

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/15/2011
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN46506		
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W0000	<p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00094561 completed September 23, 2011.</p> <p>Complaint #IN00094561- Not Corrected.</p> <p>This survey was completed in conjunction with the investigation of complaint #IN00100760 which resulted in an Immediate Jeopardy that was removed.</p> <p>Dates of Survey: December 12, 13, 14, and 15, 2011</p> <p>Provider Number: 15G632 Facility Number: 001208 AIM Number: 100240170</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12-19-11 by C. Neary, Program Coordinator.</p>	W0000			
W0122	<p>The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview, and record review, the facility failed to meet</p>	W0122	<b>The facility must ensure that specific client protections requirements are met.</b> On	12/31/2011	

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

TITLE

(X6) DATE

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

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	<p>the Condition of Participation: Client Protections. The facility neglected to develop and implement systematic effective interventions and provide sufficient oversight supervision to ensure protection for clients to prevent staff abuse, neglect, and mistreatment. The facility failed to immediately report allegations of staff to client abuse/neglect/mistreatment to BDDS (Bureau of Developmental Disability Services), failed to ensure thorough investigations, and failed to implement sufficient corrective action to prevent abuse, neglect, and mistreatment for 5 of 8 clients (clients A, B, E, G, and H) living in the facility.</p> <p>Findings include:</p> <p>Please refer to W149. For the neglect of the facility to develop and to implement their policy and procedure prohibiting abuse/neglect/mistreatment. The facility neglected to ensure systematic effective interventions and provide oversight of the facility staff to protect clients and neglected to ensure sufficient supervision to prevent client injuries and discomfort after a staff had recurrent suspensions for allegations of abuse, neglect, and mistreatment of clients for 5 of 8 clients (clients A, B, E, G, and H) who lived in the group home.</p>		<p>12/15/2011 the agency updated the Investigation Procedure - Person Served procedure to include additional direction for supervisors following the return of staff who were suspended for allegation of Abuse/Neglect/Exploitation that is unsubstantiated. This updated procedure specifies that supervisors are required to work with the Human Resources Department to determine if an employee needs additional training and/or oversight following a suspension as deemed necessary. (See Attachment B)The updated Investigation Procedure - Person Served was retrained to the supervising manager and QDP on 12/15/2011. (See attachment C) The purpose of the Investigation Procedure is to ensure all investigations are conducted timely and thoroughly and to promote the health and safety of persons served and to ensure their well-being. All supervisors were retrained on the updated Investigation Procedure - Person Served on 12/21/2011. Additionally, the Residential Manager, QDP and DSPs were retrained on the agency's Incident/Abuse/Neglect Policy (see attachments C – H). More specifically, the Residential Manager, QDP and DSPs were retrained that all allegations of abuse/neglect/mistreatment must be reported to the on-call</p>		

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W0149	<p>This federal tag relates to complaint #IN00094561.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 5 of 8 clients (clients A, B, E, G, and H) who lived in the group home, the facility neglected develop and to implement their policy and procedure prohibiting abuse/neglect/mistreatment. The facility neglected to ensure systematic effective interventions and provide oversight of the facility staff to protect clients and neglected to ensure sufficient supervision to prevent client injuries and discomfort after a staff had recurrent suspensions for allegations of abuse, neglect, and mistreatment of clients.</p>	W0149	<p>manager immediately. Furthermore, all reportable incidents must be reported to BDDS within 24 hours of the incident. To ensure this deficiency does not occur again, the Human Resources Department and Supervisor will review all documentation prior to the return of the suspended employee and proceed with additional training/oversight and/or reassignment as deemed necessary. Furthermore, the Residential Manager and Coordinator will monitor the implementation of the of Incident/Abuse/Neglect Policy through ongoing training and observation. <b>Human Resources and Supervisor Responsible</b></p> <p><b>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</b> On 12/15/2011 the agency updated the Investigation Procedure - Person Served procedure to include additional direction for supervisors following the return of staff who were suspended for allegation of Abuse/Neglect/Exploitation that is unsubstantiated. This updated procedure specifies that supervisors are required to work with the Human Resources Department to determine if an employee needs additional</p>	12/31/2011	

