STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G394	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	701 RILEY BLVD BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00180602. Complaint #IN00180602: Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149, W154, W156 and W157. Unrelated deficiency cited. Survey Date: September 24, 25, 28 and 29, 2015 Facility Number: 000908 Provider Number: 15G394 AIM Number: 100244380 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/30/15.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for	W 0102	Program Directors (QIDP) and	10/29/2015

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	3 of 16 incident/investigative reports reviewed affecting clients B, E, F, G and H, the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to implement its policies and procedures to conduct a thorough investigation of an injury of unknown origin to client E and prevent client to client abuse. The governing body failed to ensure there was a reproducible system for maintaining the group home's completed investigations. The governing body failed to ensure the investigation was included for the facility to review patterns and trends. The governing body failed to ensure the investigation of client E's injury of unknown origin included interviews with group home staff #4, #8 and #11 who worked on 8/18/15. The governing body failed to ensure the investigation included interviews, with the exception of day program staff #2, of the day program staff who worked with client E on 8/18/15. The governing body failed to ensure the investigation included documentation a review of client E's behavior documentation was conducted. The governing body failed to ensure the investigation included documentation a review of client E's Daily Support Records was conducted for the group home or the day program. The governing body failed to ensure the investigation		Quality Assurance Specialist will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation, determining any corrective action required and completing follow up as needed. Area Director and / or Regional Director will review all investigations upon completion to review for required (retrained) content. Program Directors (QIDP) will be retrained on submitting investigations so they can be reviewed by administrative staff within the required 5 working days and that appropriate corrective actions are implemented. Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that there are investigations as required, that they are completed timely, and they are reviewed for trends and patterns. Changes to plans will be made as necessary. Program Directors (QIDP) will be trained to file signed investigations with incident reports to ensure there is a reproducible copy available upon request. Area Director will store all received investigations on hard drive of computer to ensure a reproducible copy can be obtained if requested.	

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	included the information from the Daily Support Records from 8/18/15. The governing body failed to revise and/or update the investigation after the Quality Assurance Specialist (QAS) interviewed day program staff #2 on 9/24/15, after completing the investigation, and became aware his interview included in the investigation was inaccurate. The governing body failed to ensure the investigation indicated group home staff #11 observed client E limping around dinner time while at the group home prior to going to the bowling alley. The governing body failed to ensure the investigation indicated the original investigation could not be located and the investigation provided to the surveyor was completed on 9/24/15. The investigation indicated the dates of the investigation were 8/19/15, 8/21/15 and 8/24/15. The governing body failed to ensure the investigation was completed within 5 working days. The investigation indicated the Program Director (PD) completed the investigation. The QAS completed the investigation based on information obtained from the PD on 9/24/15 as well as the QAS. The governing body failed to ensure the Area Director (administrator) received the results of the investigation within 5 working days. The governing body failed to ensure corrective actions were			

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	implemented following client E's injury being discovered. Findings include: 1) Please refer to W104. For 3 of 16 incident/investigative reports reviewed affecting clients B, E, F, G and H, the facility's governing body failed to implement its policies and procedures to ensure thorough investigations were conducted into client E's injury of unknown origin and client to client abuse involving clients F and G, and the results of client E's investigation were reported to the administrator within 5 working days and corrective actions were implemented to address client E's injury of unknown origin. The facility's governing body failed to ensure there was a reproducible system for maintaining the group home's investigation of client E's injury of unknown origin. The governing body failed to ensure the investigation provided to the surveyor for client E's injury of unknown origin contained accurate information including who completed the investigation and the dates of the investigation. The governing body failed to ensure contradictory information obtained during the investigation was included in the investigation and follow-up was conducted to resolve the conflicting information obtained from			

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	day program staff #2. 2) Please refer to W122. For 3 of 16 incident/investigative reports reviewed affecting clients B, E, F, G and H, the facility failed to meet the Condition of Participation: Client Protections. The facility's governing body neglected to implement its policies and procedures to conduct a thorough investigation of an injury of unknown origin to client E and prevent client to client abuse. The facility's governing body failed to ensure the investigation included interviews with group home staff #4, #8 and #11 who worked on 8/18/15. The facility's governing body failed to ensure the investigation included interviews, with the exception of day program staff #2, of the day program staff who worked with client E on 8/18/15. The facility's governing body failed to ensure the investigation included documentation a review of client E's behavior documentation was conducted. The facility's governing body failed to ensure the investigation included documentation a review of client E's Daily Support Records was conducted for the group home or the day program. The facility's governing body failed to ensure the investigation included the information from the Daily Support Records from 8/18/15. The facility's governing body			

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	failed to revise and/or update the investigation after the Quality Assurance Specialist (QAS) interviewed day program staff #2 on 9/24/15, after completing the investigation, and became aware his interview included in the investigation was inaccurate. The facility's governing body failed to ensure the investigation indicated group home staff #11 observed client E limping around dinner time while at the group home prior to going to the bowling alley. The facility's governing body failed to ensure the investigation indicated the original investigation could not be located and the investigation provided to the surveyor was completed on 9/24/15. The investigation indicated the dates of the investigation were 8/19/15, 8/21/15 and 8/24/15. The facility's governing body failed to ensure the investigation was completed within 5 working days. The investigation indicated the Program Director (PD) completed the investigation. The QAS completed the investigation based on information obtained from the PD on 9/24/15 as well as the QAS. There was no documentation the Area Director (administrator) received the results of the investigation within 5 working days. This federal tag relates to complaint #IN00180602.			

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	9-3-1(a)			
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 3 of 16 incident/investigative reports reviewed affecting clients B, E, F, G and H, the facility's governing body failed to implement its policies and procedures to ensure thorough investigations were conducted into client E's injury of unknown origin and client to client abuse involving clients F and G, and the results of client E's investigation were reported to the administrator within 5 working days and corrective actions were implemented to address client E's injury of unknown origin. The facility's governing body failed to ensure there was a reproducible system for maintaining the group home's investigation of client E's injury of unknown origin. The governing body failed to ensure the investigation provided to the surveyor for client E's injury of unknown origin contained accurate information including who completed the investigation and the dates of the investigation. The governing body	W 0104	Program Directors (QIDP) will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation, determining any corrective action required and completing follow up as needed. Area Director and / or Regional Director will review all investigations upon completion to review for required (retrained) content. Program Directors (QIDP) will be retrained on submitting investigations so they can be reviewed by administrative staff within the required 5 working days and that appropriate corrective actions are implemented. Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that there are investigations as required, that they are completed timely, and they are	10/29/2015

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	failed to ensure contradictory information obtained during the investigation was included in the investigation and follow-up was conducted to resolve the conflicting information obtained from day program staff #2. Findings include: 1) Please refer to W149. For 3 of 16 incident/investigative reports reviewed affecting clients B, E, F, G and H, the governing body failed to implement its policies and procedures to conduct a thorough investigation of an injury of unknown origin to client E and prevent client to client abuse. The governing body failed to ensure the investigation included interviews with group home staff #4, #8 and #11 who worked on 8/18/15. The governing body failed to ensure the investigation included interviews, with the exception of day program staff #2, of the day program staff who worked with client E on 8/18/15. The governing body failed to ensure the investigation included documentation a review of client E's behavior documentation was conducted. The governing body failed to ensure the investigation included documentation a review of client E's Daily Support Records was conducted for the group home or the day program. The governing		reviewed for trends and patterns. Changes to plans will be made as necessary. Program Directors (QIDP) will be trained to file signed investigations with incident reports to ensure there is a reproducible copy available upon request. Area Director will store all received investigations on hard drive of computer to ensure a reproducible copy can be obtained if requested.	

