STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	4100 DECKARD DR BLOOMINGTON, IN 47408

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W000000	This visit was for a fundamental recertification and state licensure survey. Survey Dates: November 6, 7, 8 and 12, 2013. Facility Number: 001209 Provider Number: 15G634 AIM Number: 100240160 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/18/13 by Ruth Shackelford, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview, the governing body failed to exercise operating direction over the facility by failing to follow the state process for transferring clients #2 and #6 from one facility-operated group home to another.	W000104	Deficiency ID: W104 The Supervised Group Living (SGL) Director who moved clients without approval from BDDS was suspended on 10/9/13 and terminated on 10/10/13. An interim director was hired on 10/11/13. A permanent SGL Director was hired on 11/18/13. Plan of Correction: The SGL	11/20/2013

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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	Findings include: On 11/8/13 at 12:04 PM, the Bureau of Developmental Disabilities Services (BDDS) Regional Manager (RM) indicated the group home did not have permission to move clients #2 and #6 (they switched placements at the other's group home). The RM indicated BDDS did not approve the move. The BDDS RM indicated the facility moved clients #2 and #6 without approval or permission from BDDS. The facility was unable to provide documentation indicating BDDS approved of the moves for clients #2 and #6. A review of client #2's record was conducted on 11/7/13 at 9:36 AM. There was no documentation in client #2's record indicating BDDS approved for him to be moved to another group home. A review of client #6's record was conducted on 11/7/13 at 9:40 AM. There was no documentation in client #6's record indicating BDDS approved for him to move to this group home. On 11/7/13 at 12:11 PM, the group home Coordinator indicated clients #2		Director will be trained on IFC/DD state and federal regulations and on state reporting procedures, will be mentored by former SGL Director for the next six months or longer if needed. Clients #2 and #6 received authorization from BDDS to switch placements on 11/20/13. The BDDS Coordinator conducted a transition meeting on 11/20/13 which included site visit of the facility. The BDDS Coordinator was satisfied with condition of the facility. BDDS Coordinator reported to SGL Director that RFPs for clients #2 and #6 will be dated 10/9/13.	

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	and #6 switched placements at their group homes on 10/7/13. The Coordinator indicated there was no documentation from BDDS approving of the moves for clients #2 and #6. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS did not approve of the transfer of clients #2 and #6. 9-3-1(a)			
W000149	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 13 of 77 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, client neglect, conduct investigations of abuse and neglect, and report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. Findings include: A review of the facility's incident/investigative reports was	W000149	Deficiency ID: W149 Plan of Correction: The agency has implemented a new internal incident reporting system designed to address various failures in implementing the agency's procedures on reporting and investigation allegation A/N/E. The process included the following steps: The written incident report is submitted within 24 hours (or immediately if it contains an allegation A/N/E) to a designated administrative staff. The staff enters the incident into the electronic system, attaches required follow up/investigative forms, completes a BDDS report if indicated, notifies a supervisor if	12/06/2013

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	conducted on 11/6/13 at 11:16 AM and indicated the following: 1) On 11/4/13 "during DP (day program) in afternoon" client #4 had a video of his girlfriend on his electronic device. His girlfriend exposed her genitalia on the video. On 11/5/13 at 3:30 PM at the facility-operated day program, a female peer was touching client #4's genitalia on the outside of his clothes. On 11/5/13 at 3:40 PM, a female peer was masturbating client #4 at the facility-operated day program. There was no documentation the incidents were reported to BDDS. The Social Work Progress Notes, not dated, indicated, "Problem: Two reports of sexual acting out occurred between [female peer] and [client #4]. Incident being reviewed per Stone Belt policy. Activity: [Name of Social Worker (SW)] spoke with [female peer] about the incident and [Name of Behavior Specialist (BS)] spoke with [client #4]. Response: SW met with [female peer] on 11/5/13 regarding the incident that occurred on 9/4 (should be 11/4/13). [Female peer] reported that she was in room 100 with [client #4] and he had asked her to take photos/videos of her 'boobs, touching herself and peeing.'		indicated and sends an electronic copy of the report to the facility support team. Each member of the support team reads, reviews, documents actions taken and signs the report. The report requires the review and signature of the director before the report is electronically files. Facility staff will receive additional training on incident reporting procedures. To be competed by 12/6/13. Plan of Prevention: The implementation of an electronic system to deliver reports quickly to multiple members of the support team. The department will arrange for staff training in incident reporting and investigations from an outside expert. Per agency policy, sexual acting out is not a State reportable incident. During the clinical assessment, if it is found that the incident meets criteria of sexual abuse, a new incident report will be written and reported to the appropriate agencies and law enforcement authorities, as needed, and agency procedures followed. Quality Assurance Monitoring: The group home internal audit will be revised to reflect all of the required elements of an incident report. The QA team process will be revised to include a review of all ISDH surveys; a review and report of all SGL A/N/E investigations by third party QA team member and the QA team will recommend and monitor corrective actions.	

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	She reported that she wanted to take the photos for him. She did not know why he wanted them and did not ask. She reported that [client #4] said he would put it on his computer and promised not to put them on FaceBook. She reported that (she) had his iPod in her pocket and took it into the restroom two times, during her scheduled cath (catheter) times. She reported that in the moment it seemed like a good idea. She reported that is (sic) was good because he loved her and that it made her feel special. She reported that she just wants someone to love her for her. She reported that staff was in the room but she didn't think they heard what her and [client #4] were saying. She reported that they were listening to music on the iPod during the day and she just put it in her pocket. She reported that she did not feel any pressure from [client #4] to take the photos. [Female peer] reported that she showed the photo of her touching herself to a female friend while in the cafeteria (holding the iPod under the table). She reported [client #4] was present at the time. She reported that her friend said, 'that is very private.' SW met with [female peer] on 11/6 to discuss the 11/5 incident. [Female peer] reported that she 'wanted in his pants and wanted to hold his penis.' She			

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	reported that they were sitting together in room 100 when [client #4] nudged her and said, 'down' while leaning back and looking at his privates. She reported that she looked around to make sure staff weren't looking and she put her hand down his pants and 'squeezed his penis.' She reported that when staff looked toward them, she would take her hand out of his pants and wait until they turned their back again before putting her hand in his pants again. [Female peer] reported this happened three or four times through out the day on Tuesday. [Female peer] reported that this started happening on 11/4/13. She reported that she leaned over to [client #4] on Monday and said, 'touch me.' She reported that [client #4] put his hands down her pants three times on Monday. She reported that maybe one time he had his hand inside her briefs and two times he put his hand on the outside of her clothes on her private area. She reported that this made her feel 'special good.' She reported that she asked him on Tuesday to touch her one time and it was inside her briefs. She reported this made her feel 'special good.' [Female peer] reported that staff, [name of staff], 'caught' them one time on Tuesday and told them to put their hands on the table.			

