

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G336	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/29/2012
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3814 WALDEN RUN FORT WAYNE, IN 46815
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W0000	<p>This visit was for the investigation of complaint #IN00104050.</p> <p>Complaint #IN00104050-SUBSTANTIATED, Federal and State deficiencies related to the allegation(s) are cited at W149, W157, and W186.</p> <p>Dates of Survey: February 27, 28 and 29, 2012.</p> <p>Facility number: 000854 Provider number: 15G336 AIM number: 100243900</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed on 3/9/12 by Tim Shebel, 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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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility neglected to implement its "Reporting and Investigating Abuse/Neglect/Exploitation/Mistreatment Policy" by neglecting to protect 1 of 8 clients living in the home (client A) from her elopement behaviors.</p> <p>Findings include:</p> <p>Facility records were reviewed on 2/29/12 at 12:45 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 1/1/12 and 2/29/12. The reports indicated the following:</p> <p>A BDDS report dated 1/10/12 for an incident on 1/9/12 at 7:30 P.M. indicated "On 1/9/12, [Client A] was taken to [name] Emergency Room (ER) where she was assessed for possible admission to their behavioral unit but later released. [Client A] had been upset earlier at the workshop. She was making threats of leaving the group home and wanting to harm herself. She was not dealing well with her environment. Qualified Mental Retardation Professional (QMRP) went to the workshop and spent several hours</p>	W0149	Per IDT meeting, a third staff has been scheduled from 3:30pm – 8:30pm, or later if needed, Monday through Friday. (See schedule) An emergency cell phone has been assigned to the home to assure that staff have access to the phone should client A leave the home. If Client A leaves the home, a staff member will follow her and keep her in eyesight at all times. If Client A refuses to return home, the police will be called to provide assistance to get her to return home. Staff continues to follow the behavior support plan that was revised and continues to be appropriate. QMRP and IDT will continue to meet as necessary to review and revise plan as needed.	03/23/2012			

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	<p>with her and staff in an attempt to calm her. She eventually calmed enough to go home. However, once home, the behavior continued. At 6:30 P.M. [client A] stated she wanted to leave her group home. She put her coat on went outside and started walking down the street. Staff accompanied her, keeping her within eyesight the entire time. The police were eventually called. Once the police arrived, they escorted [client A] home and spoke with her concerning her behavior. [Client A] was then taken by staff to the [name] hospital for assessment and possible admission to the psychiatric unit, however she did not meet requirement for admission and was released home...suicide precautions have been initiated."</p> <p>A BDDS report dated 1/13/12 for an incident on 1/12/12 at 6:00 P.M. indicated "On 1/12/12, [client A] was taken to [name] ER where she was assessed and later admitted to the psychiatric unit. Earlier [client A] became upset during a phone call with a friend, the friend confronted [client A] about a lie that she had told the day before. At that point [client A] became verbally and physically aggressive towards staff. She went to her room, got her coat and headed out of the house. Staff followed [client A]. The police were called due to elopement from</p>				

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	<p>the home and refusing to come back. Once the police arrived. [Client A] became verbally and physically aggressive with them. The police transported her to the ER for evaluation. She was assessed and admitted to the psychiatric unit for further evaluation."</p> <p>A BDDS report dated 2/15/12 for an incident on 2/14/12 at 6:30 P.M. indicated "On 2/14/12, the police were called to [name of group home] to assist [client A] back into her home. At approximately 6:30 P.M. direct care staff (DCS) #1 took four of the ladies (clients D, E, G and H) into the community to go shopping. While they were gone, [client A] became upset and threatened to leave the home. DCS #2 attempted to redirect [client A] but was unsuccessful. She (client A) walked out of the house. DCS #2 was the only staff in the home at the time with the other consumers (clients A, B, C and F). DCS#2 remained in the home but kept [client A] within eyesight. [Client A] walked out of eyesight, so DCS #2 called the police for assistance. Once the police arrived, they found [client A] sitting on the ground a block away from her home. The police assisted her back home. She was counseled on her inappropriate behavior and safety. The police did not believe she met criteria for inpatient admission."</p>			

