

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/09/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 408 N REED ST SOUTH WHITLEY, IN 46787			
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W000000	<p>This visit was for the fundamental annual recertification and state licensure survey. This visit included the investigation of complaint #IN00132222.</p> <p>Complaint #IN00132222: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W149, W154, and W249.</p> <p>Dates of Survey: August 5, 6, 7, and 9, 2013.</p> <p>Facility number: 000766 Provider number: 15G243 AIM number: 100243280</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/21/13 by Ruth Shackelford, QIDP.</p>			W000000			

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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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>Based on observation, record review, and interv 2 of 4 sampled clients (clients A and B), the fac failed to ensure the contracted workshop met cli and B's identified workshop needs to offer the c paid work opportunities when paid work was av</p> <p>Findings include:</p> <p>On 8/5/13 from 8:50 AM until 10:20 AM, obser were conducted at the facility's workshop. Fron AM until 10:20 AM, client A sat at his workstat no direct staff supervision, and operated an air g attach metal screws into a block of metal. At 8: client A stated the job "was paid work by the pi 10:00 AM, client A stated he liked to work, he l get paid for working his job, and he "did not bel [name of workshop] is offering a fair job." Clie stated "I have to work by the piece, I'm paid by piece." Client A indicated other clients were of opportunity to either complete paid work by the to be paid by the hour. Client A stated "I have r been offered" to work by the hour at the worksh Client A stated there was "not always paid piece available and he wanted to be offered the choice which type of workshop job assignment he is to complete. Client A indicated he did not believe fair for a portion of the workshop clients who re piece work to be given the choice for the availa hourly work at the workshop on a regular basis stated that the hourly client "gets paid more, fas</p>	W000120	The facility will ensure that the contracted workshop meets client A and B's identified workshop needs to offer the choice of paid work opportunities when paid work is available. A meeting with the contracted workshop was held and according to the current workshop supervisor and Vice President of the workshop, there is no hourly paid work for any consumer. During the intake process, client A and B were assessed and completed a time study to determine what production rate they would need to meet in order to make minimum wage. Each of the consumers has the opportunity to make minimum wage or higher if they would meet the production rates that were determined during their time studies. This process has been explained to client A on numerous occasions and will continue to be trained on how he gets paid. Client A and B will be referred for vocational rehab. Client A has been offered the opportunity to apply for positions in the community. The QIDP will complete the day program observation form at least two times a month.	09/06/2013			

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	<p>Client A indicated he wanted to be able to work hour when no piece work was available.</p> <p>On 8/5/13 from 8:50 AM until 10:20 AM, Clier observed at the contracted workshop. From 8:5 until 9:50 AM, Client B sat in a chair in the bre watching the news, walked around, and no paid was offered to the client. From 9:50 AM until 1 AM, Client B walked with a group of clients frc break area and went outside to smoke on the coi the property. At 10:00 AM, Client B returned in workshop, sat at a table, and played Sorry (a bo game).</p> <p>On 8/5/13 at 4:20 PM, Client B stated he liked t at workshop and he liked piece work "just not a time." Client B indicated he was not offered the opportunity for hourly work. Client B stated wl piece work runs out, "We don't have anything to Client B indicated he went to the break room in morning because there was no piece work for hi complete.</p> <p>On 8/5/13 at 10:20 AM, an interview with the V Supervisor (WKS) was conducted. The WKS in clients at the contracted workshop were offered rate and hourly rate paid positions/jobs. The W provided the 9/2011 "Wage and Hour Certificat Information" for review. The document indicat workshop had "Prevailing wage per hour/Stand: per hour = (equals) Standard piece rate...Hourly are also based on the prevailing wage. Workers piece rate jobs such as material handling and jar work will be paid the current minimum wage."</p>			

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	<p>WKS stated clients A and B were not offered hc wage jobs/positions because they were paid by 1 rate. The WKS indicated clients A and B were offered the choice between the two positions. T indicated clients A and B both had the skills to c paid work at the workshop within the piece rate jobs/positions and the hourly wage rate jobs/pos. The WKS indicated client A and B's group hom were not offered hourly wage positions. The W stated the contracted workshop "does not have t mechanisms in place to allow clients to switch t forth between a piece rate job and an hourly job payroll. The WKS indicated there was no piece today for client B and when no piece work was the clients are offered television news and socia activities.</p> <p>Client A's record was reviewed on 8/6/13 at 1:2 Client A's 1/11/13 ISP (Individual Support Plan indicated a vocational goal to let staff know wh leaving the work area and to stay in the work ar paid work. Client A's workshop record indicate 2/27/13 entry "Hard worker, pleasant...The folk jobs have been performed by this individual...sc hangers, building/sleeving wires (sic), probes, (packaging." Client A's record did not indicate i A had a choice of piece rate work or hourly wor A's workshop record indicated he had been paid piece rate.</p> <p>Client B's record was reviewed on 8/6/13 at 3:0. Client B's 11/15/12 ISP indicated a vocational g express his wants/needs and to choose to join in activity or paid work. Client B's workshop recc</p>				

