DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

B. WING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/17/2013	
,	16611 S	SIMA GRAY RD		
<u> </u>	HENRY	VILLE, IN 47126		
	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
		CROSS-REFERENCED TO THE APPROPRIA	TE	ON
TION)	IAU		DATE	
ed.	00			
	B. WING S PI ATION) W000	B. WING STREET A 16611 S HENRY S ID PREFIX TAG W0000 ed.	S ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W0000 W0000 S II PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W0000 S II PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-	STREET ADDRESS, CITY, STATE, ZIP CODE 16611 SIMA GRAY RD HENRYVILLE, IN 47126 S ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE W0000 W0000 S in

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

TITLE

011663

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G745	B. WING		01/17/2013
	PROVIDER OR SUPPLIEI		16611	ADDRESS, CITY, STATE, ZIP CODE SIMA GRAY RD YVILLE, IN 47126	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DROWIDED'S DLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0102	483.410 GOVERNING BOThe facility must governing body a requirements are Based on record 1 of 2 sampled of failed to meet the Participation: Governing Body operating directimplement policiprohibited staff to prevent client battery). Findings included Please refer to Victional Clients (A), for the failure to exercise direction over the implement policiprohibited client client A swallow Please refer to Victional Swallow Please refer to Victional Client A swallow Please refer to Victional Please refer to Victi	DDY AND MANAGEMENT ensure that specific and management e met. I review and interview for clients (A), the facility the Condition of overning Body. The ty failed to exercise general tion by failing to ty/procedure that the glect of client A (failed the A from swallowing a e: W104 for 1 of 2 sampled the Governing Body's the general operating the facility by failing to the sand procedures which the neglect in regards to the triplet of the Governing to meet the Condition of the Client Protections for 1 of the (A). The Governing the of neglect, by failing to the of neglect, by failing to the singestion of metal the of neglect, by failing to the singestion of metal the of neglect, by failing to the singestion of metal the of neglect, by failing to the singestion of metal the triplets of all the triplets of all the of neglect, by failing to the singestion of metal the triplets of all the triplets of all the triplets of the triplets o	W0102	W102: Governing Body and Management The facility must ensure that specific governing body and management requirements are met. Corrective Action (Specific): The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitation Policy and Procedure and Clie A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items. How Others Will Be Identified (Systemic): The Operations Manager for Supported Group Living and Program Coordinat will review all individuals Program Plans and ensure that each pl specifically meets the needs of individuals. All Program Plans be reviewed at least quarterly ensure that all plans remain effective.	on ent ent ed es e e e e e e e e e e e e e e e e e
	one to one staffi	ng supervision.		Measures to be put in Place:	

