

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2015	
NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 7614 LAMLIE RD FORT WAYNE, IN 46818			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00172081.</p> <p>Complaint #IN00172081: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W154, and W186.</p> <p>Dates of survey: May 19, 20, 21, and 22, 2015.</p> <p>Facility number: 001035 Provider number: 15G521 AIM number: 100239820</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>			W 0000			
W 0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS						

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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Bldg. 00	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3 sampled clients (clients A, B and C), and for 3 additional clients (clients D, E and F) the facility failed to implement policy and procedures which prohibit abuse and neglect. The facility failed to protect clients A, B, C, D, E and F from neglect by failing to ensure there were adequate staff to meet the clients' needs. The facility failed for 2 of 3 sampled clients (clients A and B) to document a thorough investigation into 1 of 2 injuries of unknown origin involving client B, and 1 incident of potential neglect involving client A.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 5/19/15 at 3:50 PM. A report dated 4/19/15 and reported 4/20/15 indicated the BDDS coordinator for the group home spoke with client F's father regarding an incident that occurred on 4/19/15 at 6:00 PM. When client F's father brought him home from a visit at 6:00 PM, there was only one staff on duty with clients A, B, C, D and E. The staff present indicated one employee had to leave early and another employee had called in sick. The residential manager</p>	W 0149	All Residential Director's, QIDP's and managers will receive re-training on the Abuse, Neglect and Exploitation Policy and Injuries of unknown origin. All staff will complete a post-test after the training is complete to ensure their understanding. The post-test will be monitored by the Regional Director for compliance. All staff, Managers and QIDP's will receive re-training on the minimum staffing requirements of the home. Call lists have been updated to include instructions for staff regarding contacting additional professional staff should their on-call supervisor fail to be present at the home if the home is short staffed. Weekly spot checks of the time entry system will be completed for the next 3 months by the director to ensure that the home is maintaining proper staffing. Managers and Q's from other homes and/or the director are also completing weekly unannounced house visits for the next 3 months to ensure that the home is maintaining the minimum staffing requirements. The Director will monitor compliance and all corrections will be in place by 6/21/15. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes time verification of the	06/21/2015

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	<p>(RM) was on call if needed. Client F's father indicated to the BDDS coordinator, the RM lived an hour away and this was a "health and safety issue" with only one staff in the home when there should have been 2 staff present. The BDDS coordinator submitted the report "as an allegation of neglect." Plan of action was to be determined by the facility.</p> <p>A follow up report dated 4/29/15 included in the report indicated client F's father called facility staff and the group home manager was told to go to the group home. Client F's father stayed at the home until 7:50 PM when the manager arrived. The investigation "revealed that the house manager was ill and failed to go to the home to cover the open hours due to her illness. She was seen in the emergency room on that day following the incident and was unable to work. However, Benchmark procedure indicates that multiple professional staff are available and should be notified if a manager cannot fulfill their on-call responsibilities. The staff training also instructs staff to continue calling professional staff on the list until they reach someone and receive the assistance they need. All staff at the [group home] have been re-trained on the call list and it's (sic) use. They have also been instructed to contact the Residential</p>		time entry system, on site supervision from the newly assigned manager, quarterly unannounced site visits of the management team.				

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	<p>Director in any instance where their manager is not available. The manager is meeting with administrative staff to discuss this incident and is being counseled on failing to notify her supervisor of her inability to fulfill her on call responsibilities, her failure to maintain appropriate staffing and to discuss alternative work."</p> <p>An Investigative Report Summary dated 4/24/15 preliminary and 5/1/15 final was reviewed on 5/19/15 at 4:30 PM and indicated immediate safeguards were put in place at the onset of the investigation including communication to staff what their appropriate staffing levels were and who they should call if they were not at those approved levels. Additionally, the staff were instructed on calling their director and other on-call personnel until they spoke to a supervisor in person and received staffing assistance. The manager continued working under the on-call direction of the director until she was sent home from work on 4/30/15 and resigned her position with Benchmark on 5/1/15. The RM indicated she had instructed staff "she was headed that way" when staff had indicated she was the only staff in the home. The staff working in the home indicated the house manager had told her to call if she was needed. The investigation indicated the</p>			