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	SW reviewed the inappropriateness of her choices, the dangers of giving private pictures of herself to another person, the need for her guardian to give permission for people to have any pictures of her. Per [name of client #4's BC]: I spoke with [client #4] yesterday at about 6:00 (sic) at [name of group home]. I asked him if he would tell me what had happened with [female peer]. He said that '[female peer] played with my d--- and I played with hers.' I asked where this had happened. He said in day program and that it had happened more than once in the past week. He said that they had planned it on the phone. When asked if it was a good choice or a bad choice, he said 'Both.' When asked what made it a good choice, he started talking about how he and [female peer] are engaged and that he wants to have sex with her, and that he should be able to have sex with her. When asked what made it a bad choice, he said it was in the classroom. We discussed appropriate places for intimacy. I then asked him about the pictures and videos. He admitted to doing this. He said he wanted to make a DVD for himself and that is why he was loading it on his computer. He then went into the discussion about how he and [female			

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	peer] are engaged and that he wants to have sex with her. I asked him if he had been trying to put it on facebook. He said no. I asked him if he understood that [female peer] needed her mom's permission and while he said yes, he knew [female peer] had a guardian, he then said they were engaged and he should be able to have sex with her. I tried to talk with him about how disrespectful it was to put nude pictures of your girlfriend on the internet, but by this time he was done talking with me and just wanted me to stop talking with him. So, I explained to him the consequences of his actions as we had discussed. He was a little hostile by this time, not wanting to talk about it any more, but none the less agreed to the restrictions. SW spoke with [name of staff]. She reported that there were no issues for the majority of the day. She reported that when the lead instructor was out of the room for the afternoon, [female peer] and [client #4] attempted to seclude themselves from classroom activities a little. She reported that when she saw the touching, she redirected both clients and they complied without argument. Conclusion: It appears that both clients were willing participants in both incidents. It appears that both clients			

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	knew the behavior was not appropriate for a public place. It appears that both clients took measures to make sure staff were unaware of what was happening in the classroom and restroom. Plan: [Stone Belt] staff that support both clients met on 11/4/13. It was determined that the clients should be separated during program time at day program, they could have lunch together only if supervised by staff in 2:1 ratio, if available. The photos/videos were discovered by staff on 11/4/13. Immediate restriction was put in place of removing [client #4's] iPod and computer. SW, [name of SW] worked with IT (information technology) staff to ensure the pictures/videos were permanently deleted from the iPod and computer. It was confirmed that the photos/videos were not posted on FaceBook. [Client #4's] team met to discuss further restrictions: iPod not to leave the house, his internet time will be supervised by staff, incidents of sexual acting out in the future will result in a suspension of no more than three days. [Female peer's] guardian was notified, no requests/recommendations from guardian at this time. SW was given permission to complete further assessment with [female peer] on capacity to consent. Teams will			

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	continue to monitor and assess need for further education and potential changes to plans." On 11/8/13 at 10:39 AM, the interim Director indicated the facility was trying to allow the clients to be human beings, learn how to interact, and be partners (boyfriend and girlfriend). The Director indicated the facility needed to assess the clients' cognitive and developmental functions. The Director indicated the facility would look to see how aggressive, forceful, if threats were used, secret keeping, bribery, coercion and monetary rewards were offered to keep the incident a secret. The Director indicated the clients needed to receive training about appropriate interactions. The Director indicated sexual acting out was not reported to BDDS due to it not being a reportable incident since it was not considered sexual abuse. The Director indicated the facility's clinical staff assess and determine if it was sexual abuse or sexual acting out. 2) On 10/27/13 at 8:10 PM, client #2 was asked by a male peer at another group home to leave his bedroom. Client #2 became upset and threw papers and binders on the floor. Client #2 threw a light bulb against a wall and pulled a bulletin board off the wall. On			

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	10/28/13, client #2 reported to staff that his shoulder hurt and he was icing his wrist. He told the staff while he was in the peer's room on 10/27/13, the peer pulled his wrist and pulled on his upper arm which also pulled his shoulder in an effort to get him to leave his room. The incident was reported to BDDS on 10/30/13. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports were to be submitted within 24 hours. 3) On 10/7/13 at 10:00 PM, client #6 reported the overnight staff (#8) was not cleaning. Client #6 reported the incident on 10/15/13. Client #6 indicated staff #8 was working while wearing headphones. Client #6 reported staff #8 slept on the couch. In staff #8's interview included in the investigation, staff #8 indicated, "When asked if he ever fell asleep on during (sic) the night that he indicated that he never slept, but if he would ever have dosed (sic) off he would have heard any clients who were up." The investigation, dated 10/17/13, indicated, in part, in the Findings section, "Inconclusive (the information			

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	from sources examined is incomplete and/or contradictory. It is not conclusive whether or not the rights of [client #6] have been violated due to inappropriate services; it comes down to staff's word against the client's. There is a discrepancy in the evidence as to whether [staff #8] was asleep while on night shift at [name of group home]. He claims not but [client #6] describes two situations in which he perceived [staff #8] to be sleeping during the night: on the couch in the living room and in a chair in the office. In both instances he indicated [staff #8] was wearing headphones, which was corroborated by [staff #8] who reported that he listens to books on his iPod. [Staff #8] claims that the alarm on [client #6's] door would alert him if [client #6] left his room." 4) On 10/12/13 at 12:00 PM, client #1 did not have a bowel movement for 5 days. The BDDS report, dated 10/14/13, indicated, "Per [client #1's] risk plan (for constipation), if [client #1] does not have a bowl (sic) movement in for (sic) three days, he is to be administered 6.5 oz (ounces) of Magnesium Citrate. If he does not have a bowl (sic) movement after 5 days, he is to be administered an enema. After a period of 5 days without a bowl (sic) movement, staff failed to administer both the Magnesium Citrate			

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	and the enema." There was no investigation of the neglect to provide the as needed medications. On 11/7/13 at 12:11 PM, the Coordinator indicated the facility did not conduct an investigation. The Coordinator indicated the facility narrowed the issue down to two staff and they received corrective action. 5) On 9/22/13 at 6:00 PM, the BDDS report, dated 9/24/13, indicated, "[client #2] could not pack what he wanted for lunch. Staff advised him that it was in his best interest to take 2 cheeseburgers for lunch. His roommates reported hearing the door close and noticed that he was gone. Staff went looking for him. He was found walking back to [name of group home]. Staff explained that it was okay to walk away from an uncomfortable situation however it was unacceptable to walk outside of the house without staff supervision." There was no investigation into the incident. There was no documentation indicating where the staff located client #2. The BDDS report did not indicate how long client #2 was gone. On 11/7/13 at 12:11 PM, the Coordinator indicated the facility should have conducted an investigation.			