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	<p>indicated a 11/15/12 entry "Reliable, hard work following jobs have been performed by this individual...sorting hangers, re boxing parts, making/tearing down boxes, probes, (and) mate handling." Client B's record did not indicate if he had a choice of piece rate work or hourly work. B's workshop record indicated he had been paid piece rate.</p> <p>On 8/6/13 at 12:30pm, an interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted. The QIDP/PD indicated clients A and B both had the skills to complete paid work at the contracted workshop. The QIDP/PD indicated clients A and B could both be good workers. The QIDP/PD indicated the clients had voiced to the staff that piece work was not always available.</p> <p>9-3-2(a)</p>				

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W000149	<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 39 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (for clients D and H), the facility neglected to implement the facility's policy and procedure to prevent abuse, neglect, and/or mistreatment, neglected to protect client H from client D's physically aggressive behaviors, and neglected to thoroughly investigate the events of client H's injuries.</p> <p>Findings include:</p> <p>On 8/5/13 at 11:45 AM, the facility's BDDS Reports and Investigations were reviewed from 08/01/12 through 08/05/13 and the following reports were reviewed for clients D and H:</p> <p>-A 7/1/13 BDDS report for an incident on 6/30/13 at 8:15 AM, indicated client H was transferred to the local hospital Emergency Room (ER) by ambulance and admitted. The report indicated client H was at the group home, had made "several negative comments towards" client D, and client D walked past client H. The report indicated when client D walked past client H, he "bumped his body into [client</p>	W000149	The facility will implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility will have evidence that all alleged violations are thoroughly investigated. The QIDP received disciplinary action on 8/15/13 for not following ResCare's protocol for thoroughly reviewing and investigating incidents of a reportable nature. The QIDP will be retrained on reviewing and investigating incidents of a reportable nature. The Director of Supported Group Living and the Quality Department will monitor BDDS reported incidents from the home and assure that any incident meeting criteria will be reviewed and investigated.	09/06/2013
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	<p>H] causing [client H] to fall. [Client H] was unable to get up" and complained of pain. The report indicated client H was "assessed and diagnosed with a right hip fracture" and was admitted to the hospital for surgery to repair his hip. The report indicated the facility staff followed client D's BSP (Behavior Support Plan) and client D "did not appear agitated" when the events occurred.</p> <p>-A 7/10/13 Follow up BDDS report for the 6/30/13 incident indicated client H had a 6/30/13 fracture checklist completed which indicated the following: Client H had a history of falls, used a walker to help prevent falls, but did not indicate if client H's walker was in use during the incident. Client H's 6/30/13 Fracture Checklist indicated client H had "Diabetic Neuropathy" (nerve damage and pain from Diabetes) which could contribute to his falls. The facility's "team discussed [client H's] use of the walker and encouraging [client H] to use the walker in all situations including keeping it within reach or using at all times."</p> <p>-A 7/10/13 Follow up BDDS report for the 6/30/13 incident indicated "since the incident [client D] was admitted to [Behavioral Hospital inpatient unit]" and discharged on 7/9/13. Client D's Geodon medication (for behaviors) was increased and will follow up with his psychiatrist on 7/16/13. The report indicated client D's "Physical aggression is addressed in [client D's] plan. The team met on 7/2/13</p>			

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	<p>and [Client D's] plan was reviewed and revised to include 'purposely bumping into others.'</p> <p>On 8/5/13 at 11:45 AM, a review of the facility's investigation into the 6/30/13 incident was conducted. The investigation had interviews completed by the QIDP (Qualified Intellectual Disabilities Professional) with the facility staff on duty and indicated the following:</p> <p>-On 7/2/13 no time documented, the QIDP interviewed Group Home Staff (GHS) #1. GHS #1 indicated she was "the primary staff present with [client D] when the incident occurred between [clients D and H]." GHS #1 stated that client H "had made a comment about 20 minutes earlier that if [client D] laid a hand on him again, he was going to have [client D] put in jail." GHS #1 indicated GHS #2 had gone into the medication room and told GHS #1 "[client D] was her primary responsibility and to make sure that she was with [client D] the whole time." GHS #1 indicated she and client D were moving laundry from the washer to the dryer. GHS #1 indicated she was positioned on client D's left side, "which would have been the closest to the garage door, but away from the rest of the house." Client D would have been closest to other clients. GHS #1 indicated client</p>			