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	<p>RM was aware of the appropriate staffing levels of the home and is responsible for scheduling and covering shifts. The RM "is also trained on the Abuse and Neglect Policy which states 'Neglect includes failure to provide appropriate care, food medical care or supervision...' Due to [RM's] failure to staff the house appropriately, her failure to contact her supervisor, and her statement, which is inconsistent with the staff statement, and the actual events that occurred, the 6 allegations of neglect are being substantiated." The investigation indicated the RM resigned from her position as RM on 5/1/15 effective that same day.</p> <p>The facility's staff schedule was reviewed on 5/19/15 at 3:00 PM and indicated there should be two staff working at all times during clients' waking hours.</p> <p>Client A's record was reviewed on 5/22/15 at 12:40 PM. A Behavior Support Plan (BSP) dated 4/8/15 indicated target behaviors of self injurious behavior, physical aggression, elopement, eating too fast, refusal, property abuse and pica. The BSP indicated client A had a history of attempting to take his incontinence brief apart and placing the loose brief into his mouth and client A "has recently placed</p>			

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	<p>particles of glass, from a broken picture frame into his mouth." The BSP indicated client A was not to have glass picture frames in his room. Interventions in his plan included staff redirection, escorting to a quiet area and remaining with client A while outside of the group home. A residential report dated 1/14/15 indicated client A "is full of energy and always on the go," and "If he does not get what he wants, he will try to hit himself in the head with his hand or throw himself on the floor and try to bang his head on the floor. [Client A] has behavior of hand to mouth stimulation and is monitored by staff." The report indicated he was "in need of intensive training on daily living skills."</p> <p>Client B's record was reviewed on 5/22/15 at 12:30 PM. A BSP signed 5/14/15 by client B's guardian indicated target behaviors of refusal, physical aggression, inappropriate social behavior (rubbing himself on objects, putting his hands down his pants, and undressing in public places), grabbing others and self injurious behavior(biting hand, rubbing nose and ear excessively and dropping to his knees). Intervention included physical redirection escort to a quiet area, "ask for assistance of another person, if necessary...."</p>			

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	<p>Client C's record was reviewed on 5/22/15 at 1:20 PM. A BSP dated 3/1/15 indicated target behaviors of self injurious behavior (biting hand, placing fingers in mouth/down throat), property abuse (pounding on the walls, knocking over pictures, pushing frames off of the walls/shelves), refusal, dropping to the floor. Interventions included offering choices, redirection, blocking, and using her communication board to assist her in making requests.</p> <p>The Residential Director was interviewed on 5/19/15 at 4:40 PM and indicated clients A, B, C, D, E and F required more than one staff working in the home to meet their needs and the failure to provide appropriate supervision levels for the clients was a violation of the facility's policy and procedure to protect clients from abuse and neglect.</p> <p>2. A BDDS report dated 2/12/15 indicated on 2/12/15 "at approximately 6:40 PM, staff heard something break in [client A's] bedroom. Staff immediately entered [client A's] bedroom and found a shattered picture frame on the floor. [Client A] had a small cut on his foot and his mouth was bleeding. Staff treated the small cut on his foot and his mouth and noticed that he had a small cut on his tongue." Client A was taken to the ER</p>			

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	<p>(emergency room) and x-rays "revealed 2 small pieces of glass in his stomach." Client A was hospitalized until the glass passed from his stomach and was discharged with an order for an abdominal x-ray in four weeks. Corrective action indicated the picture frame was mounted on the wall and was a present from a relative and there was no history of client A ingesting any foreign object since admission to the group home. Client A's plan was revised to include pica and safety measures. There was no evidence of an investigation into the incident in regards to the incident to determine the circumstances surrounding client A breaking the frame and ingesting the glass before staff was able to intervene.</p> <p>The RD was interviewed on 5/22/15 at 12:55 PM and indicated it was not a violation of client A's plan to be unsupervised in his bedroom and that there had not been a formal investigation completed as it was known how client A had obtained the glass. He indicated client A's plan had been revised to include pica, including ingesting glass, and there were now to be no picture frames in client A's bedroom.</p> <p>3. During review of the BDDS reportable incidents and internal incidents on</p>			