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	6) On 8/25/13 at 2:00 PM, client #5 was struck on the shoulder by client #3. Client #3 was not injured. There was no documentation the facility conducted an investigation. On 11/7/13 at 12:11 PM, the Coordinator indicated the facility should have conducted an investigation. The Coordinator indicated the staff should prevent client to client abuse. The Coordinator indicated client to client abuse was preventable. 7) On 8/15/13, a female peer of client #2's reported to the Social Worker that on either Monday (8/12/13) or Tuesday (8/13/13) that week, client #2 was talking to her about wanting her to be his girlfriend. The note indicated, "She stated that he then kissed her on the forehead and rubbed the top of her head with his hand. She stated that she told him she did not feel comfortable with the touches. He then attempted to put his hand down her shirt. She stated she caught his hand before he touched her breast and told him that she did not feel comfortable with that kind of touch. She stated that [client #2] stopped attempting to touch her." The note indicated, "The finding by the social worker is that this was a substantiated			

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	incident of sexual acting out. The two individuals appeared to have discussed the inappropriate behaviors and have agreed to not allow this to happen." The incident was not reported to BDDS. On 11/8/13 at 10:39 AM, the interim Director indicated the facility was trying to allow the clients to be human beings, learn how to interact, and be partners (boyfriend and girlfriend). The Director indicated the facility needed to assess the clients' cognitive and developmental functions. The Director indicated the facility would look to see how aggressive, forceful, if threats were used, secret keeping, bribery, coercion and monetary rewards were offered to keep the incident a secret. The Director indicated the clients needed to receive training about appropriate interactions. The Director indicated sexual acting out was not reported to BDDS due to not being a reportable incident since it was not considered sexual abuse. The Director indicated the facility's clinical staff assess and determine if it was sexual abuse or sexual acting out. 8) On 7/20/13 at 7:00 PM (reported to BDDS on 7/23/13), client #5 was prompted to clean his room. Client #5 ignored the requests and went to the kitchen where he attempted to slap a			

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	housemate. Staff placed client #5 in a bearhug for 1 minute and escorted client #5 to the hallway. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports were to be submitted within 24 hours. 9) On 7/11/13 at 9:00 PM, client #4 was sitting in the backyard after being physically aggressive toward staff. The BDDS report, dated 7/12/13, indicated, "Staff was alerted that [client #4] had moved to the front yard. Staff went out to check on [client #4] and he was nowhere to be found. Staff contacted the house manager, who advised calling the police. As staff were out looking for [client #4], another Stone Belt group home nearby contacted [client #4's] house and informed staff that he had gone there." The facility did not conduct an investigation. On 11/7/13 at 12:11 PM, the Coordinator indicated the incident was not investigated. The Coordinator indicated he was not asked to investigate the incident. He indicated the incident should have been investigated.			

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	On 11/8/13 at 10:39 AM, the interim Director indicated the incident should have been investigated. 10) On 6/28/13 client #1 was observed alone in a locked car at a gas station. The investigation, dated 7/5/13, indicated neglect was substantiated (the findings support the event as described). The investigation indicated, in part, "The allegation of client neglect is substantiated for this incident. The statements of the staff and the community witness are consistent in that the client was alone in the staff car for 2-6 minutes unsupervised. The staff chose to leave him sitting in the car as she obtained drinks in the store, rather than have him accompany her. Due to the client's BSP (behavior support plan) that indicates that he is not to be out of arm's length of his 1:1 staff in the community, his seizure risk plan that indicates 911 is to be called if his seizure lasts longer than 5 minutes, and the fact that the day was hot, in the high 80's and the windows were cracked 2 inches this incident meets the criteria for the Stone Belt definition of Neglect: Neglect: Any action or behavioral interventions that risks the physical or emotional safety and well being of an individual, and results in a potentially			

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	dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party." 11) On 6/14/13 at 5:30 PM, the BDDS report, dated 6/16/13, indicated staff heard client #3 call for help from his bedroom. Staff entered to find that client #5 had pinned client #3 to his bed and was punching his body. Staff told client #5 to get off client #3. Client #5 got off client #3. The investigation (Client to Client Aggression Inquiry) was completed on 6/26/13 and reviewed by the administrator on 6/30/13. On 11/8/13 at 10:39 AM, the interim Director indicated investigations should be conducted within 5 business days. The Director indicated BDDS reports should be submitted within 24 hours. 12) On 6/13/13 at 3:30 PM, client #4 went up to a female peer at the facility-operated day program, bent over and kissed her on the lips without asking. Client #4 then asked the peer if he could touch her breasts. Client #4 attempted to touch her breast with his open hand but she blocked his hand with her hand. The Social Work Progress Note, not dated, indicated, in part, "He did not actually touch her breast, but touched her hand which was shielding			

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	her breast. She stated that she was frustrated that he would do such a thing." The female peer reported the incident to a housemate but neither client reported the incident to staff. The housemate reported the incident to the SW on 6/20/13. The SW wrote an incident report and notified client #4's team. The SW interviewed client #4 on 6/21/13 and he denied the allegation. The Social Work Progress Note indicated, "The finding for this incident is inconclusive in that the only witness to the event denies that there was any touching which occurred of a sexual nature. It is determined by the social worker that [female peer] acted in an appropriately assertive manner, given that she thought that [client #4] was attempting to touch her inappropriately. He did not actually touch her breast, but was blocked by [female peer's] assertive action. Social Worker will consult with [client #4's] psychologist concerning this event." There was no documentation the incident was reported to BDDS. On 11/8/13 at 10:39 AM, the interim Director indicated the facility was trying to allow the clients to be human beings, learn how to interact, and be partners (boyfriend and girlfriend). The Director indicated the facility needed to assess the clients' cognitive and developmental			

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	functions. The Director indicated the facility would look to see how aggressive, forceful, if threats were used, secret keeping, bribery, coercion and monetary rewards were offered to keep the incident a secret. The Director indicated the clients needed to receive training about appropriate interactions. The Director indicated sexual acting out was not reported to BDDS due to not being a reportable incident since it was not considered sexual abuse. The Director indicated the facility's clinical staff assess and determine if it was sexual abuse or sexual acting out. 13) According to the Stone Belt Incident Report, dated 6/21/13, on 6/12/13, client #2 left his bedroom at night after going to bed and the motion alarms were set. Client #2's bedroom alarm went off however staff #8 did not hear the alarm. Client #2 went into client #4's room. Clients #2 and #4 watched movies on client #4's computer and looked at his adult magazines. Client #4 touched client #2's leg, stomach and tried to touch his genitals. This was reported to the home manager and the social worker on 6/14/13 by client #2. The action taken section indicated, "[SW] is going to talk to [client #4] about appropriate ways to release sexual frustrations; this is a			