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	body failed to ensure the investigation included the information from the Daily Support Records from 8/18/15. The governing body failed to revise and/or update the investigation after the Quality Assurance Specialist (QAS) interviewed day program staff #2 on 9/24/15, after completing the investigation, and became aware his interview included in the investigation was inaccurate. The governing body failed to ensure the investigation indicated group home staff #11 observed client E limping around dinner time while at the group home prior to going to the bowling alley. The governing body failed to ensure the investigation indicated the original investigation could not be located and the investigation provided to the surveyor was completed on 9/24/15. The investigation indicated the dates of the investigation were 8/19/15, 8/21/15 and 8/24/15. The governing body failed to ensure the investigation was completed within 5 working days. The investigation indicated the Program Director (PD) completed the investigation. The QAS completed the investigation based on information obtained from the PD on 9/24/15 as well as the QAS. The governing body failed to ensure the Area Director (administrator) received the results of the investigation within 5 working days.			

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	2) Please refer to W154. For 3 of 16 investigative reports reviewed affecting clients B, E, F, G and H, the facility's governing body failed to ensure thorough investigations were conducted for an injury of unknown origin to client E and two incidents of client to client abuse. 3) Please refer to W156. For 1 of 16 incident/investigative reports reviewed affecting client E, the facility's governing body failed to ensure the results of the investigation were reported to the administrator within five working days of the incident. This federal tag relates to complaint #IN00180602. 9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 3 of 16 incident/investigative reports reviewed affecting clients B, E, F, G and H, the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policies and procedures to	W 0122	Program Directors (QIDP) will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation,	10/29/2015

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	conduct a thorough investigation of an injury of unknown origin to client E and prevent client to client abuse. The facility failed to ensure the investigation included interviews with group home staff #4, #8 and #11 who worked on 8/18/15. The facility failed to ensure the investigation included interviews, with the exception of day program staff #2, of the day program staff who worked with client E on 8/18/15. The facility failed to ensure the investigation included documentation a review of client E's behavior documentation was conducted. The facility failed to ensure the investigation included documentation a review of client E's Daily Support Records was conducted for the group home or the day program. The facility failed to ensure the investigation included the information from the Daily Support Records from 8/18/15. The facility failed to revise and/or update the investigation after the Quality Assurance Specialist (QAS) interviewed day program staff #2 on 9/24/15, after completing the investigation, and became aware his interview included in the investigation was inaccurate. The facility failed to ensure the investigation indicated group home staff #11 observed client E limping around dinner time while at the group home prior to going to the bowling alley. The facility failed to ensure the		determining any corrective action required and completing follow up as needed. Area Director and / or Regional Director will review all investigations upon completion to review for required (retrained) content. Program Directors (QIDP) will be retrained on submitting investigations so they can be reviewed by administrative staff within the required 5 working days and that appropriate corrective actions are implemented. Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that there are investigations as required, that they are completed timely, and they are reviewed for trends and patterns. Changes to plans will be made as necessary. Program Directors (QIDP) will be trained to file signed investigations with incident reports to ensure there is a reproducible copy available upon request. Area Director will store all received investigations on hard drive of computer to ensure a reproducible copy can be obtained if requested.	

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	investigation indicated the original investigation could not be located and the investigation provided to the surveyor was completed on 9/24/15. The investigation indicated the dates of the investigation were 8/19/15, 8/21/15 and 8/24/15. The investigation was not completed within 5 working days. The investigation indicated the Program Director (PD) completed the investigation. The QAS completed the investigation based on information obtained from the PD on 9/24/15 as well as the QAS. There was no documentation the Area Director (administrator) received the results of the investigation within 5 working days. Findings include: 1) Please refer to W149. For 3 of 16 incident/investigative reports reviewed affecting clients B, E, F, G and H, the facility neglected to implement its policies and procedures to conduct a thorough investigation of an injury of unknown origin to client E and prevent client to client abuse. The facility failed to ensure the investigation included interviews with group home staff #4, #8 and #11 who worked on 8/18/15. The facility failed to ensure the investigation included interviews, with the exception of day program staff #2, of the day			

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	program staff who worked with client E on 8/18/15. The facility failed to ensure the investigation included documentation a review of client E's behavior documentation was conducted. The facility failed to ensure the investigation included documentation a review of client E's Daily Support Records was conducted for the group home or the day program. The facility failed to ensure the investigation included the information from the Daily Support Records from 8/18/15. The facility failed to revise and/or update the investigation after the Quality Assurance Specialist (QAS) interviewed day program staff #2 on 9/24/15, after completing the investigation, and became aware his interview included in the investigation was inaccurate. The facility failed to ensure the investigation indicated group home staff #11 observed client E limping around dinner time while at the group home prior to going to the bowling alley. The facility failed to ensure the investigation indicated the original investigation could not be located and the investigation provided to the surveyor was completed on 9/24/15. The investigation indicated the dates of the investigation were 8/19/15, 8/21/15 and 8/24/15. The investigation was not completed within 5 working days. The investigation indicated the Program			

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	Director (PD) completed the investigation. The QAS completed the investigation based on information obtained from the PD on 9/24/15 as well as the QAS. There was no documentation the Area Director (administrator) received the results of the investigation within 5 working days. The facility failed to ensure corrective actions were implemented following client E's injury being discovered. 2) Please refer to W154. For 2 of 16 investigative reports reviewed affecting clients E, F and G, the facility failed to conduct thorough investigations of an injury of unknown origin to client E and two incidents of client to client abuse. 3) Please refer to W156. For 1 of 16 incident/investigative reports reviewed affecting client E, the facility failed to ensure the results of the investigation were reported to the administrator within five working days of the incident. 4) Please refer to W157. For 1 of 16 incident/investigative reports reviewed affecting client E, the facility failed to implement appropriate corrective actions following the discovery of client E's injury of unknown origin. This federal tag relates to complaint			

