

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2012
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W0000	<p>This visit was for the investigation of complaint #IN00115782 which resulted in an immediate jeopardy.</p> <p>Complaint #IN00115782: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154 and W157.</p> <p>Dates of Survey: 9/11/12, 9/12/12, 9/13/12, 9/14/12 and 9/17/12.</p> <p>Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/24/12 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> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 1 of 4 sampled clients (B), the governing body failed to meet the Condition of Participation: Governing Body. The governing body failed to ensure the facility met the Condition of Participation of Client Protections.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to complete a thorough investigation regarding client to client aggression between client A and client B. The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to develop and implement corrective measures to prevent physical aggression and intimidation/emotional abuse toward client B. Please see W104.</li> <li>The governing body failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (B). The governing body failed to implement its policy and procedures to complete a</li> </ol>	W0102	<p><i>The facility must ensure that specific governing body and management requirements are met. Specifically, the QDDPD who maintained supervisory responsibility at the facility no longer works for the company. An administrative level Clinical Specialist from the agency is currently overseeing the operation of the facility, while the agency works toward obtaining a qualified replacement.</i></p> <p>The agency's Quality Assurance Manager has completed an investigation into the circumstances of an incident of physical aggression from Client A toward Client B which resulted in injury. Upon interdisciplinary team review of the investigation results, the team modified Client A's Behavior Support Plan to include arm's length staffing when he displays precursor behaviors and/or begins to escalate as well as the use of advanced personal safety techniques (one &amp; two person holds) when he becomes physically aggressive. All facility staff have received training toward proper implementation of Client A's revised plan and the use of advanced personal safety techniques. Additionally Client B has moved to another facility that</p>	10/10/2012			

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	<p>thorough investigation regarding client to client aggression between clients A and B. The governing body failed to implement its policy and procedures to develop and implement corrective measures to prevent physical aggression and intimidation/emotional abuse toward client B. Please see W122.</p> <p>This federal tag relates to complaint #IN00115782.</p> <p>9-3-1(a)</p>		<p>the interdisciplinary team has assessed better meets Client B's developmental, social and behavior needs.</p> <p><b>PREVENTION:</b> When incidents requiring investigation occur when facility supervisory staff are present, members of the Operations and Quality Assurance Teams will assume responsibility for conducting the investigation. Facility professional and administrative staff have been retrained on components of a thorough investigation including but not limited to specifics of what occurred and whether or not staff on duty responded to the incident appropriately. The Program Manager –Supervised Group Living will review completed investigations to assure they meet established investigation protocols.</p> <p>Additionally, when incidents of a serious nature, including but not limited to serious injury occur, a Clinical Specialist or other designated member of the agency's administrative team will participate in the interdisciplinary process to assure the facility develops and implements appropriate corrective measures that focus on prevention of future incidents and protection of individuals from potential abuse/neglect/mistreatment. Professional staff have been</p>		

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			<p>retrained regarding the need to document corrective measures through the interdisciplinary process and to assure that once the IDT reaches consensus, the team implements programmatic modifications without delay. The Quality Assurance Team will review investigation results and interdisciplinary team meeting records, and will follow-up as needed with facility supervisory staff and the Operations Team to assure the facility implements corrective measures as needed.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Residential Manager, Support Associates, Operations Team, Quality Assurance Team</p>		

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W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 4 sampled clients (B), the governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to complete a thorough investigation regarding client to client aggression between client A and client B. The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to develop and implement corrective measures to prevent physical aggression and intimidation/emotional abuse toward client B.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to complete a thorough investigation regarding client to client aggression between client A and client B. The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to develop and implement corrective</p>	W0104	<p><b>CORRECTION:</b></p> <p><i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the QDDPD who maintained supervisory responsibility at the facility no longer works for the company. An administrative level Clinical Specialist from the agency is currently overseeing the operation of the facility, while the agency works toward obtaining a qualified replacement.</i></p> <p>The agency's Quality Assurance Manager has completed an investigation into the circumstances of an incident of physical aggression from Client A toward Client B which resulted in injury. Upon interdisciplinary team review of the investigation results, the team modified Client A's Behavior Support Plan to include arm's length staffing when he displays precursor behaviors and/or begins to escalate as well as the use of advanced personal safety techniques (one &amp; two person holds) when he becomes physically aggressive. All facility staff have received training toward proper implementation of Client A's revised plan and the use of advanced personal safety techniques. Additionally Client B</p>	10/10/2012			

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	<p>measures to prevent physical aggression and intimidation/emotional abuse toward client B. Please see W149.</p> <p>2. The governing body failed to exercise operating direction over the facility to ensure the facility completed a thorough investigation regarding an incident of client to client aggression between client A and client B. Please see 154.</p> <p>3. The governing body failed to exercise operating direction over the facility to ensure the facility developed and implemented corrective measures to prevent physical aggression and intimidation/emotional abuse toward client B. Please see W157.</p> <p>This federal tag relates to complaint #IN00115782.</p> <p>9-3-1(a)</p>		<p>has moved to another facility that the interdisciplinary team has assessed better meets Client B's developmental, social and behavior needs</p> <p><b>PREVENTION:</b> When incidents requiring investigation occur when facility supervisory staff are present, members of the Operations and Quality Assurance Teams will assume responsibility for conducting the investigation. Facility professional and administrative staff have been retrained on components of a thorough investigation including but not limited to specifics of what occurred and whether or not staff on duty responded to the incident appropriately. The Program Manager –Supervised Group Living will review completed investigations to assure they meet established investigation protocols.</p> <p>Additionally, when incidents of a serious nature, including but not limited to serious injury occur, a Clinical Specialist or other designated member of the agency's administrative team will participate in the interdisciplinary process to assure the facility develops and implements appropriate corrective measures that focus on prevention of future incidents and protection of individuals from potential abuse/neglect/mistreatment.</p>		