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	continued on going conversation. [SW] talked to all parties involved and has concluded that is not an instance of sexual abuse only sexual acting out." The Social Work Progress Note, not dated, indicated, in part, "[Client #2] told [SW] on 6/12/13 during her routine visit at the house that he did not want to live at [name of group home] anymore and that he wanted to move to [name of another group home]. I asked [client #2] why he wanted to live at [name of group home] and he said he was mad at [client #3] for cussing at him, and at [client #4] for trying to touch her (sic) privates. I told him that I had read about [client #3] being angry and cussing at him on Forums (staff communication), but I did not know about [client #4] trying to touch him on his privates. I knew that this had happened several months ago, but I thought it had stopped since staff was now listening for the alarms and that the guys were not going into each others (sic) rooms. [Client #2] stated that a couple of weeks previously he had been in [client #4's] rooms (sic) watching video on [client #4's] computer, it seemed that they might have been watching explicit movies. I asked why staff had not responded to the alarms on [client #2's] door when he left his room and when he opened the door to [client #4's] room. [Client #2] stated			

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	that the alarms did go off, but staff was cleaning and did not hear them. [Client #2] stated that [client #4] was also showing him his Playboy magazines and they were in [client #4's] bed. I asked what happened? [Client #2] stated that [client #4] was touching his head and his belly and then tried to touch his private area with his hand over [client #2's] clothing and under his clothes. [Client #2] said that he liked the touching on his head, and belly but he did not like being touched on his private area and he told [client #4] to stop it. [Client #4] did stop." The incident was not reported to BDDS. On 11/8/13 at 10:39 AM, the interim Director indicated the facility was trying to allow the clients to be human beings, learn how to interact, and be partners. The Director indicated the facility needed to assess the clients' cognitive and developmental functions. The Director indicated the facility would look to see how aggressive, forceful, if threats were used, secret keeping, bribery, coercion and monetary rewards were offered to keep the incident a secret. The Director indicated the clients needed to receive training about appropriate interactions. The Director indicated sexual acting out was not reported to BDDS due to not being a			

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	reportable incident since it was not considered sexual abuse. The Director indicated the facility's clinical staff assess and determine if it was sexual abuse or sexual acting out. A review of the facility's abuse and neglect policy, dated September 2013, was conducted on 11/12/13 at 11:37 AM. The policy indicated, "Abuse and neglect are never acceptable. 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." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file			

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	of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a client, parent/guardian, advocate, staff member, or other involved party." The policy indicated, in part, "Sexual abuse: Consists of any intentional inappropriate sexual behavior where an individual suffers emotional/psychological harm or trauma, to include touch of sexual genitalia, areas of the body considered private such as the breasts and buttocks, This also includes: 1. Touching self in a sexual way with an unwilling audience. 2. Nonconsensual sexual activity or touching. 3. Sexual molestation. 4. Sexual coercion. 5. Sexual exploitation. 6. Sexual abuse should not be confused with sexual acting out, which may involve inappropriate sexual behavior, such as vulgar sexual language, touching self, sexual advances towards another without intent to harm or injure another. Sexual acting out may also include consensual sexual acts between clients who both have the capacity to give consent, but where choice of timing, place or other factor determines the act to be inappropriate. Cognitive			

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	competence as well as the developmental and emotional stage of the client initiating the sexual behavior will be assessed by professionals." 9-3-2(a)			
W000153	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 9 of 77 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, and #5, the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. Findings include: A review of the facility's incident/investigative reports was conducted on 11/6/13 at 11:16 AM and indicated the following: 1) On 11/4/13 "during DP (day program) in afternoon" client #4 had a	W000153	Deficiency W 153Plan of Correction: Facility staff have will be retrained on 12/6/13 on all aspects of incident reporting including what constitutes an incident, timelines including reporting to the administrator immediately and to the state agency within 24 hours of a reportable condition. The facility has also reorganized the home management system to include more coordination (Q) positions in order to increase client support, staff training and supervision, facility monitoring and compliance with incident reporting and investigation. Plan of Prevention: The facility has developed a new electronic incident reporting system to ensure that all allegations of mistreatment,	12/06/2013

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	video of his girlfriend on his electronic device. His girlfriend exposed her genitalia on the video. On 11/5/13 at 3:30 PM at the facility-operated day program, a female peer was touching client #4's genitalia on the outside of his clothes. On 11/5/13 at 3:40 PM, a female peer was masturbating client #4 at the facility-operated day program. There was no documentation the incidents were reported to BDDS. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports were to be submitted within 24 hours. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports should be submitted within 24 hours. The Director indicated sexual acting out was not reported to BDDS due to not being a reportable incident since it was not considered sexual abuse. The Director indicated the facility's clinical staff assess and determine if it was sexual abuse or sexual acting out. 2) On 10/27/13 at 8:10 PM, client #2 was asked by a male peer at another group home to leave his bedroom. Client #2 became upset and threw		abuse, neglect and injuries of unknown source are reported immediately to the administrator or designated staff in accordance with state law. The department will arrange for staff training in incident reporting and investigations form an outside expert. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA member including failure to comply with state law regarding A/N/E reports and the QA team will recommend and monitor corrective actions.	

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	papers and binders on the floor. Client #2 threw a light bulb against a wall and pulled a bulletin board off the wall. On 10/28/13, client #2 reported to staff that his shoulder hurt and he was icing his wrist. He told the staff while he was in the peer's room on 10/27/13, the peer pulled his wrist and pulled on his upper arm which also pulled his shoulder in an effort to get him to leave his room. The incident was reported to BDDS on 10/30/13. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports were to be submitted within 24 hours. 3) On 10/12/13 at 12:00 PM, client #1 did not have a bowel movement for 5 days. The BDDS report, dated 10/14/13, indicated, "Per [client #1's] risk plan (for constipation), if [client #1] does not have a bowl (sic) movement in for (sic) three days, he is to be administered 6.5 oz (ounces) of Magnesium Citrate. If he does not have a bowl (sic) movement after 5 days, he is to be administered an enema. After a period of 5 days without a bowl (sic) movement, staff failed to administer both the Magnesium Citrate			

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	and the enema." The BDDS report was not submitted within 24 hours. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports were to be submitted within 24 hours. 4) On 9/22/13 at 6:00 PM, the BDDS report, dated 9/24/13, indicated, "[client #2] could not pack what he wanted for lunch. Staff advised him that it was in his best interest to take 2 cheeseburgers for lunch. His roommates reported hearing the door close and noticed that he was gone. Staff went looking for him. He was found walking back to [name of group home]. Staff explained that it was okay to walk away from an uncomfortable situation however it was unacceptable to walk outside of the house without staff supervision." There was no documentation indicating where the staff located client #2. The BDDS report did not indicate how long client #2 was gone. The BDDS report was not submitted within 24 hours. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours.			

