He stated that it did not occur to him that this would have been an inappropriate restraint, and abusive behavior toward [client #2]. Now thinking and talking about it as part of the investigation he reported the event as described to him by [staff #9], and realizes that this would be considered to be aggravating to [client #2] who is a person with autism and very wary of personal touch. He had also begun to associate what [staff #8] may have been doing to [client #2] at the group home with how [client #2] had been increasing in aggression and agitation when he came to Day Program.</p>			

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	<p>The interviewer asked [staff #13] about the incident report that he had written, indicating that he had concerns about [staff #8] and how he interacted with [client #2], who is a client in [staff #13's] class room. I asked [staff #13] to describe what he had observed. [Staff #13] stated that when [staff #8] was around [client #2] he would 'touch him all the time.' [Staff #13] stated that he had observed [client #2] being agitated a lot lately, and the (sic) he had even started to hit a person which is very unlike him. [Staff #13] stated that [client #2] had hit him hard by slapping him on the back which was very unlike [client #2] and he also had observed [client #2] biting his hand. [Staff #13] stated that this has been noted in [client #2's] behavior tracking and [client #2] had recently had a medication increase related to increase in aggressive behaviors. [Staff #13] stated that last Friday he had read on [local news website] that [staff #8] had been arrested on 2 charges of battery and molesting a child. He became concerned that [staff #8] may have been 'messing with clients' as well. He had mentioned this to [staff #9] who had worked with [staff #8] at [name of group home] House and Day Program 'man cave' and [staff #9] told him that when he and [staff #8] had been working on Thursday morning that he</p>			

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	<p>had observed [staff #8] to be holding [client #2's] hands down to his sides and telling [client #2] 'you're strong, try to pull you (sic) arms up,' he was apparently trying to get [client #2] to resist [staff #8] holding his arms down. [Staff #13] stated that when [client #2] came in to his classroom Thursday, he was very agitated and [staff #13] stated that he was thinking about whether [staff #8] messing with [client #2] is why [client #2] has been so upset recently. [Staff #9] had told [staff #13] that [staff #8] was very 'touchy' with [client #4]. He said that he was 'poking [client #4] all the time.' [Staff #13] stated that he had seen [client #4] sitting next to [staff #8] on the couch in the man cave and [staff #8] was 'poking at him' and 'trying to cheer him up.' [Staff #13] stated that he had seen [staff #8] 'hugging' on clients at day program. I asked which clients he had observed this with? He stated, [client #4], [DP client #3], and [client #2]. I asked if he had witnessed [staff #8] giving extra attention to any other clients. [Staff #13] stated that [staff #8] paid extra attention to [DP client #4] from [name of another facility group home]. He stated that he was concerned because [staff #8] would drive the [name of another group home] clients alone in the van, and also he understood [staff #8] had worked some overnights at [name of another group home]. I asked [staff #13]</p>			

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	<p>if he had ever written any incident reports or notified the supervisor at [name of another group home] House of his concerns. He stated that he did not. He stated that he thought an incident report had been written for the event in which [client #2] hit him on the back.</p> <p>[Day Program staff #14] stated that she had observed [staff #9] and [staff #8] to be 'screaming in [client #4's] face' in the man cave to 'make him have a behavior.' She stated that on one occasion the screaming was so loud that it disrupted her day program class and she went to talk to [staff #9] and [staff #8] about it. [Staff #9] had told her that they would scream at [client #4] to 'try to make him have a behavior.' He said they would say '[Client #4], if you need to cry just let it all come out.' She stated this happened in mid-January. She stated that she was so upset by what she saw, that she talked to [staff #11] and [behavior specialist] about it. She stated that [Behavior Specialist] came to do a retraining with staff about [client #4's] behavior plan and showing respect to clients in interactions. [Staff #14] stated that after she talked to [staff #11] about what was happening, [staff #11] went to talk to the staff and [staff #9] told her 'we 're just having fun.' I asked when this event happened and [staff #14] stated that it occurred at the</p>			

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	<p>end of the day, around mid January. Also during this month, [staff #11] was informed that [client #4] had started to defecate on himself and throw and smear feces, which was a very old and infrequent behavior for him. [LLL Director] had requested that [behavior specialist] retrain Day Program staff on [client #4's] behavior plan."</p> <p>The investigation included an interview with former client #5. [Client #5] reported that sometimes he would stop in to the shop and see staff interacting with [client #4]. [Client #5] reported that sometimes they would be rough-housing, though when asked what that looked like, [client #5] said he was not sure. [Client #5] also said that he knew that staff [staff #9, staff #1 and staff #10] didn't like the way [staff #8] worked with [client #4], mostly due to 'the wrestling.' He knew this because he had heard these staff say this. When asked what 'the wrestling' looked like, [client #5] was unable to describe it. [Client #5] sometimes heard [staff #8] talking to [client #4], though he was unsure to recall what was said. He did say that [staff #8] was 'talking to him mean,' and when asked how he would feel is somebody talked to him that way, [client #5] replied that he would feel 'sad.'</p> <p>An interview with client #3 in the</p>			

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	<p>investigation indicated, in part, "Social worker asked if [client #3] had ever seen [staff #8] give any one a ' bad touch.' He was able to say that he had seen [staff #8] ' hit ' someone. He was given choices of the clients who live in the house, including [clients #4 and #2] concerning who he had seen [staff #8] 'hit.' [Client #3] was able to express that he saw [staff #8] ' hit' [client #4]. When asked where he had seen this happen, [client #3] stated ' man cave.' [Client #3] was able to clearly state that he had seen [staff #8] hit [client #4] in the ' man cave.' He was not able to say when this happened. [Client #3] was asked if [staff #8] had ever touched him in a way he did not like or that made him feel sad, afraid or mad. He said no. He was asked if he had ever seen [staff #8] touch [client #2] in a way that made [client #2] feel sad, afraid or mad. He said no."</p> <p>The investigation included an interview with client #2. Client #2 was non-verbal. The investigation indicated, in part, "A photo of staff [#8] was shown to [client #2], and [Social Worker] began to ask if [client #2] knew who this was. [Client #2] made no vocal response, but became clearly agitated in his body, then abruptly stood up and walked to the farthest corner of the room. He pressed himself into the corner and stood with his arms crossed.</p>						