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Event ID: DDPY11

Facility ID: 011663

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PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		A. BUILDING B. WING	00	COMPLETED 01/17/2013			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	RE SOUTHEAST IN			SIMA GRAY RD /VILLE, IN 47126				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE			
IAG		relates to complaint	IAG	The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitatic Policy and Procedure and Clie A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items. Monitoring of Corrective Action: The Operations Mana and Program Coordinator will review internal incident reports and ensure that IDT's are held and any programmatic change occur as indicated and that all staff are in-serviced on those changes. Completion Date: February 2013	ger			
			1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPI			COMPL	ETED
		15G745	B. WIN			01/17/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				SIMA GRAY RD		
RES CAE	RE SOUTHEAST IN	ΠΙΔΝΔ			VILLE, IN 47126		
					T		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI TAG DEFICIENCY)		TE	COMPLETION DATE
W0104	483.410(a)(1)	ESC IDENTIFY THOSE IN GRAPHTON	+	1710			DATE
****	GOVERNING BODY						
		dy must exercise general					
		d operating direction over					
	the facility.						
	Based on record	review and interview, the	W0	104	W104: Governing Body		02/16/2013
		ng body failed, for 6 of			The governing body must		
	10 facility				exercise general policy, budge and operating direction over the		
	-	ble/investigations			facility.	. •	
	(alleged neglect,	1 of 2 sampled clients,		Corrective Action: (Specific):			
	client A) reviewe	ed, to ensure its policies					
	and procedures regarding implementation of program plans and which prohibited				The Program Coordinator and staff will be in-serviced on the		
					Abuse, Neglect and Exploitation	on	
	staff neglect of c	lients were implemented.			Policy and Procedure and Clie		
					A's Behavior Support Plan and		
	Findings include	:			the interventions regarding the	;	
					1:1 supervision and ingesting inedible items. The Operation	Q	
	Review of agenc	y reportable and routine			Manager and Director of Beha		
	incident reports	from October 2012			Services will conduct site		
	through 1/07/201	13 was done on 01/09/13			observations to ensure that		
	at 1:30 PM and 1	1/11/13 at 5:35 PM. The			Program Plans are being implemented.		
	review indicated	the following behavioral			implemented.		
		a of Developmental			How Others Will Be Identified	d:	
		ices reports, and a			(Systemic): The Operations		
		egation of staff to client			Manager for Supported Group		
	neglect involving	_			Living and Program Coordinat		
	negreet myorving	5 chem 11.			will review all individuals Progrium Plans and ensure that each plans		
	1 11/27/12 7:50	PM, staff #14 reported			specifically meets the needs o		
		estless. [Client A] went			individuals. All Program Plans		
	•	d Swoled (sic.) Quarters			be reviewed at least quarterly	to	
		as taken to a local			ensure that all plans remain effective.		
		ergency Room for			enective.		
	•	ergency Koom for					
	X-Rays.	ied of the incident by the			Measures to be Put in Place:		
		ied of the incident by the			The Program Coordinator and		
	agency on 11/28	/12. The BDDS report			staff will be in-serviced on the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15G745	B. WING		01/17/2013		
NAME OF I	PROVIDER OR SUPPLIE		STREET .	ADDRESS, CITY, STATE, ZIP CODE			
			16611 SIMA GRAY RD				
RES CAI	RE SOUTHEAST IN	NDIANA	HENRY	/VILLE, IN 47126			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	narrative indicat			Abuse, Neglect and Exploitation Policy and Procedure and Clie			
	`	disciplinary) team has met		A's Behavior Support Plan and	l l		
		not allowed to have		the interventions regarding the			
		graphy because it will		1:1 supervision and ingesting			
	make [client A]	depressed and he will		inedible items.			
		njurious behavior. [Client		Monitoring of Corrective			
	A] has a cell pho	one and had been		Action: The Operations			
	accessing porno	graphy from the Internet		Manager and Program			
	on his phone; w	hen he began having		Coordinator will review interna			
	behaviors the B	C (Behavior Clinician)		incident reports and ensure the	at		
	and staff asked	[client A] what was		IDT's are held and any programmatic changes occur as	ae		
	bothering him. [Client A] reported that		indicated and that all staff are			
	when he watche	d porn (pornography) it		in-serviced on those changes			
	causes him to fe	el depressed and have					
	behaviors. [Clie	nt A] got upset because of		Completion Date: February 1			
	watching the po	rnography and went into		Completion Date: February 16, 2013	o,		
	his room and sw	vallowed three quarters.					
	[Client A] infor	med staff of what he did					
	and staff took hi	m to ER for observation."					
	The "Plan to Re	solve" component of the					
	11/28/12 BDDS	report indicated the					
		e ER physician assessed					
	_	oted that there was (sic.)					
		his stomach. The ER					
		ned staff that the quarters					
		few days. [Client A] is to					
	_	nis PCP (Primary Care					
		o weeks. [Client A] is					
	1 -	ng with no further					
		staff at the house have					
		nt A] on one on one					
		ours and did a room					
	_	ved all items that [client					
	A] would be abl						
	111 5 414 5 5 401						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR' COMPLETE		
ANDILAN	or connection	15G745		LDING	00	01/17/201	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		-
NAME OF P	PROVIDER OR SUPPLIER				SIMA GRAY RD		
RES CAF	RE SOUTHEAST IN				VILLE, IN 47126		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	E	OMPLETION DATE
1710	REGUENTORT OR	ESC IDENTIFY TING INFORMATION)		1710	· · · · · · · · · · · · · · · · · · ·		DATE
	2 12-02-12 6:20	0 PM, staff #14 reported					
		ed to take a shower. "Wile					
	•	hower He Drank some					
		n." Client A was taken to					