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			<p>Professional staff have been retrained regarding the need to document corrective measures through the interdisciplinary process and to assure that once the IDT reaches consensus, the team implements programmatic modifications without delay. The Quality Assurance Team will review investigation results and interdisciplinary team meeting records, and will follow-up as needed with facility supervisory staff and the Operations Team to assure the facility implements corrective measures as needed.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Residential Manager, Support Associates, Operations Team, Quality Assurance Team</p>		

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (B). The facility failed to implement its policy and procedures to complete a thorough investigation regarding client to client aggression between clients A and B. The facility failed to implement its policy and procedures to develop and implement corrective measures to prevent physical aggression and intimidation/emotional abuse toward client B.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 8/30/12. The Immediate Jeopardy was identified on 9/12/12. The Clinical Supervisor was notified of the Immediate Jeopardy on 9/12/12 at 9:48 AM regarding the facility's system failure to prevent physical aggression and intimidation toward client B. On 9/13/12, the facility submitted the following plan of action to remove the jeopardy: "We are implementing arms length staff when [client A] demonstrates precursor behaviors and/or begins to escalate. We have approved advanced personal safety techniques (one and two person holds)</p>	W0122	<p><b>CORRECTION:</b> <i>The facility must ensure that specific client protections requirements are met. Specifically, The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the agency's Quality Assurance Manager has completed an investigation into the circumstances of an incident of physical aggression from Client A toward Client B which resulted in injury. Upon interdisciplinary team review of the investigation results, the team modified Client A's Behavior Support Plan to include arm's length staffing when he displays precursor behaviors and/or begins to escalate as well as the use of advanced personal safety techniques (one &amp; two person holds) when he becomes physically aggressive. All facility staff have received training toward proper implementation of Client A's revised plan and the use of advanced personal safety techniques. Additionally Client B has moved to another facility that the interdisciplinary team has assessed better meets Client B's developmental, social and behavior needs.</i></p> <p><b>PREVENTION:</b></p>	10/10/2012			

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	<p>when [client A] becomes physically aggressive. Current [group home] staff have been trained on these techniques. The QMRP (Qualified Mental Retardation Professional) is suspended pending additional investigation into the incident of client to client aggression on 9/30/12 (sic). [QM #1 (Quality Manager)] is coordinating the investigation. Currently the clinical supervisor, [CS #1 (Clinical Supervisor)], is directly overseeing the operation of the home." On 9/17/12, the facility submitted the following supplemental information to remove the jeopardy, "[QM #1] attached [client A]'s revised BSP (Behavior Support Plan) as well as documentation that staff have been inserviced on the revision."</p> <p>Through monitoring observations held on 9/13/12 from 4:45 PM through 5:25 PM, 9/14/12 from 10:15 AM through 11:01 AM and 9/17/12 from 2:20 PM through 3:10 PM, the facility had implemented their plan of action and client B had been transferred to another group home.</p> <p>The facility's inservice sheets were reviewed on 9/17/12 at 2:30 PM and indicated the facility had trained staff regarding advanced safety techniques and client A's revised BSP. Client A's BSP dated 9/13/12 was reviewed on 9/17/12 at</p>		<p>When incidents requiring investigation occur when facility supervisory staff are present, members of the Operations and Quality Assurance Teams will assume responsibility for conducting the investigation. Facility professional and administrative staff have been retrained on components of a thorough investigation including but not limited to specifics of what occurred and whether or not staff on duty responded to the incident appropriately. The Program Manager –Supervised Group Living will review completed investigations to assure they meet established investigation protocols.</p> <p>Additionally, when incidents of a serious nature, including but not limited to serious injury occur, a Clinical Specialist or other designated member of the agency's administrative team will participate in the interdisciplinary process to assure the facility develops and implements appropriate corrective measures that focus on prevention of future incidents and protection of individuals from potential abuse/neglect/mistreatment. Professional staff have been retrained regarding the need to document corrective measures through the interdisciplinary process and to assure that once the IDT reaches consensus, the team implements programmatic</p>				

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	<p>3:30 PM. Client A's BSP dated 9/13/12 indicated revisions for staff to implement one and two person holds during escalated periods of behavior to prevent injury to client A or others.</p> <p>Interview with DSP #1 (Direct Support Professional), DSP #2, and HM #1 (Home Manager) on 9/17/12 at 2:30 PM indicated they had been trained regarding advanced safety techniques and client A's revised BSP.</p> <p>Interview with PM #1 (Program Manager) on 9/17/12 at 2:50 PM indicated all staff had been trained regarding advanced safety techniques and client A's revised BSP. PM #1 indicated client B had been transferred to another group home on 9/13/12.</p> <p>The facility Program Manager was notified the immediate jeopardy was removed on 9/17/12 at 3:00 PM. While the immediate jeopardy was removed on 9/17/12 at 3:00 PM, the facility remained out of compliance at the Condition level in that the facility needed to demonstrate continued implementation of the safeguards.</p> <p>Findings include:</p> <p>1. The facility failed to implement its</p>		<p>modifications without delay. The Quality Assurance Team will review investigation results and interdisciplinary team meeting records, and will follow-up as needed with facility supervisory staff and the Operations Team to assure the facility implements corrective measures as needed.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Residential Manager, Support Associates, Operations Team, Quality Assurance Team</p>		