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	<p>He initially ignored verbal prompt to return to the couch, and to find out what had upset him. When [staff #11] approached [client #2] and reassured him that [staff #1] would soon return to pick him up, [client #2] returned on his own to the seat next to [Social Worker]. The photo of [staff #8] had been put away. [Social Worker] showed [client #2] some examples of good touch/bad touch pictures, asking [client #2] to identify a good touch picture. He pointed to a picture that indicated a good touch, though he still seemed clearly agitated... After being shown the photo of [staff #8] again and being asked whether the photo made him feel like any of the feelings drawings, [client #2] again got up and began to pace around the room. It was agreed that the interview needed to end at that point and staff [#1] was called to pick [client #2] up and take him home to [name] House. [Staff #11] remarked that it was hard for her to tell what was upsetting [client #2], the photo of [staff #8] or the change in his daily routine."</p> <p>The investigation Findings section indicated "inconclusive (the information from sources examined is incomplete, and/or contradictory)." The investigation indicated, in part, "The accounts of events related to whether [client #2] was inappropriately restrained by [staff #8],</p>			

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	<p>during his work at [name] house on the morning of 2-27-14 are contradictory. In terms of an actual restraint only one account is described and this was a second hand account which was described to [staff #13] by staff [#9], who is no longer employed by Stone Belt, and who was found to be neglectful concerning non reporting of inappropriate physical restraints and abuse by [staff #8] at Day Program toward another client. [Client #2], the client who was alleged to have been held by [staff #8] is a non verbal individual, who had been demonstrating increased aggression and agitation over the past several months, while [staff #8] was working at [name] house. [Client #2] showed indications of agitation during an interview with the social worker when shown a picture of the staff, but was not able to communicate any specific treatment by [staff #8] toward him that was upsetting.</p> <p>Therefore this incident investigation is inconclusive for neglect or abuse toward [client #2] by [staff #8], given the information obtained in this investigation. It is noted that staff did not follow incident reporting procedures concerning a variety of observed instances of suspicious behavior and client rights violations by [staff #8] including an unreported inappropriate restraint,</p>				

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	<p>shouting and yelling at clients to cause them to have negative behavioral episodes, and excessive hugging, touching and teasing of clients."</p> <p>3. On 1/13/14 at 3:00 PM at the facility-operated workshop, former client #5 "leaped out of his seat, ran quickly around (sic) table and grabbed [client #1's] shoulders. He [client #5] then proceeded to shake and squeeze [client #1]. [Client #1] tried to grab him with his hands but could not. [Client #5] let go after about 10 - 15 seconds." There was no documentation the facility conducted an investigation.</p> <p>4. On 2/13/14 at 7:45 AM, client #4 fell. The Stone Belt ARC, Inc. Incident Report, dated 2/13/14, indicated, "[Client #4] suddenly fell down after putting on (jacket). [Client #4], it seemed as if he, [client #4], passed out standing up and fell straight down." The report indicated client #4 was not found with any immediate injuries. There was no documentation the facility conducted an investigation into the incident of client #4's fall related to being "passed out." The Qualified Intellectual Disabilities Professional (QIDP) documented on the form, "Staff will continue to monitor [client #4] to help keep him safe." There was no documentation of a nursing</p>			

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	<p>assessment or the nurse being notified.</p> <p>5. On 2/13/14 at 8:45 AM at the facility-operated day program, former client #5 walked by a peer and slapped the peer's head with his hand.</p> <p>6. On 5/5/14 at 10:40 AM, client #4 kicked client #3's right leg while at the facility-operated day program.</p> <p>7. On 5/20/14 at 12:00 PM at the facility-operated day program, client #4 was eating beef and noodles. Client #4 became choked. Staff prompted him to continue coughing. When the coughing stopped and client #4 began to turn red and drool excessively, staff began steps to perform the Heimlich. The report indicated, in part, "Once staff felt his stomach muscles contract she gave a light thrust one handed at this time [client #4's] breathing came back to normal and he began to talk. [Client #4] finished (sic) his lunch & went back to his home room. [Client #4] will continue to take small bites and eat slowly." There was no documentation the facility investigated the incident to ensure client #4's risk plan for choking was implemented as written.</p> <p>8. On 7/29/14 at 8:30 AM at the facility-operated day program, the BDDS report, dated 7/29/14, indicated, "[Client</p>			

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	<p>#3] was at large group sitting on the bench by the shop. [Client #3] became verbally aggressive with one client. [Day program client] spoke to [client #3] asking him if he could get by him. [Client #3] responded by getting up and hitting [day program client] with both hands on his back."</p> <p>9. On 7/25/14 at 7:30 AM, the Bureau of Developmental Disabilities Services (BDDS) report, dated 7/25/14, indicated, "[Staff #15] was in the kitchen cleaning dishes with [client #1] and [client #4]. [Client #4] attacked [client #1] and pushed him down. [Staff #15] and [staff #5] escorted [client #4] to the matted area. [Staff #15] helped [client #1] up and assessed him for injuries. [Client #1] fell on his left knee and had scratches on top of the left side of the head."</p> <p>On 7/29/14 at 1:02 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was considered abuse. The QIDP indicated there were policies and procedures prohibiting abuse. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated client to client abuse should be investigated.</p> <p>On 7/31/14 at 3:12 PM, the Director of</p>			

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	<p>Supervised Group Living (DSGL) indicated client to client aggression was considered abuse. The DSGL indicated the facility had policies and procedures prohibiting abuse of the clients. The DSGL indicated the staff should prevent client to client abuse. The DSGL indicated client to client abuse should be investigated. The DSGL indicated the facility should have conducted an investigation of the incident on 2/13/14 of client #4's fall after a report he passed out. The DSGL indicated the incident of client #4 should have been investigated. On 8/1/14 at 9:56 AM, the DSGL indicated the facility had policies and procedures prohibiting abuse and neglect of the clients. The DSGL indicated the facility should prevent abuse and neglect of the clients. On 8/1/14 at 1:58 PM, the DSGL indicated the staff should immediately report allegations of abuse and neglect to the administrator.</p> <p>On 7/29/14 at 11:53 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</p>			

