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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G634 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/05/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4100 DECKARD DR<br>BLOOMINGTON, IN 47408 |
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| W0000              | <p>This visit was for the investigation of complaint #IN00110873.</p> <p>Complaint #IN00110873 - Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153 and W157.</p> <p>Unrelated deficiency cited.</p> <p>Survey Dates: July 2, 3 and 5, 2012.</p> <p>Facility Number: 001209<br/>Provider Number: 15G634<br/>AIM Number: 100240160</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/12/12 by Ruth Shackelford, Medical Surveyor III.</p> | W0000         |   |                      |

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

TITLE

(X6) DATE

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

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| W0102  | <p><b>483.410 GOVERNING BODY AND MANAGEMENT</b><br/>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review for 3 of 5 clients living in the group home (C, D and E), the facility failed to meet the Condition of Participation: Governing Body by failing to ensure: its policies and procedures to prevent abuse and neglect were implemented, staff immediately reported abuse to the administrator, and monitoring was increased at the group home by administrative staff after an incident of substantiated abuse.</p> <p>Findings include:</p> <p>Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections for 3 of 5 clients living in the group home (C, D and E). The governing body failed to ensure its policies and procedures to prevent abuse and neglect were implemented, staff immediately reported abuse to the administrator, and monitoring was increased at the group home by administrative staff after an incident of substantiated abuse.</p> <p>Please refer to W104. The governing body failed to exercise policy and operating direction over the facility to</p> | W0102   | <p><b>W 102 GOVERNING BODY &amp; MANAGEMENT</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt will ensure that specific governing body and management requirements are met. Specifically, Stone Belt will ensure that the policy of prevention of abuse and neglect are followed, alleged abuse is reported immediately to an administrator and will have increased monitoring by administrative staff following an incident of substantiated abuse.</p> <p><b>Responsible Person:</b></p> <p>Deckard House Coordinator &amp; SGL Director</p> <p><b>Date of Completion:</b></p> <p>August 8, 2012</p> <p><b>Plan of Prevention:</b></p> <p>House Staff and all SGL staff were retrained on Stone Belt's policy of prevention of abuse and neglect. (Attachment # 1). This</p> | 08/08/2012  |  |   |  |

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|  | <p>ensure its policies and procedures to prevent abuse and neglect were implemented, staff immediately reported abuse to the administrator, and monitoring was increased at the group home by administrative staff after an incident of substantiated abuse (clients C, D and E).</p> <p>This federal tag relates to complaint #IN00110873.</p> <p>9-3-1(a)</p> |   | <p>training also included immediate reporting and was also reviewed at SGL In-service on 8/3/2012. (Attachment # 2). Staff that did not report this specific incident was given individual training on reporting. (Attachment # 3). House Coordinator, SGL Director and other administrative staff will provide administrative oversight if other incidents occur in the future. Visits will be documents on Stone Belt Program Visit Report for SGL Director and House Coordinator. (Attachment # 4). Social Worker, Nurse and Behaviorist will document their visit on the Professional Services Sign-in Sheet. (Attachment # 5)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>Training staff on Stone Belt's policy of prevention of abuse and neglect will continue as needed with current staff and covered during initial staff orientation of new hires. House Coordinator and SGL Director will document both announced and unannounced visits to the homes on the Program Visit Report. SGL Director will review this, at a minimum, on a monthly basis. In addition, SGL Director will review visit by other administrative staff using the Professional Sign-In Sheet. These visits will be at least twice a month. If an allegation of abuse/neglect occurs in the future, Coordinator and Director and other administrative staff will</p> |                      |   |

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|  |  |   | go to the home as instructed by SGL Director.   |                      |   |

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| W0104  | <p>483.410(a)(1)<br/>GOVERNING BODY<br/>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 3 of 5 clients living in the group home (C, D and E), the governing body failed to exercise policy and operating direction over the facility to ensure its policies and procedures to prevent abuse and neglect were implemented, staff immediately reported abuse to the administrator, and monitoring was increased at the group home by administrative staff after an incident of substantiated abuse.</p> <p>Findings include:</p> <p>Please refer to W149. For 3 of 4 incident/investigative reports reviewed affecting clients C and E, the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Please refer to W153. For 2 of 4 incident/investigative reports reviewed affecting clients C and D, the facility failed to ensure staff immediately reported abuse to the administrator, in accordance with State law.</p> <p>Please refer to W157. For 1 of 4 incident/investigative reports reviewed</p> | W0104   | <p><b>W 104</b></p> <p><b>GOVERNING BODY</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt will ensure that specific governing body and management requirements are met. Specifically, Stone Belt will ensure that the policy of prevention of abuse and neglect are followed, alleged abuse is reported immediately to an administrator and will have increased monitoring by administrative staff following an incident of substantiated abuse.</p> <p><b>Responsible Person:</b></p> <p>Deckard House Coordinator &amp; SGL Director</p> <p><b>Date of Completion:</b></p> <p>August 8, 2012</p> <p><b>Plan of Prevention:</b></p> <p>House Staff and all SGL staff were retrained on Stone Belt's policy of prevention of abuse and neglect. (Attachment # 1). This training also included immediate</p> | 08/08/2012  |  |   |  |

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|  | <p>affecting client C, the facility failed to increase monitoring at the group home by administrative staff after an incident of substantiated abuse.</p> <p>This federal tag relates to complaint #IN00110873.</p> <p>9-3-1(a)</p> |   | <p>reporting and was also reviewed at SGL Inservice on 8/3/2012. (Attachment # 2). Staff that did not report this specific incident was given individual training on reporting. (Attachment # 3). House Coordinator, SGL Director and other administrative staff will provide administrative oversight if other incidents occur in the future. Visits will be documents on Stone Belt Program Visit Report for SGL Director and House Coordinator. (Attachment # 4). Social Worker, Nurse and Behaviorist will document their visit on the Professional Services Sign-in Sheet. (Attachment # 5)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>Training staff on Stone Belt's policy of prevention of abuse and neglect will continue as needed with current staff and covered during initial staff orientation of new hires. House Coordinator and SGL Director will document both announced and unannounced visits to the homes on the Program Visit Report. SGL Director will review this, at a minimum, on a monthly basis. In addition, SGL Director will review visit by other administrative staff using the Professional Sign-In Sheet. These visits will be at least twice a month. If an allegation of abuse/neglect occurs in the future, Coordinator and Director and other administrative staff will go to the home as instructed by</p> |                      |   |