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	#IN00180602. 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 16 incident/investigative reports reviewed affecting clients B, E, F, G and H, the facility neglected to implement its policies and procedures to conduct a thorough investigation of an injury of unknown origin to client E and prevent client to client abuse. The facility failed to ensure the investigation included interviews with group home staff #4, #8 and #11 who worked on 8/18/15. The facility failed to ensure the investigation included interviews, with the exception of day program staff #2, of the day program staff who worked with client E on 8/18/15. The facility failed to ensure the investigation included documentation a review of client E's behavior documentation was conducted. The facility failed to ensure the investigation included documentation a review of client E's Daily Support Records was conducted for the group home or the day program. The facility failed to ensure the	W 0149	Program Directors (QIDP) will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation, determining any corrective action required and completing follow up as needed. Area Director and / or Regional Director will review all investigations upon completion to review for required (retrained) content. Program Directors (QIDP) will be retrained on submitting investigations so they can be reviewed by administrative staff within the required 5 working days and that appropriate corrective actions are implemented. Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that there are investigations as required, that they are completed timely, and they are	10/29/2015

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	investigation included the information from the Daily Support Records from 8/18/15. The facility failed to revise and/or update the investigation after the Quality Assurance Specialist (QAS) interviewed day program staff #2 on 9/24/15, after completing the investigation, and became aware his interview included in the investigation was inaccurate. The facility failed to ensure the investigation indicated group home staff #11 observed client E limping around dinner time while at the group home prior to going to the bowling alley. The facility failed to ensure the investigation indicated the original investigation could not be located and the investigation provided to the surveyor was completed on 9/24/15. The investigation indicated the dates of the investigation were 8/19/15, 8/21/15 and 8/24/15. The investigation was not completed within 5 working days. The investigation indicated the Program Director (PD) completed the investigation. The QAS completed the investigation based on information obtained from the PD on 9/24/15 as well as the QAS. There was no documentation the Area Director (administrator) received the results of the investigation within 5 working days. The facility failed to ensure corrective actions were implemented following client E's		reviewed for trends and patterns. Changes to plans will be made as necessary. Program Directors (QIDP) will be trained to file signed investigations with incident reports to ensure there is a reproducible copy available upon request. Area Director will store all received investigations on hard drive of computer to ensure a reproducible copy can be obtained if requested.	

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	injury being discovered. Findings include: On 9/24/15 at 12:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 8/18/15 at 8:40 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/19/15, indicated, in part, "It was reported to PC (Program Coordinator), then reported to the PD (Program Director), that client [E] was limping on his foot and unable to put much pressure on it after he came back from bowling. In the morning, [client E] was walking much better on it, but program nurse said to go ahead and take him to the walk-in clinic. It was reported at 10:34 AM today (8/19/15) that [client E] does indeed have a broken bone in his foot. He is to be seen by an orthopedic dr (doctor) for a boot. An appt (appointment) is being made by PC. PC will take [client E] to Ortho (Orthopedic) doctor and follow dr orders." The investigation, dated 8/24/15, indicated in the Conclusion, "Based on the information gathered, there is evidence to support that [client E] likely hurt his foot kicking the underneath side			

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	of the seat in the van during a behavior on 8/18/15." The investigation indicated the List of Documents reviewed included client E's BDDS report dated 8/18/15 and Medical Appointment Forms dated 8/19/15 and 8/21/15. The interview with day program staff #2 in the investigation indicated day program staff #2 transported client E home from the day program on 8/18/15. Day program staff #2's statement in the investigation indicated, "[Staff #2] stated that he transported the clients home from the [name of the day program] on 8/18/15. [Staff #2] stated that [client E] was seated in the back seat of the van and was agitated. [Staff #2] stated that [client E] was kicking the underneath side of the seat. [Staff #2] stated that when he took the clients into the home, [client E] was kind of 'shuffling' his feet but didn't notice and (sic) problems and [client E] didn't make any complaints of pain." There was no documentation the investigation results were reviewed by the administrator within 5 working days. There was no documentation the facility recommended or implemented corrective actions following the discovery of client E's injury. On 9/25/15 at 11:34 AM, the Quality Assurance Specialist (QAS) indicated after she sent the surveyor the			

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	investigation for client E's injury of unknown origin, day program staff #2 called her back on 9/24/15 for his interview for the investigation. The QAS indicated she had requested a copy of the investigation prior to the survey being opened and was told by the Program Director (PD) she could not locate the investigation. The QAS indicated on 9/24/15 when she was told the surveyor was at the facility, she asked the PD about the investigation for client E's injury of unknown origin. The QAS indicated the PD said she could not find the investigation. The QAS indicated on 9/24/15 she typed up the investigation given to the surveyor for review. The QAS indicated she took the information given to her by the PD and documented it in an investigation. The QAS indicated after she typed the report and sent it to the surveyor for review, day program staff #2 contacted her by phone for the investigation. The QAS indicated she did not interview staff #2 until after she wrote the investigation. The QAS indicated staff #2 told her client E kicked with his left foot and not his right foot. The QAS indicated staff #2 told her client E did not kick the seat. The QAS indicated she did not ask and staff #2 did not indicate client E was sitting behind the driver. The QAS indicated staff #2 did not observe client E to be injured.			

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	The QAS indicated she informed the PD of the PD's recollection of staff #2's interview and the QAS' interview with staff #2 on 9/24/15. The QAS indicated the investigation was not thorough. The QAS indicated additional day program staff should have been interviewed. The QAS indicated after interviewing staff #2, she was aware the information in the investigation was incorrect. The QAS indicated investigations should be completed within 5 working days. The investigation was not thorough. The investigation did not include interviews with group home staff #4, #8 and #11 who worked on 8/18/15. The investigation did not include interviews, with the exception of day program staff #2, of the day program staff who worked with client E on 8/18/15. The investigation did not include documentation a review of client E's behavior documentation was conducted. The investigation did not include documentation a review of client E's Daily Support Records (DSRs) was conducted for the group home or the day program. The investigation did not include the information from the Daily Support Records from 8/18/15. The investigation was not revised after the Quality Assurance Specialist (QAS) interviewed day program staff #2 on			

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	9/24/15, after completing the investigation, and became aware his interview included in the investigation was inaccurate. The investigation did not indicate group home staff #11 observed client E limping around dinner time while at the group home prior to going to the bowling alley. The investigation did not indicate the original investigation could not be located. The investigation indicated the dates of the investigation were 8/19/15, 8/21/15 and 8/24/15. The investigation did not indicate the date of completion as 9/24/15. The investigation indicated the Program Director (PD) completed the investigation. The QAS completed the investigation based on information obtained from the PD on 9/24/15. There was no documentation the Area Director (administrator) received the results of the investigation within 5 working days. The facility failed to ensure corrective actions were implemented following client E's injury being discovered. On 9/25/15 at 11:26 AM, day program staff #2 indicated he transported client E home on 8/18/15. Staff #2 indicated there was no additional staff in the van at the time. Staff #2 indicated client E was aggravated about something prior to the trip home and was chasing the day program manager around. Staff #2			

