

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/28/2014
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
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W000000	<p>This visit was for an investigation of Complaint #IN00157453.</p> <p>Complaint #IN00157453: Substantiated; federal/state deficiencies related to the allegations are cited at W149, W154 and W157.</p> <p>Dates of Survey: October 27 and 28, 2014.</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>Facility Number: 003184 AIM Number: 100368720 Provider Number: 15G697</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/6/14 by Ruth Shackelford, QIDP.</p>	W000000		
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</p>	W000149		11/03/2014

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

TITLE

(X6) DATE

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

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	<p>4 of 29 incidents for 3 of 3 sampled clients (A, B and C), the facility failed to implement written policies and procedures which prohibited staff neglect or exploitation (sexual) of clients.</p> <p>Findings include:</p> <p>Review of facility BDDS/Bureau of Developmental Disabilities Services reports, investigations, and internal reports/Adverse Incident reports/AIRs on 10/27/14 at 2:00 PM indicated the following:</p> <p>1. 9/2/14 at 6:20 AM AIR by staff #8 indicated clients A, B and C were sitting on the med (medication) room couch. Staff #8 started to administer medication to another client and "thru (sic) the corner of my eye I saw [client A] rub [client B's] inner thigh. I told [client A] to go sit away from [client B], [client A] went to his room. A report was made (and) I asked [client B] if he was ok. [Client B] said he was fine." The follow up response from the QIDP (Qualified Intellectual Disabilities Professional) #2 indicated a copy of the AIR was forwarded to the BC (Behavior Clinician) who wrote client A's behavior program. QIDP #2 indicated on the AIR "behavior (client A's sexual behavior) is tracked on behavior tracking sheets." There was no other evidence of</p>		<p>In order to ensure that the facility is following and implementing written policies and procedures that prohibit mistreatment, neglect or abuse of the client, the following actions have been taken: staff #9 has been retrained as of 10/3/2014 on how to engage with a client who is designated "line of sight" by his behavior plan. Staff #9 was also trained on proper incident reporting procedures. During the group home house meeting on 11/17/2014, the remainders of the group home staff will receive specific training that will address "line of sight" protocol and proper incident reporting procedure. The QIDP and the SGLRM will ensure that staff reporting will be responded to in a timely manner and that the response will be appropriate for the situation.</p>	

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	<p>response to the incident.</p> <p>2. 9/3/14 at 6:20 AM AIR by staff #7 indicated the staff was giving medications and heard someone going into the bathroom adjacent to the medication room and "investigated...Found door closed. I knocked and opened door and saw [client A] with another client - [client B] the other client's pants were down. I said 'no,' you can't be doing this, this is inappropriate. [Client A] nodded, and gestured for the other client to pull his pants up, and to leave the bathroom...."</p> <p>The BDDS report dated 9/03/14 by QIDP (Qualified Intellectual Disabilities Professional) #2 indicated staff #7 was doing the morning medication administration and heard the bathroom next to the medication room shut. He investigated and found clients A and B in the bathroom and client B's pants were "pulled down." Staff #7 reported he redirected the clients and told them what they were doing was inappropriate. "At that point [client A] nodded and gestured that [client B] should pull his pants up and leave the bathroom. [Staff #7] took [client B] into the medication room and talked with him about good/bad touch and saying 'no.'"</p> <p>The BDDS report's "Plan to Resolve"</p>						

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	<p>component by QIDP #2 contained the following: "We know from past actions that [client A] is a sexual predator. He has been in similar situations previously with both a woman and with this housemate...Per the camera (the facility is fitted with surveillance cameras) we could see [client B] sitting on the couch outside of the medication room waiting to go in to receive his medication. He was sitting in the corner of the couch... [client A] came and sat down next to him. While watching to see if anyone could see them [client A] appeared to reach his right hand out to [client B]. We could not see what actually transpired as [client A's] body was blocking the camera view. It appeared though that [client A] was rubbing his hand on either [client B's] hand, thigh, or a more private area. [Client A] kept looking to see if observed and did this again...This went on for approximately 30-45 seconds. At this point [client A] pointed toward the restroom and [client B] got up and went in with [client A] behind him. We were unable to tell from [client B's] actions whether or not he was a willing participant and understood what was going on or whether or not he reacted to the pointing by [client A] due to doing what [client A] wanted him to do, what he wanted to do, or just the response to something he considered a redirection by</p>						