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	<p>Findings include:</p> <p>On 12/12/11 at 12:45pm, the facility BDDS (Bureau of Developmental Disability Services) reports and investigations were reviewed for the period of 1/1/11 through 12/12/11 and indicated the following:</p> <p>1. A BDDS report on 12/2/11 for an incident on 12/1/2011 at 5pm, indicated the "Site Director received a call from the group home manager (Residential Manager) that she may have a possible abuse situation." The RM received a call on 12/1/11 at 11pm from a second shift staff that client B had burned his lips on his dinner earlier that evening. Client B's lips "were blistered" and the staff asked if she could give client B Tylenol (pain reliever) which was approved. Client B had no other injuries noted at 11pm. The report indicated at 3am on 12/2/11 the RM received a call from a third shift staff who stated that client B also had a bruise above his left eye. The RM called the RC (Residential Coordinator) on 12/2/11 regarding the incident when Direct Care Staff (DCS) #6 was working with client B the evening of 12/1/11 and "the injuries seemed suspicious in nature." The report indicated "the RC went to the group home to visit [client B] and the right side</p>		<p>training and/or oversight following a suspension as deemed necessary. (See Attachment B)The updated Investigation Procedure - Person Served was retrained to the supervising manager and QDP on 12/15/2011. (See attachment C) The purpose of the Investigation Procedure is to ensure all investigations are conducted timely and thoroughly and to promote the health and safety of persons served and to ensure their well-being. All supervisors were retrained on the updated procedure on 12/21/2011. Additionally, the Residential Manager, QDP and DSPs were retrained on the agency's Incident/Abuse/Neglect Policy (see attachments C – H). More specifically, the Residential Manager, QDP and DSPs were retrained that all allegations of abuse/neglect/mistreatment must be reported to the on-call manager immediately. Furthermore, all reportable incidents must be reported to BDDS within 24 hours of the incident. To ensure this deficiency does not occur again, the Human Resources Department and Supervisor will review all documentation prior to the return of the suspended employee and proceed with additional training/oversight and/or reassignment as deemed necessary. Furthermore, the Residential Manager and</p>		

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	<p>of [client B's] upper and lower lips were swollen approximately 3cm (centimeter) larger than the left side of his lips. The lower lip has approximately a 1cm blister. The upper lip has approximately a 2cm dark red mark. The injury does not appear to be conducive (sic) to a burn. Furthermore [client B's] left eye from just below his eyebrow to the crease of his eyelid is swollen and bruised. The injury is slightly larger than the size of a dime. Additionally [client B] has a bruise on his upper right ear about the 1/2" long. The bruise is dark purple in color (sic). After reviewing progress notes and talking with staff the RC determined that the cause of [client B's] injuries were suspicious in nature." The report indicated DCS #6 was the staff assigned to client B for one on one supervision on 12/1/11. The report indicated DCS #6 was suspended on 12/2/11 pending an investigation. Client B was sent to the ER (Emergency Room) and the police were contacted.</p> <p>-A BDDS report on 12/2/2011 for an incident dated on 12/2/11 at 10am, indicated client H's outside day service provider contacted and reported Cardinal Services that client H had a 1/2" (half an inch) dark purple bruise on the top of his left ear. Client H's right eye "above his brow line was lightly bruised." The report indicated "Cardinal Services staff picked</p>		Coordinator will monitor the implementation of the of Incident/Abuse/Neglect Policy through ongoing training and observation. <b>Human Resources and Supervisor Responsible</b>				

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	<p>(sic)" up client H from the day service provider and a police officer met with the RC and client H at the group home. The report indicated "Reports indicate staff did not notice the bruises and possibly linked to another incident for other clients at the group home (sic)." The report indicated the bruises were "suspicious" and client H was sent to the ER.</p> <p>-A BDDS report on 12/2/11 for an incident on 11/23/11 at 8pm, indicated on 11/23/11 DCS #6 filed an accident report for client E. DCS #6's report indicated client E "tripped in the bathroom and hit his eye on the toilet paper holder." Client E "did not fall and was able to regain his balance." The report indicated client E "received a quarter sized bruise under his left eye." The BDDS report indicated "the incident did not meet BDDS reporting guidelines at the time. On 12/2/11 the RC investigated a separate incident with one of [client E's] peers after review of that incident the RC determined that the injury to [client E's] eye may be suspicious in nature (sic)." The report indicated client E's eye was healing and the police were notified. The report indicated DCS #6 was immediately suspended on 12/2/11.</p> <p>On 12/12/11 at 2pm, the facility's investigations and "Witness" statements were reviewed.</p>						