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|  |  |   | SGL Director.   |                      |   |

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| W0122  | <p><b>483.420</b><br/><b>CLIENT PROTECTIONS</b><br/>The facility must ensure that specific client protections requirements are met.</p> <p>Based on interview and record review for 3 of 5 clients living in the group home (C, D and E), the facility failed to meet the Condition of Participation: Client Protections by failing to ensure: its policies and procedures to prevent abuse and neglect were implemented, staff immediately reported abuse to the administrator, and monitoring was increased at the group home by administrative staff after an incident of substantiated abuse.</p> <p>Findings include:</p> <p>Please refer to W149. For 3 of 4 incident/investigative reports reviewed affecting clients C and E, the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Please refer to W153. For 2 of 4 incident/investigative reports reviewed affecting clients C and D, the facility failed to ensure staff immediately reported abuse to the administrator, in accordance with State law.</p> <p>Please refer to W157. For 1 of 4</p> | W0122   | <p><b>W 122</b><br/><br/><b>CLIENT PROTECTIONS</b><br/><br/><b>Plan of Correction:</b><br/><br/>Stone Belt will ensure that specific governing body and management requirements are met. Specifically, Stone Belt will ensure that the policy of prevention of abuse and neglect are followed, alleged abuse is reported immediately to an administrator and will have increased monitoring by administrative staff following an incident of substantiated abuse.</p> <p><b>Responsible Person:</b><br/><br/>Deckard House Coordinator &amp; SGL Director</p> <p><b>Date of Completion:</b><br/><br/>August 8, 2012</p> <p><b>Plan of Prevention:</b><br/><br/>House Staff and all SGL staff were retrained on Stone Belt's policy of prevention of abuse and neglect. (Attachment # 1). This training also included immediate reporting and was also reviewed</p> | 08/08/2012  |  |   |  |

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|  | <p>incident/investigative reports reviewed affecting client C, the facility failed to increase monitoring at the group home by administrative staff after an incident of substantiated abuse.</p> <p>This federal tag relates to complaint #IN00110873.</p> <p>9-3-2(a)</p> |   | <p>at SGL Inservice on 8/3/2012. (Attachment # 2). Staff that did not report this specific incident was given individual training on reporting. (Attachment # 3). House Coordinator, SGL Director and other administrative staff will provide administrative oversight if other incidents occur in the future. Visits will be documents on Stone Belt Program Visit Report for SGL Director and House Coordinator. (Attachment # 4). Social Worker, Nurse and Behaviorist will document their visit on the Professional Services Sign-in Sheet. (Attachment # 5)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>Training staff on Stone Belt's policy of prevention of abuse and neglect will continue as needed with current staff and covered during initial staff orientation of new hires. House Coordinator and SGL Director will document both announced and unannounced visits to the homes on the Program Visit Report. SGL Director will review this, at a minimum, on a monthly basis. In addition, SGL Director will review visit by other administrative staff using the Professional Sign-In Sheet. These visits will be at least twice a month. If an allegation of abuse/neglect occurs in the future, Coordinator and Director and other administrative staff will go to the home as instructed by SGL Director.</p> |                      |   |

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| W0149  | <p>483.420(d)(1)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 3 of 4 incident/investigative reports reviewed affecting clients C and E, the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/2/12 at 2:18 PM.</p> <p>1) On 6/20/12, client C was in his room cleaning being assisted by former staff #9. Staff #9 prompted client C to take a shower. Client C did not want a shower and staff #9 continued to prompt him for 5 more minutes. Fifteen minutes later, staff #6, from the living room, observed client C and staff #9 run outside the front door. Staff observed staff #9 "screaming" at client C. Three to five minutes later, client C came back inside and stated, "I'm going to tell my dad and [staff #2] on you." Staff #9 indicated to client C, "You can't get me fired, [client C], they will put you in jail before I get fired." Client C then walked toward the restroom. Staff #9 followed client C and pushed him into</p> | W0149   | <p><b>W 149 STAFF TREATMENT OF CLIENTS Plan of Correction:</b><br/>Stone Belt has and implements written policies and procedures that prohibit mistreatment, neglect or abuse of a client. <b>Date of Completion:</b> August 8, 2012<br/><b>Responsible Person:</b> Deckard Coordinator <b>Plan of Prevention:</b> House Staff and all SGL staff were retrained on Stone Belt's policy of prevention of abuse and neglect. (Attachment # 1). This training also included immediate reporting and was also reviewed at SGL Inservice on 8/3/2012. (Attachment # 2). <b>Quality Assurance Monitoring:</b> Deckard Coordinator and SGL Director will monitor for possible abuse and exploitation during scheduled and unscheduled site visits. Staff will be trained annually on abuse/exploitation policy at Stone Belt as well as initial new hire orientation and on a as needed basis.</p> | 08/08/2012  |  |   |  |

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|                    | <p>the cabinet inside the restroom and then placed her hands on his neck and yelled, "You better take a shower now or I'll assist you." Staff #9 let client C go and he attempted to exit the restroom. Staff #9 grabbed the back of his shirt, turned him around and again pushed client C against the cabinet, placing one hand on his stomach and the other pushing at his neck, telling him to take a shower. Client C agreed to take a shower so staff #9 walked out of the restroom and shut the door. Client C attempted to exit the restroom however staff #9 held the door shut with her body. Client C yelled, "Please let me out!" Staff #9 replied, No God ____, you aren't coming out until you take a da__ shower." Client C took a shower and then went straight to his room to get dressed and then took a nap.</p> <p>An interview with staff #6 in the investigative report, dated 6/27/12, indicated he witnessed the events on 6/20/12 at 2:45 PM. He indicated client C was refusing to take a shower. Staff #6 indicated he was not familiar with client C's behavior plan in regard to his shower procedure. Staff #5 prompted client C to take a shower in 5 minutes and client C indicated he did not want to. Client C then went to his room and slammed the door. During staff #5's prompts of client C to take a shower, staff #9 was in the</p> |               |   |                      |