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	On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports were to be submitted within 24 hours. 5) On 8/15/13, a female peer of client #2's reported to the Social Worker that on either Monday (8/12/13) or Tuesday (8/13/13) that week, client #2 was talking to her about wanting her to be his girlfriend. The note indicated, "She stated that he then kissed her on the forehead and rubbed the top of her head with his hand. She stated that she told him she did not feel comfortable with the touches. He then attempted to put his hand down her shirt. She stated she caught his hand before he touched her breast and told him that she did not feel comfortable with that kind of touch. She stated that [client #2] stopped attempting to touch her." The note indicated, "The finding by the social worker is that this was a substantiated incident of sexual acting out. The two individuals appeared to have discussed the inappropriate behaviors and have agreed to not allow this to happen." The incident was not reported to BDDS. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports should be submitted within 24 hours. The Director indicated sexual acting out was			

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	not reported to BDDS due to not being a reportable incident since it was not considered sexual abuse. The Director indicated the facility's clinical staff assess and determine if it was sexual abuse or sexual acting out. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. 6) On 7/20/13 at 7:00 PM (reported to BDDS on 7/23/13), client #5 was prompted to clean his room. Client #5 ignored the requests and went to the kitchen where he attempted to slap a housemate. Staff placed client #5 in a bearhug for 1 minute and escorted client #5 to the hallway. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports were to be submitted within 24 hours. 7) On 6/14/13 at 5:30 PM, the BDDS report, dated 6/16/13, indicated staff heard client #3 call for help from his bedroom. Staff entered to find that client #5 had pinned client #3 to his bed and was punching his body. Staff told			

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	client #5 to get off client #3. Client #5 got off client #3. The investigation (Client to Client Aggression Inquiry) was completed on 6/26/13 and reviewed by the administrator on 6/30/13. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports should be submitted within 24 hours. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. 8) On 6/13/13 at 3:30 PM, client #4 went up to a female peer at the facility-operated day program, bent over and kissed her on the lips without asking. Client #4 then asked the peer if he could touch her breasts. Client #4 attempted to touch her breast with his open hand but she blocked his hand with her hand. The Social Work Progress Note, not dated, indicated, in part, "He did not actually touch her breast, but touched her hand which was shielding her breast. She stated that she was frustrated that he would do such a thing." The female peer reported the incident to a housemate but neither client reported the incident to staff. The housemate reported the incident to the SW on 6/20/13. The SW wrote an incident report and notified client #4's			

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	team. The SW interviewed client #4 on 6/21/13 and he denied the allegation. There was no documentation the incident was reported to BDDS. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports should be submitted within 24 hours. The Director indicated sexual acting out was not reported to BDDS due to not being a reportable incident since it was not considered sexual abuse. The Director indicated the facility's clinical staff assess and determine if it was sexual abuse or sexual acting out. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. 9) According to the Stone Belt Incident Report, dated 6/21/13, on 6/12/13, client #2 left his bedroom at night after going to bed and the motion alarms were set. Client #2's bedroom alarm went off however staff #8 did not hear the alarm. Client #2 went into client #4's room. Clients #2 and #4 watched movies on client #4's computer and looked at his adult magazines. Client #4 touched client #2's leg, stomach and tried to touch his genitals. This was reported to the home manager and the social worker on 6/14/13 by client #2. The action			

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	taken section indicated, "[SW] is going to talk to [client #4] about appropriate ways to release sexual frustrations; this is a continued on going conversation. [SW] talked to all parties involved and has concluded that is not an instance of sexual abuse only sexual acting out." The incident was not reported to BDDS. On 11/8/13 at 10:39 AM, the interim Director indicated BDDS reports should be submitted within 24 hours. The Director indicated sexual acting out was not reported to BDDS due to not being a reportable incident since it was not considered sexual abuse. The Director indicated the facility's clinical staff assess and determine if it was sexual abuse or sexual acting out. On 11/7/13 at 12:11 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. 9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 4 of 77 incident/investigative reports	W000154	Deficiency W 154 Plan of Correction: The facility has developed a new electronic	11/29/2013

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	reviewed affecting clients #1, #2, #3, #4, and #5, the facility failed to conduct investigations of abuse and neglect. Findings include: A review of the facility's incident/investigative reports was conducted on 11/6/13 at 11:16 AM and indicated the following: 1) On 10/12/13 at 12:00 PM, client #1 did not have a bowel movement for 5 days. The BDDS report, dated 10/14/13, indicated, "Per [client #1's] risk plan (for constipation), if [client #1] does not have a bowl (sic) movement in for (sic) three days, he is to be administered 6.5 oz (ounces) of Magnesium Citrate. If he does not have a bowl (sic) movement after 5 days, he is to be administered an enema. After a period of 5 days without a bowl (sic) movement, staff failed to administer both the Magnesium Citrate and the enema." There was no investigation of the neglect to provide the as needed medications. On 11/7/13 at 12:11 PM, the Coordinator indicated the facility did not conduct an investigation. The Coordinator indicated the facility narrowed the issue down to two staff and they received corrective action.		incident reporting system to ensure that all allegations of mistreatment, abuse, neglect, injuries of unknown source, and elopement are reported immediately to the administrator or designated staff in accordance with state law. The department will arrange for staff training in incident reporting and investigations form an outside expert. Plan of Prevention: The new electronic incident reporting system allows for Qs to document follow up on incidents as needed. Clients will review house rules from agency handbook, which address notifying staff when leaving the residence. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA member including failure to do follow up investigations on allegations A/N/E, injuries of unknown source, and client elopement and the QA team will recommend and monitor corrective action.	

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	2) On 9/22/13 at 6:00 PM, the BDDS report, dated 9/24/13, indicated, "[client #2] could not pack what he wanted for lunch. Staff advised him that it was in his best interest to take 2 cheeseburgers for lunch. His roommates reported hearing the door close and noticed that he was gone. Staff went looking for him. He was found walking back to [name of group home]. Staff explained that it was okay to walk away from an uncomfortable situation however it was unacceptable to walk outside of the house without staff supervision." There was no documentation indicating where the staff located client #2. The BDDS report did not indicate how long client #2 was gone. On 11/7/13 at 12:11 PM, the Coordinator indicated the facility should have conducted an investigation. 3) On 8/25/13 at 2:00 PM, client #5 was struck on the shoulder by client #3. Client #3 was not injured. There was no documentation the facility conducted an investigation. On 11/7/13 at 12:11 PM, the Coordinator indicated the facility should have conducted an investigation. The Coordinator indicated the staff should			

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	prevent client to client abuse. The Coordinator indicated client to client abuse was preventable. 4) On 7/11/13 at 9:00 PM, client #4 was sitting in the backyard after being physically aggressive toward staff. The BDDS report, dated 7/12/13, indicated, "Staff was alerted that [client #4] had moved to the front yard. Staff went out to check on [client #4] and he was nowhere to be found. Staff contacted the house manager, who advised calling the police. As staff were out looking for [client #4], another Stone Belt group home nearby contacted [client #4's] house and informed staff that he had gone there." The facility did not conduct an investigation. On 11/7/13 at 12:11 PM, the Coordinator indicated the incident was not investigated. The Coordinator indicated he was not asked to investigate the incident. He indicated the incident should have been investigated. On 11/8/13 at 10:39 AM, the interim Director indicated the incident should have been investigated. 9-3-2(a)			