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	<p>his housemate. " The BDDS report indicated the clients were in the restroom alone "approximately 30 seconds" before staff #7 intervened. The 9/3/14 BDDS report indicated, "It appeared when [client B] left the bathroom that [client B] still had underwear (sic) pulled up... [client B] did not seem to be upset by the situation...[Client A] was unhappy at being interrupted...." The report indicated the agency's administrators were contacted regarding the episode and the clients are in different areas of the building during their day programming. "Staff at the home have been alerted to this situation and have increased vigilance in order to prevent further actions by [client A] toward [client B] or other housemates."</p> <p>An "Incident Investigation" by QIDP #2 dated 9/3/14 and signed by former Administrator #10 on 9/5/14 was completed and indicated the information in the AIR and BDDS reports of 9/3/14. Additional information included in the investigation was concerning the second staff, staff #8, who was on duty at the facility that morning. Staff #8 was in the kitchen area preparing breakfast when staff #7 was administering medications. The QIDP and staff #8 discussed how to better arrange the morning routine of having medications first and then having</p>			

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	<p>breakfast with clients. The QIDP indicated the "C card" (component of client A's behavior plan which identifies the staff by badge responsible to keep him in line of sight) was discussed. The investigation did not contain any other corrective measures such as program revision, staff training, or client training.</p> <p>3. 9/8/14 7:45 PM AIR by staff #5 indicated, "[Client A] exited med waiting room. Other client [C] was standing by chair. [Client A] walked up to other client, turned his back to me. I (staff #5) stood up, &amp; (and) he (client A) was touching other client's privates." The AIR had a component which asked the person filling out the form if the individual had a formal Behavior Support Plan/BSP and what proactive strategies were implemented prior to the behavior. Staff #5's written response to the query was "happened (the incident) too fast."</p> <p>4. 9/25/14 at 6:00 AM to 7:00 AM AIR by staff #9 indicated "After fixing dishwasher I stood up and turned around and when I got to the front room I observed [client A] on his knees in front of one of his peers (client C) who was sitting in a chair by the windows. He had his hand in his pants (sic) when I asked what he was doing he got up and went to sit in one of the other chairs. I tried to</p>						

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	<p>calmly ask what he was doing and when I realized I told him that was not appropriate behavior and he looked at me like he was embarrassed (sic). " Staff #9 indicated client A had exited the shower and staff #6 had not alerted staff #9 to this fact. A BDDS report was submitted for the 9/25/14 incident by Administrator #1 on 10/2/14, with a knowledge date of 10/1/14. The BDDS report indicated, "Newly hired house staff (staff #9) had left [client A] in the shower while he attended to dinner in the kitchen. While the staff was busy, [client A] walked out of the shower and approached his housemate [client C]. When [staff #9] went to check on [client A], he discovered [client A] on his knees in front of [client C] with his hand down [client C's] sweat pants. Staff asked [client A] what he was doing and [client A] immediately got up and sat down in a chair. Staff calmly addressed the incident with [client A] and informed him that [client A] was being inappropriate (sic) with [client C].</p> <p>Staff then ensured that proper line of sight protocol was observed for the remainder of his shift." Plan to resolve..."The staff involved was retrained on [client A's] behavior plan including line of sight protocol. All staff in the house are expected to understand that when they are designated line of</p>			

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	<p>sight, they are to wear a visible 'C' tag on their person as to indicate that the staff wearing the tag is responsible for providing client [client A] with line-of-sight staffing. This line of sight requires staff to stay with 15 feet of [client A] and to provide unobstructed (sic.) observation."</p> <p>There was no investigation in regards to this incident of lack of staff supervision which led to the sexual misconduct.</p> <p>Review of client A's record on 10/28/14 at 10:45 AM indicated an Individual Program Plan/IPP for the time period of 3/2014 to 3/2015. The IPP contained a "Self Direction" component which indicated, in part, client A was vulnerable to "financial, physical, emotional and sexual exploitation." The "Behavior" component indicated: "[Client A] has a behavior support plan to address sexually inappropriate behavior. [Client A] has been known to target those whom he believes are weaker in their ability to inform or defend themselves. This can be directed towards males or females. Currently staff is to provide 1:1 (one staff to one client) supervision within 15 feet, the staff that provide this supervision wear a " C " card (tag with letter C on it) to identify that [Client A] is currently their responsibility. Staff goes with [Client A] into the restroom to ensure</p>			