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|                    | <p>office. Staff #5 then left the home and staff #9 went into client C's room. Staff #6 got up and stood outside client C's room to listen to what was going on (the door was closed). He could hear them laughing and joking. Then staff #6 heard client C state, "No, I am not getting in the shower." Staff #9 then exited client C's room and stated to staff #6, "The gloves are coming off - I'm taking things out of my pockets" and she put her keys, change and jewelry in the office. Staff #6 indicated staff #9 appeared mad. Staff #9 reentered client C's room and client C told her he did not want to clean his room or take a shower. Staff #6 left briefly to attend to client A and when he returned staff #9 was taking the blankets and sheets off client C's bed so he could not sleep. Client C got up and ran outside to sit on the front sidewalk. Staff #6 then watched from the formal living room window. Staff #6 knew staff #9 was not to be working with client C (due to a directive given to him by staff #2). Client C and staff #9 then came back inside. They went to client C's room and then they ran back outside with staff #9 "screaming" at client C. Staff #6 heard client C indicate he was going to tell his dad on staff #9. Staff #9 stated, "Go ahead, go ahead, I don't care." Staff #6 then went outside. Staff #9's demeanor immediately changed. Staff #6 attempted</p> |               |   |                      |

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|                    | <p>to change the subject and get client C back inside. Staff #6 indicated each thing he said to encourage client C back into the home, staff #9 would repeat only aggressively and in a demanding tone. Staff #6 indicated staff #9 was "intense and he is scared of her." Client C returned inside to the formal living room. Staff #6 indicated he thought client C was calm and the incident was over. Staff #9 and client C sat on the couch. Staff #9 asked client C, "why don't you get into the shower." Client C went into the restroom. Client C was stomping his feet. Staff #6 then observed staff #9 push client C's back with two hands on his mid back and client C fell into the cabinet at the other side of the restroom. Staff #6 stepped into the restroom and client C turned to face staff #9. Client C's back was against the cabinet and wall. Staff #9 then grabbed client C around the neck with her two thumbs under his chin and pushed his face up with her hands. Staff #9 stated, "Are you going to take a shower and I am tired of these G__d__ games." Client C was whimpering while she held his head. Client C said, "I will. I will." Then client C said to staff #9, "I'm going to tell [staff #2] and my dad on you." Staff #6 indicated, "I don't care. Your a__ will go to jail before mine with (sic) get fired." Client C indicated he would take a shower but he not. Staff #9 stood outside</p> |               |   |                      |

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|                    | <p>the bathroom door and blocked client C from exiting for about 1 minute. Client C was trying to get out. Staff #9 was saying to client C, "Are you there yet? Are you getting into the G__ d__ shower?" Staff #6 indicated staff #9 was screaming. Staff #9 then opened the door and pushed client C with her hand on his chest. Client C hit the wall and she kept her hand on his chest to hold him against the wall. Staff #6 indicated client C was not resisting or being aggressive. Staff #9 put one hand up to his neck with her thumb under his chin and held him against the wall with this grip and the hand on his chest. She held him for 15-20 seconds. Staff #9 let him go and stated to client C, "Do I need to help you get undressed?" She then "forcefully" pulled his shirt off of him. Staff #6 indicated he told staff #9, at this point, client C could undress himself if she gave him a minute. Staff #9 indicated, "I'm sick of taking this bull___. I don't know why you are the only one that doesn't listen." Client C was whining, "Ok, Ok." Staff #9 then left the restroom with staff #6. Client C took a shower. Staff #6 indicated staff #9 then started talking to him as if nothing had happened. When client C exited the shower, staff #6 went down to his room to check for injuries but client C told him he was fine and "I hate that dumb bi___." Staff #6 told client C, "Don't deal with her</p> |               |   |                      |

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|  | <p>the rest of the night, just come to me if you need anything." Staff #6 indicated staff #9 put client C on "red" which meant he could not make any phone calls and had no television. Client C did not come out of his room the remainder of staff #6's shift (ended at 7:50 PM).</p> <p>Staff #6 indicated in the investigative report he knew what staff #9 was not right, he realized she was engaging in a power struggle with client C but he did not know what to do. He indicated staff #9 was a more experienced staff and he had only worked there for 4 months. He indicated he knew abuse had occurred and he was trying to decide what he should do next. He indicated he knew he should report what happened but he didn't want another employee to have to come to the house. He indicated he did not want to write up the incident in front of staff #9. Staff #6 did not want to bother the after hours pager. He indicated he did not want to have to face staff #9 at the Friday staff meetings. He indicated he reported the incident the next day to the staff #2 and the Program Director.</p> <p>Staff #6 indicated, on the weekend prior to the incident, the associate manager (staff #2) told him staff #9 was no longer to be paired (working) with client C. Staff #6 indicated his understanding was</p> |   |   |                      |   |

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|  | <p>staff #9 was impatient with client C and they did not get along.</p> <p>The findings of the investigation indicated abuse was substantiated (the findings support the event as described/allegation). The Findings section indicated the following, "[Staff #6] indicates he felt afraid, and intimidated by a staff with more years of experience and who he perceived to be in an authority role. He failed to act in an assertive manner to stop the abuse and protect the client from further abuse. It was apparent that both [staff #9] and [staff #6] were unfamiliar with [client C's] behavior plan. There is some indication that [staff #9's] supervisors were aware that she was irritable and spoke to clients and staff in an aggressive, intimidating and loud tone in the past. She had been referred for counseling concerning these behaviors and had been instructed to not work with [client C] specifically."</p> <p>The Corrective Action section indicated staff #9 was terminated from employment on 6/27/12 and staff #6 received retraining on 6/29/12 on immediately reporting abuse to the administrator. The facility contacted the police who issued a warrant for staff #9's arrest for confinement and battery on 6/22/12.</p> |   |   |   |  |   |  |