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W000156	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 3 of 77 incident/investigative reports reviewed affecting clients #2, #3, #4, #5, the facility failed to ensure the results of all investigations were reported to the administrator or designated representative or to other officials in accordance with state law within 5 working days of the incident. Findings include: A review of the facility's incident/investigative reports was conducted on 11/6/13 at 11:16 AM and indicated the following: 1) On 11/4/13 "during DP (day program) in afternoon" client #4 had a video of his girlfriend on his electronic device. His girlfriend exposed her genitalia on the video. On 11/5/13 at 3:30 PM at the facility-operated day program, a female peer was touching client #4's genitalia on the outside of his clothes. On 11/5/13 at 3:40 PM, a female peer was masturbating client #4	W000156	Deficiency W156 Plan of Correction: Facility staff will be retrained on 12/6/13 on all aspects or reporting including what constitutes an incident, notifying supervisors and/or on-call personnel of allegations of A/N/E or other incidents of immediate jeopardy, and reporting to the state agency within 24 hours of a reportable condition. The facility has also hired a new SGL Director who is a Licensed Clinical Social Worker knowledgeable of the state and agency client protection laws and policies including completion of investigations within 5 days. Plan of Prevention: The facility has developed a new electronic incident reporting system to ensure that all allegations of mistreatment, abuse, neglect and injuries of unknown source are reported immediately to the administrator or designated staff in accordance with state law. The department will arrange for staff training in incident reporting and investigations form an outside expert. Quality Assurance Monitoring: The agency's QA process will be revised to include	12/06/2013

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	at the facility-operated day program. The facility was unable to provide documentation when the administrator reviewed the results of the investigation. On 11/8/13 at 10:39 AM, the interim Director indicated investigations should be completed within 5 working days. The Director did not provide documentation when the investigation was reviewed. 2) On 8/15/13, a female peer of client #2's reported to the Social Worker that on either Monday (8/12/13) or Tuesday (8/13/13) that week, client #2 was talking to her about wanting her to be his girlfriend. The note indicated, "She stated that he then kissed her on the forehead and rubbed the top of her head with his hand. She stated that she told him she did not feel comfortable with the touches. He then attempted to put his hand down her shirt. She stated she caught his hand before he touched her breast and told him that she did not feel comfortable with that kind of touch. She stated that [client #2] stopped attempting to touch her." The note indicated, "The finding by the social worker is that this was a substantiated incident of sexual acting out. The two individuals appeared to have discussed the inappropriate behaviors and have		a review and report of all ISDH surveys by a third party QA member including failure to comply with state law regarding A/N/E reports and the QA team will recommend and monitor corrective actions.	

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	agreed to not allow this to happen." The facility did not provide documentation when the investigation was reviewed by the administrator. On 11/8/13 at 10:39 AM, the interim Director indicated investigations should be completed within 5 working days. The Director was unable to provide documentation the administrator reviewed the results of the investigation within 5 working days. 3) On 6/14/13 at 5:30 PM, the BDDS report, dated 6/16/13, indicated staff heard client #3 call for help from his bedroom. Staff entered to find that client #5 had pinned client #3 to his bed and was punching his body. Staff told client #5 to get off client #3. Client #5 got off client #3. The investigation (Client to Client Aggression Inquiry) was completed on 6/26/13 and reviewed by the administrator on 6/30/13. On 11/8/13 at 10:39 AM, the interim Director indicated investigations should be conducted within 5 business days. The Director was unable to provide documentation the administrator reviewed the results of the investigation within 5 working days. 9-3-2(a)			

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W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, interview and record review for 2 of 5 clients living at the group home (#1 and #6), the facility failed to ensure there was sufficient staff to manage and supervise the clients in accordance with their program plans. Findings include: An observation was conducted at the group home on 6:27 AM to 8:18 AM. At 7:49 AM, staff #5 and #8 left the group home with clients #3, #4 and #5. Staff #7 stayed at the group home with clients #1 and #6. At 7:55 AM, client #1 hit his head against the wall. At 7:56 AM, client #1 was offered a helmet by staff #7. Client #1 continued to hit his head against various objects (walls, Plexiglas, and doors). Staff #5 and #8	W000186	W186 Plan of Correction: The facility will review Client #1 and Client #6's ISP and BSP to ensure plans are appropriate, appropriate staffing ratios will be implemented to manage and supervise clients in accordance with their individual program plans. Staff #7 will be trained on all clients' individual program plans. Training will take place on 12/6/13. Plan of Prevention: Incoming facility staff will receive training on all clients' program support plans. Facility coordinator will make observations for three times weekly for the next two months to ensure clients are receiving active treatment and personal program plans are being implemented. Information will be documented by coordinator on a Supvision and Monitoring Report. Quality Assurance Monitoring: Following the two months of	12/06/2013

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	returned to the group home at 8:12 AM. An interview with staff #7, on 11/7/13 at 7:52 AM, was conducted. Staff #7 indicated he was at the home to be client #6's 1:1 staff. Staff #7 indicated he was supposed to be outside of client #6's bedroom door. Staff #7 indicated there was not enough staff to implement client #1 and #6's 1:1 plans. Staff #7 indicated there was never enough staff to implement client #1 and #6's 1:1 plans in the mornings. Staff #7 indicated although client #6 was in bed, client #6 was usually awake during this time of day. Staff #7 indicated he had to supervise clients #1 and #6 by himself when the other staff transported the clients to the day program. Staff #7 indicated client #6's 1:1 time was from 6:00 AM to 10:00 PM. A review of client #1's record was conducted on 11/7/13 at 11:00 AM. Client #1's Behavioral Support Plan (BSP), dated 5/15/13, indicated, in part, "[Client #1] will have a designated 1:1 (one on one) staff during day program hours (8:00 AM to 4:00 PM), and at home during transition times, on outings and during times of increased agitation." On 11/7/13 at 9:40 AM, a review of client #6's BSP, dated 7/31/13,		increased supervision to ensure compliance, Coordinator (Q) will follow agency Supervision and Monitoring Procedures which states: All day and evening shifts will have monitoring visits by management at least one time per month. All overnight shifts will be monitored at least two times per quarter with one visit performed during a week-end shift. Items reviewed: Monitors will assess general interactions and active engagement with clients, cleanliness, and appropriateness of activities.	