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	<p>that no one is there and then tell [Client A] 'all clear.' Staff also goes with him on breaks and at lunch. [Client A] goes 5 minutes earlier than others and returns five minutes before others to help prevent problems during transition."</p> <p>Review of client B's record on 10/28/14 at 3:28 PM indicated an IPP for the time period of 3/2014 to 3/2015. The IPP's "Decision Making" component indicated: "[Client B] is able to make very simple choices between two very concrete choices, such as choices of a snack. He is not able to make decisions on major life choices and relies on others to assist him. He is at risk to physical, financial, and sexual exploitation."</p> <p>Review of client C's record on 10/28/14 at 2:59 PM indicated an IPP for the time period of 1/2014 to 1/2015 and it contained a "Decision Making" component which indicated the following: "[Client C] is able to make very simple choices between two very concrete choices, such as choices of a snack. He is not able to make decisions on major life choices and relies on others to assist him. He is at risk for physical, financial, and sexual exploitation. [Client C] has a housemate (client A) who has been know to demonstrate unwelcome sexual touch.</p>				

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	<p>It is believed that [client C] would not want this type of touch and he would retaliate. By staff reports there have not been any inappropriate interactions or acting out by [client C]."</p> <p>Review of agency policies and procedures on 10/27/14 at 2:39 PM indicated a Standard Operating Procedure for Identifying and Reporting Suspected Abuse and Neglect dated 4/12/2006. The review indicated the agency prohibited client abuse/neglect/exploitation. Definitions were in the procedure: "3. Sexual Abuse: Includes all allegations of unwanted sexual advances, rape, sexual misconduct, or sexual exploitation. 4. Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care...or supervision." The policy indicated the suspicion of an individual being the victim of abuse or neglect must be reported to supervisory staff within "one hour" of the discovery. The allegation will be documented within 24 hours. Supervisory staff will report the allegation to the appropriate state agencies and the agency's administrative staff. The allegations will be fully investigated and the results of the investigation will be submitted to the agency's administration (Program</p>			

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	<p>Manager, Program Director or designee and Executive Director).</p> <p>During an interview with Group Living Division Manager/Administrator #1 on 10/27/14 at 2:30 PM, AD #1 stated client A was a known "sexual predator" and was to be monitored "in line of sight" by facility staff to prevent sexual misconduct toward his housemates. The interview indicated the agency prohibited abuse and neglect of clients they served.</p> <p>QIDP #2 was asked why there was no investigation on 10/27/14 at 3:15 PM of the 9/25/14 incident between clients A and C. QIDP #2 indicated client A had his hand in his own pants and was not touching another individual so there was no need to investigate the incident.</p> <p>Administrator/AD #1 was asked on 10/28/14 at 10:35 AM about the 10/2/14 BDDS report which indicated sexual misconduct had indeed happened between clients A and C on 9/25/14. AD #1 called staff #9 to clarify the details of the incident and reported on 10/28/14 at 11:22 AM client A did have his hand in client C's pants and the incident should have been investigated.</p> <p>This federal tag relates to complaint #IN00157453.</p>						