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	<p>policy and procedures to complete a thorough investigation regarding client to client aggression between client A and client B. The facility failed to implement its policy and procedures to develop and implement corrective measure to prevent physical aggression and intimidation/emotional abuse toward client B. Please see W149.</p> <p>2. The facility failed to complete a thorough investigation in regarding an incident of client to client aggression between client A and client B. Please see W154.</p> <p>3. The facility failed to develop and implement corrective measures to prevent physical aggression and intimidation/emotional abuse toward client B. Please see W157.</p> <p>This federal tag relates to complaint #IN00115782.</p> <p>9-3-2(a)</p>				

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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. Based on record review and interview for 1 of 4 sampled clients (B), the facility failed to implement its policy and procedures to complete a thorough investigation regarding client to client aggression between client A and client B. The facility failed to implement its policy and procedures to develop and implement corrective measures to prevent physical aggression and intimidation/emotional abuse toward client B.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IARs (Incident/Accident Reports) and investigations were reviewed on 9/12/12 at 8:30 AM. The review indicated the following:</p> <p>-IAR dated 8/30/12 indicated on 8/30/12 at 3:45 PM, "[Client A] became irrate (sic) when [client B] got clothes out of the dryer that were apparently [client B]'s but [client A] said they have no unknown (sic) origin. I asked if they were [client A]'s but he stated, 'No.' I advised [client A] to let staff handle it. [Client A] stated that he was, 'Going to handle it' himself</p>	W0149	<p><b>CORRECTION:</b> <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the agency's Quality Assurance Manager has completed an investigation into the circumstances of an incident of physical aggression from Client A toward Client B which resulted in injury. Upon interdisciplinary team review of the investigation results, the team modified Client A's Behavior Support Plan to include arm's length staffing when he displays precursor behaviors and/or begins to escalate as well as the use of advanced personal safety techniques (one &amp; two person holds) when he becomes physically aggressive. All facility staff have received training toward proper implementation of Client A's revised plan and advanced personal safety techniques. Additionally Client B has moved to another facility that the interdisciplinary team has assessed better meets Client B's developmental, social and behavior needs. <b>PREVENTION:</b> When incidents requiring investigation occur when facility supervisory staff are present, members of the Operations and Quality Assurance Teams will</i></p>	10/10/2012			

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	<p>saying he was going to, 'Bash [client B] up side the head' using the magnet curtain rod that he had already chased [client B] in his room with. When [client B] came out his (sic) room [client B] hurried by with out (sic) giving [client A] or myself any attention. [Client A] stated, '[Client B] flipped him the middle finger' but I did not see that. Next thing I know [client A] ran past me and struck [client B] in the back just below his neck. [Client B] dropped to the floor in pain; (sic) while [client A] continued to rant and curse. [Client B] got up and said he had, 'Had enough' and walked out the door and continued down the street. I followed [client B] advising him to go around back instead of walking through the house where [client A] is (sic). [Client B] contacted the police."</p> <p>The IAR dated 8/30/12 indicated, "[Client B] is pressing charges for assault with a weapon." The IAR dated 8/30/12 indicated clients A and B, DCS (Direct Care Staff) #1 and #2 and QMRP (Qualified Mental Retardation Professional) #1 were listed as witnesses and/or others involved in the incident. The IAR dated 8/30/12 indicated client B was injured as a result of being hit by client A. The IAR dated 8/30/12 indicated client B's injury was described as, "Swelling the size of a fist red in color</p>		<p>assume responsibility for conducting the investigation. Facility professional and administrative staff have been retrained on components of a thorough investigation including but not limited to specifics of what occurred and whether or not staff on duty responded to the incident appropriately. The Program Manager –Supervised Group Living will review completed investigations to assure they meet established investigation protocols. Additionally, when incidents of a serious nature, including but not limited to serious injury occur, a Clinical Specialist or other designated member of the agency's administrative team will participate in the interdisciplinary process to assure the facility develops and implements appropriate corrective measures that focus on prevention of future incidents and protection of individuals from potential abuse/neglect/mistreatment. Professional staff have been retrained regarding the need to document corrective measures through the interdisciplinary process and to assure that once the IDT reaches consensus, the team implements programmatic modifications without delay. The Quality Assurance Team will review investigation results and interdisciplinary team meeting records, and will follow-up as needed with facility supervisory</p>				