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	indicated client E got into the van and sat directly behind him in the van. Staff #2 indicated client E was kicking his left foot in between the front seats but did not make contact with anything. Staff #2 indicated client E did not kick the driver's seat at anytime during the trip to his group home. Staff #2 indicated client E walked without issues after arriving to the group home. Staff #2 indicated he did not observe client E do anything that could have caused the injury. Staff #2 indicated he was interviewed for the investigation by the QAS on 9/24/15. On 9/24/15 at 3:19 PM, the Program Coordinator (PC) indicated she was aware of a behavior client E had while at the day program on 8/18/15 prior to being picked up to come home. The PC indicated day program staff #2 told her about the behavior client E had at the day program. Client E took client A's notebook and staff asked him to give it back. The PC stated client E had a "tantrum" at the day program. The PC indicated client E had behaviors in the van on the way to the group home. The PC indicated staff noticed he was shuffling his feet when he got to the group home. The PC indicated client E was noted to be limping at the bowling alley later in the evening. The PC indicated the staff who worked on			

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	8/18/15 were staff #4, #8 and #11. On 9/25/15 at 11:49 AM, the Program Director (PD) indicated client E had a behavior regarding a pad of paper while at the facility-operated day program on 8/18/15. The PD indicated day program staff #2 told the PD that he thought client E kicked the seat in the van and broke his foot. The PD indicated day program staff #2 did not say client E kicked the seat just that he thought he might have kicked the seat. The PD indicated she could not recall who she interviewed for her investigation she was unable to locate. The PD indicated she told the QAS on 9/24/15 she could not find the notes or the investigation she completed. The PD indicated the QAS documented the investigation given to the surveyor. The PD indicated she did not send the QAS an investigation. The PD indicated she did not review client E's Daily Support Records for the investigation. The PD indicated the DSRs should have been reviewed. The PD indicated the staff at the group home should have been interviewed. The PD indicated she did not review the investigation the surveyor had regarding client E's injury of unknown origin. The PD indicated she did not know when the QAS wrote the investigation. On 9/28/15 at 1:51 PM, the PD indicated she did not recommend			

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	or implement corrective actions after the facility discovered client E had an injury of unknown origin. On 9/25/15 at 12:51 PM, the Area Director (AD) indicated he reviewed the investigation regarding client E's injury of unknown origin in August 2015 after the PD completed the investigation. The AD indicated he did not have documentation of the original investigation completed by the PD. The AD indicated the facility should complete investigations within 5 working days and the administrator should review the results of the investigations within 5 working days. The AD indicated day program staff #2 said in the original investigation client E kicked the back of the seat in the van. The AD indicated he reviewed the Daily Support Record from the day program on 8/18/15. The AD indicated the note did not contain much information for a 7 hour day. The AD indicated the day program needed to document additional information in their notes. The AD indicated client E was first noted to be limping while he was at the bowling alley. The AD indicated the QAS typed up the investigation given to the surveyor for review on 9/24/15. The AD indicated the investigation was not thorough. The AD indicated the investigation should have included			

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	interviews with the staff, including day program staff, for the 24 hours preceding the injury of unknown origin being found. The AD indicated the investigation should have included a review of client E's daily support records and behavior tracking. The AD indicated the investigation the PD completed could not be located. The AD indicated the original investigation was completed within 5 working days. The AD indicated the investigation completed by the QAS on 9/24/15 should have been dated 9/24/15. The AD indicated the PD documented in her original investigation day program staff #2 said client E kicked the seat. The AD indicated he did not know how day program staff #2 would know which foot client E used to kick with since there was one staff in the van at the time. The AD stated, "How would [day program staff #2] know that?" The AD indicated the investigation did not include a sufficient amount of interviews with the staff who worked with client E. The AD stated, "What did they check out?" for the investigation. The AD indicated the facility needed to obtain additional information from day program staff #2 to clarify what occurred on the van. The AD stated the facility needed to "figure out" if day program staff #2 was giving accurate information or not. The AD indicated day program staff #2 may			

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	be talking about a different date. The AD indicated the investigation was not falsified. The AD indicated the dates were wrong in the QAS' investigation. The AD indicated the QAS used the PD's information, from word of mouth, to write the investigation on 9/24/15. On 9/24/15 at 3:23 PM, staff #4 indicated staff #11 noticed client E was limping around dinner time on 8/18/15. The group ate dinner and went to the gas station before bowling to get drinks. Staff #4 indicated staff #11 again noted client E was limping as he walked to the van after getting his drink at the gas station. Staff #4 indicated she noticed client E was limping at the bowling alley. Staff #4 indicated as the night went on his limping got worse and worse. Staff #4 indicated she checked his foot while at the bowling alley and did not see any bruising or issues with his foot. Staff #4 indicated when client E got home after bowling, staff #8 checked his foot and observed a bruise. Staff #4 indicated the nurse was called and the nurse recommended icing, elevating his foot and monitoring his foot. On 9/24/15 at 4:51 PM, staff #8 indicated she worked on 8/18/15 but did not go to the bowling alley with the group. Staff #8 indicated when the group arrived			

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	home, client E was limping. Staff #8 indicated she did not observe client E limping prior to going to the bowling alley. On 9/24/15 at 3:31 PM, a review of client E's records was conducted. The Daily Support Note documented by staff #4 for 8/18/15 from 4:00 PM to 10:00 PM at the group home indicated, "[Client E] had supper. Went for soda and bowling. Had snack and another staff brought to my attention a limp [client E] had. She noticed it when he came in to supper. She told me on (sic) way to bowling alley. We watch (sic) him walk. We took off his shoe, inspected foot on right side. Did not see any bruising but it got worse (limping) as he cont (continued) bowling. By the time we got home he could barely walk. After sitting at home (sic) didn't want to put any weight on it. Another staff looked when we arrived home and then saw bruising. It seemed to get worse as night went on. We iced it and he took ibuprofen. On call was called." On 9/25/15 at 11:16 AM, a review of client E's 8/18/15 Daily Support Record for the day program was conducted. The note indicated client E attended the day program from 8:30 AM to 3:30 PM. The note indicated, "[Client E] went recycling in AM (and) [client E] went recycling in PM (and) when time to			

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	load he got mad. The staff that he wanted was busy, he then was trying to hit peers (with) his book, so other staff got between him (and) peers (and) walked him to van. He dropped (sic) book when loading so staff brought it in. He left." A Medical Appointment Form, dated 8/19/15, indicated client E had a right, 5th metatarsal fracture. The form indicated client E had a closed fracture of metatarsal bone. Client E's Health Care Coordination/Monthly Health Review form, dated August 2015, indicated on 8/18/15 at 9:30 PM the nurse received a call from staff #11. The note indicated, "Received call from staff [#11] and told that [client E] has a bruise approx. (approximately) 3 (inches) (by) 3 (inches) on his outer right foot. Client was walking strangly (sic) and that is how it was found. Started while bowling, not sure if stepped wrong or what. Slight swelling. Told them to monitor tonight and see how he is doing in the morning." The nurse's note dated 8/19/15 (no time indicated) indicated, "Received message from PC stating that [client E] is not wanting to put full weight on right foot. Taking to walk in clinic for eval (evaluation). Told that [client E] does have a broken bone in his foot. PC will make appt. with Ortho for him."			