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|                    | <p>A review of staff #6's training record was conducted on 7/3/12 at 12:39 PM. Staff #6 received training on the prevention of abuse and neglect on 2/20/12. Staff #6 received training on client C's Behavioral Support Plan (BSP) on 5/4/12.</p> <p>A review of staff #9's training record was conducted on 7/3/12 at 12:31 PM. Staff #9 received training on the prevention of abuse and neglect on 10/14/10, 2/11/11, and 1/6/12. Staff #9 received training on conflict resolution on 4/6/12.</p> <p>A review of client C's record was conducted on 7/3/12 at 11:42 AM. Client C's BSP, dated 10/26/11, indicated he had the following targeted behaviors: refusals (persistent unwillingness to complete a requested task or activity), aggressive behavior/property destruction (acting out toward staff or peers by hitting, kicking, pushing, biting, or swearing at staff or peers), use of personal possessions (utilization of his individual belongings, including but not limited to his television and game systems, his clothing and toys, personal hygiene products and other similar items), inappropriate telephone conduct (calling people obsessively throughout the day, or becoming physically or verbally aggressive when using/wanting to use the telephone), inappropriate sexual behavior</p> |               |   |                      |

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|                    | <p>(inappropriate sexual behavior including going into housemates' rooms in the middle of the night) and public masturbation, compulsive eating, false accusations, and non-compliance to medical/dental procedures (refusal, agitation and aggressive behavior during a medical or dental procedure).</p> <p>A review of the facility's Behavioral Intervention Policy, dated 10/2010, was conducted on 7/2/12 at 2:09 PM. 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, "Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over consumer support; misuse of consumer or agency goods or resources; breaches of agency policy;</p> |               |   |                      |

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|  | <p>serious breaches of the employee code of conduct." The policy indicated Events Requiring Investigations included, "Situations involving suspected or alleged abuse, neglect or exploitation of consumers or any rights issue as described in agency policies will be investigated by staff designated and trained by the agency for this role."</p> <p>An interview with client C was conducted on 7/3/12 at 11:19 AM. Client C indicated he felt safe at the group home. Client C stated, "She (staff #9) pushed me for no reason. I'm mad at her. She's not there anymore." Client C then walked away from the interview.</p> <p>An interview with staff #6 was conducted on 7/5/12 at 10:49 AM. Staff #6 indicated staff #9 abused client C. Staff #6 indicated he thought he had 24 hours to report the incident to administrative staff. Staff #6 indicated he was trained prior to the incident in new employee orientation and after he was to immediately report abuse.</p> <p>An interview with staff #2 was conducted on 7/2/12 at 5:08 PM. Staff #2 indicated he first heard about the incident the day after the incident occurred when staff #6 reported it to him. Staff #2 indicated the Program Director (PD) was at the group</p> |   |   |   |  |   |  |

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|                    | <p>home at the time and the incident was reported to him. Staff #2 indicated following the incident, he trained staff #6 on immediately reporting abuse and neglect to administrative staff. Staff #2 indicated he had never seen staff #9 being abusive to the clients. He indicated the PD talked to him about not having staff #9 work with client C due to client C not responding positively to her. Staff #2 indicated client C responded to staff #9 with verbal and physical aggression. Staff #2 indicated the action of not having staff #9 working with client C was due to client C's responses to her prompting. Staff #2 indicated there was no indication of abuse by staff #9 at any time.</p> <p>An interview with Social Worker (SW) #2 was conducted on 7/3/12 at 1:08 PM. SW #2 indicated she interviewed staff #9 for the facility's investigation. SW #2 stated of staff #9's interview, "Her version was different." Staff #9 indicated she held the bathroom door closed for 3-4 seconds. Staff #9 indicated client C was banging his head so she held his chin up so his head was against the wall to protect him. SW #2 indicated this was not an approved technique. Staff #9 described inappropriate restraints during the interview. SW #2 indicated staff #9 abused client C. SW #2 indicated the facility prohibited and should prevent</p> |               |   |                      |

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|                    | <p>abuse of the client. SW #2 indicated staff #6 should have reported the incident immediately.</p> <p>An interview with the Program Director (PD) was conducted on 7/5/12 at 11:25 AM. The PD indicated staff #9 abused client C. The PD indicated the incident was preventable. The PD indicated staff #9 was not supposed to be working with client C due to personality conflicts between the two. The PD indicated staff #9 knew she was not to be working with client C. The PD indicated staff #6 should have immediately reported the incident to administrative staff.</p> <p>2) On 6/12/12 at 12:30 PM at the facility-operated day program, client D allegedly touched a female peers breasts during break. It was also alleged client D took pictures of a female peer's breasts. The incident report was dated 6/13/12. There was no documentation administrative staff were notified. There was no documentation an investigation was conducted into the incident. An email, dated 6/14/12, from the social worker addressed to client D's interdisciplinary team indicated the social worker spoke to client D. Client D told her it was his idea to take pictures of her breasts and his face. The email indicated, "So, I think we need to intercept the</p> |               |   |                      |

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|  | <p>camera and pictures." There was no documentation the female peer was interviewed or client B who initially reported the incident to staff on 6/12/12. There was no documentation an interview was conducted with the staff client B reported the incident to. There was no documentation if the camera was intercepted. There was no documentation an investigation was conducted. There was no documentation indicating if the incident was substantiated or not.</p> <p>3) On 5/10/12 at 10:15 AM at the facility-operated workshop, client C pushed client E into a wall. Client E was not injured.</p> <p>An interview with the Director was conducted on 7/3/12 at 11:54 AM. The Director indicated staff should immediately report abuse and neglect to administrative staff. The Director indicated the facility prohibited abuse and neglect of the clients. The Director indicated the facility staff should prevent abuse and neglect of the clients. The Director indicated the incident involving client D should have been investigated and documented.</p> <p>This federal tag relates to complaint #IN00110873.</p> |   |   |                      |   |