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	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 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						

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W000153	<p>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 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."</p> <p>9-3-2(a)</p> <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 record review and interview for</p>	W000153		08/01/2014

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	<p>1 of 62 incident/investigative reports reviewed affecting client #4, the facility failed to ensure staff immediately reported suspected abuse to the administrator.</p> <p>Findings include:</p> <p>On 7/29/14 at 11:40 AM a review of the facility's incident/investigative reports indicated the following:</p> <p>On 2/26/14 (no time indicated), client #4 was injured (bruises on upper right arm and an abrasion above his right eye) during a behavioral incident at the facility-operated day program. The investigation, dated 3/3/14, indicated, "[Former staff #8] was not able to be interviewed. He was arrested by [name of city] police on 2/27/2014 on charges unrelated to this investigation. It was reported to this writer by staff who read the police blotter that charges included battery and sexual assault of a child. Fortunately, both [name], LLL (Life Long Learning) Director, and [name], Behavior Specialist, were able to interview [staff #8] on 2/26/2014. His account of events is contained in their reports along with the internal incident report that he completed."</p> <p>Staff #8's interview with the LLL</p>		<p>W153483.420 (d)(2) 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.</p> <p>Corrective action for resident(s) found to have been affected (Plan of correction)</p> <p>Staff accused of abuse was suspended following accusation of abuse and was terminated when investigation deemed it factual. Staff have been trained on Stone Belt policies and procedures that prohibit mistreatment, neglect or abuse of the client (Attachment W153A, Attachment 153– (Plan of identify and plan of correction) All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility coordinator and house manager will complete weekly observations of interactions between direct care staff and provide training of behavior plans as needed (Attachment W153C).</p> <p>How corrective actions will be</p>				

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	<p>Director was as follows: "I spoke to [staff #8] on 2/26/14 at approximately 2:30 pm about a behavior incident that occurred earlier in the day with [client #4] that may have caused bruising. He relayed to me that he felt the bruising may have occurred when he was transporting [client #4] to the mat. He described the method he used with both of his hands on the upper portions of [client #4's] arms, either facing [client #4] or behind [client #4], with one hand on each upper arm. I let him know this was not a method we use or train, for escorting/transporting in a behavior situation, or at any time. He told me this is the method everyone uses with [client #4], both at day program and the house. Further, he made a statement that [staff #1] will just throw [client #4] onto the mat in the corner very quickly. I said wait a minute what do you mean? He retracted the statement quickly saying, oh no, that's not what I mean, I just mean [staff #1] will get [client #4] to the mat quickly when he's having a behavior. I asked [staff #8] for the sequence of events from the morning incident. He described that [client #4] became agitated and then started to grab at him. He and the other staff in the room used the blocking mats for about 30 minutes and then [client #4] began to bite his hand. Neither of them had ever seen [client #4] do this and were concerned he would</p>		<p>monitored to ensure no recurrence (Plan of monitoring) Facility director will review online observations at LARC and home monthly. Facility director and behavior consultant will provide monthly observations and provide training as needed at LARC and home monthly.</p>				

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	<p>really injure himself. [Staff #8] said that [staff #9] told him it was time to take him to the mat. [Staff #8] escorted [client #4] to the mat with the method described above and utilized a seated basket hold for about 5 minutes with [staff #9] observing [client #4's] breathing. [Client #4] then relaxed and the intervention was released. [Staff #8] stated he had never seen [client #4] bite himself or been trained that this was something to expect."</p> <p>The following was from the written statement given by the behavior specialist: "On 2/26/14 at approximately 2pm, [name] House manager (staff #1) asked to speak with me. He entered the conference room at [name of day program] and explained to me that a physical intervention had been used on [client #4]. I asked [staff #1] why the intervention was used and he said it was because [client #4] had been biting himself. I informed [staff #1] that I would go back to 'The Shop' room ([client #4's] classroom) and find out what had gone on. I proceeded to go back to the classroom where staff, (staff #10), was in there alone. I asked [staff #10] if he could tell me what had happened and he replied no, as he had just gotten in to work and the incident occurred prior to his arrival. [Staff #10]</p>			

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	<p>then stated that [client #4] had bruises on the back of his right arm. At this time, [client #4] was sitting on the couch. I sat next to him and asked him if I could see his arm, he obliged and raised his arm up. On the backside of his right arm were four bruises that were purple and red in color. I asked [client #4] if his arm hurt and replied no. I then asked [staff #10] if he knew where the bruises came from and he replied that he thought the bruises were a result of the incident that had occurred earlier in the day. He also noted that [name] house staff had to use the blocking pads on [client #4] the night before (2/25) as he was attempting to be aggressive, and once [client #4] had calmed down house staff did a body check and no bruises were discovered. At this point, staff (#8), entered the classroom. I asked [staff #8] if he could tell me what happened and he said yes.</p> <p>[Staff #8] and I went into the [name] office at [name of day program] and discussed the incident. [Staff #8] informed me that this was the most aggressive he had ever seen [client #4] and was visibly shaken (as evidenced by rapid speech and flushed cheeks). [Staff #8] explained that [client #4] had made comments about [name of city] and [name of a person] (these, historically, have been statements that have preceded</p>			

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	<p>aggressive behavior from [client #4]). [Staff #8] said he became nervous that a behavioral outburst would follow. He stated that [client #4] began to become aggressive with staff by attempting to strike and grab at them. [Staff #8] said he and staff (#9), got [client #4] to the mat (his calming area) and began using the blocking pads to keep [client #4] safe from injury. [Staff #8] said during the use of the blocking pads he looked down and saw [client #4] biting his hand between his thumb and forefinger. [Staff #8] stated that he looked at [staff #9] and said, 'I am going to restrain him' and [staff #9] replied, 'Ok.' At that time, [staff #8] said he put [client #4] in a seated baskethold and 'almost immediately' [client #4] began to calm down. [Staff #8] also said that he thought [client #4] calmed down because he wanted attention and sensory input and the hold provided that. [Staff #8] said he and [staff #9] monitored [client #4] on the mat while he calmed down.</p> <p>I then explained to [staff #8] that using physical interventions with a client is a very restrictive measure and should only be used as a last resort. [Staff #8] informed me that he was scared [client #4] was hurting himself and didn't know what else to do. [Staff #8] and I then discussed agency policy and state</p>			