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	<p>and scratches the size of a pen tip."</p> <p>-BDDS report dated 8/30/12 indicated on 8/30/12 at 4:30 PM, "[Client A] (individual supported by [facility]) became upset because he believed that [client B] (individual supported by [facility]) had taken some of his housemates' clothing. [Client A] picked up a small curtain rod and threatened to beat everyone in the house. Three staff and five individuals were home at the time. One staff was working with [client B] in his room to sort through his clothing in order to return items that did not belong to him. The second staff was keeping the other three individuals away from [client A]. The QMRP attempted repeatedly to convince [client A] to put down the curtain rod without success. [Client B] came out of his room with staff. [Client A] quickly got between staff and [client B] and hit him on the back of the neck with the curtain rod. Staff separated the two individuals immediately and [client B] called the police. Police arrived and took [client A] into custody. Staff provided [client B] with emotional support and assessed him for injuries. Staff noted a red and slightly swollen area on the back of [client B]'s neck. Staff notified the nurse and made arrangements for him to be assessed."</p>		<p>staff and the Operations Team to assure the facility implements corrective measures as needed.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Residential Manager, Support Associates, Operations Team, Quality Assurance Team</p>	

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	<p>-Investigation dated 8/30/12 included a written statement by DCS #2 which indicated, "Interviewer: 'What were you doing when [client A] fought with [client B]?' Interviewee (DCS #2), "There was no fight, [client A] hit [client B] with curtain rod that had a magnet on side of it. Staff said, 'I heard [client B] scream then he feel (sic) in living room.'" The Investigation dated 8/30/12 included a written statement by DCS #2 which indicated, "Supervisor was here." The Investigation dated 8/30/12 included a written statement by DCS #1 which indicated when asked who did you contact about what you observed or discovered and when did you contact them, "[QMRP #1] soon after (also a witness)." The Investigation dated 8/30/12 included a written statement by DCS #1 which indicated when asked was someone hurt as a result of the fight? If so, who and what is the injury, "Yes, [client B] was struck from the back with a magnetic curtain rod. The back of his neck is swollen, red, (sic) and has scratches." The investigation dated 8/30/12 indicated the conclusion substantiated client A did cause injury to client B as a result of client A's behavior. The Investigation dated 8/30/12 indicated client A's behavior was a "Historical behavior" for him. The Investigation dated 8/30/12 did not indicate a statement or interview of</p>			

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	<p>QMRP #1. The Investigation dated 8/30/12 did not indicate QMRP #1's actions or specify where or how client A obtained the curtain rod. The Investigation dated 8/30/12 indicated QMRP #1 completed the investigation.</p> <p>Client A's record was reviewed on 9/12/12 at 9:04 AM. Client A's IDT (Interdisciplinary Team) meeting form dated 9/3/12 indicated the following meeting agenda discussion, "At this time the team has agreed that [client A] needs to be seen by his psychiatrist for his aggressive behavior, he is displaying agitation when he does not get his way and wanting to boss the individuals, (sic) and staff at the site." The IDT form dated 9/3/12 did not indicate team discussion regarding how client A would be monitored/supervised when he returned to the group home from jail in relation to client B, if current supports such as his BSP (Behavior Support Plan) remained appropriate and/or other preventative measures to ensure client B's safety. Client A's BSP dated 5/2/11 updated on 12/7/11 indicated client A had the targeted behaviors of verbal aggression, property destruction, physical aggression, elopement and intimidation. Client A's BSP updated on 12/7/11 indicated when client A is physically aggressive toward others staff should, "Gently block all</p>			

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	<p>aggressive moves to protect [client A] and others around him." Client A's BSP updated on 12/7/11 indicated when client A is physically aggressive toward others staff should, "Physically redirect. Move [client A] away from the person she (sic) is targeting to insure (sic) everyone's safety." Client A's BSP updated on 12/7/11 indicated staff should respond to client A when he is intimidating others by, "Verbally redirect [client A] by asking him to stop. If he continues, re-engineer the environment by removing any object that could be used to potentially cause physical harm to himself or others."</p> <p>Client A was interviewed on 9/11/12 at 4:56 PM. Client A stated, "[Client B] stuck his middle finger in my face. That's when I lost it. I just felt like, you know, if [client B]'s going to stick his hand in my face I need to defend myself. I hit [client B] on the back. I had a curtain rod and I used it to hit him." Client A indicated DCS #1, DCS #2 and QMRP #1 were working at the home during the incident. When asked if there were any changes since he had returned to the group home, from being incarcerated, with his staff or client B, client A stated, "No, nothing has really changed. I just try to keep my space. Stay away from [client B]." Client A indicated he was not on any restrictions from being around or in the same</p>						

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	<p>proximity to client B. Client A indicated the staff was not monitoring him differently since he returned to the group home from jail.</p> <p>Client B was interviewed on 9/11/12 at 5:10 PM. Client B indicated client A had hit him in the back of the neck with a metal curtain rod. Client B indicated he had been walking toward the front entry hallway when client A hit him in the back/neck area from behind. Client B indicated DCS #1, DCS #2 and QMRP #1 were present during the incident. When asked if client A intimidated him or made him feel uncomfortable, client B stated, "A little bit. Sometimes [client A] makes me nervous and uncomfortable. I usually try to stay away from him."</p> <p>HM (Home Manager) #1 was interviewed on 9/11/12 at 5:20 PM. When asked if the facility had conducted an IDT following client A's return to the group home following his incarceration, HM #1 stated, "Yes, we had an IDT. I think [client A] is on line of sight. I wasn't at the meeting." HM #1 indicated DCS #1, DCS #2 and QMRP #1 were present during the 8/30/12 incident with client A. HM #1 indicated staff should block or use You're Safe, I'm Safe physical management techniques to prevent client A from aggressing against his peers as indicated</p>						