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	<p>5/19/15 at 3:40 PM, there was no evidence in the reports provided of bruising to client B's left arm or knee.</p> <p>During interview with client B's guardian on 5/21/15 at 7:34 PM, client B's guardian indicated client B had been found with bruises of unknown origin on a home visit on May 3, 2015. The bruises were along his upper left arm about 5 inches long and part of the bruise appeared to be the size of a thumbprint. She indicated she had notified the staff (unidentified) at the group home when she returned client B later that day and the staff indicated she had assisted client B with bathing earlier in the day and had not noticed the bruises. She indicated client B had been found with bruises to both knees during a home visit on 5/10/15. The guardian indicated the QIDP (Qualified Intellectual Disabilities Professional) had told the guardian (date unspecified) it was witnessed client B had dropped to the floor on his knees causing his bruising to his knee. The guardian indicated she had reported the injuries to client B to the RD on 5/10/15 and the RD would ensure the injuries were reported.</p> <p>The RD was interviewed on 5/22/15 at 12:55 PM and indicated client B's injuries had been reported, but not</p>			

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	<p>investigated as they had called client B's teacher the following day after the bruising was reported to him by the guardian. The RD indicated client B's teacher was contacted the day after the incident of bruising was reported to him by the guardian. The teacher indicated he had dropped to his knees at school the Friday before 5/10/15 (5/8/15), causing his bruising to his knees. The RD indicated he would locate the report as the nurse had completed the report, but the incident had not been formally investigated.</p> <p>A report of injury dated 5/1/15 was reviewed on 5/22/15 at 11:30 AM and indicated "Bruise R (right arm), redness on both knees...School reported that [client B] had multiple behaviors during the day."</p> <p>The facility's Group Home Abuse and Neglect policy dated 8/08 was reviewed on 5/22/15 at 12:45 PM and indicated "Benchmark Human Services (BHS) does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse...Neglect includes failure to provide appropriate care, food, medical care or supervision," and "If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this</p>			

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	<p>immediately to their supervisor and the BHS Residential Director. The supervisor is responsible for reporting the incident to all appropriate entities. These include, but are not limited to: Bureau of Developmental Disability Services, Adult/Child Protective Services, and client representatives...Other entities may need to be notified depending upon from which program the client is receiving services."</p> <p>This federal tag relates to complaint #IN00172081.</p> <p>9-3-2(a)</p>						
W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients A and B) to document a thorough investigation into</p>	W 0154	All Residential Director's, QIDP's and managers will receive re-training on the Abuse, Neglect	06/21/2015			

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	<p>1 of 2 injuries of unknown origin involving client B, and 1 incident of potential neglect involving client A.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 5/19/15 at 3:50 PM. A BDDS report dated 2/12/15 indicated on 2/12/15 "at approximately 6:40 PM, staff heard something break in [client A's] bedroom. Staff immediately entered [client A's] bedroom and found a shattered picture frame on the floor. [Client A] had a small cut on his foot and his mouth was bleeding. Staff treated the small cut on his foot and his mouth and noticed that he had a small cut on his tongue." Client A was taken to the ER (emergency room) and x-rays "revealed 2 small pieces of glass in his stomach." Client A was hospitalized until the glass passed from his stomach and was discharged with an order for an abdominal x-ray in four weeks. Corrective action indicated the picture frame was mounted on the wall and was a present from a relative and there was no history of client A ingesting any foreign object since admission to the group home. Client A's plan was revised to include pica and safety measures. There was no evidence of an</p>		<p>and Exploitation Policy. All staff will complete a post-test after the training is complete to ensure their understanding. The post-test will be monitored by the Regional Director for compliance. The Director's, managers and QIDP's will also be trained on the investigation procedures which includes injuries of unknown origin and documenting all conversations related to the injury on the appropriate forms. The Director will review and sign all injury reports to ensure that injuries of unknown origin are properly investigated. All investigations will be reviewed by the Regional Director, Compliance, and the program Vice President to ensure thoroughness. This process will be ongoing but will be implemented by 6/21/15.</p>	