	an Urgent Care (
	evaluation.						
	3. 12-26-12 8:25	5 PM, client A indicated					
		nate, when he came out of					
	the bathroom, he	e told staff #13 he had					
	"swallowed som	e body wash that he had					
	left in there this	morning."					
		5 PM, client A was in the					
	1	rea when three male staff					
		took a peer's MP3					
	1 ^ -	l cord and attempted to					
	1 -	ndicated on the incident					
		A] was walking in					
	_	around, not saying					
	'	, just hanging around.					
	_	lient A] pick a cord out of					
	` / 1	he end off of it putting					
		f immediately reacted					
	1	out of his mouth. The					
		A] on couch holding his					
		n mouth. H/M (House					
		diately helped staff hold Another staff [DCS #16]					
	helped get object						
	ncipcu get objec	t irom nanu.					
	5. 12-28-12 1:4:	5 PM, staff #12 was					
		nt A and reported an					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		A. BUILDING	construction 00	COME	E SURVEY PLETED 7/2013	
NAME OF I	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CO		
RES CAF	RE SOUTHEAST IN	DIANA		I SIMA GRAY RD RYVILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	metal hook: "[Client A] was a TV. He walked of watch (another for happened on the window and X-re beside [client A] eyeballing X-ma notice him twistic curtain. He swall noticing him. Aff me he had swall smile on his face Client A was tak Hospital Emerge This 12/28/12 in BDDS on 12/29/ A was admitted to Behavioral Unit X-rays taken in to "foreign body (n intestine." The re documented in the metal hook's pro- digestive system hook was remove by means of an a the hospital according staff #4 on 1/10/ was released into 1/4/13.	en to a local ER/ ncy Room for evaluation. cident was reported to 12 and indicated Client to the hospital's for "bipolar disorder." he ER indicated a netal hook) in his small netal hook's size was not ne BDDS reports. The				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G745	B. WIN			01/17/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					SIMA GRAY RD		
RES CARE SOUTHEAST INDIANA				HENRY	VILLE, IN 47126		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
		documented client A had					
	1 –	e items again: "[Client A]					
		home and walked away					
		one staff and walked to					
		the house and took the					
	1	e remote and swallowed					
		ted [client A] to the ER					
	for observation.	[Client A's] one on one					
	•	aced on administrative					
	leave pending a	QA (Quality Assurance)					
	investigation." T	The BDDS report					
	indicated client	A had been admitted to					
	the hospital via t	he ER and QA was					
	investigating the	situation.					
	The Investigation	n was finished on 1/11/13					
	and reviewed at	5:35 PM.					
	The investigation	n's "summary of					
	evidence" compo	onent indicated:					
	_						
	"On 1-6-2013 at	6:00 AM [Direct Contact					
	Staff/DCS #17],	SA (Support Associate)					
	=], SA if she would take					
	over his 1 on 1 s						
		h [client A], Individual so					
		and get [client A's]					
		ly. [DCS #15] agreed					
		to [client A's] side of the					
		over the 1:1 staffing for					
		nd 6:30 AM [DCS #17]					
	1	#15] walked into the					
	-	lient A] and when [DCS					
	_	her about where [client					
		15] told [DCS #17] that					
	A] was, [DCS #.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G745		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 01/17/	ETED	
	PROVIDER OR SUPPLIER			16611 S	DDRESS, CITY, STATE, ZIP CODE IMA GRAY RD VILLE, IN 47126		
					VILLE, IN 47 120	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE	(X5) COMPLETION DATE
	A] walked in to dinformed [DCS #he had taken a batand swallowed it Staff transported County ER for eadmitted to the batand County Hospital "[Client A], Indion 1-10-2013; he and found a remote and that there wasn't The conclusion a of the investigating following: "It is the conclusion and the investigation in [client A's] Behaving following: The investigation in the properties of the investigation in t	is-5 minutes later [client (sic.) the office and [#15] and [DCS #17] that aftery out of the remote is. [client A] to the [local] valuation and he was behavior unit at [the local]. vidual was interviewed e stated that he woke up on the and took a battery out in disample and swallowed it. He stated any staff around." and findings component on indicated the ion of the investigation here was a violation in and Procedure and failure itent A's] Behavior written and in-serviced. Sailed to implement vior Support Plan as it in-serviced which it A] gaining access to a lowing it." n's findings were HR/Human Resources					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	COI	TE SURVEY MPLETED 17/2013	
		1007.10	B. WING	ADDRESS, CITY, STATE, ZIP CO		17,2010
NAME OF F	PROVIDER OR SUPPLIER	2		SIMA GRAY RD	ODL	
RES CAF	RE SOUTHEAST IN	IDIANA		YVILLE, IN 47126		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT		DATE
	taken."	ciplinary action to be				
	taken.					
	The "Abuse/Neo	glect/Exploitation Policy				
	_	component of the				
		tional Policy and				
	1 2 2 1	al (revised 07/02/2012)				
		January 9, 2013 at 2:05				
		indicated the agency				
		ct of clients. The				
		glect were as follows:				
	"F. NeglectPro	ogram				
	Implementation/	Intervention				
	Definition:					
	1. Failure to pro	ovide goods and/or				
	services necessa	ry for the individual to				
	avoid physical h	arm.				
	2. Intentional fa	ilure to implement a				
	support plan, ina	appropriate application				
	intervention, etc	. which may result in				
	jeopardy withou	t qualified person				
	notification/review	ew."				
		30 PM, client A's record				
		vior Support Plan/BSP				
		which indicated the client				
		swallowing objects and				
	_	ipervision to prevent this.				
	`	sciplinary Team) meeting				
		r staff dated 1/03/13 was				
		The IDT was conducted by				
		specialist and outlined the				
		nt A safe upon his return				
	from the behavior	or unit after ingesting the				1