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	<p>in client A's BSP. HM #1 indicated client A had been taken to jail and had returned to the group home. HM #1 indicated he was not certain which day client A had returned to the group home from his incarceration.</p> <p>DCS #1 was interviewed on 9/11/12 at 5:35 PM. DCS #1 indicated she was working on 8/30/12 during the incident regarding client A. DCS #1 indicated client A was yelling and cursing at client B after he accused client B of stealing some of his clothing. DCS #1 indicated she attempted to verbally redirect client A but he continued to yell and curse at client B. DCS #1 indicated client B had gone to his bedroom while client A stood outside client B's bedroom door yelling and cursing at him through the closed door. DCS #1 indicated she was in the hallway with client A attempting to redirect him when client B walked out of his bedroom toward the front door area of the group home. DCS #1 stated, "[Client A]'s face just got real red. [Client A] just stared at [client B] and said, 'That's it!'" DCS #1 stated, "[Client A] then ran past me and raised the metal bar, it had magnets on the end, above his head and swung with all his strength at [client B]'s back. The next thing I knew, [client B] screamed and fell to the floor." DCS #1 indicated client A's BSP indicated staff should block client A</p>			

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	<p>from aggressing toward his peers using You're Safe, I' m Safe techniques. DCS #1 indicated client A's BSP indicated staff should redirect client A away from his peers when he is threatening them. DCS #1 indicated client A would not return to his bedroom but remained outside client B's bedroom door. When asked if DCS #2 or QMRP #1 was assisting her during the situation, DCS #1 stated, "[QMRP #1] did not come back there. [QMRP #1] was sitting at her desk. [QMRP #1] was talking on the phone to somebody, I think it was about some meds. [QMRP #1] kept yelling for [client A] to stop cursing and yelling but she didn't get up or come help." DCS #1 indicated DCS #2 was the one to one assigned staff for another client at the time of the incident. When asked if client B was intimidated or afraid of client A, DCS #1 stated, "Yes, I think he is. [Client A] likes to intimidate. Yes, I think [client B] is kind of afraid of [client A]."</p> <p>DCS #2 was interviewed on 9/11/12 at 5:45 PM. DCS #2 indicated he was working as another client's one on one staff at the time of the incident regarding client A and client B. DCS #2 indicated he could hear client A cursing and yelling at client B from the living room area where he was working. DCS #2 indicated when client A is attempting to be</p>			

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	<p>physically aggressive toward his peers, staff should redirect and then use You're Safe, I'm Safe physical management blocking techniques to keep himself and others safe. DCS #2 stated, "[DCS #1] and [QMRP #1] were working that night. [DCS #1] was in the back with [client A]. [QMRP #1] was here. I think [QMRP #1] was sitting at her desk. I was with [client D]. I heard the yelling and then I heard [client B] scream and fall to the floor in the living room." When asked if client B was afraid of client A, DCS #2 stated, "Yeah. [Client B] seems to be nervous. Seems to not want to be around him. I think he might be scared of [client A]."</p> <p>Nurse #1 was interviewed on 9/12/12 at 9:35 AM. Nurse #1 indicated she had been notified regarding client B's neck on 8/30/12 and did a physical assessment of client B on 8/31/12. Nurse #1 indicated client B's neck had a red mark, was tender to touch and had some abrasions.</p> <p>AS (Administrative Staff) #1 was interviewed on 9/12/12 at 9:38 AM. When asked if the investigation dated 8/30/12 regarding the incident of client to client aggression with clients A and B was thorough, AS #1 indicated QMRP #1 was involved in the incident and should not have completed the investigation. AS #1 indicated the investigation should have</p>				

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	<p>included an interview or statement from QMRP #1 regarding her actions during the incident. AS #1 indicated the investigation did not include information regarding how client A obtained a curtain rod. AS #1 stated, "I think the investigation should tell me why [client A] was able to have a curtain rod in the first place. Why staff didn't remove it or him from the area where [client B] was at." When asked if the IDT on 9/3/12 had made recommendations regarding how client A would be monitored/supervised when he returned to the group home from jail in relation to client B, if current supports such as his BSP remained appropriate and/or other preventative measures to ensure client B's safety, AS #1 stated, "No, I don't see any additional recommendations." When asked if client B had been injured as a result of being hit by client A, AS #1 stated, "Yes." When asked if harm or potential harm was likely to recur between client A and client B, AS #1 stated, "Yes." When asked if the circumstances of client B's injury had been thoroughly investigated, AS #1 stated, "No." When asked if the facility had implemented corrective actions to prevent recurrence, AS #1 stated, "No."</p> <p>The facility's policy and procedures were reviewed on 9/12/12 at 9:45 AM. The facility's 9/14/07 policy and procedure</p>						

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	<p>entitled Abuse, Neglect, Exploitation operating standard 1.26 indicated, "Following ResCare protocol for the exact process to report incidents, once the suspicion has been reported to the supervisor and/or PD (Program Director), the PD will report, within 24 hours, the suspected abuse, neglect or exploitation as follows:</p> <p>G. "To the BDDS central office..."</p> <p>"All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the polices of Adept, ResCare, and local, state and federal guidelines."</p> <p>"Emotional/Intimidation/emotional abuse: the act or failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation. Discouraging or inhibiting behavior by threatening both actual or implied. Attitude or acts that interfere with the psychological and social well being of an individual.</p> <p>Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm.</p>						