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	<p>-DCS #4's witness statement indicated on 12/2/11 she worked on the opposite side of the home that night on 12/1/11. DCS #4 did not note injuries on client B's face at 5pm. DCS #4 indicated at 8:20pm, another group home staff asked DCS #4 to look at client B's lip. DCS #4 indicated she saw a small red dot and a small amount of dried blood on client B's lips. DCS #4 indicated client B had no swelling, no blister, and no bruising on his left eye or left ear. DCS #4 indicated she did not observe client H. DCS #4 indicated on 11/23/11 she did not work with client E that evening but "remembered he seemed upset that evening, later she noticed when in passing him his eye did look like it was going to bruise."</p> <p>-DCS #7's witness statement indicated she did not notice client H's bruise on 12/1/11 or 12/2/11. DCS #7 indicated on 11/23/11 she worked the overnight shift. When she arrived she was told client E had fallen and had hurt himself while taking a shower. DCS #7 indicated the next morning client E had a black eye.</p> <p>-DCS #11's witness statement indicated on 12/2/11 she made the pureed food for client B and it had sat "at least 10 minutes" before serving the food and the food was served to client B "after the</p>				

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	<p>other clients were served." DCS #11 stated she "did not believe the food caused the burn. No way was the food too hot." DCS #11 stated "no blister was seen at 3am bed checks." DCS #11 stated at 3am "there was blood area on his lower lip and his upper lip was hugely swollen, no blister seen (sic)." DCS #11 stated she "noticed a bruise about 1 inch in length on his left eyebrow that was quite swollen and turning purple" and no other marks were noticed.</p> <p>2. A BDDS report dated on 9/12/11 for an incident on 9/9/11 at 6:20am, indicated client A was in the restroom, "staff [DCS #6] helped [client A] pull his pants down so he could sit on the toilet. Staff went to [client A's] bedroom to get his clothes. Staff heard a loud sound from the restroom, staff ran into the restroom to check" on client A and found client A on the floor in front of the toilet. Client A's shirt was over client A's head. Client A had a bump and a scrape on his forehead. The report indicated "Plan to resolve: staff will stay with [client A] until he has completely undressed/dressed. Staff will not leave [client A] unattended in the restroom." The 9/12/11 BDDS report indicated client A's 8/10/11 "Mobility Screening and Fall assessment" indicated client A needed staff supervision in the bathroom because he did not recognize</p>				

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	<p>risks and "staff need to be present while showering/bathing," The report indicated DCS #6 was the staff assigned to client A. No evidence of corrective action was available for review.</p> <p>3. A BDDS report dated on 8/17/11 for an incident on 8/17/11 at 3:20pm indicated client B "had bruises on his knees little over 3 inches in circular shape (sic)." The report indicated client B had sat in a recliner with legs drawn up into his favorite sitting position and client B "Bruises easily." The report indicated client B's "Bruises appear self inflicted." DCS #6 was his assigned caregiver on 8/17/11 and client B was to have had pillows between knees. No evidence of corrective action was available for review.</p> <p>4. An investigation dated for 7/28/11 with no BDDS report available for review for client B was reviewed. The investigation for an incident on 7/27/11 at 11:15, no am or pm was documented, indicated client B arrived home from the local hospital by ambulance on a cot and was assisted to bed. Client B "was weak and fully dependent on staff" because of his illness. The investigation indicated no documented bed checks, no bed changes, and no toileting were completed throughout the night for client B by assigned facility staff DCS #6. The</p>			

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	<p>investigation indicated on 7/28/11 at 12:45pm, the RC stated client B was left in a soiled adult brief overnight in his bed. The RC indicated "this is the third time you have been suspended on allegations of abuse/neglect. What is going on with you?" DCS #6 was suspended pending the ongoing investigation. The Investigation indicated client B was "covered in urine and feces on 7/28/11 in the same gown and depends he left the hospital in." No evidence of corrective action was available for review.</p> <p>5. A BDDS report on 3/30/11 for an incident on 3/29/11 at 2am, indicated "It came to attention of management (sic)" that DCS #6 had "inappropriately interacted with a client (client A)." The report indicated client A woke up at 2am during bed checks and DCS #6 rubbed his back and encouraged him to go back to bed. The other staff on duty was watching from a distance and thought that DCS #6 had physically pushed client A back to bed. DCS #6 was suspended pending the investigation. The investigation was unsubstantiated abuse because the DCS #6 "gave a reason and description" that DCS #6 did not push client A's "head down." No evidence of corrective action was available for review.</p> <p>6. The 3/28/11 Investigation for an</p>				