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W000154	<p>9-3-2(a)</p> <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 29 incidents for 2 of 3 sampled clients (A and C), the facility failed to thoroughly investigate instances of sexual exploitation and staff neglect of clients.</p> <p>Findings include:</p> <p>Review of facility BDDS/Bureau of Developmental Disabilities Services reports, investigations, and internal reports/Adverse Incident reports/AIRs on 10/27/14 at 2:00 PM indicated the following:</p> <p>A 9/25/14 at 6:00 AM to 7:00 AM AIR by staff #9 indicated "After fixing dishwasher I stood up and turned around</p>	W000154	<p>As of 11/03/2014, the QIDP ensured that a thorough investigation was conducted in order to determine if the alleged violation could be substantiated. Her findings conclude that the reporting by multiple house staff was contradictory regarding the nature and extent of client A's inappropriate sexual conduct with client C. Regardless of the lack of concrete evidence, appropriate measures has been taken:</p> <p>In order to ensure that the facility is following and implementing written policies and procedures that prohibit mistreatment, neglect or abuse of the client, the following actions have been taken: staff #9 has been retrained as of 10/3/2014 on how to engage with a client who is designated "line of sight" by his</p>	11/03/2014
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	and when I got to the front room I observed [client A] on his knees in front of one of his peers (client C) who was sitting in a chair by the windows. He had his hand in his pants (sic) when I asked what he was doing he got up and went to sit in one of the other chairs. I tried to calmly ask what he was doing and when I realized I told him that was not appropriate behavior and he looked at me like he was embarrassed (sic). " Staff #9 indicated client A had exited the shower and staff #6 had not alerted staff #9 to this fact. A BDDS report was submitted for the 9/25/14 incident by Administrator #1 on 10/2/14, with a knowledge date of 10/1/14. The BDDS report indicated, "Newly hired house staff (staff #9) had left [client A] in the shower while he attended to dinner in the kitchen. While the staff was busy, [client A] walked out of the shower and approached his housemate [client C]. When [staff #9] went to check on [client A], he discovered [client A] on his knees in front of [client C] with his hand down [client C's] sweat pants. Staff asked [client A] what he was doing and [client A] immediately got up and sat down in a chair. Staff calmly addressed the incident with [client A] and informed him that [client A] was being inappropriate (sic) with [client C]. Staff then ensured that proper line of		behavior plan. Staff #9 was also trained on proper incident reporting procedures. During the group home house meeting on 11/17/2014, the remainders of the group home staff will receive specific training that will address "line of sight" protocol and proper incident reporting procedure. The QIDP and the SGLRM will ensure that staff reporting will be responded to in a timely manner and that the response will be appropriate for the situation. These measures have been put in place to prevent any such future incidents involving a lapse in Client A's "line of sight" protocol. Also, the lights in the living room have been turned up brighter in order for the HRC approved surveillance cameras to work more effectively.				

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	<p>sight protocol was observed for the remainder of his shift." Plan to resolve..."The staff involved was retrained on [client A's] behavior plan including line of sight protocol. All staff in the house are expected to understand that when they are designated line of sight, they are to wear a visible 'C' tag on their person as to indicate that the staff wearing the tag is responsible for providing client [client A] with line-of-sight staffing. This line of sight requires staff to stay with 15 feet of [client A] and to provide onobstructed (sic.) observation."</p> <p>There was no investigation in regards to this incident of lack of staff supervision which led to the sexual misconduct.</p> <p>Review of client A's record on 10/28/14 at 10:45 AM indicated an Individual Program Plan/IPP for the time period of 3/2014 to 3/2015. The IPP contained a "Self Direction" component which indicated, in part, client A was vulnerable to "financial, physical, emotional and sexual exploitation." The "Behavior" component indicated: "[Client A] has a behavior support plan to address sexually inappropriate behavior. [Client A] has been known to target those whom he believes are weaker in their ability to inform or defend themselves. This can be directed towards males or females.</p>			

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	<p>Currently staff is to provide 1:1 (one staff to one client) supervision within 15 feet, the staff that provide this supervision wear a " C " card (tag with letter C on it) to identify that [Client A] is currently their responsibility. Staff goes with [Client A] into the restroom to ensure that no one is there and then tell [Client A] 'all clear.' Staff also goes with him on breaks and at lunch. [Client A] goes 5 minutes earlier than others and returns five minutes before others to help prevent problems during transition."</p> <p>Review of client C's record on 10/28/14 at 2:59 PM indicated an IPP for the time period of 1/2014 to 1/2015 and it contained a "Decision Making" component which indicated the following: "[Client C] is able to make very simple choices between two very concrete choices, such as choices of a snack. He is not able to make decisions on major life choices and relies on others to assist him. He is at risk for physical, financial, and sexual exploitation. [Client C] has a housemate (client A) who has been know to demonstrate unwelcome sexual touch. It is believed that [client C] would not want this type of touch and he would retaliate. By staff reports there have not been any inappropriate interactions or acting out by [client C]."</p>						