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	<p>Failure to provide the support necessary to an individual's psychological and social well being...." Program intervention neglect is defined as, "failure to provide good and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan, inappropriate application of intervention without a qualified person notification/review.</p> <p>Intimidation/Emotional abuse: the act or failure to act that results or could result in emotional injury to an individual...</p> <p>Discouraging or inhibiting behavior by threatening both actual and implied.</p> <p>Attitude or actions that interfere with the psychological and social well being of an individual...."</p> <p>This federal tag relates to complaint #IN00115782.</p> <p>9-3-2(a)</p>			

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W0154	<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 for 1 of 10 incidents of abuse, neglect or injuries of unknown origin reviewed for 1 of 4 sampled clients (B), the facility failed to complete a thorough investigation in regarding an incident of client to client aggression between client A and client B.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IARs (Incident/Accident Reports) and investigations were reviewed on 9/12/12 at 8:30 AM. The review indicated the following:</p> <p>-IAR dated 8/30/12 indicated on 8/30/12 at 3:45 PM, "[Client A] became irrate (sic) when [client B] got clothes out of the dryer that were apparently [client B]'s but [client A] said they have no unknown (sic)origin. I asked if they were [client A]'s but he stated, 'No.' I advised [client A] to let staff handle it. [Client A] stated that he was, 'Going to handle it' himself saying he was going to, 'Bash [client B] up side the head' using the magnet curtains rod that he had already chased [client B] in his room with. When [client</p>	W0154	<p><b>CORRECTION:</b> <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the agency's Quality Assurance Manager has completed an investigation into the circumstances of an incident of physical aggression from Client A toward Client B which resulted in injury.</p> <p><b>PREVENTION:</b> When incidents requiring investigation occur when facility supervisory staff are present, members of the Operations and Quality Assurance Teams will assume responsibility for conducting the investigation. Facility professional and administrative staff have been retrained on components of a thorough investigation including but not limited to specifics of what occurred and whether or not staff on duty responded to the incident appropriately. The Program Manager –Supervised Group Living will review completed investigations to assure they meet established investigation protocols.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Residential Manager, Support Associates, Operations</p>	10/10/2012	

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	<p>B] came out his room [client B] hurried by without giving [client A] or myself any attention. [Client A] stated, '[Client B] flipped him the middle finger' but I did not see that. Next thing I know [client A] ran past me and struck [client B] in the back just below his neck. [Client B] dropped to the floor in pain; (sic) while [client A] continued to rant and curse. [Client B] got up and said he had, 'Had enough' and walked out the door and continued down the street. I followed [client B] advising him to go around back instead of walking through the house where [client A] is (sic). [Client B] contacted the police."</p> <p>The IAR dated 8/30/12 indicated, "[Client B] is pressing charges for assault with a weapon." The IAR dated 8/30/12 indicated clients A and B, DCS (Direct Care Staff) #1 and #2 and QMRP (Qualified Mental Retardation Professional) #1 were listed as witnesses and/or others involved in the incident. The IAR dated 8/30/12 indicated client B was injured as a result of being hit by client A. The IAR dated 8/30/12 indicated client B's injury was described as, "Swelling the size of a fist red in color and scratches the size of a pen tip."</p> <p>-BDDS report dated 8/30/12 indicated on 8/30/12 at 4:30 PM, "[Client A]</p>		Team, Quality Assurance Team		

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	<p>(individual supported by [facility]) became upset because he believed that [client B] (individual supported by [facility]) had taken some of his housemates' clothing. [Client A] picked up a small curtain rod and threatened to beat everyone in the house. Three staff and five individuals were home at the time. One staff was working with [client B] in his room to sort through his clothing in order to return items that did not belong to him. The second staff was keeping the other three individuals away from [client A]. The QMRP attempted repeatedly to convince [client A] to put down the curtain rod without success. [Client B] came out of his room with staff. [Client A] quickly got between staff and [client B] and hit him on the back of the neck with the curtain rod. Staff separated the two individuals immediately and [client B] called the police. Police arrived and took [client A] into custody. Staff provided [client B] with emotional support and assessed him for injuries. Staff noted a red and slightly swollen area on the back of [client B]'s neck. Staff notified the nurse and made arrangements for him to be assessed."</p> <p>-Investigation dated 8/30/12 included a written statement by DCS #2 which indicated, "Interviewer: 'What were you doing when [client A] fought with [client</p>				

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	B)]? Interviewee (DCS #2), "There was no fight, [client A] hit [client B] with curtain rod that had magnet on side of it. Staff said, 'I heard [client B] scream then he feel (sic) in living room.'" The Investigation dated 8/30/12 included a written statement by DCS #2 which indicated, "Supervisor was here." The Investigation dated 8/30/12 included a written statement by DCS #1 which indicated when asked who did you contact about what you observed or discovered and when did you contact them, "[QMRP #1] soon after (also a witness)." The Investigation dated 8/30/12 included a written statement by DCS #1 which indicated when asked was someone hurt as a result of the fight? If so, who and what is the injury, "Yes, [client B] was struck form the back with a magnetic curtain rod. The back of his neck is swollen, red, (sic) and has scratches." The investigation dated 8/30/12 indicated the conclusion substantiated client A did cause injury to client B as a result of client A's behavior. The Investigation dated 8/30/12 indicated client A's behavior was a, "Historical behavior" for him. The Investigation dated 8/30/12 did not indicate a statement or interview of QMRP #1. The Investigation dated 8/30/12 did not indicate QMRP #1's actions or specify where or how client A obtained the curtain rod. The			