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| W0153  | <p>483.420(d)(2)<br/><b>STAFF TREATMENT OF CLIENTS</b><br/>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 2 of 4 incident/investigative reports reviewed affecting clients C and D, the facility failed to ensure staff immediately reported abuse to the administrator, in accordance with State law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/2/12 at 2:18 PM.</p> <p>1) On 6/12/12 at 12:30 PM at the facility-operated day program, client D allegedly touched a female peer's breasts during break. It was also alleged client D took pictures of the female peer's breasts. The incident report was dated 6/13/12. There was no documentation administrative staff were notified.</p> <p>2) On 6/20/12, client C was in his room cleaning being assisted by former staff #9. Staff #9 prompted client C to take a shower. Client C did not want a shower and staff #9 continued to prompt him for</p> | W0153   | <p><b>W153</b></p> <p><b>STAFF TREATMENT OF CLIENTS</b></p> <p><b>Plan of Correction</b></p> <p>Stone Belt ensures that all allegations of mistreatment, abuse or neglect are reported immediately to the administrator or other officials. Stone Belt will report the incident within 24 hours.</p> <p><b>Date of Completion</b></p> <p>August 10, 2012</p> <p><b>Responsible Person</b></p> <p>Deckard Coordinator and SGL Director</p> <p><b>Plan of Prevention</b></p> <p>The Coordinator will assure that such reports are completed within 24 hours of the incident. The training included Incident Reporting Procedures. (Attachment # 6 and # 6A)</p> | 08/08/2012  |  |   |  |

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|                    | <p>5 more minutes. Fifteen minutes later, staff #6, from the living room, observed client C and staff #9 run outside the front door. Staff observed staff #9 "screaming" at client C. Three to five minutes later, client C came back inside and stated, "I'm going to tell my dad and [staff #2] on you." Staff #9 indicated to client C, "You can't get me fired, [client C], they will put you in jail before I get fired." Client C then walked toward the restroom. Staff #9 followed client C and pushed him into the cabinet inside the restroom and then placed her hands on his neck and yelled, "You better take a shower now or I'll assist you." Staff #9 let client C go and he attempted to exit the restroom. Staff #9 grabbed the back of his shirt, turned him around and again pushed client C against the cabinet, placing one hand on his stomach and the other pushing at his neck, telling him to take a shower. Client C agreed to take a shower so staff #9 walked out of the restroom and shut the door. Client C attempted to exit the restroom however staff #9 held the door shut with her body. Client C yelled, "Please let me out!" Staff #9 replied, No G__d__, you aren't coming out until you take a da__ shower." Client C took a shower and then went straight to his room to get dressed and then took a nap.</p> <p>An interview with staff #6 in the</p> |               | <p><b>Quality Assurance Monitoring</b></p> <p>The SGL Director will review all incident reports and assure they are reported within the 24 hour period.</p> |                      |

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|                    | <p>investigative report, dated 6/27/12, indicated he witnessed the events on 6/20/12 at 2:45 PM. He indicated client C was refusing to take a shower. Staff #6 indicated he was not familiar with client C's behavior plan in regard to his shower procedure. Staff #5 prompted client C to take a shower in 5 minutes and client C indicated he did not want to. Client C then went to his room and slammed the door. During staff #5's prompts of client C to take a shower, staff #9 was in the office. Staff #5 then left the home and staff #9 went into client C's room. Staff #6 got up and stood outside client C's room to listen to what was going on (the door was closed). He could hear them laughing and joking. Then staff #6 heard client C state, "No, I am not getting in the shower." Staff #9 then exited client C's room and stated to staff #6, "The gloves are coming off - I'm taking things out of my pockets" and she put her keys, change and jewelry in the office. Staff #6 indicated staff #9 appeared mad. Staff #9 reentered client C's room and client C told her he did not want to clean his room or take a shower. Staff #6 left briefly to attend to client A and when he returned staff #9 was taking the blankets and sheets off client C's bed so he could not sleep. Client C got up and ran outside to sit on the front sidewalk. Staff #6 then watched from the formal living room</p> |               |   |                      |

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|                    | <p>window. Staff #6 knew staff #9 was not to be working with client C. Client C and staff #9 then came back inside. They went to client C's room and then they ran back outside with staff #9 "screaming" at client C. Staff #6 heard client C indicate he was going to tell his dad on staff #9. Staff #9 stated, "Go ahead, go ahead, I don't care." Staff #6 then went outside. Staff #9's demeanor immediately changed. Staff #6 attempted to change the subject and get client C back inside. Staff #6 indicated each thing he said to encourage client C back into the home, staff #9 would repeat only aggressively and in a demanding tone. Staff #6 indicated staff #9 was "intense and he is scared of her." Client C returned inside to the formal living room. Staff #6 indicated he thought client C was calm and the incident was over. Staff #9 and client C sat on the couch. Staff #9 asked client C, "why don't you get into the shower." Client C went into the restroom. Client C was stomping his feet. Staff #6 then observed staff #9 push client C's back with two hands on his mid back and client C fell into the cabinet at the other side of the restroom. Staff #6 stepped into the restroom and client C turned to face staff #9. Client C's back was against the cabinet and wall. Staff #9 then grabbed client C around the neck with her two thumbs under his chin and pushed his</p> |               |   |                      |