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	<p>A BDDS report dated 2/16/12 for an incident on 2/15/12 at 2:30 P.M. indicated "On 2/15/12, [client A] was taken to [name] ER and later admitted to their behavioral unit. [Client A] refused to go to workshop and had been non-compliant all morning, making verbal and physical threats toward staff and saying she was going to kill herself. At around 2:00 P.M. [client A] called the program coordinator (PC) into her bedroom. [Client A] had a Wii controller wrapped around her neck. [Client A] stated she was going to kill herself. [Client A] became increasingly more agitated. The PC made several attempts to redirect [client A] but was unsuccessful. Staff became fearful of [client A] hurting herself and called the police for additional support. The police were able to remove the cord. [Client A] continued yelling at the officers...The police officers assisted her to the police car. She was taken to [name] ER. Once at the ER, [client A] was assessed and there were no injuries noted... She was admitted to the behavioral unit...."</p> <p>A BDDS report dated 2/29/12 for an incident on 2/28/12 at day program, indicated "On 2/28/12, the police were called to the [name] of workshop and escorted [client A] to her [name] of group home. While at workshop, [client</p>			

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	<p>A] became upset, she became verbally aggressive and walked outside of the workshop. The PC was contacted and went to the workshop, staying with [client A] She calmed and went back into the workshop... at 3:00 P.M. [client A] refused to get into the van and walked off the [name] of workshop property and headed down the street. After several unsuccessful attempts to get [client A] to return...the police were called. The police were not able to talk [client A] into returning...The police handcuffed [client A] and took her to her group home. They remained in her home until she calmed. [Client A] told staff she wanted to go to the hospital ...and was having suicidal thoughts but did not attempt to harm herself in any way. Suicidal precautions are in place."</p> <p>The facility policy for Reporting and Investigating Abuse/Neglect/Exploitation and Mistreatment, dated 6/2011 was reviewed on 2/29/12 at 11:45 A.M.. The policy indicated the following: "ResCare Northern Region Indiana staff actively advocate for the rights and safety of all individuals...If you witness an incident of alleged abuse, neglect or exploitation of a consumer, it is your responsibility to intervene on behalf of the individual."</p> <p>The Director of Supported Group Living</p>				

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	<p>(DSGP) was interviewed on 2/29/12 at 2:12 P.M.. When asked if the facility policy had been followed, the DSGP stated, "She left the home, was out of eyesight only 5 (five) minutes, the staff did what they could do, and contacted the police who arrived in 5 (five) minutes. " The DSPG indicated the policy had not been followed since (client A) had been unsupervised for 5 (five) minutes.</p> <p>This federal tag relates to complaint #IN00104050.</p> <p>9-3-2(a)</p>			

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to implement appropriate corrective actions to prevent 1 of 8 clients who lived in the home (client A) from her elopement behavior and suicidal threats/ideation.</p> <p>Findings include:</p> <p>Facility records were reviewed on 2/29/12 at 12:45 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 1/1/12 and 2/29/12. The reports indicated the following:</p> <p>A BDDS report dated 1/10/12 for an incident on 1/9/12 at 7:30 P.M. indicated "On 1/9/12, [Client A] was taken to [name] Emergency Room (ER) where she was assessed for possible admission to their behavioral unit but later released. [Client A] had been upset earlier at the workshop. She was making threats of leaving the group home and wanting to harm herself. She was not dealing well with her environment. Qualified Mental Retardation Professional (QMRP) went to the workshop and spent several hours with her and staff in an attempt to calm her. She eventually calmed enough to go</p>	W0157	Per IDT meeting, a third staff has been scheduled from 3:30pm – 8:30pm, or later if needed, Monday through Friday. (See schedule) An emergency cell phone has been assigned to the home to assure that staff have access to the phone should client A leave the home. If Client A leaves the home, a staff member will follow her and keep her in eyesight at all times. If Client A refuses to return home, the police will be called to provide assistance to get her to return home. Staff continues to follow the behavior support plan that was revised and continues to be appropriate. QMRP and IDT will continue to meet as necessary to review and revise plan as needed.	03/23/2012			

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	<p>home. However, once home, the behavior continued. At 6:30 P.M. [client A] stated she wanted to leave her group home. She put her coat on went outside and started walking down the street. Staff accompanied her, keeping her within eyesight the entire time. The police were eventually called. Once the police arrived, they escorted [client A] home and spoke with her concerning her behavior. [Client A] was then taken by staff to the [name] hospital for assessment and possible admission to the psychiatric unit, however she did not meet requirement for admission and was released home...suicide precautions have been initiated."</p> <p>Plan of action: "[Client A] has a scheduled initial appointment with her primary care physician (PCP) next week. [Name] of counseling services (prior provider of behavioral services) were contacted for possible recommendations in assisting [client A] with these behaviors.</p> <p>BDDS follow-up dated 1/18/12 for the incident on 1/10/12 indicated "[Client A's] Behavior Support Plan (BSP) was developed and implemented." PCP made a referral to have (client A) seen by a psychiatrist on 2/3/12.</p>			