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	<p>Investigation dated 8/30/12 indicated QMRP #1 completed the investigation.</p> <p>Client A was interviewed on 9/11/12 at 4:56 PM. Client A indicated DCS #1, DCS #2 and QMRP #1 were working at the home during the incident.</p> <p>Client B was interviewed on 9/11/12 at 5:10 PM. Client B indicated client A had hit him in the back of the neck with a metal curtain rod. Client B indicated he had been walking toward the front entry hallway when client A hit him in the back/neck area from behind. Client B indicated DCS #1, DCS #2 and QMRP #1 were present during the incident.</p> <p>HM (Home Manager) #1 was interviewed on 9/11/12 at 5:20 PM. HM #1 indicated DCS #1, DCS #2 and QMRP #1 were present during the 8/30/12 incident with client A.</p> <p>DCS #1 was interviewed on 9/11/12 at 5:35 PM. DCS #1 indicated she was working on 8/30/12 during the incident regarding client A. When asked if DCS #2 or QMRP #1 was assisting her during the situation, DCS #1 stated, "[QMRP #1] did not come back there. [QMRP #1] was sitting at her desk. [QMRP #1] was talking on the phone to somebody, I think it was about some meds. [QMRP #1] kept</p>						

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	<p>yelling for [client A] to stop cursing and yelling but she didn't get up or come help." DCS #1 indicated DCS #2 was the one to one assigned staff for another client at the time of the incident.</p> <p>DCS #2 was interviewed on 9/11/12 at 5:45 PM. DCS #2 indicated he was working as another client's one on one staff at the time of the incident regarding client A and client B. DCS #2 indicated he could hear client A cursing and yelling at client B from the living room area where he was working. DCS #2 stated, "[DCS #1] and [QMRP #1] were working that night. [DCS #1] was in the back with [client A]. [QMRP #1] was here. I think [QMRP #1] was sitting at her desk. I was with [client D]. I heard the yelling and then I heard [client B] scream and fall to the floor in the living room."</p> <p>AS (Administrative Staff) #1 was interviewed on 9/12/12 at 9:38 AM. When asked if the investigation dated 8/30/12 regarding the incident of client to client aggression with clients A and B was thorough, AS #1 indicated QMRP #1 was involved in the incident and should not have completed the investigation. AS #1 indicated the investigation should have included an interview or statement from QMRP #1 regarding her actions during the incident. AS #1 indicated the</p>				

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	<p>investigation did not include information regarding how client A obtained a curtain rod. AS #1 stated, "I think the investigation should tell me why [client A] was able to have a curtain rod in the first place. Why staff didn't remove it or him from the area where [client B] was at."</p> <p>This federal tag relates to complaint #IN00115782.</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. Based on record review and interview for 1 of 10 incidents of abuse, neglect or injuries of unknown origin reviewed for 1 of 4 sampled clients (B), the facility failed to develop and implement corrective measures to prevent physical aggression and intimidation/emotional abuse toward client B.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IARs (Incident/Accident Reports) and investigations were reviewed on 9/12/12 at 8:30 AM. The review indicated the following:</p> <p>-IAR dated 8/30/12 indicated on 8/30/12 at 3:45 PM, "[Client A] became irrate (sic) when [client B] got clothes out of the dryer that were apparently [client B]'s but [client A] said they have no unknown (sic)origin. I asked if they were [client A]'s but he stated, 'No.' I advised [client A] to let staff handle it. [Client A] stated that he was, 'Going to handle it' himself saying he was going to, 'Bash [client B] up side the head' using the magnet curtain rod that he had already chased [client B] in his room with. When [client B] came</p>	W0157	<p><b>CORRECTION:</b> <i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, in response to the incident of aggression from Client A toward Client B on 8/30/12, the team has modified Client A's Behavior Support Plan to include arm's length staffing when he displays precursor behaviors and/or begins to escalate as well as the use of advanced personal safety techniques (one &amp; two person holds) when he becomes physically aggressive. All facility staff have received training toward proper implementation of Client A's revised plan and advanced personal safety techniques. Additionally Client B has moved to another facility that the interdisciplinary team has assessed better meets Client B's developmental, social and behavior needs.</i></p> <p><b>PREVENTION:</b> When incidents of a serious nature, including but not limited to serious injury, the Clinical Specialist or other designated member of the agency's administrative team will participate in the interdisciplinary process to assure the facility develops and implements appropriate corrective measures</p>	10/10/2012			