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	Client E's 7/22/15 Behavioral Support Plan indicated he had the following targeted behavior: low to moderate intensity physical aggression (may include: striking, pinching, biting, pulling hair, kicking, and/or other aggressive movements which are typically directed at others and can or do result in injury on infrequent occasions which may require basic first aid treatment), injurious to self (may include: striking, pinching, scratching, biting, kicking, etc. self in the head or other body parts, striking one's head or other body parts against walls, floors, furniture, or other surfaces, which can or does result in injury, or which may or repeatedly does require medical treatment. Intentional use of an object which repeatedly results in injury and/or requires medical treatment) and disruptive behavior (may include: refusing to leave, screaming/yelling, stomping feet, flailing arms, pounding tables, walls, and/or other aggressive movements which are NOT directed at others or destructive of property. If left unattended, these behaviors could lead to physical aggression or SIB (self-injurious behavior)). On 9/25/15 at 11:22 AM, day program staff #1 indicated client E was obsessed with a certain staff on 8/18/15 at the end			

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	of the day program hours. The staff was busy and told client E he had to wait. Client E was upset and started waving a notebook around trying to hit others. Staff #1 indicated she went outside with him to the van. Staff #1 indicated client E did not kick anything during his behavior. Staff #1 indicated day program staff #2, who transported client E home on 8/18/15 from the day program, indicated client E kicked things in the van during the trip to the group home. 2) On 9/14/15 at 3:00 PM at the facility-operated day program, client G walked past client F. Client F smacked client G on the buttocks. Client G told client F to stop it. Client F hit client G on the side of the head. Client F indicated he was playing around. The investigation, dated 9/18/15, indicated in the Conclusion, "Evidence supports staff intervened appropriately." The investigation did not indicate whether or not the facility substantiated client to client abuse. On 9/25/15 at 11:46 AM, the QAS indicated client to client aggression was considered abuse and the facility should prevent abuse. The QAS indicated the facility had a policy and procedure prohibiting abuse of the clients.			

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	On 9/28/15 at 1:51 PM, the PD indicated the investigation should indicate whether or not the incident occurred as described in the brief summary of the incident. The PD indicated she was instructed to not use the word "substantiated" during her training for conducting investigations. 3) On 7/21/15 at 4:00 PM at the facility-operated day program, clients B and H were getting into the group home van to go home from the day program. Client H hit client B in the middle of the back due to client B cutting in front of him to get onto the van. The investigation, dated 7/22/15, indicated in the Factual Findings section, "Findings show that staff intervened properly when incident occurred. Staff was near clients and [client H] hit [client B], she was there to intervene." On 9/25/15 at 11:46 AM, the QAS indicated client to client aggression was considered abuse and the facility should prevent abuse. The QAS indicated the facility had a policy and procedure prohibiting abuse of the clients. The facility's policy and procedures related to abuse, neglect, exploitation and injuries of unknown origin were reviewed on 9/24/15 at 11:55 AM. The facility's Quality and Risk Management policy dated April 2011 indicated, "Indiana MENTOR promotes a high quality of			

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	service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The policy indicated, in part, "Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee... Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident." The Human Rights policy, dated April 2011, indicated, "Any instances of abuse, neglect, exploitation, or violation of rights will be communicated to the appropriate local authorities, the legal representative, the administrator, identified as the Area Director for this purpose, and emergency contact designated by the individual in the ISP (individual support plan)." The July 2011 Indiana Mentor Internal Investigation Procedures Q (question) and A (answer) procedures indicated, in part, "What is the purpose of an investigation? An investigation determines the facts surrounding the incident. An investigation allows for all relevant information to be reviewed in order to ensure that appropriate actions are taken and recurring incidents are addressed to support the health and safety of our clients. An investigation allows Indiana Mentor to make changes in policy/procedures that will ensure Quality of services... What requires investigation? All incidents requiring a BDDS incident report will require some form of investigation. This includes all injuries, abuse, neglect, and exploitation such as: ...10. Injuries of unknown origin. 11. Significant injuries such as fractures, burns, choking, large contusions... Who is responsible for ensuring an investigation			

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	is completed? The Area Director is responsible for ensuring that an investigation is completed and findings submitted to him/her within 5 days, along with ensuring a written summary of those findings is completed... What do I do when I get contradictory information from interviewees? Follow-up on all contradictory information. This may (sic) done with additional interviews with the parties providing the information or through record review...." This federal tag relates to complaint #IN00180602. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 16 investigative reports reviewed affecting clients E, F and G, the facility failed to conduct thorough investigations of an injury of unknown origin to client E and two incidents of client to client abuse. Findings include: On 9/24/15 at 12:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:	W 0154	Program Directors (QIDP) will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation, determining any corrective action required and completing follow up as needed. Area Director and / or Regional Director will review all investigations upon completion to review for required (retrained) content.	10/29/2015

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	1) On 8/18/15 at 8:40 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/19/15, indicated, in part, "It was reported to PC (Program Coordinator), then reported to the PD (Program Director), that client [E] was limping on his foot and unable to put much pressure on it after he came back from bowling. In the morning, [client E] was walking much better on it, but program nurse said to go ahead and take him to the walk-in clinic. It was reported at 10:34 AM today (8/19/15) that [client E] does indeed have a broken bone in his foot. He is to be seen by an orthopedic dr (doctor) for a boot. An appt (appointment) is being made by PC. PC will take [client E] to Ortho (Orthopedic) doctor and follow dr orders." The investigation, dated 8/24/15, indicated in the Conclusion, "Based on the information gathered, there is evidence to support that [client E] likely hurt his foot kicking the underneath side of the seat in the van during a behavior on 8/18/15." The investigation indicated the List of Documents reviewed included client E's BDDS report dated 8/18/15 and Medical Appointment Forms dated 8/19/15 and 8/21/15. The interview with day program staff #2 in the investigation indicated day program staff #2 transported client E home from the day			

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	program on 8/18/15. Day program staff #2's statement in the investigation indicated, "[Staff #2] stated that he transported the clients home from the [name of the day program] on 8/18/15. [Staff #2] stated that [client E] was seated in the back seat of the van and was agitated. [Staff #2] stated that [client E] was kicking the underneath side of the seat. [Staff #2] stated that when he took the clients into the home, [client E] was kind of 'shuffling' his feet but didn't notice and (sic) problems and [client E] didn't make any complaints of pain." On 9/25/15 at 11:34 AM, the Quality Assurance Specialist (QAS) indicated after she sent the surveyor the investigation for client E's injury of unknown origin, day program staff #2 called her back on 9/24/15 for his interview for the investigation. The QAS indicated she had requested a copy of the investigation prior to the survey being opened and was told by the Program Director (PD) she could not locate the investigation. The QAS indicated on 9/24/15 when she was told the surveyor was at the facility, she asked the PD about the investigation for client E's injury of unknown origin. The QAS indicated the PD said she could not find the investigation. The QAS indicated on 9/24/15 she typed up the investigation			