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	<p>investigation into the incident.</p> <p>The RD was interviewed on 5/22/15 at 12:55 PM and indicated it was not a violation of client A's plan to be unsupervised in his bedroom and that there had not been a formal investigation completed as it was known how client A had obtained the glass. He indicated client A's plan had been revised to include pica, including ingesting glass, and there were now to be no picture frames in client A's bedroom.</p> <p>2. During review of the BDDS reportable incidents and internal incidents on 5/19/15 at 3:40 PM, there was no evidence in the reports provided of bruising to client B's left arm or knee.</p> <p>During interview with client B's guardian on 5/21/15 at 7:34 PM, client B's guardian indicated client B had been found with bruises of unknown origin on a home visit on May 3, 2015. The bruises were along his upper left arm about 5 inches long and part of the bruise appeared to be the size of a thumbprint. She indicated she had notified the staff (unidentified) at the group home when she returned client B later that day and the staff indicated she had assisted client B with bathing earlier in the day and had not noticed the bruises. She indicated</p>			

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	<p>client B had been found with bruises to both knees during a home visit on 5/10/15. The guardian indicated the QIDP (Qualified Intellectual Disabilities Professional) had told the guardian (date unspecified) it was witnessed client B had dropped to the floor on his knees causing his bruising to his knee. The guardian indicated she had reported the injuries to client B to the RD on 5/10/15 and the RD would ensure the injuries were reported.</p> <p>The RD was interviewed on 5/22/15 at 12:55 PM and indicated client B's injuries had been reported, but not investigated as they had called client B's teacher the following day after the bruising was reported to him by the guardian. The RD indicated client B's teacher was contacted the day after the incident of bruising was reported to him by the guardian. The teacher indicated he had dropped to his knees at school the Friday before 5/10/15 (5/8/15), causing his bruising to his knees. The RD indicated he would locate the report as the nurse had completed the report, but the incident had not been formally investigated.</p> <p>A report of injury dated 5/1/15 was reviewed on 5/22/15 at 11:30 AM and indicated "Bruise R (right arm), redness</p>			

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W 0186 Bldg. 00	<p>on both knees...School reported that [client B] had multiple behaviors during the day."</p> <p>This federal tag relates to complaint #IN00172081.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>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 for 3 of 3 sampled clients (clients A, B and C), and for 3 additional clients (clients D, E and F) the facility failed to ensure there were adequate staff to meet the clients' needs.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the</p>	W 0186	All staff, Managers and QIDP's will receive re-training on the minimum staffing requirements of the home. Call lists have been updated to include instructions for staff regarding contacting additional professional staff should their on-call supervisor fail to be present at the home if the home is short staffed. Weekly spot checks of the time entry system will be completed for the	06/21/2015	

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	<p>Bureau of Developmental Disabilities Services (BDDS) were reviewed on 5/19/15 at 3:50 PM. A report dated 4/19/15 and reported 4/20/15 indicated the BDDS coordinator for the group home spoke with client F's father regarding an incident that occurred on 4/19/15 at 6:00 PM. When client F's father brought him home from a visit at 6:00 PM, there was only one staff on duty with clients A, B, C, D, and E. The staff present indicated one employee had to leave early and another employee had called in sick. The residential manager (RM) was on call if needed. Client F's father indicated to the BDDS coordinator, the RM lived an hour away and this was a "health and safety issue" with only one staff in the home when there should have been 2 staff present. The BDDS coordinator submitted the report "as an allegation of neglect." Plan of action was to be determined by the facility.</p> <p>A follow up report dated 4/29/15 included in the report indicated client F's father called facility staff and the group home manager was told to go to the group home. Client F's father stayed at the home until 7:50 PM when the manager arrived. The investigation "revealed that the house manager was ill and failed to go to the home to cover the open hours due to her illness. She was</p>		<p>next 3 months by the director to ensure that the home is maintaining proper staffing. Managers and Q's from other homes and/or the director are also completing weekly unannounced house visits for the next 3 months to ensure that the home is maintaining the minimum staffing requirements. The Director will monitor compliance and all corrections will be in place by 6/21/15. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes time verification of the time entry system, on site supervision from the newly assigned manager, quarterly unannounced site visits of the management team.</p>	