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	of Correction identification number: 15G745	(X2) MULTIPLE CON A. BUILDING B. WING	00	COMPI 01/17	LETED
	PROVIDER OR SUPPLIER RE SOUTHEAST INDIANA	STREET AL 16611 SI	DDRESS, CITY, STATE, ZIP CODE MA GRAY RD /ILLE, IN 47126	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	metal hook by having a one to one staff assigned to him 24 hours a day.				
	Residential agency administrative staff #1 was interviewed on January 9, 2013 at 1:30 PM and indicated the incident on 1/06/13 involving client A swallowing a (triple A sized) battery while under the supervision of staff #15 was being investigated as an allegation of possible neglect. Human Resources Manager staff #19 was contacted on January 14, 2013 at 4:35 PM and indicated staff #15 had violated agency policy by neglecting to provide supervision with client A and the staff's employment had been terminated. This federal tag relates to complaint #IN00122282. 9-3-1(a)				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		15G745	B. WIN			01/17/2013	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				SIMA GRAY RD		
RES CAF	RE SOUTHEAST IN	DIANA			VILLE, IN 47126		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0122	483.420 CLIENT PROTECT The facility must oprotections require Based on record 1 of 2 sampled confailed to meet the Participation: Clifacility failed to clients to be free prevent client A' objects via behave to one staffing). Findings include The facility faile all clients to be for by failing to prevent of metal objects interventions (on Please refer to Work clients (A), for the implement written procedures which clients.	ensure that specific client rements are met. review and interview for lients (A), the facility recondition of ient Protections. The resure the rights of all of neglect, by failing to singestion of metal vioral interventions (one reconstructed of neglect, went client A's ingestion via behavioral reto one staffing).	Wo		W122: Client Protections The facility must ensure that specific client protections requirements are met Corrective Action- (Specific): The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitatic Policy and Procedure and Clie A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items. The Operation Manager and Director of Beha Services will conduct site observations to ensure that Program Plans are being implemented. How others will be identified: (Systemic) The Operations Manager for Supported Group Living and Program Coordinat will review all individuals Progr Plans and ensure that each plaspecifically meets the needs of individuals. All Program Plans be reviewed at least quarterly ensure that all plans remain effective. Measures to be put in place:	on ent d e s vior	02/16/2013
	9-3-2(a)				The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitatic Policy and Procedure and Clie A's Behavior Support Plan and	on ent	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DULL DING 00		(X3) DATE SURVEY COMPLETED	
		15G745	A. BUILDING B. WING		01/17/2013
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	•
				SIMA GRAY RD	
	RE SOUTHEAST IN			VILLE, IN 47126	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	the interventions regarding the 1:1 supervision and ingesting inedible items. The Operation Manager and Director of Beh Services will conduct site observations to ensure that Program Plans are being implemented. Monitoring of Corrective Action: The Operations Manager and Program Coordinator will review internincident reports and ensure to IDT's are held and any programmatic changes occur indicated and that all staff are in-serviced on those changes. Completion Date: February 2013	al hat