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	given to the surveyor for review. The QAS indicated she took the information given to her by the PD and documented it in an investigation. The QAS indicated after she typed the report and sent it to the surveyor for review, day program staff #2 contacted her by phone for the investigation. The QAS indicated she did not interview staff #2 until after she wrote the investigation. The QAS indicated staff #2 told her client E kicked with his left foot and not his right foot. The QAS indicated staff #2 told her client E did not kick the seat. The QAS indicated she did not ask and staff #2 did not indicate client E was sitting behind the driver. The QAS indicated staff #2 did not observe client E to be injured. The QAS indicated she informed the PD of the PD's recollection of staff #2's interview and the QAS' interview with staff #2 on 9/24/15. The QAS indicated the investigation was not thorough. The QAS indicated additional day program staff should have been interviewed. The QAS indicated after interviewing staff #2, she was aware the information in the investigation was incorrect. The investigation was not thorough. The investigation did not include interviews with group home staff #4, #8 and #11 who worked on 8/18/15. The investigation did not include interviews,			

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	with the exception of day program staff #2, of the day program staff who worked with client E on 8/18/15. The investigation did not include documentation a review of client E's behavior documentation was conducted. The investigation did not include documentation a review of client E's Daily Support Records (DSRs) was conducted for the group home or the day program. The investigation did not include the information from the Daily Support Records from 8/18/15. The investigation was not revised after the Quality Assurance Specialist (QAS) interviewed day program staff #2 on 9/24/15, after completing the investigation, and became aware his interview included in the investigation was inaccurate. The investigation did not indicate group home staff #11 observed client E limping around dinner time while at the group home prior to going to the bowling alley. The investigation did not indicate the original investigation could not be located. The investigation indicated the dates of the investigation were 8/19/15, 8/21/15 and 8/24/15. The investigation did not indicate the date of completion as 9/24/15. The investigation indicated the Program Director (PD) completed the investigation. The QAS completed the investigation based on information obtained from the PD on			

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	9/24/15. There was no documentation the Area Director (administrator) received the results of the investigation within 5 working days. On 9/25/15 at 11:26 AM, day program staff #2 indicated he transported client E home on 8/18/15. Staff #2 indicated there was no additional staff in the van at the time. Staff #2 indicated client E was aggravated about something prior to the trip home and was chasing the day program manager around. Staff #2 indicated client E got into the van and sat directly behind him in the van. Staff #2 indicated client E was kicking his left foot in between the front seats but did not make contact with anything. Staff #2 indicated client E did not kick the driver's seat at anytime during the trip to his group home. Staff #2 indicated client E walked without issues after arriving to the group home. Staff #2 indicated he did not observe client E do anything that could have caused the injury. Staff #2 indicated he was interviewed for the investigation by the QAS on 9/24/15. On 9/24/15 at 3:19 PM, the Program Coordinator (PC) indicated she was aware of a behavior client E had while at the day program on 8/18/15 prior to being picked up to come home. The PC indicated day program staff #2 told her			

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	about the behavior client E had at the day program. Client E took client A's notebook and staff asked him to give it back. The PC stated client E had a "tantrum" at the day program. The PC indicated client E had behaviors in the van on the way to the group home. The PC indicated staff noticed he was shuffling his feet when he got to the group home. The PC indicated client E was noted to be limping at the bowling alley later in the evening. The PC indicated the staff who worked on 8/18/15 were staff #4, #8 and #11. On 9/25/15 at 11:49 AM, the Program Director (PD) indicated client E had a behavior regarding a pad of paper while at the facility-operated day program on 8/18/15. The PD indicated day program staff #2 told the PD that he thought client E kicked the seat in the van and broke his foot. The PD indicated day program staff #2 did not say client E kicked the seat just that he thought he might have kicked the seat. The PD indicated she could not recall who she interviewed for her investigation she was unable to locate. The PD indicated she told the QAS on 9/24/15 she could not find the notes or the investigation she completed. The PD indicated the QAS documented the investigation given to the surveyor. The PD indicated she did not send the QAS			

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	an investigation. The PD indicated she did not review client E's Daily Support Records for the investigation. The PD indicated the DSRs should have been reviewed. The PD indicated the staff at the group home should have been interviewed. The PD indicated she did not review the investigation the surveyor had regarding client E's injury of unknown origin. The PD indicated she did not know when the QAS wrote the investigation. On 9/25/15 at 12:51 PM, the Area Director (AD) indicated he reviewed the investigation regarding client E's injury of unknown origin in August 2015 after the PD completed the investigation. The AD indicated he did not have documentation of the original investigation completed by the PD. The AD indicated day program staff #2 said in the original investigation client E kicked the back of the seat in the van. The AD indicated he reviewed the Daily Support Record from the day program on 8/18/15. The AD indicated the note did not contain much information for a 7 hour day. The AD indicated the day program needed to document additional information in their notes. The AD indicated client E was first noted to be limping while he was at the bowling alley. The AD indicated the QAS typed			

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	up the investigation given to the surveyor for review on 9/24/15. The AD indicated the investigation was not thorough. The AD indicated the investigation should have included interviews with the staff, including day program staff, for the 24 hours preceding the injury of unknown origin being found. The AD indicated the investigation should have included a review of client E's daily support records and behavior tracking. The AD indicated the investigation the PD completed could not be located. The AD indicated the original investigation was completed within 5 working days. The AD indicated the investigation completed by the QAS on 9/24/15 should have been dated 9/24/15. The AD indicated the PD documented in her original investigation day program staff #2 said client E kicked the seat. The AD indicated he did not know how day program staff #2 would know which foot client E used to kick with since there was one staff in the van at the time. The AD stated, "How would [day program staff #2] know that?" The AD indicated the investigation did not include a sufficient amount of interviews with the staff who worked with client E. The AD stated, "What did they check out?" for the investigation. The AD indicated the facility needed to obtain additional information from day program staff #2 to clarify what occurred on the			

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	van. The AD stated the facility needed to "figure out" if day program staff #2 was giving accurate information or not. The AD indicated day program staff #2 may be talking about a different date. The AD indicated the investigation was not falsified. The AD indicated the dates were wrong in the QAS' investigation. The AD indicated the QAS used the PD's information, from word of mouth, to write the investigation on 9/24/15. On 9/24/15 at 3:23 PM, staff #4 indicated staff #11 noticed client E was limping around dinner time on 8/18/15. The group ate dinner and went to the gas station before bowling to get drinks. Staff #4 indicated staff #11 again noted client E was limping as he walked to the van after getting his drink at the gas station. Staff #4 indicated she noticed client E was limping at the bowling alley. Staff #4 indicated as the night went on his limping got worse and worse. Staff #4 indicated she checked his foot while at the bowling alley and did not see any bruising or issues with his foot. Staff #4 indicated when client E got home after bowling, staff #8 checked his foot and observed a bruise. Staff #4 indicated the nurse was called and the nurse recommended icing, elevating his foot and monitoring his foot.			