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|                    | <p>face up with her hands. Staff #9 stated, "Are you going to take a shower and I am tired of these G__ d__ games." Client C was whimpering while she held his head. Client C said, "I will. I will." Then client C said to staff #9, "I'm going to tell [staff #2] and my dad on you." Staff #6 indicated, "I don't care. Your a__ will go to jail before mine with (sic) get fired." Client C indicated he would take a shower but he did not. Staff #9 stood outside the bathroom door and blocked client C from exiting for about 1 minute. Client C was trying to get out. Staff #9 was saying to client C, "Are you there yet? Are you getting into the G__ d__ shower?" Staff #6 indicated staff #9 was screaming. Staff #6 then opened the door and pushed client C with her hand on his chest. Client C hit the wall and she kept her hand on his chest to hold him against the wall. Staff #6 indicated client C was not resisting or being aggressive. Staff #9 put one hand up to his neck with her thumb under his chin and held him against the wall with this grip and the hand on his chest. She held him for 15-20 seconds. Staff #9 let him go and stated to client C, "Do I need to help you get undressed?" She then "forcefully" pulled his shirt off of him. Staff #6 indicated he told staff #9, at this point, client C could undress himself if she gave him a minute. Staff #9 indicated, "I'm sick of taking this</p> |               |   |                      |

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|                    | <p>bull _____. I don't know why you are the only one that doesn't listen." Client C was whining, "Ok, Ok." Staff #9 then left the restroom with staff #6. Client C took a shower. Staff #6 indicated staff #9 then started talking to him as if nothing had happened. When client C exited the shower, staff #6 went down to his room to check for injuries but client C told him he was fine and "I hate that dumb bi ____." Staff #6 told client C, "Don't deal with her the rest of the night, just come to me if you need anything." Staff #6 indicated staff #9 put client C on "red" which meant he could not make any phone calls and had no television. Client C did not come out of his room the remainder of staff #6's shift (ended at 7:50 PM).</p> <p>Staff #6 indicated in the investigative report he knew what staff #9 was not right, he realized staff #9 was engaging in a power struggle with client C but he did not know what to do. He indicated staff #9 was a more experienced staff and he had only worked there for 4 months. He indicated he knew abuse had occurred and he was trying to decide what he should do next. He indicated he knew he should report what happened but he didn't want another employee to have to come to the house. He indicated he did not want to write up the incident in front of staff #9. Staff #6 did not want to bother the after</p> |               |   |                      |

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|  | <p>hours pager. He indicated he did not want to have to face staff #9 at the Friday staff meetings. He indicated he reported the incident the next day to the staff #2 and the Program Director.</p> <p>The findings of the investigation indicated abuse was substantiated (the findings support the event as described/allegation). The Findings section indicated the following, "[Staff #6] indicates he felt afraid, and intimidated by a staff with more years of experience and who he perceived to be in an authority role. He failed to act in an assertive manner to stop the abuse and protect the client from further abuse. It was apparent that both [staff #9] and [staff #6] were unfamiliar with [client C's] behavior plan. There is some indication that [staff #9's] supervisors were aware that she was irritable and spoke to clients and staff in an aggressive, intimidating and loud tone in the past. She had been referred for counseling concerning these behaviors and had been instructed to not work with [client C] specifically."</p> <p>The Corrective Action section indicated staff #9 was terminated from employment on 6/27/12 and staff #6 received retraining on 6/29/12 on immediately reporting abuse to the administrator. The facility contacted the police who issued a</p> |   |   |                      |   |

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|  | <p>warrant for staff #9's arrest for confinement and battery on 6/22/12.</p> <p>An interview with client C was conducted on 7/3/12 at 11:19 AM. Client C indicated he felt safe at the group home. Client C stated, "She (staff #9) pushed me for no reason. I'm mad at her. She's not there anymore." Client C then walked away from the interview.</p> <p>An interview with the Program Director (PD) was conducted on 7/5/12 at 11:25 AM. The PD indicated staff #6 should have immediately reported the incident to administrative staff.</p> <p>An interview with Social Worker (SW) #2 was conducted on 7/3/12 at 1:08 PM. SW #2 indicated staff #6 should have reported the incident immediately.</p> <p>An interview with the Director was conducted on 7/3/12 at 11:54 AM. The Director indicated the incidents should have been reported immediately.</p> <p>This federal tag relates to complaint #IN00110873.</p> <p>9-3-2(a)</p> |   |   |                      |   |

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| W0154  | <p>483.420(d)(3)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 4 incident/investigative reports reviewed affecting client D, the facility failed to conduct a thorough investigation of alleged sexual contact at the facility-operated workshop.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/2/12 at 2:18 PM.</p> <p>On 6/12/12 at 12:30 PM at the facility-operated day program, client D allegedly touched a female peers breasts during break. It was also alleged client D took pictures of a female peer's breasts. The incident report was dated 6/13/12. There was no documentation administrative staff were notified. There was no documentation an investigation was conducted into the incident. An email, dated 6/14/12, from the social worker addressed to client D's interdisciplinary team indicated the social worker spoke to client D. Client D told her it was his idea to take pictures of her breasts and his face. The email indicated, "So, I think we need to intercept the</p> | W0154   | <p><b>W154</b></p> <p><b>STAFF TREATMENT OF CLIENTS</b></p> <p><b>Plan of Correction</b></p> <p>Stone Belt will ensure that all allegations are investigated thoroughly.</p> <p><b>Date of Completion</b></p> <p>August 10, 2012</p> <p><b>Responsible Person</b></p> <p>Deckard Coordinator/SGL Director</p> <p><b>Plan of Prevention</b></p> <p>The Coordinator and Social Worker reviewed and completed training on Stone Belt investigation procedures. This included how to conduct proper investigations and who should be interviewed. (Attachment # 8)</p> <p><b>Quality Assurance Monitoring</b></p> <p>The SGL Director will ensure, after reviewing the incident, that investigations will be completed thoroughly.</p> | 08/10/2012           |   |