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	<p>regulations that require staff to use least restrictive techniques before moving on to most restrictive. I provided [staff #8] with some examples of least restrictive techniques that should have been used prior to implementing a seated baskethold, such as prompting, redirection and/or a brief physical hold. [Staff #8] understood. I told him that I did not feel as though this was an incident which required the use of a seated baskethold and that we need to continue to follow the behavior plan, which emphasizes the use of least restrictive interventions first. [Staff #8] then said, 'So you're saying I should never put him in a hold?' I replied no, that the hold is in the plan for the rare occasion in which other least restrictive techniques have been utilized unsuccessfully and staff are unable to keep themselves, others or [client #4] safe. [Staff #8] understood.</p> <p>I then spoke with [staff #11 - day program supervisor] about the incident. We discussed the need for BSP (behavior support plan) re-training for staff. [Staff #11] agreed that both [staff #9] and [staff #8] should be re-trained on the BSP and the hierarchy of interventions. I also informed her that there were visible bruises on [client #4].</p>			

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	<p>I left [staff #11's] office and returned to [client #4's] classroom to gather information about how [staff #8] and [staff #9] transported [client #4] to the mat. I asked [staff #8] to demonstrate (on staff [#10]) how he was transported. At first, [staff #8] placed [staff #10] in front of him, grabbed his upper arms (around his biceps) and pushed/guided him to the mat. [Staff #8] then said no, that actually wasn't how it happened. I then asked him to show me again what actually happened. He then had his back to the mat, with [staff #10] in front of him, and placed his elbows under [staff #10's] armpits and pulled him backwards towards the mat. I asked him if, at any point, he was facing [client #4], grabbed his upper arms and pushed him backwards and [staff #8] replied, 'Yea, maybe, I think that happened.' [Staff #8] also mentioned that his methods of transport were methods that he, 'was taught by house staff and that's what they do at the house.' I asked [staff #8] if he noticed the bruises on [client #4's] arm. He said yes but was unsure of where they could have come from. He mentioned that he believed that [client #4] may have given himself the bruises by reaching one arm over the other.</p> <p>I then spoke with [LLL Director] and expressed my concerns about the</p>						

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	<p>incident. Primarily the bruises on [client #4], but also the lack of following the BSP and using least restrictive interventions first. [LLL Director] agreed and noted that she had a conversation with [staff #8] about the incident in which she noted he was both scared and honest. She also expressed her concern that physical interventions were used inappropriately.</p> <p>After leaving [name of day program] I went to [name] house for a visit. I spoke with staff [staff #1] and [staff #2] about how they transport [client #4] to the mat/calming area when he is having behavioral difficulties at home. They stated that often times asking [client #4] to go to the mat to calm down is sufficient, but if it is not they will hold their hands out and [client #4] will put his wrists in their hands and they will lead him to the mat. I asked if they ever escorted him by his upper arms and both individuals replied no.</p> <p>This afternoon, I received the IR (incident report) for electronic review and the narrative on the IR does not match the story that was told to me by staff ([#8]) who was present. [Behavior Specialist]."</p> <p>The interview with staff #9 indicated, "[Staff #9] stated that he began work at</p>						

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	<p>8am at [name of day program] on 2/26 in the area called 'the shop.' There were 5 clients present: [client #4], [names of four clients] and two DSPs (Direct Support Professionals): [staff #9] and [staff #8]. [Staff #9] reported that [client #4] was having a normal morning, nothing out of the ordinary. At approximately 10:15am, [staff #9] left the room to assist another client with the restroom. When asked who was in the room when he left, [staff #9] said [names of three clients], [client #4] were with [staff #8]. (I asked [staff #9] if he insured that when he left the room, the adjoining door was open. [Staff #9] said he did not open the door and did not notice if the door was opened at any time that day). [Staff #9] said that it took about 15 minutes to clean and change the male client and when he returned to the room, [client #4] was sitting on the mat. [Staff #9] said that [client #4] was not having any behaviors or saying anything but he did not look right. When asked for more details - [staff #9] said [client #4] looked kind of in a daze. When asked if [staff #9] noticed any marks or bruises at that time, [staff #9] responded that he did not notice any marks or bruises on [client #4]. [Staff #9] reported that when [staff #9] came in and noticed [client #4] on the mat, [staff #8] offered an explanation saying that [client #4] 'had</p>			

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	<p>behaviors.' [Staff #9] asked [client #4] if he wanted to get up and [client #4] said yes. [Client #4] then sat on the couch next to [staff #9] and [client #4] then said '[staff #8] hurt [client #4]' a few times. [Staff #9] asked [staff #8] 'what did you do to him?' and [staff #8] said 'nothing' he was talking about being a baby and being upset...</p> <p>[Staff #9] reported observing several things that morning that disturbed him. I asked him to describe what he observed. [Staff #9] reported that [client #4's] attitude and mood got progressively worse during the rest of the morning because [staff #8] started doing some strange things like bouncing the basketball on the walls and floor right next to [client #4], squeezing [client #4's] head to the point that [client #4] yelled out and these things were obviously bothering [client #4]. [Staff #9] then reported that [staff #8] often 'rough-housed' with [client #4] but he thought it had gone too far. I asked him what 'rough-housing' looked like. He said you know 'rough-housing.' I said - no I don't know. Describe it. He said [staff #8] would grab [client #4] by his upper body and lift him up in the air, would tickle, would sit next to him on the couch and they would alternate leaning/pushing on each other. [Staff #9]</p>			