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	<p>H was at the opposite end of the kitchen counter. GHS #1 stated she "was a step behind [client D] and even had a hold of a little piece of [client D's] shirt, but could not stop him before he shoulder bumped [client H], causing [client H] to fall to the floor." The investigation did not document information that the facility staff on duty should have implemented "Arranging the Environment" (positioning herself between client D and the other clients) per client D's BSP (Behavior Support Plan). The investigation did not include client D's identified behavioral support and staff supervision needs. The investigation did not include a conclusion or recommendations.</p> <p>Client D's record was reviewed on 8/6/13 at 12:35pm. Client D's 3/4/13 ISP (Individual Support Plan) and 3/4/13 BSP both indicated client D "had monthly rates in every area...Physical Aggression, inappropriate touching...Physical Aggression 100% increase...changes to medications are made as the team deems necessary." Client D's 3/4/13 BSP indicated "Reactive Strategies: In the event that [client D] demonstrates the following behaviors, implement that indicated (sic) interventions in response to those behaviors. Note that all members of the interdisciplinary team are expected to maintain a positive training</p>						

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	<p>environment at all times. In other words, Arranging the Environment is a given unless otherwise specified in a specific intervention strategy." Client D's 3/4/13 and revised 7/2/13 BSP indicated "...Physical Aggression...If it is not medical (sic), staff will move closer to [client D] to be able to interrupt or redirect any moves towards peers" was added to client D's plan.</p> <p>On 8/5/13 at 12:30 PM, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The facility policy indicated the facility would thoroughly investigate allegations of abuse, neglect, and mistreatment of clients.</p>			

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	<p>On 8/05/13 at 12:30 PM, a review of the facility's 6/2011 "Operations Standard. Reporting and Investigating abuse/neglect/exploitation/mistreatment," indicated "ResCare Northern Region Indiana staff actively advocate for the rights and safety of all individuals...ResCare strictly prohibits abuse/neglect/exploitation. All allegations or occurrences of abuse/neglect/exploitation/mistreatment... will be thoroughly investigated under the policies of ResCare Northern Region Indiana...."</p> <p>On 8/6/13 at 12:30 PM, an interview with the QIDP was conducted. The QIDP indicated the investigation did not indicate the facility staff on duty should have implemented "Arranging the Environment" (positioning herself between client D and the other clients) per client D's BSP (Behavior Support Plan). The QIDP indicated the facility staff were trained to position themselves between client D and the other clients. The QIDP indicated the investigation neglected to include client D's behavioral support and staff supervision needs. The QIDP indicated the investigation did not include a conclusion or recommendations. The QIDP stated client H's hip was fractured as a result of the fall on 6/30/13 after being "body bumped" by client D. The</p>			

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	<p>QIDP indicated the facility's staff neglected to protect client H from the potential of injury as a result of client D's physically aggressive behaviors.</p> <p>This federal tag relates to complaint #IN00132222.</p> <p>9-3-2(a)</p>			

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W000154	<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 39 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (for clients D and H), the facility failed to thoroughly investigate client H's fractured hip injury during client D's incident of physical aggression.</p> <p>Findings include:</p> <p>On 8/5/13 at 11:45 AM, the facility's BDDS Reports and Investigations were reviewed from 08/01/12 through 08/05/13 and the following reports were reviewed for clients D and H:</p> <p>-A 7/1/13 BDDS report for an incident on 6/30/13 at 8:15 AM, indicated client H was transferred to the local hospital Emergency Room (ER) by ambulance and admitted. The report indicated client H was at the group home, had made "several negative comments towards" client D, and client D walked past client H. The report indicated when client D walked past client H, he "bumped his body into [client H] causing [client H] to fall. [Client H] was unable to get up" and complained of pain. The report indicated client H was "assessed and diagnosed with a right hip</p>	W000154	The facility will implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility will have evidence that all alleged violations are thoroughly investigated. The QIDP received disciplinary action on 8/15/13 for not following ResCare's protocol for thoroughly reviewing and investigating incidents of a reportable nature. The QIDP will be retrained on reviewing and investigating incidents of a reportable nature. The Director of Supported Group Living and the Quality Department will monitor BDDS reported incidents from the home and assure that any incident meeting criteria will be reviewed and investigated.	09/06/2013			