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|                    | <p>camera and pictures." There was no documentation the female peer was interviewed or client B who initially reported the incident to staff on 6/12/12. There was no documentation an interview was conducted with the staff client B reported the incident to. There was no documentation if the camera was intercepted. There was no documentation indicating if the incident was substantiated or not.</p> <p>An interview with Social Worker #1 (SW) was conducted on 7/3/12 at 10:45 AM. The SW indicated she did not conduct a formal investigation into the incident. The SW indicated client D and the female peer were dating. The SW indicated both of the clients had the capacity to make the choice. The SW indicated the camera was intercepted and there was one photo of client B laying his head on the female peer's clothed chest area. The SW indicated although the clients were interviewed, there was no documentation of the interviews.</p> <p>An interview with SW #2 was conducted on 7/3/12 at 1:08 PM. SW #2 indicated the facility did not investigate sexual acting out. SW #2 indicated the SW conducted assessments of the incident to determine if sexual acting out or sexual abuse. SW #2 indicated in the past, all</p> |               |   |                      |

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|  | <p>incidents of a sexual nature were investigated as abuse.</p> <p>An interview with the Director was conducted on 7/3/12 at 11:54 AM. The Director indicated the incident should have been investigated and documented.</p> <p>9-3-2(a)</p> |   |   |                      |   |

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| W0157              | <p>483.420(d)(4)<br/>STAFF TREATMENT OF CLIENTS<br/>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 1 of 4 incident/investigative reports reviewed affecting client C, the facility failed to increase monitoring at the group home by administrative staff after an incident of substantiated abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/2/12 at 2:18 PM.</p> <p>On 6/20/12, client C was in his room cleaning being assisted by former staff #9. Staff #9 prompted client C to take a shower. Client C did not want a shower and staff #9 continued to prompt him for 5 more minutes. Fifteen minutes later, staff #6, from the living room, observed client C and staff #9 run outside the front door. Staff observed staff #9 "screaming" at client C. Three to five minutes later, client C came back inside and stated, "I'm going to tell my dad and [staff #2] on you." Staff #9 indicated to client C, "You can't get me fired, [client C], they will put you in jail before I get fired." Client C then walked toward the restroom. Staff #9 followed client C and pushed him into</p> | W0157         | <p><b>W157</b></p> <p><b>STAFF TREATMENT OF CLIENTS</b></p> <p><b>Plan of Correction</b></p> <p>Stone Belt will ensure that if a violation is verified, appropriate corrective action will be taken and in be completed in a timely manner. This would include increased monitoring of the facility after an alleged violation of abuse and neglect is substantiated.</p> <p><b>Date of Completion</b></p> <p>August 8, 2012</p> <p><b>Responsible Person</b></p> <p>Deckard Coordinator/SGL Director</p> <p><b>Plan of Prevention</b></p> <p>House Coordinator, SGL Director and other administrative staff will provide administrative oversight if other incidents occur in the future. Visits will be documents on Stone Belt Program Visit Report for SGL Director and House Coordinator. (Attachment # 4). Social Worker, Nurse and Behaviorist will</p> | 08/08/2012           |

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|                    | <p>the cabinet inside the restroom and then placed her hands on his neck and yelled, "You better take a shower now or I'll assist you." Staff #9 let client C go and he attempted to exit the restroom. Staff #9 grabbed the back of his shirt, turned him around and again pushed client C against the cabinet, placing one hand on his stomach and the other pushing at his neck, telling him to take a shower. Client C agreed to take a shower so staff #9 walked out of the restroom and shut the door. Client C attempted to exit the restroom however staff #9 held the door shut with her body. Client C yelled, "Please let me out!" Staff #9 replied, No G__d___, you aren't coming out until you take a d__ shower." Client C took a shower and then went straight to his room to get dressed and then took a nap.</p> <p>An interview with staff #6 in the investigative report, dated 6/27/12, indicated he witnessed the events on 6/20/12 at 2:45 PM. He indicated client C was refusing to take a shower. Staff #6 indicated he was not familiar with client C's behavior plan in regard to his shower procedure. Staff #5 prompted client C to take a shower in 5 minutes and client C indicated he did not want to. Client C then went to his room and slammed the door. During staff #5's prompts of client C to take a shower, staff #9 was in the</p> |               | <p>document their visit on the Professional Services Sign-in Sheet. (Attachment # 5)</p> <p><b>Quality Assurance Monitoring</b></p> <p>House Coordinator and SGL Director will document both announced and unannounced visits to the homes on the Program Visit Report. SGL Director will review this, at a minimum, on a monthly basis. In addition, SGL Director will review visit by other administrative staff using the Professional Sign-In Sheet. These visits will be at least twice a month. If an allegation of abuse/neglect occurs in the future, Coordinator and Director and other administrative staff will go to the home as instructed by SGL Director.</p> |                      |

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|                    | <p>office. Staff #5 then left the home and staff #9 went into client C's room. Staff #6 got up and stood outside client C's room to listen to what was going on (the door was closed). He could hear them laughing and joking. Then staff #6 heard client C state, "No, I am not getting in the shower." Staff #9 then exited client C's room and stated to staff #6, "The gloves are coming off - I'm taking things out of my pockets" and she put her keys, change and jewelry in the office. Staff #6 indicated staff #9 appeared mad. Staff #9 reentered client C's room and client C told her he did not want to clean his room or take a shower. Staff #6 left briefly to attend to client A and when he returned staff #9 was taking the blankets and sheets off client C's bed so he could not sleep. Client C got up and ran outside to sit on the front sidewalk. Staff #6 then watched from the formal living room window. Staff #6 knew staff #9 was not to be working with client C. Client C and staff #9 then came back inside. They went to client C's room and then they ran back outside with staff #9 "screaming" at client C. Staff #6 heard client C indicate he was going to tell his dad on staff #9. Staff #9 stated, "Go ahead, go ahead, I don't care." Staff #6 then went outside. Staff #9's demeanor immediately changed. Staff #6 attempted to change the subject and get client C back inside.</p> |               |   |                      |