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	<p>During an interview with Group Living Division Manager/Administrator #1 on 10/27/14 at 2:30 PM, AD #1 stated client A was a known "sexual predator" and was to be monitored "in line of sight" by facility staff to prevent sexual misconduct toward his housemates.</p> <p>QIDP #2 was asked why there was no investigation on 10/27/14 at 3:15 PM of the 9/25/14 incident between clients A and C. QIDP #2 indicated client A had his hand in his own pants and was not touching another individual so there was no need to investigate the incident.</p> <p>Administrator/AD #1 was asked on 10/28/14 at 10:35 AM about the 10/2/14 BDDS report which indicated sexual misconduct had indeed happened between clients A and C on 9/25/14. AD #1 called staff #9 to clarify the details of the incident and reported on 10/28/14 at 11:22 AM client A did have his hand in client C's pants and the incident should have been investigated.</p> <p>This federal tag relates to complaint #IN00157453.</p> <p>9-3-2(a)</p>						

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W000157	<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 4 of 29 incidents for 3 of 3 sampled clients (A, B and C), the facility failed to take sufficient corrective action to address a pattern of inappropriate sexual behavior.</p> <p>Findings include:</p> <p>Review of facility BDDS/Bureau of Developmental Disabilities Services reports, investigations, and internal reports/Adverse Incident reports/AIRs on 10/27/14 at 2:00 PM indicated the following:</p> <p>1. 9/2/14 at 6:20 AM AIR by staff #8 indicated clients A, B and C were sitting on the med (medication) room couch. Staff #8 started to administer medication to another client and "thru (sic) the corner</p>	W000157	<p>As of 11/03/2014, the QIDP ensured that a thorough investigation was conducted in order to determine if the alleged violation could be substantiated. Her findings conclude that the reporting by multiple house staff was contradictory regarding the nature and extent of client A's inappropriate sexual conduct with client C. Regardless of the lack of concrete evidence, appropriate measures has been taken:</p> <p>In order to ensure that the facility is following and implementing written policies and procedures that prohibit mistreatment, neglect or abuse of the client, the following actions have been taken: staff #9 has been retrained as of 10/3/2014 on how to engage with a client who is designated "line of sight" by his behavior plan. Staff #9 was also</p>	11/03/2014

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	<p>of my eye I saw [client A] rub [client B's] inner thigh. I told [client A] to go sit away from [client B], [client A] went to his room. A report was made (and) I asked [client B] if he was ok. [Client B] said he was fine." The follow up response from the QIDP (Qualified Intellectual Disabilities Professional) #2 indicated a copy of the AIR was forwarded to the BC (Behavior Clinician) who wrote client A's behavior program. QIDP #2 indicated on the AIR "behavior (client A's sexual behavior)is tracked on behavior tracking sheets." There was no other evidence of response to the incident.</p> <p>2. 9/3/14 at 6:20 AM AIR by staff #7 indicated the staff was giving medications and heard someone going into the bathroom adjacent to the medication room and "investigated...Found door closed. I knocked and opened door and saw [client A] with another client - [client B] the other client's pants were down. I said 'no,' you can't be doing this, this is inappropriate. [Client A] nodded, and gestured for the other client to pull his pants up, and to leave the bathroom...." The BDDS report dated 9/03/14 by QIDP (Qualified Intellectual Disabilities Professional) #2 indicated staff #7 was doing the morning medication administration and heard the bathroom</p>		<p>trained on proper incident reporting procedures. During the group home house meeting on 11/17/2014, the remainders of the group home staff will receive specific training that will address "line of sight" protocol and proper incident reporting procedure. The QIDP and the SGLRM will ensure that staff reporting will be responded to in a timely manner and that the response will be appropriate for the situation. These measures have been put in place to prevent any such future incidents involving a lapse in Client A's "line of sight" protocol. Also, the lights in the living room have been turned up brighter in order for the HRC approved surveillance cameras to work more effectively. Also, the cameras will be adjusted and/or added in order to correct any "blind spots" that obstruct any incident that occurred.</p> <p>As of 11/3/2014, The SGLRM has counseled the QIDP about the proper procedure and protocol regarding incident investigations and what types of incident reports need to be investigated.</p>	