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	indicated, in part, "[Client #6] requires 1:1 staff during waking hours while at [name of group home]...". The plan indicated, in part, "It is best practice for [client #6] is to have 1:1 staffing while at [name of group home] between the hours of 6am and 10pm. Specifically, this means that staff is to be within 3 feet of [client #6] at all times during these hours. On each shift, to be rotated as necessary throughout the shift, [client #6] will have a specific staff member assigned as his 1:1. During the hours listed above (unless he is in a private space by himself; such as his room, the bathroom, or at home with no other consumers present). Not only will this staff stay within 3 feet of [client #6], but they will also supervise him closely and if he shows signs of agitation, will make sure he does not enter within 4 feet of the personal space of his housemates or others, so as to ensure that [client #6] does not have any opportunities to aggress on his housemates." On 11/7/13 at 12:42 PM, the Coordinator indicated there were not enough staff to implement client #1 and #6's BSPs. On 11/8/13 at 2:08 PM, the Coordinator indicated when staff #7 started working at the group home he was to only work as client #6's 1:1 staff. There was no intent for staff #7 to work			

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	with the other clients. The Coordinator indicated client #1 had risk plans addressing constipation, falls, pica (ingesting non-nutritive substances) and self-injurious behavior. 9-3-3(a)			
W000189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, interview and record review for 1 of 3 clients in the sample (#1), the facility failed to ensure staff received training prior to working alone with client #1. Findings include: An observation was conducted at the group home on 6:27 AM to 8:18 AM. At 7:49 AM, staff #5 and #8 left the group home with clients #3, #4 and #5. Staff #7 stayed at the group home with clients #1 and #6. At 7:55 AM, client #1 hit his head against the wall. At 7:56 AM, client #1 was offered a helmet by staff #7. Client #1 continued to hit his head against various objects (walls, Plexiglas, and doors). Staff #5 and #8	W000189	W189 Plan of Correction: Staff #7 will be trained on all clients' individual program plans. Training will take place on 12/6/13. Plan of Prevention: Incoming facility staff will receive training on all clients' program support plans, as well as participate in agency's monthly trainings and any additional training as needed. Quality Assurance Monitoring: The agency has an electronic system in place to track staff trainings. Facility coordinator will review the training information on a monthly basis to ensure all facility staff have received the appropriate training.	12/06/2013

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	returned to the group home at 8:12 AM. An interview with staff #7, on 11/7/13 at 7:52 AM, was conducted. Staff #7 indicated he was at the home to be client #6's 1:1 staff. Staff #7 indicated he was supposed to be outside of client #6's bedroom door. Staff #7 indicated there was not enough staff to implement client #1 and #6's 1:1 plans. Staff #7 indicated there was never enough staff to implement client #1 and #6's 1:1 plans in the mornings. Staff #7 indicated although client #6 was in bed, client #6 was usually awake during this time of day. Staff #7 indicated he had to supervise clients #1 and #6 by himself when the other staff transported the clients to the day program. Staff #7 indicated client #6's 1:1 time was from 6:00 AM to 10:00 PM. Staff #6 indicated he read client #1's plan but had not received formal training on his plans. A review of client #1's record was conducted on 11/7/13 at 11:00 AM. Client #1's Behavioral Support Plan (BSP), dated 5/15/13, indicated, in part, "[Client #1] will have a designated 1:1 (one on one) staff during day program hours (8:00 AM to 4:00 PM), and at home during transition times, on outings and during times of increased agitation."			

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	On 11/7/13 at 9:40 AM, a review of client #6's BSP, dated 7/31/13, indicated, in part, "[Client #6] requires 1:1 staff during waking hours while at [name of group home]...". The plan indicated, in part, "It is best practice for [client #6] is to have 1:1 staffing while at [name of group home] between the hours of 6am and 10pm. Specifically, this means that staff is to be within 3 feet of [client #6] at all times during these hours. On each shift, to be rotated as necessary throughout the shift, [client #6] will have a specific staff member assigned as his 1:1. During the hours listed above (unless he is in a private space by himself; such as his room, the bathroom, or at home with no other consumers present). Not only will this staff stay within 3 feet of [client #6], but they will also supervise him closely and if he shows signs of agitation, will make sure he does not enter within 4 feet of the personal space of his housemates or others, so as to ensure that [client #6] does not have any opportunities to aggress on his housemates." On 11/8/13 at 2:08 PM, the Coordinator indicated although he had trained staff #7 he did not have documentation to verify it. The Coordinator indicated when staff #7 started working at the			

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	group home he was to only work as client #6's 1:1 staff. There was no intent for staff #7 to work with the other clients. The Coordinator indicated client #1 had risk plans addressing constipation, falls, pica (ingesting non-nutritive substances) and self-injurious behavior. On 11/8/13 at 1:40 PM, the Employee Relations Manager indicated after reviewing staff #7's training database there was no documentation indicating staff #7 had received training to work with client #1. 9-3-3(a)			
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 of 3 clients in the sample (#1) and one additional client (#6), the facility failed to ensure their program plans were implemented as written.	W000249	W249 Plan of Correction: Facility staff will be trained on clients' personal program plans, including active treatment. Item #1: Client #1's ISP has been amended to use his gait belt prn. Facility staff have been retrained on Client #1's Fall Risk plan which includes	12/06/2013

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	Findings include: 1) An observation was conducted at the group home on 6:27 AM to 8:18 AM. During the observation, client #1 was not wearing a gait belt. At 6:50 AM, staff #5 prompted client #1 and staff #7 to assist client #1 to put on a gait belt and use the restroom. Staff #7 did not assist client #1 to put on a gait belt. At 8:12 AM, client #1 was not wearing a gait belt. At 8:14 AM, staff #5 indicated there was a recent conversation about client #1 not needing to wear a gait belt at all times. A review of client #1's record was conducted on 11/7/13 at 11:00 AM. Client #1's Nurse Quarterly Physical, dated 10/24/13, indicated, in part, "Staff continues to use a gait belt with [client #1] at all times when he is ambulating. His mother is requesting the use of gait belt be PRN (as needed) - will discuss at tx (treatment) team meeting." Client #1's Fall Risk Plan, dated 8/6/13, indicated, in part, "Staff will use a gait belt with [client #1] (around waist) at all times when [client #1] is ambulating, whether at home or in the community." An interview with the Coordinator was conducted on 11/7/13 at 12:40 PM. The Coordinator indicated client #1 should		the prn use of his gait belt. (See attached labeled W249). Date completed: 11/22/13. Item #2: Staff #7 will be trained on all clients' individual program plans. Training will take place on 12/6/13. Item #3: Facility staff be retrained on Individualize Habilitation Plans (IHP). This training will take place on 12/6/13. Facility staff were trained on medication administration on 11/18/13 (See attachment labeled W249). Plan of Prevention: Incoming facility staff will receive training on all clients' program support plans, as well as participate in agency's monthly trainings and any additional training as needed. Facility coordinator will make weekly observations for he next month to ensure clients are receiving active treatment and personal program plans are being implemented. Quality Assurance Monitoring: Coordinator (Q) will follow agency Supervision and Monitoring Procedures which states: All day and evening shifts will have monitoring visits by management at least one time per month. All overnight shifts will be monitored at least two times per quarter with one visit performed during a week-end shift. Items reviewed: Monitors will assess general interactions and active engagement with clients, cleanliness, and appropriateness of activities.	