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	<p>A BDDS report dated 1/13/12 for an incident on 1/12/12 at 6:00 P.M. indicated "On 1/12/12, [client A] was taken to [name] ER where she was assessed and later admitted to the psychiatric unit. Earlier [client A] became upset during a phone call with a friend, the friend confronted [client A] about a lie that she had told the day before. At that point [client A] became verbally and physically aggressive towards staff. She went to her room, got her coat and headed out of the house. Staff followed [client A]. The police were called due to elopement from the home and refusing to come back. Once the police arrived. [Client A] became verbally and physically aggressive with them. The police transported her to the ER for evaluation. She was assessed and admitted to the psychiatric unit for further evaluation."</p> <p>A follow-up BDDS report dated 1/23/12 for the incident on 1/12/12 indicated "[Client A] was discharged from the behavioral unit on 1/17/12. Her Depakote (mood stabilizer) was discontinued and Trileptal (anti-convulsant) 450mg (milligrams) twice daily was started. [Client A] was not injured or handcuffed throughout this incident. Her Interdisciplinary Team (IDT) met on 1/13/12 and changes were made to her BSP, guidelines were set about home</p>			

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	<p>visits and limiting use of her cell phone that belongs to her mother."</p> <p>A BDDS report dated 2/15/12 for an incident on 2/14/12 at 6:30 P.M. indicated "On 2/14/12, the police were called to [name of group home] to assist [client A] back into her home. At approximately 6:30 P.M. direct care staff (DCS) #1 took four of the ladies (clients D, E, G and H) into the community to go shopping. While they were gone, [client A] became upset and threatened to leave the home. DCS #2 attempted to redirect [client A] but was unsuccessful. She (client A) walked out of the house. DCS #2 was the only staff in the home at the time with the other consumers (clients A, B, C and F). DCS#2 remained in the home but kept [client A] within eyesight. [Client A] walked out of eyesight, so DCS #2 called the police for assistance. Once the police arrived, they found [client A] sitting on the ground a block away from her home. The police assisted her back home. She was counseled on her inappropriate behavior and safety. The police did not believe she met criteria for inpatient admission."</p> <p>A follow-up BDDS report dated 2/22/12 for the incident on 2/14/12 indicated "[Client A] was discharged from the behavioral unit on 2/21/12. Her Ativan</p>			

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	<p>(anxiety) and Zoloft (anti-depressant) were discontinued. She was started on Pristique (anti-depressant) 100mg daily and Neurontin (anti-convulsant) 300mg twice daily. An IDT meeting is scheduled for 2/23/12."</p> <p>A BDDS report dated 2/16/12 for an incident on 2/15/12 at 2:30 P.M. indicated "On 2/15/12, [client A] was taken to [name] ER and later admitted to their behavioral unit. [Client A] refused to go to workshop and had been non-compliant all morning, making verbal and physical threats toward staff and saying she was going to kill herself. At around 2:00 P.M. [client A] called the program coordinator (PC) into her bedroom. [Client A] had a Wii controller wrapped around her neck. [Client A] stated she was going to kill herself. [Client A] became increasingly more agitated. The PC made several attempts to redirect [client A] but was unsuccessful. Staff became fearful of [client A] hurting herself and called the police for additional support. The police were able to remove the cord. [Client A] continued yelling at the officers...The police officers assisted her to the police car. She was taken to [name] ER. Once at the ER, [client A] was assessed and there were no injuries noted... She was admitted to the behavioral unit...."</p>			

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	<p>A BDDS report dated 2/29/12 for an incident on 2/28/12 at day program, indicated "On 2/28/12, the police were called to the [name] of workshop and escorted [client A] to her [name] of group home. While at workshop, [client A] became upset, she became verbally aggressive and walked outside of the workshop. The PC was contacted and went to the workshop, staying with [client A] She calmed and went back into the workshop... at 3:00 P.M. [client A] refused to get into the van and walked off the [name] of workshop property and headed down the street. After several unsuccessful attempts to get [client A] to return...the police were called. The police were not able to talk [client A] into returning...The police handcuffed [client A] and took her to her group home. They remained in her home until she calmed. [Client A] told staff she wanted to go to the hospital ...and was having suicidal thoughts but did not attempt to harm herself in any way. Suicidal precautions are in place."</p> <p>Interdisciplinary Team (IDT) meeting notes dated 2/29/12 were reviewed on 2/29/12 at 2:10 P.M.. The IDT notes indicated the following: "...It was determined that the behaviors occurs after workshop in the early evening. She (client A) has not left the home after she has</p>			