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	<p>next to the medication room shut. He investigated and found clients A and B in the bathroom and client B's pants were "pulled down." Staff #7 reported he redirected the clients and told them what they were doing was inappropriate. "At that point [client A] nodded and gestured that [client B] should pull his pants up and leave the bathroom. [Staff #7] took [client B] into the medication room and talked with him about good/bad touch and saying 'no.'"</p> <p>The BDDS report's "Plan to Resolve" component by QIDP #2 contained the following: "We know from past actions that [client A] is a sexual predator. He has been in similar situations previously with both a woman and with this housemate...Per the camera (the facility is fitted with surveillance cameras) we could see [client B] sitting on the couch outside of the medication room waiting to go in to receive his medication. he was sitting in the corner of the couch...[client A] came and sat down next to him. While watching to see if anyone could see them [client A] appeared to reach his right hand out to [client B]. We could not see what actually transpired as [client A's] body was blocking the camera view. It appeared though that [client A] was rubbing his hand on either [client B's] hand, thigh, or a more private area. [Client A] kept looking to see if observed</p>			

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	<p>and did this again...This went on for approximately 30-45 seconds. At this point [client A] pointed toward the restroom and [client B] got up and went in with [client A] behind him. We were unable to tell from [client B's] actions whether or not he was a willing participant and understood what was going on or whether or not he reacted to the pointing by [client A] due to doing what [client A] wanted him to do, what he wanted to do, or just the response to something he considered a redirection by his housemate. " The BDDS report indicated the clients were in the restroom alone "approximately 30 seconds" before staff #7 intervened. The 9/3/14 BDDS report indicated, "It appeared when [client B] left the bathroom that [client B] still had underwear (sic) pulled up... [client B] did not seem to be upset by the situation...[Client A] was unhappy at being interrupted...." The report indicated the agency's administrators were contacted regarding the episode and the clients are in different areas of the building during their day programming. "Staff at the home have been alerted to this situation and have increased vigilance in order to prevent further actions by [client A] toward [client B] or other housemates."</p> <p>An "Incident Investigation" by QIDP #2</p>			

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	<p>dated 9/3/14 and signed by former Administrator #10 on 9/5/14 was completed and indicated the information in the AIR and BDDS reports of 9/3/14. Additional information included in the investigation was concerning the second staff, staff #8, who was on duty at the facility that morning. Staff #8 was in the kitchen area preparing breakfast when staff #7 was administering medications. The QIDP and staff #8 discussed how to better arrange the morning routine of having medications first and then having breakfast with clients. The QIDP indicated the "C card" (component of client A's behavior plan which identifies the staff by badge responsible to keep him in line of sight) was discussed. The investigation did not contain any other corrective measures such as program revision, staff training, or client training.</p> <p>3. 9/8/14 7:45 PM AIR by staff #5 indicated, "[Client A] exited med waiting room. Other client [C] was standing by chair. [Client A] walked up to other client, turned his back to me. I (staff #5) stood up, &amp; (and) he (client A) was touching other client's privates." The AIR had a component which asked the person filling out the form if the individual had a formal Behavior Support Plan/BSP and what proactive strategies were implemented prior to the behavior.</p>			