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	On 9/24/15 at 4:51 PM, staff #8 indicated she worked on 8/18/15 but did not go to the bowling alley with the group. Staff #8 indicated when the group arrived home, client E was limping. Staff #8 indicated she did not observe client E limping prior to going to the bowling alley. On 9/24/15 at 3:31 PM, a review of client E's records was conducted. The Daily Support Note documented by staff #4 for 8/18/15 from 4:00 PM to 10:00 PM at the group home indicated, "[Client E] had supper. Went for soda and bowling. Had snack and another staff brought to my attention a limp [client E] had. She noticed it when he came in to supper. She told me on (sic) way to bowling alley. We watch (sic) him walk. We took off his shoe, inspected foot on right side. Did not see any bruising but it got worse (limping) as he cont (continued) bowling. By the time we got home he could barely walk. After sitting at home (sic) didn't want to put any weight on it. Another staff looked when we arrived home and then saw bruising. It seemed to get worse as night went on. We iced it and he took ibuprofen. On call was called." On 9/25/15 at 11:16 AM, a review of client E's 8/18/15 Daily Support Record for the day program was conducted. The note indicated client E			

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	attended the day program from 8:30 AM to 3:30 PM. The note indicated, "[Client E] went recycling in AM (and) [client E] went recycling in PM (and) when time to load he got mad. The staff that he wanted was busy, he then was trying to hit peers (with) his book, so other staff got between him (and) peers (and) walked him to van. He dropped (sic) book when loading so staff brought it in. He left." A Medical Appointment Form, dated 8/19/15, indicated client E had a right, 5th metatarsal fracture. The form indicated client E had a closed fracture of metatarsal bone. Client E's Health Care Coordination/Monthly Health Review form, dated August 2015, indicated on 8/18/15 at 9:30 PM the nurse received a call from staff #11. The note indicated, "Received call from staff [#11] and told that [client E] has a bruise approx. (approximately) 3 (inches) (by) 3 (inches) on his outer right foot. Client was walking strangly (sic) and that is how it was found. Started while bowling, not sure if stepped wrong or what. Slight swelling. Told them to monitor tonight and see how he is doing in the morning." The nurse's note dated 8/19/15 (no time indicated) indicated, "Received message from PC stating that [client E] is not wanting to put full weight on right foot.			

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	Taking to walk in clinic for eval (evaluation). Told that [client E] does have a broken bone in his foot. PC will make appt. with Ortho for him." On 9/25/15 at 11:22 AM, day program staff #1 indicated client E was obsessed with a certain staff on 8/18/15 at the end of the day program hours. The staff was busy and told client E he had to wait. Client E was upset and started waving a notebook around trying to hit others. Staff #1 indicated she went outside with him to the van. Staff #1 indicated client E did not kick anything during his behavior. Staff #1 indicated day program staff #2, who transported client E home on 8/18/15 from the day program, indicated client E kicked things in the van during the trip to the group home. 2) On 9/14/15 at 3:00 PM at the facility-operated day program, client G walked past client F. Client F smacked client G on the buttocks. Client G told client F to stop it. Client F hit client G on the side of the head. Client F indicated he was playing around. The investigation, dated 9/18/15, indicated in the Conclusion, "Evidence supports staff intervened appropriately." The investigation indicated in the Recommendation/Corrective Measures to Prevent the Likelihood of Future			

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	15G394		09/29/2015

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	Occurrences section, "Staff remind clients that they should not be horseplaying. Someone could get hurt." The investigation did not indicate whether or not the facility substantiated client to client abuse. On 9/28/15 at 1:51 PM, the PD indicated the investigation should indicate whether or not the incident occurred as described in the brief summary of the incident. The PD indicated she was instructed to not use the word "substantiated" during her training for conducting investigations. This federal tag relates to complaint #IN00180602. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 16 incident/investigative reports reviewed affecting client E, the facility failed to ensure the results of the investigation were reported to the administrator within five working days of	W 0156	Program Directors (QIDP) will be retrained on submitting investigations so they can be reviewed by administrative staff within the required 5 working days and that appropriate corrective actions are implemented. Area Director will review with Program	10/29/2015

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	the incident. Findings include: On 9/24/15 at 12:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/18/15 at 8:40 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/19/15, indicated, in part, "It was reported to PC (Program Coordinator), then reported to the PD (Program Director), that client [E] was limping on his foot and unable to put much pressure on it after he came back from bowling. In the morning, [client E] was walking much better on it, but program nurse said to go ahead and take him to the walk-in clinic. It was reported at 10:34 AM today (8/19/15) that [client E] does indeed have a broken bone in his foot. He is to be seen by an orthopedic dr (doctor) for a boot. An appt (appointment) is being made by PC. PC will take [client E] to Ortho (Orthopedic) doctor and follow dr orders." The investigation, dated 8/24/15, indicated in the Conclusion, "Based on the information gathered, there is evidence to support that [client E] likely hurt his foot kicking the underneath side of the seat in the van during a behavior		Directors (QIDP) weekly all incidents to ensure that there are investigations as required, that they are completed timely, and they are reviewed for trends and patterns. Changes to plans will be made as necessary.	

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	on 8/18/15." The investigation indicated the List of Documents reviewed included client E's BDDS report dated 8/18/15 and Medical Appointment Forms dated 8/19/15 and 8/21/15. The interview with day program staff #2 in the investigation indicated day program staff #2 transported client E home from the day program on 8/18/15. Day program staff #2's statement in the investigation indicated, "[Staff #2] stated that he transported the clients home from the [name of the day program] on 8/18/15. [Staff #2] stated that [client E] was seated in the back seat of the van and was agitated. [Staff #2] stated that [client E] was kicking the underneath side of the seat. [Staff #2] stated that when he took the clients into the home, [client E] was kind of 'shuffling' his feet but didn't notice and (sic) problems and [client E] didn't make any complaints of pain." There was no documentation the investigation results were reviewed by the administrator within 5 working days. On 9/25/15 at 11:34 AM, the Quality Assurance Specialist (QAS) indicated after she sent the surveyor the investigation for client E's injury of unknown origin, day program staff #2 called her back on 9/24/15 for his interview for the investigation. The QAS indicated she had requested a copy of the			