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	<p>reported that that morning he had stepped out of the room for something and walked by the 'shop' and when he looked in the room he observed [staff #8] 'straddling [client #4]' on the couch. I asked him to demonstrate. He described [client #4] prone on his side on the couch and it appeared that [staff #8] was laying stretched out on top of [client #4's] hands up/out with one leg on the couch and one leg hanging by the floor. He said he didn't think [staff #8] saw him. I asked him if what he saw was sexual, he said no it was more vulgar. It bothered him. I asked him if he reported any of these actions that [staff #8] was doing to anyone. He said he reported it to [staff #11] on Thursday 2/27 because it had gotten 'out of hand' on Wednesday. On 2/26 around noon, [client #4's] behavior started to escalate, he started talking about being a baby, lunging/kicking at staff, screaming, grabbed [staff #9's] sweatshirt and pulled the zipper down (it had been reported that [client #4] ripped [staff #9's] shirt. [Staff #9] said no, he just pulled the zipper down). It was at that time that [staff #9] and [staff #8] decided to move [client #4] to the mat. [Staff #9] said he was on medical restrictions and could not do any physical interventions. [Staff #9] got on one side of [client #4] and [staff #8] was on the other side and they walked [client #4] to</p>			

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	<p>the mat. [Client #4] got to the mat and flailed and squirmed as is his custom and continued to lunge and kick. [Staff #9] and [staff #8] got the pads and used them to block. At some point, [staff #8] said '[client #4's] biting himself we can't let him do that.' [Staff #9] said he was above [client #4] and couldn't see but that [staff #8] tried to pull [client #4's] hand away and then decided to put him in a basket-hold. [Staff #9] again explained he was on restriction and could not do any physical intervention so [staff #8] had to do it. The basket-hold lasted 30 seconds and then [client #4] calmed and the incident was over. I asked [staff #9] if he was familiar with [client #4's] behavior plan. He said yes. I asked him if he knew what interventions to use with a bite, what staff were supposed to do if [client #4] was getting upset, or started hurting himself. He said he didn't see what [staff #8] did about the biting and couldn't have helped with a release anyway. I asked [staff #9] to show me how he and [staff #8] escorted [client #4] to the mat. I asked him several times if he saw [staff #8] hold or grab [client #4] by his upper arms or move him toward the mat by pushing or pulling him by his upper arms, he said no. I asked him if he saw the bruises on Wednesday, he said no. I asked him if he had any idea how [client #4] got bruises. He said no. Then</p>			

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	<p>he said maybe he got them the night before at the house. I told him the nurse examined [client #4] on Wednesday afternoon and described the color of the bruises as blue and that they looked fresh. [Staff #9] said he did not know how [client #4] received bruises. He said he thought maybe the mark above his eye came from the mat because [client #4] would thrash face down and turn back and forth on quickly. I then told him that [staff #8] admitted to grabbing [client #4] by his upper arms and moving him toward the mat that way. He said that is not what happened when he was in the room...</p> <p>Follow Up Interview: After speaking with clients [Day Program (DP) client #1] and [DP client #2], this writer had concerns about [staff #9's] knowledge of [staff #8's] mistreatment of [client #4] prior to Wednesday. I shared my concerns with [LLL Director] and she suspended [staff #9]. [Staff #9] was concerned about the suspension. I told him that we received information during the day that needed follow up and it was part of our procedure to suspend. I reviewed/summarized the information that I had received from him in the morning. He agreed to the information as I presented it and as written above. This writer and [name of social worker] asked</p>			

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	<p>in depth questions about [staff #8's] 'straddling' of [client #4] by [staff #8]. He again described it and said it did not seem sexual in nature but 'vulgar.' Asked if he had seen anything like that before Wednesday, he said no. Asked [staff #9] if clients had ever reported to him that [staff #8] mistreated [client #4], [staff #9] said Wednesday was the first time. He said that [name of client] told him on 2/27 that [staff #8] pulled [client #4's] legs and pushed them up in the air when he sat on the couch. [Name of client] said he bounced the ball against the wall to bother him and squeezed [client #4's] head til (sic) he yelled. When asked what did you do when [name of client] told you, [staff #9] replied that he told [staff #11]. We asked if [staff #11] had written an incident report, [staff #9] said I don't know. [Staff #9] reported that he and [staff #8] had been working together for about a month. We asked if [staff #9] noticed anything before Wednesday. He said he noticed that [client #4] would scoot away from [staff #8] if he could and that [client #4] was acting more strange lately. [Staff #9] said he asked [staff #8] 'what did you do to him?' [Staff #8] replied 'nothing.' [Staff #9] also noticed that [client #4] wanted him ([staff #9]) to sit beside him on the couch more than usual. We asked [staff #9] if there were clients in the 'shop' that would</p>			

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	<p>recognize inappropriate staff behavior? [Staff #9] said yes. We asked would those clients report bad staff behavior? [Staff #9] replied - yes. We asked have clients told you about staff bad behavior? [Staff #9]: not until Thursday. We asked looking back, is it possible that clients have tried to tell you about staff bad behavior? [Staff #9]: 'It's possible. We all make mistakes. Maybe I didn't want to see it.' [Staff #9] said that he recalls reporting to [staff #11] that he thought [staff #8] needed to learn to work better with [client #4]. He said he told her about the rough housing. He said he probably told her two or three times in the past two weeks that [staff #8] was not working well with [client #4]. We asked - what was her response? [Staff #9]: her response was that [staff #8] is new and was still learning. [Staff #9] said he did not know what else to do except tell [staff #11]...</p> <p>This writer introduced herself to [client #4]. He settled into a chair and seemed calm and friendly. We said we heard he had an injury on his arm and asked if we could see. [Client #4] was very cooperative and lifted up his arm. He had bruises on his upper right arm/tricep area; and a small abrasion above his right eyebrow. This writer asked [client #4] if she could take pictures and he indicated</p>			