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	<p>Staff #5's written response to the query was "happened (the incident) too fast." No evidence of corrective measures were implemented after this incident.</p> <p>4. 9/25/14 at 6:00 AM to 7:00 AM AIR by staff #9 indicated "After fixing dishwasher I stood up and turned around and when I got to the front room I observed [client A] on his knees in front of one of his peers (client C) who was sitting in a chair by the windows. He had his hand in his pants (sic) when I asked what he was doing he got up and went to sit in one of the other chairs. I tried to calmly ask what he was doing and when I realized I told him that was not appropriate behavior and he looked at me like he was embarrassed (sic). " Staff #9 indicated client A had exited the shower and staff #6 had not alerted staff #9 to this fact. A BDDS report was submitted for the 9/25/14 incident by Administrator #1 on 10/2/14, with a knowledge date of 10/1/14. The BDDS report indicated, "Newly hired house staff (staff #9) had left [client A] in the shower while he attended to dinner in the kitchen. While the staff was busy, [client A] walked out of the shower and approached his housemate [client C]. When [staff #9] went to check on [client A], he discovered [client A] on his knees in front of [client C] with his hand down</p>			

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	<p>[client C's] sweat pants. Staff asked [client A] what he was doing and [client A] immediately got up and sat down in a chair. Staff calmly addressed the incident with [client A] and informed him that [client A] was being inappropriate (sic) with [client C].</p> <p>Staff then ensured that proper line of sight protocol was observed for the remainder of his shift." Plan to resolve... "The staff involved was retrained on [client A's] behavior plan including line of sight protocol. All staff in the house are expected to understand that when they are designated line of sight, they are to wear a visible 'C' tag on their person as to indicate that the staff wearing the tag is responsible for providing client [client A] with line-of-sight staffing. This line of sight requires staff to stay with 15 feet of [client A] and to provide unobstructed (sic.) observation."</p> <p>There was no evidence of corrective measures in regards to this incident of lack of staff supervision which led to the sexual misconduct.</p> <p>Review of client A's record on 10/28/14 at 10:45 AM indicated an Individual Program Plan/IPP for the time period of 3/2014 to 3/2015. The IPP contained a "Self Direction" component which indicated, in part, client A was vulnerable to "financial, physical, emotional and</p>						

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	<p>sexual exploitation." The "Behavior" component indicated: "[Client A] has a behavior support plan to address sexually inappropriate behavior. [Client A] has been known to target those whom he believes are weaker in their ability to inform or defend themselves. This can be directed towards males or females. Currently staff is to provide 1:1 (one staff to one client) supervision within 15 feet, the staff that provide this supervision wear a " C " card (tag with letter C on it) to identify that [Client A] is currently their responsibility. Staff goes with [Client A] into the restroom to ensure that no one is there and then tell [Client A] 'all clear.' Staff also goes with him on breaks and at lunch. [Client A] goes 5 minutes earlier than others and returns five minutes before others to help prevent problems during transition."</p> <p>Review of client B's record on 10/28/14 at 3:28 PM indicated an IPP for the time period of 3/2014 to 3/2015. The IPP's "Decision Making" component indicated: "[Client B] is able to make very simple choices between two very concrete choices, such as choices of a snack. He is not able to make decisions on major life choices and relies on others to assist him. He is at risk to physical, financial, and sexual exploitation."</p>			

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	<p>Review of client C's record on 10/28/14 at 2:59 PM indicated an IPP for the time period of 1/2014 to 1/2015 and it contained a "Decision Making" component which indicated the following: "[Client C] is able to make very simple choices between two very concrete choices, such as choices of a snack. He is not able to make decisions on major life choices and relies on others to assist him. He is at risk for physical, financial, and sexual exploitation. [Client C] has a housemate (client A) who has been know to demonstrate unwelcome sexual touch. It is believed that [client C] would not want this type of touch and he would retaliate. By staff reports there have not been any inappropriate interactions or acting out by [client C]."</p> <p>A copy of a staff meeting (9/29/14) was reviewed on 10/27/14 at 2:30 PM. The staff meeting was a training by QIDP #2 in response to client A's continued sexual misconduct. The meeting was not held until after the 9/25/14 episode.</p> <p>During an interview with Group Living Division Manager/Administrator #1 on 10/27/14 at 2:30 PM, AD #1 stated client A was a known "sexual predator" and was to be monitored "in line of sight" by facility staff to prevent sexual</p>			

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	<p>misconduct toward his housemates. The 9/29/14 staff meeting was the only response offered as a correction to the episodes of sexual misconduct by client A toward his housemates.</p> <p>This federal tag relates to complaint #IN00157453.</p> <p>9-3-2(a)</p>			