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DDPY11

Facility ID: 011663

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		15G745	B. WIN	G		01/17/	2013
	PROVIDER OR SUPPLIER			16611	ADDRESS, CITY, STATE, ZIP CODE SIMA GRAY RD (VILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0149	483.420(d)(1) STAFF TREATM The facility must of written policies are mistreatment, need Based on record 6 of 10 facility incidents/reportar (alleged neglect, client A) reviewed implement policiprohibited staff in failing to ensure according to his prevent his ingest battery from a tedevice, coins, lied hook). Findings include Review of agence incident reports at through 1/07/20 at 1:30 PM and 1 review indicated incidents, Bureau Disabilities Serv substantiated alloneglect involving 1. 11/27/12 7:50 client A, "was R To His Room an	ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client. review and interview, for ble/investigations 1 of 2 sampled clients, ed, the facility failed to des and procedures which deglect of client A by staff monitored him behavior program to sting foreign objects (a devision's remote control quid soap, and a metal : y reportable and routine from October 2012 di was done on 01/09/13 di/11/13 at 5:35 PM. The the following behavioral and of Developmental dices reports, and a degation of staff to client	W0		W 149: Staff Treatment of Clients The facility must deve and implement written policies and procedures that prohibit mistreatment, neglect or abuse the client. Corrective Action (Specific): The Program Coordinator and staff will be in-serviced on the Abuse, Neg and Exploitation Policy and Procedure and Client A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inec items. The Program Coordina and staff will be in-serviced on appropriate and timely documentation of behaviors of the A-B-C data sheet. The Operations Manager and Direc of Behavior Services will cond site observations to ensure the Program Plans are being implemented. How others will be identified: (Systemic): Th Operations Manager for Supported Group Living and Program Coordinator will revie all individuals Program Plans a ensure that each plan specific meets the needs of all individu All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective. Measures to be p in place: The Program Coordinator and staff will be	e of : glect e lible ttor ctor uct at l e	02/16/2013

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Event ID: DDPY11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		15G745	B. WIN			01/17/2	2013
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		16611 5	SIMA GRAY RD		
	RE SOUTHEAST IN	IDIANA	_	HENRY	VILLE, IN 47126		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		loot	DATE
	^	ergency Room for			in-serviced on the Abuse, Neg and Exploitation Policy and	ieci	
	X-Rays.				Procedure and Client A's		
		ied of the incident by the			Behavior Support Plan and the		
	agency on 11/28/12. The BDDS report narrative indicated:				interventions regarding the 1:1		
					supervision and ingesting ined		
		lisciplinary) team has met			items. The Program Coordina and staff will be in-serviced on		
		not allowed to have			appropriate and timely		
	access to pornog	raphy because it will			documentation of behaviors or	n	
	make [client A]	depressed and he will			the A-B-C data sheet. The		
	engage in self-in	jurious behavior. [Client			Operations Manager and Direct		
	A] has a cell pho	one and had been			of Behavior Services will cond site observations to ensure that		
	accessing pornog	graphy from the Internet			Program Plans are being	1	
	on his phone; wh	nen he began having			implemented.Monitoring of		
	behaviors the BO	C (Behavior Clinician)			Corrective Action: The		
		client A] what was			Operations Manager and		
	-	Client A] reported that			Program Coordinator will revie internal incident reports and	w	
		d porn (pornography) it			ensure that IDT's are held and		
		el depressed and have			any programmatic changes oc		
		nt A] got upset because of			as indicated and that all staff a	ire	
	_	nography and went into			in-serviced on those changes.		
		allowed three quarters.			The Operations Manager and Director of Behavior Services	A/ill	
		ned staff of what he did			conduct site observations to	vv iII	
	-	m to ER for observation."			ensure that Program Plans are	,	
			1		being implemented. Completion		
		solve" component of the			Date: February 16, 2013		
		report indicated the					
		e ER physician assessed					
		oted that there was (sic.)					
		his stomach. The ER					
		ned staff that the quarters					
	•	few days. [Client A] is to					
		is PCP (Primary Care					
		o weeks. [Client A] is					
		g with no further					
	complaints. The	staff at the house have					