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	<p>that it was ok. This writer then asked [client #4] what happened to his arm. He said 'mat.' This writer asked what happened to his eye? [Client #4] said 'mat.' This writer asked who took hold of his arm and [client #4] said 'mat.' [Client #4] was calm and at ease during these questions. This writer thanked [client #4] and [staff #11] took him back to his program.</p> <p>[A client who attended the day program (DP) - DP client #1] dictated a note to [staff #11] on 2/26/2014: "[Staff #9] was outside on his phone. [Staff #8] squeezed [client #4's] head. [Client #4] said Stop. [DP client #1] said [staff #8] did it a second time and [client #4] said Stop. [Staff #8] stopped after the second time.</p> <p>This writer told [DP client #1] that I had read the note he dictated to [staff #11] on Wednesday. [DP client #1] said '[staff #8] tormented [client #4].' We asked him what did [staff #8] do to torment [client #4]? [DP Client #1] reported that [staff #8] would squeeze [client #4's] head until he yelled. He would put paint on his finger and put it up to [client #4's] face like he was going to paint him; he would pull [client #4's] legs down or raise them up when [client #4] was sitting on the couch. ([DP client #1] demonstrated these actions on [staff #12]). [Staff #8]</p>			

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	would get a ball and bounce it near [client #4] and make a lot of noise and sometimes bounce a ball off [client #4's] head. When [client #4] cries, [staff #8] yells at him. [DP client #1] said this mostly happens every time [staff #9] goes out of the room. When asked, this happened Wednesday or before Wednesday. He said before Wednesday and Wednesday. [DP client #1] reported that he feels protective of [client #4] and does not like it when [staff #8] bothers [client #4]. When asked, have you told anyone? [DP client #1] said I tell [staff #9] when [staff #8] does this stuff. When asked if he was in the 'shop' on Wednesday when [client #4] was upset, [DP client #1] said yes. [DP client #1] said that [client #4] was on the couch and [staff #8] was bouncing the ball near [client #4], squeezing his head, [client #4] was getting upset and [DP client #1] said [staff #8] grabbed [client #4] off the couch and put him on the mat. We asked, was [staff #9] in the room? [DP client #1] said no - [staff #9] was gone. We asked [DP client #1] to demonstrate what he saw. He indicated that [staff #8] had grabbed [client #4] by the arm and pulled him off the couch and then had his hands on his upper arms and marched him backwards and put him on the mat. [DP client #1] said he tries 'to be the bigger person' that [staff #12] taught him			

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	<p>that. He likes [client #4] and doesn't think it's right what [staff #8] does to him. When asked if he saw [staff #8] pick on other clients, [DP client #1] replied no, just [client #4]...</p> <p>[DP client #2] said that [staff #8] doesn't help him much. [Staff #8] opens the paint for him. He said he mostly helps other clients in the room more than him. When asked to talk about how [staff #8] and [client #4] get along. [DP client #2] reported that [client #4] sits on the couch and [staff #8] talks to him especially when he has behaviors. He said sometimes when [client #4] sits on the couch [staff #8] squeezes his head and sometimes he bounces the ball on [client #4's] head. We asked, who is in the room when he does this? [DP client #2] replied clients. He said [staff #9] is outside talking on his cell phone. [Staff #8] waits til (sic) [staff #9] goes outside. When asked if he tells anyone what [staff #8] does, he said yes I tell [staff #9]. We asked if he remembers Wednesday when [client #4] was upset. He said [staff #8] took [client #4] off the couch and put him on the mat. He said I saw bruises on [client #4's] arm when I came back from work. When asked if he has seen [staff #8] bother other clients, [DP client #2] said no."</p>			

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	<p>The Statement of Findings section of the investigation indicated, "Testimony provided by LLL clients and staff revealed that [staff #8] targeted [client #4] by initiating a number of actions that were deliberately irritating, annoying, bullying, incendiary and/or outright physically abusive. It is not clear how long or how frequent this pattern of behavior was conducted since [staff #8] preferred to initiate these actions when other staff left the area and clients could not give details about dates and times and frequency. This writer did not have the opportunity to interview [staff #8] to ascertain the scope and severity of his actions.</p> <p>There is a confusion concerning the behavior that occurred at 12:15 (PM) when both [staff #9] and [staff #8] escorted [client #4] to the mat area. [Staff #8] describes that event on the internal IR (incident report) as the one where he grabbed [client #4] by his upper arms to move him. [Staff #9] reports that [client #4] went to the mat of his own power and was not physically assisted there. LLL clients reported that when [staff #9] left the room (10:15am) [staff #8] started to 'torment' [client #4] and caused him to become very upset resulting in [staff #8] grabbing [client #4] by his upper arm(s) from the couch,</p>			

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	<p>moving him to the mat where he thrashed and flailed, apparently receiving the abrasion above his right eye. When [staff #9] returned to the room and sat beside [client #4], [client #4] told him that [staff #8] hurt him. It is this writer's conclusion that there were two incidents on the morning of 2/26 involving [client #4] being moved to the mat. One occurred when [staff #9] was out of the room which resulted in [client #4's] injuries and one occurred when [staff #9] was in the room.</p> <p>It is the conclusion of this investigation that [staff #8] physically abused [client #4] on 2/26/2014 by forcibly pulling him off of the couch causing injury. It is also a finding from reports and interviews that it is likely that [staff #9] witnessed a number of abusive interactions between [client #4] and [staff #8] prior to 2/26/2014 without reporting them. Even if he did not recognize them as abusive, he did admit that the interactions between [staff #8] and [client #4] troubled him. It is also likely that [staff #9] was aware of mistreatment taking place in his absence per client testimony that they reported [staff #8] to [staff #9]. It is a great concern to this writer that [staff #9] received a text message from [staff #8] eight days prior to the incident of this investigation that described detailed</p>			