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	<p>gone to bed at night, has not left the home in the morning and has not left the home on the weekend. it was determined that a third staff member will be scheduled at the home from approximately 3:30-8:30 P.M. Monday through Friday. this will allow for 2 (two) staff to always be in the home should [client A] decide to leave the home. Should [client A] leave the home, a staff member will follow her and keep her in eyesight at all times. If [client A] refuses to return home, the police will be called to provide assistance to get her to return home. An emergency cell phone will be assigned to the home to assure that staff have access to the phone should [client A] leave the home. [Client A] has demonstrated some behaviors at the workshop and has 'sat' outside the workshop threatening to leave. When this occurs, the workshop will call the home and/or the PC and a staff member will go to the workshop immediately to assure that [client A] is safe. If [client A] leaves the workshop and our staff is not at the workshop, the workshop will contact the police for assistance."</p> <p>Client A's record was reviewed on 2/17/12 at 5:00 P.M.. Client A's record indicated she was admitted to the group home on 12/11/11. The facility reviewed and implemented the BSP from client A's prior placement. On 12/30/11 the BSP</p>			

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	<p>was revised to include " 1. Staff should remain with [client A] if she leaves the home and accompany her until she returns home. 2. Police should be called as a last resort if she is outside (15 minutes at most), refusing staff intervention, endangering herself by walking on [name] of road." On 2/16/12 the BSP was revised to include the "remove all sharps,hazards, also remove cords." On 2/18/12 the BSP was revised "to remove shoes or strings, pants strings, cell phone cords, game cords, TV cords" as part of the suicide precautions. The staff checks on (client A) were changed from every 10 (ten) minutes to every 5 (five) minutes.</p> <p>The Director of Supported Group Living (DSGP) was interviewed on 2/29/12 at 2:12 P.M.. When asked if the facility had been able to prevent client A's elopement behavior, the DSPG stated, "She ran again last night from workshop." The DSPG indicated the corrective actions they had taken so far had not prevented client A from elopement, and she had been unsupervised for five minutes on 2/14/12.</p> <p>This federal tag relates to complaint #IN00104050.</p> <p>9-3-2(a)</p>			

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W0186	<p>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.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure there were a sufficient number of staff to supervise and provide needed care for 1 of 8 clients living in the home (client A) to protect her from her elopement behaviors.</p> <p>Findings include:</p> <p>Facility records were reviewed on 2/29/12 at 12:45 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 1/1/12 and 2/29/12. The reports indicated the following:</p> <p>A BDDS report dated 1/10/12 for an incident on 1/9/12 at 7:30 P.M. indicated "On 1/9/12, [Client A] was taken to [name] Emergency Room (ER) where she was assessed for possible admission to their behavioral unit but later released. [Client A] had been upset earlier at the workshop. She was making threats of leaving the group home and wanting to</p>	W0186	Per IDT meeting, a third staff has been scheduled from 3:30pm – 8:30pm, or later if needed, Monday through Friday. (See schedule) An emergency cell phone has been assigned to the home to assure that staff have access to the phone should client A leave the home. If Client A leaves the home, a staff member will follow her and keep her in eyesight at all times. If Client A refuses to return home, the police will be called to provide assistance to get her to return home. Staff continues to follow the behavior support plan that was revised and continues to be appropriate. QMRP and IDT will continue to meet as necessary to review and revise plan as needed.	03/23/2012			

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	<p>harm herself. She was not dealing well with her environment. Qualified Mental Retardation Professional (QMRP) went to the workshop and spent several hours with her and staff in an attempt to calm her. She eventually calmed enough to go home. However, once home, the behavior continued. At 6:30 P.M. [client A] stated she wanted to leave her group home. She put her coat on went outside and started walking down the street. Staff accompanied her, keeping her within eyesight the entire time. The police were eventually called. Once the police arrived, they escorted [client A] home and spoke with her concerning her behavior. [Client A] was then taken by staff to the [name] hospital for assessment and possible admission to the psychiatric unit, however she did not meet requirement for admission and was released home...suicide precautions have been initiated."</p> <p>A BDDS report dated 1/13/12 for an incident on 1/12/12 at 6:00 P.M. indicated "On 1/12/12, [client A] was taken to [name] ER where she was assessed and later admitted to the psychiatric unit. Earlier [client A] became upset during a phone call with a friend, the friend confronted [client A] about a lie that she had told the day before. At that point [client A] became verbally and physically</p>			