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Event ID: DDPY11

Facility ID: 011663

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 17/2013
		STREET A 16611 S	SIMA GRAY RD	CODE	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
place (sic.) [clien staffing for 24 he sweep and remove	nt A] on one on one ours and did a room wed all items that [client				
client A requeste (sic.) Taking a S Baby Body wash	ed to take a shower. "Wile hower He Drank some n." Client A was taken to				
he needed to uring the bathroom, he "swallowed som	nate, when he came out of told staff #13 he had e body wash that he had				
facility's office a intervened as he player's electrical ingest it. Staff in report: "[Client circleslooking anything to staff Staff watched [client watched [client watched [client watched [client watched box (sic.)pull the into mouth. Staff knocking object staff put [client watched watche	rea when three male staff took a peer's MP3 I cord and attempted to adicated on the incident A] was walking in around, not saying around. Itent A] pick a cord out of the end off of it putting fimmediately reacted out of his mouth. The A] on couch holding his a mouth. H/M (House diately helped staff hold				
	ROVIDER OR SUPPLIER RE SOUTHEAST IN SUMMARY S' (EACH DEFICIEN REGULATORY OR place (sic.) [clier staffing for 24 he sweep and remove A] would be ableed. 2. 12-02-12 6:20 client A requeste (sic.) Taking a S' Baby Body wash an Urgent Care (evaluation. 3. 12-26-12 8:25 he needed to uring the bathroom, he "swallowed some left in there this in the player's electrical ingest it. Staff in report: "[Client active circles-looking anything to staff Staff watched [client Active circles-looking object staff put [client Active circles-	DESTRICTION NUMBER: 15G745 ROVIDER OR SUPPLIER RE SOUTHEAST INDIANA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) place (sic.) [client A] on one on one staffing for 24 hours and did a room sweep and removed all items that [client A] would be able to swallow." 2. 12-02-12 6:20 PM, staff #14 reported client A requested to take a shower. "Wile (sic.) Taking a Shower He Drank some Baby Body wash." Client A was taken to an Urgent Care Center/UCC for	ROVIDER OR SUPPLIER RE SOUTHEAST INDIANA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Place (sic.) [client A] on one on one staffing for 24 hours and did a room sweep and removed all items that [client A] would be able to swallow." 2. 12-02-12 6:20 PM, staff #14 reported client A requested to take a shower. "Wile (sic.) Taking a Shower He Drank some Baby Body wash." Client A was taken to an Urgent Care Center/UCC for evaluation. 3. 12-26-12 8:25 PM, client A indicated he needed to urinate, when he came out of the bathroom, he told staff #13 he had "swallowed some body wash that he had left in there this morning." 4. 12-27-12 2:45 PM, client A was in the facility's office area when three male staff intervened as he took a peer's MP3 player's electrical cord and attempted to ingest it. Staff indicated on the incident report: "[Client A] was walking in circleslooking around, not saying anything to staff, just hanging around. Staff watched [client A] pick a cord out of box (sic.)pull the end off of it putting into mouth. Staff immediately reacted knocking object out of his mouth. The staff put [client A] on couch holding his hands away from mouth. H/M (House Manager) immediately helped staff hold	ROYIDER OR SUPPLIER RESOUTHEAST INDIANA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Place (sic.) [client A] on one on one staffing for 24 hours and did a room sweep and removed all items that [client A] would be able to swallow." 2. 12-02-12 6:20 PM, staff #14 reported client A requested to take a shower. "Wile (sic.) Taking a Shower He Drank some Baby Body wash." Client A was taken to an Urgent Care Center/UCC for evaluation. 3. 12-26-12 8:25 PM, client A indicated he needed to urinate, when he came out of the bathroom, he told staff #13 he had "swallowed some body wash that he had left in there this morning." 4. 12-27-12 2:45 PM, client A was in the facility's office area when three male staff intervened as he took a peer's MP3 player's electrical cord and attempted to ingest it. Staff indicated on the incident report: "[Client A] was walking in circleslooking around, not saying anything to staff, just hanging around. Staff watched [client A] pick a cord out of box (sic.)pull the end off of it putting into mouth. Staff immediately reacted knocking object out of his mouth. The staff put [client A] on couch holding his hands away from mouth. H/M (House Manager) immediately helped staff hold	ROVIDER OR SUPPLIER RE SOUTHEAST INDIANA SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) place (sic.) [client A] on one on one staffing for 24 hours and did a room sweep and removed all items that [client A] would be able to swallow." 2. 12-02-12 6:20 PM, staff #14 reported client A requested to take a shower. "Wile (sic.) Taking a Shower He Drank some Baby Body wash." Client A was taken to an Urgent Care Center/UCC for evaluation. 3. 12-26-12 8:25 PM, client A indicated he needed to urinate, when he came out of the bathroom, he told staff #13 he had "swallowed some body wash that he had left in there this morning." 4. 12-27-12 2:45 PM, client A was in the facility's office area when three male staff intervened as he took a peer's MP3 player's electrical cord and attempted to ingest it. Staff indicated on the incident report: "[Client A] was walking in circles—looking around, not saying anything to staff, just hanging around. Staff watched [client A] pick a cord out of box (sic.)—pull the end off of it putting into mouth. Staff immediately reacted knocking object out of his mouth. The staff put [client A] on couch holding his hands away from mouth. H/M (House Manager) immediately helped staff hold