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	<p>abuse of a two year old child and [staff #9] did not report this to authorities even though he was aware that [staff #8] was a person of interest to law enforcement. It is the conclusion of this investigation that [staff #9] was neglectful in that he minimized [client #4's] mistreatment by [staff #8] (calling it rough housing, understating in his reports to supervisors that [staff #8] needs more training with [client #4]) and failed to report the true nature of the interactions he witnessed to supervisors. Further, there was a plan in place to open the door between the 'shop' and the adjoining room when one staff had to leave the area. This was to ensure immediate assistance if additional staff was needed. [Staff #9] failed to ensure that this happened when he left the room which according to client testimony happened several times during the day to talk on his phone. It is this writer's understanding that cell phone reception is poor at [name of day program] and there are only certain areas of the building where the signal gets through. It makes sense that [staff #9] would leave the 'shop' area to make/receive calls."</p> <p>The Statement of Substantiation section of the investigation indicated both abuse and neglect were substantiated. The investigation indicated, "Abuse: The findings go beyond the original concern</p>						

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	<p>which was that improper escort techniques were used. Neglect: The findings indicate staff failed to report client mistreatment. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual . Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma."</p> <p>The investigation indicated, "The reports of the LLL clients are consistent with [staff #8's] report that he had [client #4] by his upper arms and moved him toward the mat area. However there were two incidents during the morning where [client #4] was transported to the mat area. The conclusion is that [staff #8] initiated a series of actions including bouncing a ball on the wall near and/or on [client #4], squeezing [client #4's] head, straddling him on the couch (tormenting him according to a client witness) when staff left the room at 10:15am - that caused great distress and escalated [client #4's] behavior to the point that [staff #8] grabbed [client #4]</p>			

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	<p>by his upper arm (s) and pulled him from the couch and moved him to the mat. The kind, number and location of the bruises are consistent with unnecessary force being applied during an action of this nature. Two clients gave consistent and similar accounts that [staff #8] often provoked and picked on [client #4], often when staff left the room and both said they told [staff #9] what [staff #8] was doing when he left the room. They could not say when or how many times they reported this to [staff #9] but both said it was not just this week.</p> <p>Agency policy was followed to suspended (sic) staff for suspected abuse and neglect. Agency policy was not followed in failing to ensure client protections. Agency policy was not followed when client reports of mistreatment went unreported. Agency policy was not followed in that least restrictive measures were not implemented and unauthorized physical interventions were used resulting in client injury." The investigation indicated staff #8 and #9 were terminated and the facility-operated day program staff were retrained on preventing abuse, neglect and exploitation.</p> <p>On 8/1/14 at 1:58 PM, the Director of Supervised Group Living indicated the</p>				

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W000154	<p>staff should immediately report allegations of abuse and neglect to the administrator.</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 investigated.</p> <p>Based on record review and interview for 3 of 62 incident/investigative reports reviewed affecting clients #1, #4 and former client #5, the facility failed to conduct investigations of client to client abuse, client #4's choking incident and an incident in which staff reported client #4 fell after passing out.</p> <p>Findings include:</p> <p>On 7/29/14 at 11:40 AM a review of the facility's incident/investigative reports indicated the following:</p> <p>1. On 1/13/14 at 3:00 PM at the facility-operated workshop, former client #5 "leaped out of his seat, ran quickly around (sic) table and grabbed [client #1's] shoulders. He [client #5] then proceeded to shake and squeeze [client #1]. [Client #1] tried to grab him with</p>	W000154	<p>W154483.420 (d)(3) The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Corrective action for resident(s) found to have been affected (Plan of correction)</p> <p>Staff accused of abuse was suspended following accusation of abuse and was terminated when investigation deemed it factual. Staff have been trained on Stone Belt policies and procedures that prohibit mistreatment, neglect or abuse of the client (Attachment W154A, Attachment 154B- (Plan of identify and plan of correction)) All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility coordinator and house manager</p>	08/01/2014

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	<p>his hands but could not. [Client #5] let go after about 10 - 15 seconds." There was no documentation the facility conducted an investigation.</p> <p>2. On 2/13/14 at 7:45 AM, client #4 fell. The Stone Belt ARC, Inc. Incident Report, dated 2/13/14, indicated, "[Client #4] suddenly fell down after putting on (jacket). [Client #4], it seemed as if he, [client #4], passed out standing up and fell straight down." The report indicated client #4 was not found with any immediate injuries. The Qualified Intellectual Disabilities Professional (QIDP) documented on the form, "Staff will continue to monitor [client #4] to help keep him safe." There was no documentation the facility conducted an investigation into the incident of client #4's fall related to being "passed out."</p> <p>3. On 5/20/14 at 12:00 PM at the facility-operated day program, client #4 was eating beef and noodles. Client #4 became choked. Staff prompted him to continue coughing. When the coughing stopped and client #4 began to turn red and drool excessively, staff began steps to perform the Heimlich. The report indicated, in part, "Once staff felt his stomach muscles contract she gave a light thrust one handed at this time [client #4's] breathing came back to normal and</p>		<p>will complete weekly observations of interactions between direct care staff and provide training of behavior plans as needed (Attachment W154C).</p> <p>How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility director will review online observations at LARC and home monthly. Facility director and behavior consultant will provide monthly observations and provide training as needed at LARC and home monthly will facilitate or review these trainings monthly and provide additional training as needed.</p>				

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	<p>he began to talk. [Client #4] finished (sic) his lunch & went back to his home room. [Client #4] will continue to take small bites and eat slowly." There was no documentation the facility investigated the incident to ensure client #4's risk plan for choking was implemented as written.</p> <p>On 7/29/14 at 1:02 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client abuse should be investigated.</p> <p>On 7/31/14 at 3:12 PM, the Director of Supervised Group Living (DSGL) indicated client to client aggression was considered abuse. The DSGL indicated the facility had policies and procedures prohibiting abuse of the clients. The DSGL indicated the staff should prevent client to client abuse. The DSGL indicated client to client abuse should be investigated. The DSGL indicated the facility should have conducted an investigation of the incident on 2/13/14 of client #4's fall after a report he passed out. The DSGL indicated the incident of client #4 should have been investigated.</p> <p>9-3-2(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 2 clients in the sample (#4), the facility's nursing services failed to document an assessment of client #4 after a report he "passed out."</p> <p>Findings include:</p> <p>On 7/29/14 at 11:40 AM a review of the facility's incident/investigative reports indicated the following:</p> <p>On 2/13/14 at 7:45 AM, client #4 fell. The Stone Belt ARC, Inc. Incident Report, dated 2/13/14, indicated, "[Client #4] suddenly fell down after putting on (jacket). [Client #4], it seemed as if he, [client #4], passed out standing up and fell straight down." The report indicated client #4 was not found with any immediate injuries. There was no documentation the facility conducted an investigation into the incident of client #4's fall related to being "passed out." The Qualified Intellectual Disabilities Professional (QIDP) documented on the form, "Staff will continue to monitor [client #4] to help keep him safe." There was no documentation of a nursing assessment or the nurse being notified.</p>	W000331	<p>W331 483.460 (c) Nursing Services Corrective action for resident(s) found to have been affected (Plan of correction) Nurse was trained by DON on providing nursing assessments following incidents (Attachment W331A). How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Nurse will provide monthly head to toe assessments and share concerns and progress with team. Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) QIDP trained on monitoring nursing services (Attachment W331 B). How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Director will complete quarterly quality checklist to monitor that nursing services are appropriate</p>	08/01/2014			