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	<p>aggressive towards staff. She went to her room, got her coat and headed out of the house. Staff followed [client A]. The police were called due to elopement from the home and refusing to come back. Once the police arrived. [Client A] became verbally and physically aggressive with them. The police transported her to the ER for evaluation. She was assessed and admitted to the psychiatric unit for further evaluation."</p> <p>A BDDS report dated 2/15/12 for an incident on 2/14/12 at 6:30 P.M. indicated "On 2/14/12, the police were called to [name of group home] to assist [client A] back into her home. At approximately 6:30 P.M. direct care staff (DCS) #1 took four of the ladies (clients D, E, G and H) into the community to go shopping. While they were gone, [client A] became upset and threatened to leave the home. DCS #2 attempted to redirect [client A] but was unsuccessful. She (client A) walked out of the house. DCS #2 was the only staff in the home at the time with the other consumers (clients A, B, C and F). DCS#2 remained in the home but kept [client A] within eyesight. [Client A] walked out of eyesight, so DCS #2 called the police for assistance. Once the police arrived, they found [client A] sitting on the ground a block away from her home. The police assisted her back home. She</p>			

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	<p>was counseled on her inappropriate behavior and safety. The police did not believe she met criteria for inpatient admission."</p> <p>A BDDS report dated 2/16/12 for an incident on 2/15/12 at 2:30 P.M. indicated "On 2/15/12, [client A] was taken to [name] ER and later admitted to their behavioral unit. [Client A] refused to go to workshop and had been non-compliant all morning, making verbal and physical threats toward staff and saying she was going to kill herself. At around 2:00 P.M. [client A] called the program coordinator (PC) into her bedroom. [Client A] had a Wii controller wrapped around her neck. [Client A] stated she was going to kill herself. [Client A] became increasingly more agitated. The PC made several attempts to redirect [client A] but was unsuccessful. Staff became fearful of [client A] hurting herself and called the police for additional support. The police were able to remove the cord. [Client A] continued yelling at the officers...The police officers assisted her to the police car. She was taken to [name] ER. Once at the ER, [client A] was assessed and there were no injuries noted... She was admitted to the behavioral unit...."</p> <p>A BDDS report dated 2/29/12 for an incident on 2/28/12 at day program,</p>				

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	<p>indicated "On 2/28/12, the police were called to the [name] of workshop and escorted [client A] to her [name] of group home. While at workshop, [client A] became upset, she became verbally aggressive and walked outside of the workshop. The PC was contacted and went to the workshop, staying with [client A] She calmed and went back into the workshop... at 3:00 P.M. [client A] refused to get into the van and walked off the [name] of workshop property and headed down the street. After several unsuccessful attempts to get [client A] to return...the police were called. The police were not able to talk [client A] into returning...The police handcuffed [client A] and took her to her group home. They remained in her home until she calmed. [Client A] told staff she wanted to go to the hospital...and was having suicidal thoughts but did not attempt to harm herself in any way. Suicidal precautions are in place."</p> <p>The Director of Supported Group Living (DSGP) was interviewed on 2/29/12 at 2:12 P.M.. When asked about client A's elopement on 2/14/12, the DSGP stated, "She left the home, was out of eyesight only 5 (five) minutes, the staff did what he could do, and contacted the police who arrived in 5 (five) minutes. " The DSPG indicated there had been only two staff</p>			
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	<p>working at the time, and one of the staff had taken some of the clients into the community. The DSPG indicated they currently were not having the staff take clients out of the home for outings unless all the clients went on the outing and/or (client A) went on the outing. When asked about the rights of clients B, C, D, E, F, G and H to go into the community. The DSPG stated, "They (clients B, C, D, E, F, G, and H) are really good at planning ahead and letting the staff know ahead of time when they want to go someplace. "The DSPG indicated they currently only had two staff working in the evenings and on the weekends. The DSPG indicated they had considered adding another staff.</p> <p>This federal tag relates to complaint #IN00104050.</p> <p>9-3-3(a)</p>						