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	<p>allegation on 3/28/11 at 8:30pm, for client E was reviewed and no BDDS report was available for review. The 3/28/11 at 8:30pm investigation indicated DCS #16 stated "I saw [DCS #6] push [client E]" and indicated DCS #16 "could not remember the date." DCS #6 was trying to get a movie to play for the clients on the TV. Client E kept bringing him a pair of pants and wanted the belt out. DCS #6 told client E "[client E] knew how to do this himself several times." The investigation indicated client E walked away then came right back and DCS #6 was still working on the TV. DCS #6 "put his hand on [client E] and pushed [client E] out of the way. It was more like he moved him." No evidence of corrective action was available for review.</p> <p>7. A BDDS report on 1/14/11 for an incident on 1/13/11 at 4:15pm, indicated "It came to the attention of management that there might have been some kind of abuse toward" client G by DCS #6. The report indicated DCS #6 was suspended pending an investigation. The report indicated client G and DCS #6 were alone inside client G's room and client G "came out of the room very upset and stomping his feet in a very unusual way." The investigation indicated DCS #6 went into client G's room, client G was napping in his bedroom, and DCS #6 began</p>				

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	<p>"cleaning." The investigative notes and interview indicated DCS #6 stated he "didn't know why he (DCS #6) didn't clean other rooms first (sic)." The report indicated DCS #6 "wanted" to clean client G's room. DCS #6 "said he did wake [client G] up intentionally so he could clean" and client G "got mad." The investigation results indicated DCS #6 "didn't know [client G] was sleeping in his bedroom" and no abuse was identified. No retraining or evidence of corrective actions were available for review.</p> <p>Observations and interviews were completed at the group home on 12/12/11 from 3:55pm until 5:45pm. At 4:05pm, DCS #17 stated clients A, B, E, G, and H were non verbal and "none of the clients" recognized dangers or abuse. At 4:05pm, DCS #5 stated "none" of the clients in the group home recognized danger or if the client was being "abused." DCS #5 stated she had "worked in the group home three (3) years" and "was present on duty" at the group home on 11/23/11. DCS #5 stated she had taken a different client on an outing on 11/23/11 and when she returned to the group home "around 9:30pm" she was told of client E's "fall in the bathroom." DCS #5 stated she remembered client E sat up in his bed when she was assisting client B to bed and she did not notice client E's "black</p>				

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	<p>eye." DCS #5 indicated on 12/2/11 she was told of client B's burns to his mouth/lips. DCS #5 showed the places on client B's lips and one area on client B's lower lip was dark red/purple and DCS #5 stated the area "appeared to be still healing." DCS #5 showed and stated a bruise over client B's left eye "was brown (and green)" and "appeared to be still healing." At 4:05pm, DCS #5 showed the surveyor the bathroom toilet paper holder which was anchored into the bathroom wall below the level of the toilet grab bars on the right side of the bathroom which was below the right side of the window ledge. DCS #5 stated "there is no way" client E fell into the toilet paper holder, bloodied his lips, blackened his left eye, and did not "fall." DCS #5 stated "no client" in the group home "should be left alone" in the bathroom or in the shower. At 4:25pm, DCS #5, DCS #17, and DCS #18 stated clients A, B, and E were "hesitant to go outside" the group home on outings with DCS #6 "but we didn't know why (because) those clients all like to go anywhere."</p> <p>On 12/13/11 from 12:25pm until 1:05pm, observation and interview was completed at the group home. At 1pm, DCS #2 stated "I have seen clients (in the group home) hesitant about going out with [DCS #6], I remember [client G] in March</p>				

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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN46506		
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	<p>(2011) came out of his room where [client G] and [DCS #6] were alone, got [DCS #13's] attention, [client G] made a two finger swiping motion for pain across his forehead, then hit himself and made a loud slap sound." DCS #2 stated "we reported it, cause [client G] doesn't act like that. Something was wrong." DCs #2 stated "after that (incident) [client G] would not stay in the same room with [DCS #6]."</p> <p>On 12/14/11 at 9am, an interview with the RC and QDDP was completed. Both indicated no BDDS report was available for review for client G in March, 2011.</p> <p>On 12/13/11 at 9:55am, an interview with the RC was completed. The RC indicated DCS #6 had been terminated from employment on 12/5/11 with the agency after the 12/2/11 incident. The RC stated "our system is broke, it (the system) did not protect" clients living in the group home from injuries, abuse, neglect, or mistreatment. The RC indicated no corrective action was available for review in addition to what was documented on the reports provided. The RC indicated there was no additional oversight of the facility staff after being suspended for allegations of abuse, neglect, or mistreatment for clients living in the group home.</p>				