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	<p>seen in the emergency room on that day following the incident and was unable to work. However, Benchmark procedure indicates that multiple professional staff are available and should be notified if a manager cannot fulfill their on-call responsibilities. The staff training also instructs staff to continue calling professional staff on the list until they reach someone and receive the assistance they need. All staff at the [group home] have been re-trained on the call list and it's (sic) use. They have also been instructed to contact the Residential Director in any instance where their manager is not available. The manager is meeting with administrative staff to discuss this incident and is being counseled on failing to notify her supervisor of her inability to fulfill her on call responsibilities, her failure to maintain appropriate staffing and to discuss alternative work."</p> <p>An Investigative Report Summary dated 4/24/15 preliminary and 5/1/15 final was reviewed on 5/19/15 at 4:30 PM and indicated immediate safeguards were put in place at the onset of the investigation including communication to staff what their appropriate staffing levels were and who they should call if they were not at those approved levels. Additionally, the staff were instructed on calling their</p>						

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	<p>director and other on-call personnel until they spoke to a supervisor in person and received staffing assistance. The manager continued working under the on-call direction of the director until she was sent home from work on 4/30/15 and resigned her position with Benchmark on 5/1/15. The RM indicated she had instructed staff "she was headed that way" when staff had indicated she was the only staff in the home. The staff working in the home indicated the house manager had told her to call if she was needed. The investigation indicated the RM was aware of the appropriate staffing levels of the home and is responsible for scheduling and covering shifts. The RM "is also trained on the Abuse and Neglect Policy which states 'Neglect includes failure to provide appropriate care, food medical care or supervision...'Due to [RM's] failure to staff the house appropriately, her failure to contact her supervisor, and her statement, which is inconsistent with the staff statement, and the actual events that occurred, the 6 allegations of neglect are being substantiated." The investigation indicated the RM resigned from her position as RM on 5/1/15 effective that same day.</p> <p>The facility's staff schedule was reviewed on 5/19/15 at 3:00 PM and indicated</p>			

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	<p>there should be two staff working at all times during clients' waking hours.</p> <p>Client A's record was reviewed on 5/22/15 at 12:40 PM. A Behavior Support Plan (BSP) dated 4/8/15 indicated target behaviors of self injurious behavior, physical aggression, elopement, eating too fast, refusal, property abuse and pica. The BSP indicated client A had a history of attempting to take his incontinence brief apart and placing the loose brief into his mouth and client A "has recently placed particles of glass, from a broken picture frame into his mouth." The BSP indicated client A was not to have glass picture frames in his room. Interventions in his plan included staff redirection, escorting to a quiet area and remaining with client A while outside of the group home. A residential report dated 1/14/15 indicated client A "is full of energy and always on the go," and "If he does not get what he wants, he will try to hit himself in the head with his hand or throw himself on the floor and try to bang his head on the floor. [Client A] has behavior of hand to mouth stimulation and is monitored by staff." The report indicated he was "in need of intensive training on daily living skills."</p> <p>Client B's record was reviewed on</p>			

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	<p>5/22/15 at 12:30 PM. A BSP signed 5/14/15 by client B's guardian indicated target behaviors of refusal, physical aggression, inappropriate social behavior (rubbing himself on objects, putting his hands down his pants, and undressing in public places), grabbing others and self injurious behavior(biting hand, rubbing nose and ear excessively, dropping to his knees). Intervention included physical redirection escort to a quiet area, "ask for assistance of another person, if necessary...."</p> <p>Client C's record was reviewed on 5/22/15 at 1:20 PM. A BSP dated 3/1/15 indicated target behaviors of self injurious behavior (biting hand, placing fingers in mouth/down throat), property abuse (pounding on the walls, knocking over pictures, pushing frames off of the walls/shelves), refusal and dropping to the floor. Interventions included offering choices, redirection, blocking, and using her communication board to assist her in making requests.</p> <p>The Residential Director was interviewed on 5/19/15 at 4:40 PM and indicated clients A, B, C, D, E and F required more than one staff working in the home to meet their needs and the failure to provide appropriate supervision levels for the clients was a violation of the facility's</p>			

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	<p>policy and procedure to protect clients from abuse and neglect.</p> <p>This federal tag relates to complaint #IN00172081.</p> <p>9-3-3(a)</p>			