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	<p>out his room [client B] hurried by without giving [client A] or myself any attention. [Client A] stated, '[Client B] flipped him the middle finger' but I did not see that. Next thing I know [client A] ran past me and struck [client B] in the back just below his neck. [Client B] dropped to the floor in pain; (sic) while [client A] continued to rant and curse. [Client B] got up and said he had, 'Had enough' and walked out the door and continued down the street. I followed [client B] advising him to go around back instead of walking through the house where [client A] is (sic). [Client B] contacted the police."</p> <p>The IAR dated 8/30/12 indicated, "[Client B] is pressing charges for assault with a weapon." The IAR dated 8/30/12 indicated clients A and B, DCS (Direct Care Staff)'s #1 and #2 and QMRP (Qualified Mental Retardation Professional) #1 were listed as witnesses and/or others involved in the incident. The IAR dated 8/30/12 indicated client B was injured as a result of being hit by client A. The IAR dated 8/30/12 indicated client B's injury was described as, "Swelling the size of a fist red in color and scratches the size of a pen tip."</p> <p>-BDDS report dated 8/30/12 indicated on 8/30/12 at 4:30 PM, "[Client A] (individual supported by [facility])</p>		<p>that focus on prevention of future incidents and protection of individuals from potential abuse/neglect/mistreatment. Professional staff have been retrained regarding the need to document corrective measures through the interdisciplinary process and to assure that once the IDT reaches consensus, the team implements programmatic modifications without delay. The Quality Assurance Team will review investigation results and interdisciplinary team meeting records, and will follow-up as needed with facility supervisory staff and the Operations Team to assure the facility implements corrective measures as needed.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Residential Manager, Support Associates, Operations Team, Quality Assurance Team</p>				

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	<p>became upset because he believed that [client B] (individual supported by [facility]) had taken some of his housemates' clothing. [Client A] picked up a small curtain rod and threatened to beat everyone in the house. Three staff and five individuals were home at the time. One staff was working with [client B] in his room to sort through his clothing in order to return items that did not belong to him. The second staff was keeping the other three individuals away from [client A]. The QMRP attempted repeatedly to convince [client A] to put down the curtain rod without success. [Client B] came out of his room with staff. [Client A] quickly got between staff and [client B] and hit him on the back of the neck with the curtain rod. Staff separated the two individuals immediately and [client B] called the police. Police arrived and took [client A] into custody. Staff provided [client B] with emotional support and assessed him for injuries. Staff noted a red and slightly swollen area on the back of [client B]'s neck. Staff notified the nurse and made arrangements for him to be assessed."</p> <p>Client A's record was reviewed on 9/12/12 at 9:04 AM. Client A's IDT (Interdisciplinary Team) meeting form dated 9/3/12 indicated the following meeting agenda discussion, "At this time</p>						

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	<p>the team has agreed that [client A] needs to be seen by his psychiatrist for his aggressive behavior, he is displaying agitation when he does not get his way and wanting to boss the individuals, (sic) and staff at the site." The IDT form dated 9/3/12 did not indicate team discussion regarding how client A would be monitored/supervised when he returned to the group home from jail in relation to client B, if current supports such as his BSP (Behavior Support Plan) remained appropriate and/or other preventative measures to ensure client B's safety. Client A's BSP dated 5/2/11 updated on 12/7/11 indicated client A had the targeted behaviors of verbal aggression, property destruction, physical aggression, elopement and intimidation. Client A's BSP updated on 12/7/11 indicated when client A is physically aggressive toward others staff should, "Gently block all aggressive moves to protect [client A] and others around him." Client A's BSP updated on 12/7/11 indicated when client A is physically aggressive toward others staff should, "Physically redirect. Move [client A] away from the person she (sic) is targeting to insure (sic) everyone's safety." Client A's BSP updated on 12/7/11 indicated staff should respond to client A when he is intimidating others by, "Verbally redirect [client A] by asking him to stop. If he continues, re-engineer</p>			

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	<p>the environment by removing any object that could be used to potentially cause physical harm to himself or others."</p> <p>Client A was interviewed on 9/11/12 at 4:56 PM. When asked if there were any changes since he had returned to the group home, from being incarcerated, with his staff or client B, client A stated, "No, nothing has really changed. I just try to keep my space. Stay away from [client B]." Client A indicated he was not on any restrictions from being around or in the same proximity to client B. Client A indicated he staff was not monitoring him differently since he returned to the group home from jail.</p> <p>Client B was interviewed on 9/11/12 at 5:10 PM. Client B indicated client A had hit him in the back of the neck with a metal curtain rod. When asked if client A intimidated him or made him feel uncomfortable, client B stated, "A little bit. Sometimes [client A] makes me nervous and uncomfortable. I usually try to stay away from him."</p> <p>HM (Home Manager) #1 was interviewed on 9/11/12 at 5:20 PM. When asked if the facility had conducted an IDT following client A's return to the group home following his incarceration, HM #1 stated, "Yes, we had an IDT. I think [client A] is</p>			

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	<p>on line of sight. I wasn't at the meeting."</p> <p>AS (Administrative Staff) #1 was interviewed on 9/12/12 at 9:38 AM. When asked if the IDT on 9/3/12 had made recommendations regarding how client A would be monitored/supervised when he returned to the group home from jail in relation to client B, if current supports such as his BSP remained appropriate and/or other preventative measures to ensure client B's safety, AS #1 stated, "No, I don't see any additional recommendations." When asked if client B had been injured as a result of being hit by client A, AS #1 stated, "Yes." When asked if harm or potential harm was likely to recur between client A and client B, AS #1 stated, "Yes." When asked if the facility had implemented corrective actions to prevent recurrence, AS #1 stated, "No."</p> <p>This federal tag relates to complaint #IN00115782.</p> <p>9-3-2(a)</p>				