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	<p>On 12/13/11 at 10:30am, an interview with the RC and the QDDP (Qualified Developmental Disability Professional) was completed. Both indicated no additional facility oversight and no additional staff training or retraining were available for review for the period of time from 1/1/11 through 12/12/11 after staff had received written reprimands and suspensions for allegations of abuse, neglect, and mistreatment. Both indicated the RM and the QDDP each completed one documented monthly visit and four non documented monthly visits of the group home to monitor active treatment and the group home. Both stated "no additional" monitoring was available for review. The RC stated "I know [DCS #6's] suspensions were discussed with HR [Human Resources Department for the Agency], but I am not aware of any additional trainings or monitoring" for "any" of DCS #6's suspensions. The RC stated "We have to do something, because our system didn't work. It continued to happen." The RC stated "Additional monitoring should have been (put) in place." The RC stated "Our internal system is the problem, we didn't protect" the clients from the potential of further abuse, neglect, and mistreatment after documented allegations had been reported by facility staff and investigated.</p>			

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	<p>Client A's record was reviewed on 12/12/11 at 2:15pm. Client A's 8/10/11 ISP (Individual Support Plan) indicated he was non verbal and was to have "one on one staff supervision during all waking hours." Client A's record indicated he did not recognize personal danger, abuse, or neglect. Client A's record indicated he required staff assistance for incontinence care, bed checks throughout the night, and staff to monitor his well being.</p> <p>Client B's record was reviewed on 12/13/11 at 10:55am. Client B's 1/6/11 ISP indicated he was non verbal and required 24 hour staff supervision. Client B's record indicated he did not recognize personal danger, abuse, or neglect. Client B's record indicated he required staff assistance for incontinence care, bed checks throughout the night, and staff to monitor his well being.</p> <p>Client E's record was reviewed on 12/12/11 at 2:30pm. Client E's 4/20/11 ISP indicated he was non verbal and required 24 hour staff supervision. Client E's 4/20/11 BSP (Behavior Support Plan) indicated a program objective to teach him personal space. Client E's record indicated he did not recognize personal danger, abuse, or neglect. Client E's record indicated he required staff</p>			

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	<p>assistance for incontinence care, bed checks throughout the night, and staff to monitor his well being.</p> <p>On 12/12/11 at 1:30pm, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."</p> <p>The facility's 9/11 Policy for the Prevention and Resolution of Abuse, Neglect, and Mistreatment of Individuals was reviewed on 12/12/11 at 1:30pm, and indicated "[The name of the Agency] is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated, incidents will be reported and thoroughly investigated. 431 IAC 1-1-3-1 obligates [facility name] to report to the Bureau of Developmental Disabilities Services/BDDS and Adult Protective Services (APS) any suspicion or allegation of neglect or abuse whether that suspicion or allegation is based upon</p>				

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	<p>fact or not. The agency may not screen such allegations...Physical abuse/sexual abuse: Suspected, alleged, or confirmed physical or sexual abuse of a person served. This includes: forced physical activity, willful infliction of injury, by hitting, pinching, or kicking, physical restraints, using painful noxious stimuli...physical harm or pain...Neglect: Incidents involving persons served which could be construed as neglect...depriving a person served of necessary support...The reporting staff must always report all incidents immediately to an on call supervisor. That supervisor will report all incidents to the Department Coordinator for further follow up." The agency's policies and procedures did not indicate administrative oversight to prevent abuse/neglect/mistreatment and did not indicated specific implementation of interventions to protect clients from the potential of abuse, neglect, and mistreatment when a staff had a documented history of suspensions for alleged abuse/neglect/mistreatment.</p> <p>On 12/13/11 at 9:55am, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the</p>			

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	<p>company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to facility staff."</p> <p>This deficiency was cited on 8/23/2011. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00094561.</p> <p>9-3-2(a)</p>				