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Event ID: DDPY11

Facility ID: 011663

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G745	B. WIN			01/17/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DEC CAE		DIANA			SIMA GRAY RD		
RES CAF	RE SOUTHEAST IN	DIANA		HENRY	VILLE, IN 47126		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		<u> </u>		IAU			DATE
	helped get object	t Hom nand.					
	5 12 20 12 1.44	5 DM stoff #12 was					
		5 PM, staff #12 was					
	supervising client A and reported an incident wherein client A swallowed a						
	metal hook:	chefit A swanowed a					
		gitting on sofe wetching					
		sitting on sofa watching over to (sic.) window to					
		acility's) behavior that					
	`	road. I was between the					
		nas (Christmas) tree					
		,					
		. Because he had been s ornaments, I didn't					
	'	· ·					
		ing hook off of (sic.)					
		lowed hook without me					
	I -	ter the incident, he told					
	smile on his face	owed something with a					
	Client A was tak						
		ency Room for evaluation.					
		12 and indicated Client					
	A was admitted	for "bipolar disorder."					
		*					
	1	the ER indicated a					
		netal hook) in his small					
		netal hook's size was not					
		ne BDDS reports. The					
	_	gress through his					
		was monitored. The					
		ed from his lower bowel					
	l -	anal probe performed at					
	_	ording to interview with					
	statt #4 on 1/10/	13 at 3:00 PM. Client A					

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Event ID: DDPY11

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G745	A. BUII		00	COMPL 01/17/	
		100740	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	01/17/	2010
NAME OF P	PROVIDER OR SUPPLIEF	R			SIMA GRAY RD		
RES CAF	RE SOUTHEAST IN	IDIANA			VILLE, IN 47126		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		o the agency's care on		1710			DATE
	1/4/13.	o the agency seare on					
	1/4/13.						
	6 1-06-13 2:30	PM, a BDDS report					
	dated 1/07/2013 documented client A had						
		e items again: "[Client A]					
	_	home and walked away					
		one staff and walked to					
	the other side of	the house and took the					
	battery out of the remote and swallowed						
	it. Staff transported [client A] to the ER						
	for observation. [Client A's] one on one						
	staff has been pl	aced on administrative					
	leave pending a	QA (Quality Assurance)					
	•	he BDDS report					
		A had been admitted to					
	_	the ER and QA was					
	investigating the						
	_	n was finished on 1/11/13					
	and reviewed at	5:35 PM.					
	The investigation	n's "summary of					
	evidence" comp	-					
	evidence comp	onent marcatea.					
	"On 1-6-2013 at	6:00 AM [Direct Contact					
		SA (Support Associate)					
], SA if she would take					
	over his 1 on 1 s	hift (one to one					
	supervision) with	h [client A], Individual so					
	that he could go	and get [client A's]					
	medications read	dy. [DCS #15] agreed					
	and walked over	to [client A's] side of the					
	house and took of	over the 1:1 staffing for					
	[client A]. Arou	and 6:30 AM [DCS #17]					

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Event ID: DDPY11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		(X2) MUL A. BUILD B. WING		00	(X3) DATE S COMPL: 01/17/	ETED	
	PROVIDER OR SUPPLIER			16611 S	DDRESS, CITY, STATE, ZIP CODE IMA GRAY RD		
	RE SOUTHEAST IN	DIANA		HENRY	VILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	stated that [DCS office without [c #17] questioned A] was, [DCS #1 [client A] was as Approximately 3 A] walked in to informed [DCS #1 he had taken a brand swallowed it Staff transported County ER for eadmitted to the brand County Hospital "[Client A], Indion 1-10-2013; he and found a remote of the remote and that there wasn't The conclusion a of the investigating following: "It is the conclusion and the investigating following: "It is the conclusion and the investigating following: "It is the conclusion and found a remote and the investigating following: "It is the conclusion and following:	#15] walked into the lient A] and when [DCS her about where [client 15] told [DCS #17] that sleep. 8-5 minutes later [client (sic.) the office and #15] and [DCS #17] that attery out of the remote t. [client A] to the [local] valuation and he was behavior unit at [the local]." vidual was interviewed the stated that he woke up tote and took a battery out diswallowed it. He stated any staff around."					

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Event ID: DDPY11

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G745	B. WIN			01/17/2013
NAME OF I	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE	
					SIMA GRAY RD	
RES CAI	RE SOUTHEAST IN	IDIANA		HENRY	VILLE, IN 47126	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	battery and swal	•				
	_	n's findings were				
		HR/Human Resources				
	Director #19 for					
		ciplinary action to be				
	taken."					
	The "Abuse/Neglect/Exploitation Policy and Procedure" component of the					
	agency's Operational Policy and					
	Procedure Manual (revised 07/02/2012)					
	was reviewed on January 9, 2013 at 2:05					
	PM. The review	indicated the agency				
	prohibited negle	ct of clients. The				
	definitions of ne	glect were as follows:				
	"F. NeglectPro	ogram				
	Implementation/	Intervention				
	Definition:					
	1. Failure to pro	vide goods and/or				
	services necessar	ry for the individual to				
	avoid physical h	arm.				
	2. Intentional fa	ilure to implement a				
		ppropriate application				
	intervention, etc.	which may result in				
	jeopardy withou	t qualified person				
	notification/review					
	Residential agen	cy administrative staff #1				
	1	on January 9, 2013 at				
		licated the incident on				
		g client A swallowing a				
		pattery while under the				
		aff #15 was being				
	_	n allegation of possible				

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Event ID: DDPY11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/17/2013
	PROVIDER OR SUPPLIE RE SOUTHEAST II		16611	ADDRESS, CITY, STATE, ZIP CODE SIMA GRAY RD YVILLE, IN 47126	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	contacted on Jan and indicated st agency policy b supervision with employment had	res Manager staff #19 was nuary 14, 2013 at 4:35 PM aff #15 had violated y neglecting to provide a client A and the staff's d been terminated. relates to complaint			