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	<p>On 7/29/14 at 12:46 PM, a focused review of client #4's record indicated there was no documentation in his record of the incident. There was no documentation the staff or nurse took his vitals or he was sent to the doctor for an evaluation. There was no documentation the nurse conducted an assessment.</p> <p>On 7/29/14 at 1:12 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated there should be documentation in client #4's record indicating a nursing assessment was completed. The QIDP indicated someone should have taken client #4's blood pressure following the incident.</p> <p>On 7/30/14 at 10:13 AM, the Licensed Practical Nurse (LPN) initially indicated she was not aware client #4 passed out. On 7/30/14 at 10:37 AM, the LPN indicated after reviewing her records she was informed and was aware of the incident. The LPN indicated she was notified and should have conducted an assessment.</p> <p>On 8/1/14 at 11:11 AM, the Nurse Manager (NM) indicated a nurse should have assessed client #4 after the incident. The NM indicated client #4's sitting and standing blood pressure should have been</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2606 H ST BEDFORD, IN 47421
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W000368	<p>obtained and a general assessment completed.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on interview and record review for 1 of 2 clients in the sample (#4), the facility failed to ensure staff administered client #4's medications as ordered by the physician.</p> <p>Findings include:</p> <p>On 7/30/14 at 6:10 AM, staff #5 stated client #4 had been awake all night "obsessing" on his medications. Staff #5 indicated client #4 kept asking about his medications during the night, which was not unusual for him to do.</p> <p>On 7/30/14 at 7:31 AM, staff #2 indicated client #4 did not received his HS (hour of sleep) medications, as ordered, on 7/29/14. Staff #2 indicated he discovered the error while doing a buddy check for the morning medication pass. Staff #2 indicated he was not sure</p>	W000368	<p>Addendum: Plan of correction: Staff making error received a written warning and a medication error. He also completed training per policy. Plan of prevention: Facility house managers / associate manager / day aid will complete daily medication administration observations. This may titrate down to once weekly if no further medication errors occur. Plan of monitoring: Facility coordinator will complete bi-weekly medication administration observations . This may titrate down to once weekly if no further medication errors occur. W368</p> <p>483.460 (k) (1) Medication Administration Corrective action for resident(s) found to have been affected (Plan of correction) Staff #5 received a written warning and a medication error. PCP was consulted and it was determined</p>	08/01/2014

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	<p>what happened but none of client #4's HS medications were initialed as administered. Staff #2 indicated he checked the medication packages which indicated none of client #4's HS medications were administered on 7/29/14. Staff #2 indicated staff #5 should have completed a buddy check at 10:00 PM when he started his shift on 7/29/14. Staff #2 indicated there was a miscommunication between staff on 7/29/14 which led to client #4 not receiving his medications.</p> <p>On 7/30/14 at 7:39 AM, a review of client #4's July 2014 Medication Administration Record indicated none of his HS medications were initialed as administered on 7/29/14. The medications included Budesonide (asthma), Fiber-Lax (constipation), Ibuprofen (arthritis), Levetiraceta (seizures), Omeprazole (acid reflux), Orap (Intermittent Explosive Disorder - IED), Risperidone (IED), and Trazodone (IED).</p> <p>On 7/30/14 at 8:11 AM, a review of a Medication Error Report, dated 7/30/14, indicated, in part, "Overnight staff (#5) received miscommunication from evening staff (#3)... Missed medication/Ordered Medication not given." The report indicated the error</p>		<p>that missing a dose of medications would not be detrimental to client #4. (Attachment W368 A). How facility will identify other residents potentially affected & what measures taken Continue completion of buddy shift checks to identify and prevent additional medication errors. Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility coordinator and nurse will complete weekly medication administration observations. They will document visit online and submit to facility director for review. Concerns notes will immediately be addressed by training. How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Director will monitor observations and discuss monthly with team.</p>				

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	<p>was found during, "AM buddy check."</p> <p>On 7/30/14 at 8:11 AM, a review of an Employee Warning Notice, dated 7/30/14, indicated, "[Staff #5] failed to administer [client #4] HS medications. Evening DSP (Direct Support Professional) had put [client #4] to bed therefore [staff #5] felt that meds had been admin (administered)."</p> <p>On 7/30/14 at 7:32 AM, the Director of Supervised Group Living indicated on 7/29/14 there was a miscommunication between staff leading to client #4 not receiving his HS medications as ordered. The Director indicated the HS medication was not administered to client #4.</p> <p>On 7/30/14 at 7:58 AM, staff #5 indicated client #4 tried to tell staff #5 that client #4 did not receive his medications. Staff #5 indicated client #4 talking about his medications was not unusual so staff #5 did not check to ensure client #4 received his medications.</p> <p>On 7/30/14 at 10:05 AM, the Licensed Practical Nurse (LPN) indicated client #4 did not receive his HS medications as ordered. The LPN indicated it was a communication issue between the staff. The LPN indicated client #4 received his medications later in the evening than the</p>						

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	other clients which may have contributed to the issue. The LPN indicated it was a medication error. 9-3-6(a)				