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|                    | <p>Staff #6 indicated each thing he said to encourage client C back into the home, staff #9 would repeat only aggressively and in a demanding tone. Staff #6 indicated staff #9 was "intense and he is scared of her." Client C returned inside to the formal living room. Staff #6 indicated he thought client C was calm and the incident was over. Staff #9 and client C sat on the couch. Staff #9 asked client C, "why don't you get into the shower." Client C went into the restroom. Client C was stomping his feet. Staff #6 then observed staff #9 push client C's back with two hands on his mid back and client C fell into the cabinet at the other side of the restroom. Staff #6 stepped into the restroom and client C turned to face staff #9. Client C's back was against the cabinet and wall. Staff #9 then grabbed client C around the neck with her two thumbs under his chin and pushed his face up with her hands. Staff #9 stated, "Are you going to take a shower and I am tired of these G__ d___ games." Client C was whimpering while she held his head. Client C said, "I will. I will." Then client C said to staff #9, "I'm going to tell [staff #2] and my dad on you." Staff #6 indicated, "I don't care. Your a__ will go to jail before mine with (sic) get fired." Client C indicated he would take a shower but he did not. Staff #9 stood outside the bathroom door and blocked</p> |               |   |                      |

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|                    | <p>client C from exiting for about 1 minute. Client C was trying to get out. Staff #9 was saying to client C, "Are you there yet? Are you getting into the G__d___ shower?" Staff #6 indicated staff #9 was screaming. Staff #6 then opened the door and pushed client C with her hand on his chest. Client C hit the wall and she kept her hand on his chest to hold him against the wall. Staff #6 indicated client C was not resisting or being aggressive. Staff #9 put one hand up to his neck with her thumb under his chin and held him against the wall with this grip and the hand on his chest. She held him for 15-20 seconds. Staff #9 let him go and stated to client C, "Do I need to help you get undressed?" She then "forcefully" pulled his shirt off of him. Staff #6 indicated he told staff #9, at this point, client C could undress himself if she gave him a minute. Staff #9 indicated, "I'm sick of taking this bull___. I don't know why you are the only one that doesn't listen." Client C was whining, "Ok, Ok." Staff #9 then left the restroom with staff #6. Client C took a shower. Staff #6 indicated staff #9 then started talking to him as if nothing had happened. When client C exited the shower, staff #6 went down to his room to check for injuries but client C told him he was fine and "I hate that dumb bi___." Staff #6 told client C, "Don't deal with her the rest of the night, just come to me if</p> |               |   |                      |

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|                    | <p>you need anything." Staff #6 indicated staff #9 put client C on "red" which meant he could not make any phone calls and had no television. Client C did not come out of his room the remainder of staff #6's shift (ended at 7:50 PM).</p> <p>Staff #6 indicated in the investigative report he knew what staff #9 was not right, he realized she was engaging in a power struggle with client C but he did not know what to do. He indicated staff #9 was a more experienced staff and he had only worked there for 4 months. He indicated he knew abuse had occurred and he was trying to decide what he should do next. He indicated he knew he should report what happened but he didn't want another employee to have to come to the house. He indicated he did not want to write up the incident in front of staff #9. Staff #6 did not want to bother the after hours pager. He indicated he did not want to have to face staff #6 at the Friday staff meetings. He indicated he reported the incident the next day to the staff #2 and the Program Director.</p> <p>Staff #6 indicated, on the weekend prior to the incident, the associate manager (staff #2) told him staff #9 was no longer to be paired (working) with client C. Staff #6 indicated his understanding was staff #9 was impatient with client C and</p> |               |   |                      |

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|  | <p>they did not get along.</p> <p>The findings of the investigation indicated abuse was substantiated (the findings support the event as described/allegation). The Findings section indicated the following, "[Staff #6] indicates he felt afraid, and intimidated by a staff with more years of experience and who he perceived to be in an authority role. He failed to act in an assertive manner to stop the abuse and protect the client from further abuse. It was apparent that both [staff #9] and [staff #6] were unfamiliar with [client C's] behavior plan. There is some indication that [staff #9's] supervisors were aware that she was irritable and spoke to clients and staff in an aggressive, intimidating and loud tone in the past. She had been referred for counseling concerning these behaviors and had been instructed to not work with [client C] specifically."</p> <p>The Corrective Action section indicated staff #9 was terminated from employment on 6/27/12 and staff #6 received retraining on 6/29/12 on immediately reporting abuse to the administrator. The facility contacted the police who issued a warrant for staff #9's arrest for confinement and battery on 6/22/12.</p> <p>An interview with client C was conducted</p> |   |   |   |  |   |  |

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|                    | <p>on 7/3/12 at 11:19 AM. Client C indicated he felt safe at the group home. Client C stated, "She (staff #9) pushed me for no reason. I'm mad at her. She's not there anymore." Client C then walked away from the interview.</p> <p>An interview with staff #2 was conducted on 7/2/12 at 5:08 PM. Staff #2 indicated he first heard about the incident the day after the incident occurred when staff #6 reported it to him. Staff #2 indicated the Program Director (PD) was at the group home at the time and the incident was reported to him. Staff #2 indicated following the incident, he trained staff #6 on immediately reporting abuse and neglect to administrative staff. Staff #2 indicated he had never seen staff #9 being abusive to the clients. He indicated the PD talked to him about not having staff #9 work with client C due to client C not responding positively to her. Staff #2 indicated client C responded to staff #9 with verbal and physical aggression. Staff #2 indicated the action of not having staff #9 working with client C was due to client C's responses to her prompting. Staff #2 indicated there was no indication of abuse by staff #9 at any time.</p> <p>An interview with the Director was conducted on 7/3/12 at 11:54 AM. The Director indicated there had been no</p> |               |   |                      |

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|                          | <p>changes in the monitoring of the group home by administrative staff. The Director indicated the Program Director visits the home at least two times per week.</p> <p>This federal tag relates to complaint #IN00110873.</p> <p>9-3-2(a)</p> |                     |  |                            |