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	<p>fracture" and was admitted to the hospital for surgery to repair his hip. The report indicated the facility staff followed client D's BSP (Behavior Support Plan) and client D "did not appear agitated" when the events occurred.</p> <p>-A 7/10/13 Follow up BDDS report for the 6/30/13 incident indicated client H had a 6/30/13 fracture checklist completed which indicated the following: Client H had a history of falls, used a walker to help prevent falls, but did not indicate if client H's walker was in use during the incident. Client H's 6/30/13 Fracture Checklist indicated client H had "Diabetic Neuropathy" (nerve damage and pain from Diabetes) which could contribute to his falls. The facility's "team discussed [client H's] use of the walker and encouraging [client H] to use the walker in all situations including keeping it within reach or using at all times."</p> <p>-A 7/10/13 Follow up BDDS report for the 6/30/13 incident indicated "since the incident [client D] was admitted to [Behavioral Hospital inpatient unit]" and discharged on 7/9/13. Client D's Geodon medication (for behaviors) was increased and will follow up with his psychiatrist on 7/16/13. The report indicated client D's "Physical aggression is addressed in [client D's] plan. The team met on 7/2/13 and [Client D's] plan was reviewed and revised to include 'purposely bumping into others.'"</p>			
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	<p>On 8/5/13 at 11:45 AM, a review of the facility's investigation into the 6/30/13 incident was conducted. The investigation had interviews completed by the QIDP (Qualified Intellectual Disabilities Professional) with the facility staff on duty and indicated the following:</p> <p>-On 7/2/13 no time documented, the QIDP interviewed Group Home Staff (GHS) #1. GHS #1 indicated she was "the primary staff present with [client D] when the incident occurred between [clients D and H]." GHS #1 stated that client H "had made a comment about 20 minutes earlier that if [client D] laid a hand on him again, he was going to have [client D] put in jail." GHS #1 indicated GHS #2 had gone into the medication room and told GHS #1 "[client D] was her primary responsibility and to make sure that she was with [client D] the whole time." GHS #1 indicated she and client D were moving laundry from the washer to the dryer. GHS #1 indicated she was positioned on client D's left side, "which would have been the closest to the garage door, but away from the rest of the house." Client D was closest to the other clients. GHS #1 indicated client H was at the opposite end of the kitchen counter. GHS #1 stated she "was a step behind [client D] and even had a hold of a little piece of [client D's] shirt, but could not</p>			
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	<p>stop him before he shoulder bumped [client H], causing [client H] to fall to the floor." The investigation did not document information that the facility staff on duty should have implemented "Arranging the Environment" (positioning herself between client D and the other clients) per client D's BSP (Behavior Support Plan). The investigation did not include client D's identified behavioral support and staff supervision needs. The investigation did not include a conclusion or recommendations. The investigation did not include an interview with clients D and H.</p> <p>Client D's record was reviewed on 8/6/13 at 12:35pm. Client D's 3/4/13 ISP (Individual Support Plan) and 3/4/13 BSP both indicated client D "had monthly rates in every area...Physical Aggression, inappropriate touching...Physical Aggression 100% increase...changes to medications are made as the team deems necessary." Client D's 3/4/13 BSP indicated "Reactive Strategies: In the event that [client D] demonstrates the following behaviors, implement that indicated interventions (sic) in response to those behaviors. Note that all members of the interdisciplinary team are expected to maintain a positive training environment at all times. In other words, Arranging the Environment is a given</p>						

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	<p>unless otherwise specified in a specific intervention strategy." Client D's 3/4/13 and revised 7/2/13 BSP indicated "...Physical Aggression...If it is not medical (sic), staff will move closer to [client D] to be able to interrupt or redirect any moves towards peers" was added to client D's plan.</p> <p>On 8/6/13 at 12:30 PM, an interview with the QIDP was conducted. The QIDP indicated the investigation did not indicate what the facility staff on duty should have implemented "Arranging the Environment" (positioning herself between client D and the other clients) per client D's BSP (Behavior Support Plan). The QIDP indicated the facility staff were trained to position themselves between client D and the other clients. The QIDP indicated the investigation failed to include client D's behavioral support and staff supervision needs. The QIDP indicated the investigation did not include a conclusion or recommendations. The QIDP stated client H's hip was fractured as a result of the fall on 6/30/13 after being "body bumped" by client D.</p> <p>This federal tag relates to complaint #IN00132222.</p> <p>9-3-2(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client D), the facility failed to implement client D's BSP (Behavior Support Plans) to ensure the safety of clients.</p> <p>Findings include:</p> <p>On 8/5/13 at 11:45 AM, the facility's BDDS Reports and Investigations were reviewed from 08/01/12 through 08/05/13 and the following reports were reviewed for clients D and H:</p> <p>-A 7/1/13 BDDS report for an incident on 6/30/13 at 8:15 AM, indicated client H was transferred to the local hospital Emergency Room (ER) by ambulance and admitted. The report indicated client H was at the group home, had made "several negative comments towards" client D, and client D walked past client H. The report indicated when client D walked past client H, he "bumped his body into [client H] causing [client H] to fall. [Client H] was unable to get up." The report</p>	W000249	The facility will ensure that as soon as the interdisciplinary team has formulated a client's individual program plan, each client will receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Staff were retrained on client D's behavior support plan on 8/21/13. The QIDP will continue to review the BSP monthly and revise as needed. There were no other clients affected by the deficient practice. The QIDP and Residential Manager will continue to complete active habilitation observations weekly and monitor staff to assure that they are following clients D's BSP.	09/06/2013			