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	investigation prior to the survey being opened and was told by the Program Director (PD) she could not locate the investigation. The QAS indicated on 9/24/15 when she was told the surveyor was at the facility, she asked the PD about the investigation for client E's injury of unknown origin. The QAS indicated the PD said she could not find the investigation. The QAS indicated on 9/24/15 she typed up the investigation given to the surveyor for review. The QAS indicated she took the information given to her by the PD and documented it in an investigation. The QAS indicated after she typed the report and sent it to the surveyor for review, day program staff #2 contacted her by phone for the investigation. The QAS indicated she did not interview staff #2 until after she wrote the investigation. The QAS indicated staff #2 told her client E kicked with his left foot and not his right foot. The QAS indicated staff #2 told her client E did not kick the seat. The QAS indicated she did not ask and staff #2 did not indicate client E was sitting behind the driver. The QAS indicated staff #2 did not observe client E to be injured. The QAS indicated she informed the PD of the PD's recollection of staff #2's interview and the QAS' interview with staff #2 on 9/24/15. The QAS indicated after interviewing staff #2, she was aware			

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	the information in the investigation was incorrect. The QAS indicated investigations should be completed within 5 working days. The investigation was not revised after the Quality Assurance Specialist (QAS) interviewed day program staff #2 on 9/24/15, after completing the investigation, and became aware his interview included in the investigation was inaccurate. The investigation did not indicate group home staff #11 observed client E limping around dinner time while at the group home prior to going to the bowling alley. The investigation did not indicate the original investigation could not be located. The investigation indicated the dates of the investigation were 8/19/15, 8/21/15 and 8/24/15. The investigation did not indicate the date of completion as 9/24/15. The investigation indicated the Program Director (PD) completed the investigation. The QAS completed the investigation based on information obtained from the PD on 9/24/15. There was no documentation the Area Director (administrator) received the results of the investigation within 5 working days. On 9/25/15 at 12:51 PM, the Area Director (AD) indicated he reviewed the investigation regarding client E's injury			

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	of unknown origin in August 2015 after the PD completed the investigation. The AD indicated he did not have documentation of the original investigation completed by the PD. The AD indicated the facility should complete investigations within 5 working days and the administrator should review the results of the investigations within 5 working days. The AD indicated the QAS typed up the investigation given to the surveyor for review on 9/24/15. The AD indicated the investigation completed by the QAS on 9/24/15 should have been dated 9/24/15. The AD indicated the dates were wrong in the QAS' investigation. The AD indicated the QAS used the PD's information, from word of mouth, to write the investigation on 9/24/15. This federal tag relates to complaint #IN00180602. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 16 incident/investigative reports reviewed affecting client E, the facility	W 0157	Program Directors (QIDP) will be retrained on submitting investigations so they can be	10/29/2015

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	failed to implement appropriate corrective actions following the discovery of client E's injury of unknown origin. Findings include: On 9/24/15 at 12:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/18/15 at 8:40 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/19/15, indicated, in part, "It was reported to PC (Program Coordinator), then reported to the PD (Program Director), that client [E] was limping on his foot and unable to put much pressure on it after he came back from bowling. In the morning, [client E] was walking much better on it, but program nurse said to go ahead and take him to the walk-in clinic. It was reported at 10:34 AM today (8/19/15) that [client E] does indeed have a broken bone in his foot. He is to be seen by an orthopedic dr (doctor) for a boot. An appt (appointment) is being made by PC. PC will take [client E] to Ortho (Orthopedic) doctor and follow dr orders." The investigation, dated 8/24/15, indicated in the Conclusion, "Based on the information gathered, there is		reviewed by administrative staff within the required 5 working days and that appropriate corrective actions are implemented. Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that there are investigations as required, that they are completed timely, and they are reviewed for trends and patterns. Changes to plans will be made as necessary.	

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	evidence to support that [client E] likely hurt his foot kicking the underneath side of the seat in the van during a behavior on 8/18/15." The investigation indicated the List of Documents reviewed included client E's BDDS report dated 8/18/15 and Medical Appointment Forms dated 8/19/15 and 8/21/15. The interview with day program staff #2 in the investigation indicated day program staff #2 transported client E home from the day program on 8/18/15. Day program staff #2's statement in the investigation indicated, "[Staff #2] stated that he transported the clients home from the [name of the day program] on 8/18/15. [Staff #2] stated that [client E] was seated in the back seat of the van and was agitated. [Staff #2] stated that [client E] was kicking the underneath side of the seat. [Staff #2] stated that when he took the clients into the home, [client E] was kind of 'shuffling' his feet but didn't notice and (sic) problems and [client E] didn't make any complaints of pain." There was no documentation the investigation results were reviewed by the administrator within 5 working days. There was no documentation the facility recommended or implemented corrective actions following the discovery of client E's injury. A Medical Appointment Form, dated			

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	8/19/15, indicated client E had a right, 5th metatarsal fracture. The form indicated client E had a closed fracture of metatarsal bone. Client E's Health Care Coordination/Monthly Health Review form, dated August 2015, indicated on 8/18/15 at 9:30 PM the nurse received a call from staff #11. The note indicated, "Received call from staff [#11] and told that [client E] has a bruise approx. (approximately) 3 (inches) (by) 3 (inches) on his outer right foot. Client was walking strangly (sic) and that is how it was found. Started while bowling, not sure if stepped wrong or what. Slight swelling. Told them to monitor tonight and see how he is doing in the morning." The nurse's note dated 8/19/15 (no time indicated) indicated, "Received message from PC stating that [client E] is not wanting to put full weight on right foot. Taking to walk in clinic for eval (evaluation). Told that [client E] does have a broken bone in his foot. PC will make appt. with Ortho for him." On 9/28/15 at 1:51 PM, the Program Director (PD) indicated she did not recommend or implement corrective actions after the facility discovered client E had an injury of unknown origin. This federal tag relates to complaint #IN00180602.			

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	9-3-2(a)			
W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1(a) Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 15. A fall resulting in injury, regardless of the severity of the injury. This state rule was not met as evidenced by: Based on record review and interview for 1 of 16 incident reports reviewed affecting client C, the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law, a fall resulting	W 9999	In review of documentation submitted to surveyor, at the time of the survey, a BDDS report for 7/17/15 was in the information reviewed and submitted timely on the day of the incident.	10/29/2015

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	in injury to client C. Findings include On 9/24/15 at 12:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the facility did not have a BDDS incident report for a fall for client C on 7/17/15. On 9/25/15 at 3:01 PM, a review of client C's Health Care Coordination/Monthly Health Review, dated July 2015, was conducted. The note indicated, in part, "7/17/15 (no time indicated) - ...[client C] did fall while getting out of the vehicle. He obtained a scrape on his right elbow, a scrape on his right eye, and (sic) small scrape on his left wrist. First aid was applied." There was no documentation given for review indicating the facility submitted a BDDS report for client C's fall with injury. On 9/28/15 at 1:51 PM, the Program Director (PD) indicated client C's fall with injury should have been reported to BDDS. The PD indicated she was not aware of the fall with injury involving client C. 9-3-1(b)			

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