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	be wearing, at all times per the current plan, a gait belt. An interview with the interim Director of Supported Group Living was conducted on 11/8/13 at 10:39 AM. The Director indicated client #1 should be wearing his gait belt. 2) An observation was conducted at the group home on 6:27 AM to 8:18 AM. At 7:49 AM, staff #5 and #8 left the group home with clients #3, #4 and #5. Staff #7 stayed at the group home with clients #1 and #6. At 7:55 AM, client #1 hit his head against the wall. At 7:56 AM, client #1 was offered a helmet by staff #7. Client #1 continued to hit his head against various objects (walls, Plexiglas, and doors). Staff #5 and #8 returned to the group home at 8:12 AM. An interview with staff #7, on 11/7/13 at 7:52 AM, was conducted. Staff #7 indicated he was at the home to be client #6's 1:1 staff. Staff #7 indicated he was supposed to be outside of client #6's bedroom door. Staff #7 indicated there was not enough staff to implement client #1 and #6's 1:1 plans. Staff #7 indicated there was never enough staff to implement client #1 and #6's 1:1 plans in the mornings. Staff #7 indicated although client #6 was in bed, client #6			

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	was usually awake during this time of day. Staff #7 indicated he had to supervise clients #1 and #6 by himself when the other staff transported the clients to the day program. Staff #7 indicated client #6's 1:1 time was from 6:00 AM to 10:00 PM. A review of client #1's record was conducted on 11/7/13 at 11:00 AM. Client #1's Behavioral Support Plan (BSP), dated 5/15/13, indicated, in part, "[Client #1] will have a designated 1:1 (one on one) staff during day program hours (8:00 AM to 4:00 PM), and at home during transition times, on outings and during times of increased agitation." On 11/7/13 at 9:40 AM, a review of client #6's BSP, dated 7/31/13, indicated, in part, "[Client #6] requires 1:1 staff during waking hours while at [name of group home]...". The plan indicated, in part, "It is best practice for [client #6] is to have 1:1 staffing while at [name of group home] between the hours of 6am and 10pm. Specifically, this means that staff is to be within 3 feet of [client #6] at all times during these hours. On each shift, to be rotated as necessary throughout the shift, [client #6] will have a specific staff member assigned as his 1:1. During the hours listed above (unless he is in a private			

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	space by himself; such as his room, the bathroom, or at home with no other consumers present). Not only will this staff stay within 3 feet of [client #6], but they will also supervise him closely and if he shows signs of agitation, will make sure he does not enter within 4 feet of the personal space of his housemates or others, so as to ensure that [client #6] does not have any opportunities to aggress on his housemates." On 11/7/13 at 12:42 PM, the Coordinator indicated there were not enough staff to implement client #1 and #6's BSPs. 3) An observation was conducted at the group home on 6:27 AM to 8:18 AM. At 6:44 AM, client #3 received his medications from staff #5. Client #3 was not asked to name his medications, dose, reason for prescription and 2 side effects. At 6:57 AM, client #5 received his medications from staff #5. Client #5 was not prompted to indicate when it was time for his medications, obtain his medication storage container, sign his medication packaging and medication log. Client #5 was not prompted to select a certain medication and sign the first letter of the medication. Client #4 received his medications from staff #5 at 7:08 AM. Client #4 was not prompted			

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	to name his medications, check his Medication Administration Record and Medication Information Sheet and compare the documents, state the dosage, why prescribed and 2 side effects. Client #4 was not prompted to check his physician's orders and return the materials. A review of client #3's record was conducted on 11/7/13 at 10:25 AM. Client #3's 5/1/13 Individual Support Plan (ISP) indicated he had a training objective to know medications names, dosage, why prescribed, and 2 side effects. A review of client #5's ISP, dated 7/26/13, was conducted on 11/8/13 at 1:48 PM. Client #5's training objectives included indicating when it was time for his medications, obtaining his medication storage container, signing his medication log, selecting the correct medications, and signing the first letter of the medication. A review of client #4's record was conducted on 11/7/13 at 9:52 AM. Client #4's ISP, dated 5/1/13, indicated he had training objectives to wash his hands, name his medications, check his Medication Information Sheet and Medication Administration Record,			

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	compare the documents, know the dosage, why prescribed and 2 side effects. His training objectives included washing his hands, checking the physician order information and then returning the materials. The Coordinator indicated, on 11/7/13 at 12:31 PM, the clients' medication administration training objectives should be implemented at each medication pass. 9-3-4(a)			
W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 5 clients living at the group home (#1, #3, #4, #5 and #6) and one additional client (#2), the facility failed to conduct quarterly evacuation drills for each shift. Findings include: A review of the facility's evacuation drills was conducted on 11/6/13 at 12:14 PM. There were no overnight evacuation drills (for clients #1, #2, #3, #4, #5 and #6) conducted between	W000440	Deficiency W440 Plan of Correction: Facility will conduct a sleep time fire drill. Facility staff will be retrained on fire drill protocol and procedures on 12/6/13. Fire drills will be conducted according to agency schedule (See attachment labeled W440). Plan of Prevention: The agency has implemented a new electronic fire drill notification system overseen by the agency's Organizational Effectiveness Coordinator. Quality Assurance Monitoring: This system will notify the SGL Director who will ensure agency	12/06/2013

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	11/6/12 to 5/26/13 and 6/22/13 to 11/6/13. On 11/8/13 at 10:39 AM the interim Director of Supported Group Living indicated evacuation drills should be conducted quarterly for each shift. 9-3-7(a)		fire drill protocols are being followed.	
W009999	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and	W009999	Deficiency W9999 Plan of Correction: Staff #2 will receive Mantoux (5TU, PPD) tuberculosis (TB) screening by 12/6/2013. Plan of Prevention: A new electronic notification system is now being used. The notification will alert the staff person, nurse and staff person's supervisor when screening is due. Quality Assurance Monitoring: The agency's Organizational Effectiveness Coordinator will monitor this electronic process.	12/06/2013

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	laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician. This state rule was not met as evidenced by: Based on record review and interview for 1 of 3 employee files reviewed (Direct Care Staff #2), the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted. Findings include: A review of the facility's employee files was conducted on 11/6/13 at 12:26 PM. Direct Care Staff #2 had a negative TB test on 8/24/12. There was no documentation in Direct Care Staff #2's personnel file staff #2 had a annual screening or TB test conducted since 8/24/12. An interview was conducted with the Organization Effectiveness Coordinator (OEC) on 11/6/13 at 1:12 PM. The OEC indicated the staff should have an annual Mantoux. An interview with the interim Director			

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	of Supported Group Living was conducted on 11/8/13 at 10:39 AM. The Director indicated staff should have an annual TB test. 9-3-3(e)			