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	<p>indicated client H was "assessed and diagnosed with a right hip fracture" and was admitted to the hospital for surgery to repair his hip. The report indicated the facility staff followed client D's BSP (Behavior Support Plan) and client D "did not appear agitated" when the events occurred.</p> <p>-A 7/10/13 Follow up BDDS report for the 6/30/13 incident indicated "since the incident [client D] was admitted to [Behavioral Hospital inpatient unit]" and discharged on 7/9/13. The report indicated client D's "Physical aggression is addressed in [client D's] plan. The team met on 7/2/13 and [Client D's] plan was reviewed and revised to include 'purposely bumping into others.'"</p> <p>On 8/5/13 at 11:45 AM, a review of the facility's investigation into the 6/30/13 incident was conducted. The investigation had interviews completed by the QIDP (Qualified Intellectual Disabilities Professional) with the facility staff on duty and indicated the following:</p> <p>-On 7/2/13 no time documented, the QIDP interviewed Group Home Staff (GHS) #1. GHS #1 indicated she was "the primary staff present with [client D] when the incident occurred between [clients D and H]." GHS #1 stated that</p>			

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	<p>client H "had made a comment about 20 minutes earlier that if [client D] laid a hand on him again, he was going to have [client D] put in jail." GHS #1 indicated GHS #2 had gone into the medication room and told GHS #1 "[client D] was her primary responsibility and to make sure that she was with [client D] the whole time." GHS #1 indicated she and client D were moving laundry from the washer to the dryer. GHS #1 indicated she was positioned on client D's left side, "which would have been the closest to the garage door, but away from the rest of the house." Client D was closest to the other clients. GHS #1 indicated client H was at the opposite end of the kitchen counter. GHS #1 stated she "was a step behind [client D] and even had a hold of a little piece of [client D's] shirt, but could not stop him before he shoulder bumped [client H], causing [client H] to fall to the floor." The investigation did not indicate the facility staff on duty should have implemented "Arranging the Environment" (positioning herself between client D and the other clients) per client D's 3/4/13 BSP (Behavior Support Plan).</p> <p>Client D's record was reviewed on 8/6/13 at 12:35pm. Client D's 3/4/13 ISP (Individual Support Plan) and 3/4/13 BSP both indicated client D "had monthly rates</p>			

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	<p>in every area...Physical Aggression, inappropriate touching...Physical Aggression 100% increase...." Client D's 3/4/13 BSP indicated "Reactive Strategies: In the event that [client D] demonstrates the following (targeted) behaviors, implement that indicated (sic) interventions in response to those behaviors. Note that all members of the interdisciplinary team are expected to maintain a positive training environment at all times. In other words, Arranging the Environment is a given unless otherwise specified in a specific intervention strategy." Client D's 3/4/13 and revised 7/2/13 BSP indicated "...Physical Aggression...If it is not medical (sic), staff will move closer to [client D] to be able to interrupt or redirect any moves towards peers" was added to client D's plan.</p> <p>On 8/6/13 at 12:30 PM, an interview with the QIDP was conducted. The QIDP indicated the facility staff on duty should have implemented client D's plan for "Arranging the Environment" (positioning herself between client D and the other clients) per client D's BSP (Behavior Support Plan). The QIDP indicated the facility staff were trained to position themselves between client D and the other clients. The QIDP stated client H's hip was fractured as a result of the fall on</p>			

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	<p>6/30/13 after being "body bumped" by client D.</p> <p>This federal tag relates to complaint #IN00132222.</p> <p>9-3-4(a)</p>				