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Event ID: DDPY11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		15G745	B. WIN			01/17/	2013
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	SIMA GRAY RD		
RES CAE	RE SOUTHEAST IN	ΠΙΔΝΑ			VILLE, IN 47126		
					VILLE, IIV 47 120		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
W0249	483.440(d)(1)	ENACNITATION					
	PROGRAM IMPL	terdisciplinary team has					
		nt's individual program plan,					
	each client must receive a continuous active						
		n consisting of needed					
		services in sufficient					
	number and frequ	uency to support the					
		ne objectives identified in					
	the individual pro						
		review and interview, for	W0	249	W249: Program Implementati		02/16/2013
	1 of 2 sampled c	lients (A), the facility			As soon as the interdisciplinar	•	
	failed to ensure s	staff implemented			team has formulated a client's		
	behavioral interv	ventions according to the			individual program plan, each client must receive a continuo	ıc	
		Support Programs.			active treatment program	13	
		2 of F = 1 = 2 = 2 = 2 = 2 = 2 = 2 = 2 = 2 = 2			consisting of needed		
	Findings include				interventions and services in		
	r manigs include	•			sufficient number and frequen	су	
	.				to support the achievement of	the	
	_	y reportable and routine			objectives identified in the		
	•	from October 2012			individual program plan.		
	through 1/07/201	13 was done on 01/09/13			Corrective Action: (Specific) Staff will be retrained on client		
	at 1:30 PM and 1	1/11/13 at 5:35 PM. The			Behavior Support Plan and	AS	
	review indicated	the following behavioral			accompanying ABC		
	incidents involvi	ng client A:			(Antecedent/Behavior/Conseq	uen	
					ce Chart) sheet How others v		
	12-28-12 1:45 PI	M staff #12 was			be identified: (Systemic): Th	е	
		at A and reported an			Program Coordinator and all	staff	
		•			will be trained on Client A's		
		client A swallowed a			Behavior Support Plan and		
	metal hook:				accompanying ABC sheet. The Operations Manager or the	e	
		sitting on sofa watching			Program Coordinator will retra	_{in}	
	TV. He walked o	over to (sic.) window to			all staff on each Clients Behav		
	watch (another fa	acility's) behavior that			Support Plan at least annually		
		road. I was between the			and more frequently as		
	* *	nas (Christmas) tree			needed. Measures to be put	in	
		. Because he had been			place: Staff will be retrained of		
					client A's Behavior Support Pla	an	
	eyeballing X-ma	s ornaments, I didn't			and accompanying ABC		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G745	B. WIN	G		01/17/2013
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	NO VIDER OR SOLLEIEN				SIMA GRAY RD	
RES CAF	RE SOUTHEAST IN	IDIANA		HENRY	VILLE, IN 47126	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ing hook off of (sic.)			(Antecedent/Behavior/Conseq ce Chart) sheet Monitoring o	
	curtain. He swallowed hook without me				Corrective Action: The	•
	_	ter the incident, he told			Operations Manager and Direct	ctor
		owed something with a			of Behavior Services will cond	I
	smile on his face				site observations to ensure that	
	Client A was tak	en to a local ER/			the behavioral support plans a being implemented as written	re
	Hospital Emerge	ency Room for evaluation.			Completion date: February	16.
	This 12/28/12 in	cident was reported to			2013	. •,
	BDDS on 12/29/12 and indicated Client A was admitted to the hospital's Behavioral Unit for "bipolar disorder."					
	X-rays taken in t	the ER indicated a				
	"foreign body (n	netal hook) in his small				
	intestine." The r	netal hook's size was not				
	documented in the	he BDDS reports. The				
		gress through his				
	_	was monitored. The				
		ed from his lower bowel				
		anal probe performed at				
	l -	ording to interview with				
	•	13 at 3:00 PM. Client A				
		the agency's care on				
	1/4/13.	stile agency scare on				
	1, 1, 13.					
	On 1/10/13 at 1::	30 PM, client A's record				
		vior Support Plan/BSP				
		which indicated the client				
		swallowing objects and				
	1	pervision to prevent this.				
		sciplinary Team) meeting				
	`	staff dated 1/03/13 was				
		he IDT was conducted by				
		pecialist and outlined the				
		nt A safe upon his return				
	pian to keep che	in A safe upon his feturn				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		15G745	B. WIN			01/17/20	13
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
DEO OAF		IDIANA			SIMA GRAY RD		
RES CAF	RE SOUTHEAST IN	IDIANA		HENRY	VILLE, IN 47126		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	re C	OMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG			DATE
	metal hook:	or unit after ingesting the					
		and to and staff defined as					
	"He will have a one to one staff defined as a staff who will be assigned and will be						
		_					
		ately 5 feet of [client A]					
		pt when he is in the					
		ch point the staff will					
		ough to intervene and in					
	the same room.	atad ta amaaifia amaaa af					
	He will be restricted to specific areas of						
	his home: He can spend time in his						
	bedroomhis door will remain open, the bathroom nearest his bedroomthe door						
	_	the living area nearest					
		d the dining areaHe					
	1	in the hallway in between					
		and dining area long					
	_	from the living area to the					
	_	will be restricted from					
		the home for his safety.					
	I -	attempts to deviate to a the home the one on one					
		t, if he does not comply					
		t and let him know that					
		physically assist him if					
		plyif he does not					
		reasonable amount of					
		nysically assist him to a					
	different area'						
	l '	g/training was attended by					
		15 failed to implement					
		one behavioral protocol					
		00 AM to 6:30 AM when					
	she left him alon	e and he came to an					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	e survey Pleted 7/2013	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET A 16611 S	ADDRESS, CITY, STATE, ZIP CO SIMA GRAY RD 'VILLE, IN 47126	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	living room area office), found a	of the facility (second adjacent to the facility's television remote control triple A (AAA) battery device.				
	dated 1/07/2013 ingested inedible was at the group from his one on the other side of battery out of the it. Staff transpor for observation. staff has been pl leave pending a investigation." Tindicated client the hospital via tinvestigating the	documented client A had be items again: "[Client A] home and walked away one staff and walked to the house and took the eremote and swallowed ited [client A] to the ER [Client A's] one on one acced on administrative QA (Quality Assurance) The BDDS report A had been admitted to the ER and QA was esituation.				
	Staff/DCS #17], asked [DCS #15 over his 1 on 1 s supervision) with that he could go	n's "summary of onent indicated: 6:00 AM [Direct Contact SA (Support Associate)], SA if she would take				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 17/2013	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET A	ADDRESS, CITY, STATE, ZIP CO SIMA GRAY RD VILLE, IN 47126	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	house and took of [client A]. Arous stated that [DCS office without [client A] was, [DCS # [client A] was, [DCS # [client A] was as Approximately 3 A] walked in to informed [DCS he had taken a be and swallowed in Staff transported County ER for eadmitted to the be County Hospital "[Client A], Indion 1-10-2013; he and found a remost of the remote and that there wasn't The conclusion as of the investigating following: "It is the conclusion and the committee that the committee that the lagency] Policy to implement [cl Support Plan as serious committee than and the conclusion an	8-5 minutes later [client (sic.) the office and #15] and [DCS #17] that attery out of the remote t. I [client A] to the [local] valuation and he was behavior unit at [the local]." vidual was interviewed the stated that he woke up ote and took a battery out d swallowed it. He stated any staff around."				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		(X2) MUL [*] A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPLI 01/17/2	ETED		
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16611 SIMA GRAY RD HENRYVILLE, IN 47126					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
	implemented and	vior Support Plan as d in-serviced which at A] gaining access to a lowing it."						
	was interviewed 1:30 PM and ind 12/28/12 involvi metal hook while	cy administrative staff #1 on January 9, 2013 at licated the incident on ng client A swallowing a e under the supervision of t neglect but failure to lient's BSP.						
	contacted on Jan and indicated sta agency policy by supervision with the staff had bee	es Manager staff #19 was uary 14, 2013 at 4:35 PM aff #15 had violated a neglecting to provide client A on 1/06/13 and in terminated. Staff #15 ented the client's behavior						
	This federal tag a #IN00122282. 9-3-4(a)	relates to complaint						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G745		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 7/2013	
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP C	CODE	
RES CAF	RE SOUTHEAST IN	IDIANA		SIMA GRAY RD VILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		15G745	B. WING		01/17/2013		
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
DEC CARE COUTUEACT INDIANA					SIMA GRAY RD		
RES CARE SOUTHEAST INDIANA				HENK	YVILLE, IN 47126		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
W9999							
	State Findings		W99	999	W9999: 460 IAC 9-3-1		02/16/2013
					Governing Body		
	The following C	ommunity Residential			Sec 1. (b) The residential prov	rider	
	_	sons with Developmental			shall report the following		
		•			circumstances to the division t		
	Disabilities Rule	was not met.			telephone no later than the firs		
					business day followed by writte		
	460 IAC 9-3-1 G	Soverning body			summaries as requested by the division.		
					division.		
	Sec. 1. (b) The	residential provider shall		Corrective Action: (Spe			
	report the following circumstances to the division by telephone no later than the		1		The Quality Assurance team v		
					1		
		y followed by written		reportable incidents will be			
		-			reported to BDDS per State La	aw.	
	summaries as rec	quested by the division.					
	This state rule w	as not met as evidenced	How others will be identified:		:		
	by:				(Systemic): The Quality		
	-				Assurance team will report all state reportable incidents to		
	Rased on record	review and interview for			BDDS per State Law.		
	Based on record review and interview, for 1 of 10 incidents reviewed (client A), the				BDDS per State Law.		
	-	immediately report					
	,) behavioral episodes			Measures to be put in place:		
	involving outside	e medical treatment for			The Quality Assurance team v		
	client A.				be retrained that all state		
					reportable incidents will be		
	Findings include				reported to BDDS per State La	aw.	
	i manigs include.						
	Daview of a series	ar man antable and acceptions			Monitoring of Corrective		
	Review of agency reportable and routine incident reports from October 2012				Monitoring of Corrective Action: The Director of		
					Supervised Group Living will		
	through 1/07/201	13 was done on 01/09/13			ensure that all state reportable	ż	
	at 1:30 PM and 1	1/11/13 at 5:35 PM. The			incidents are reported to BDDS		
	review indicated	the following behavioral			per State Law.		
		_					
	incident involving client A:				Completion date: February 1	6,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		(X2) MULTIPLE Co A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 17/2013	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			16611	ADDRESS, CITY, STATE, ZIP C SIMA GRAY RD YVILLE, IN 47126	ODE	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	client A requested (sic.) Taking a S Baby Body wash an Urgent Care (evaluation. There this incident. The "Abuse/Neg and Procedure" of agency's Operated Procedure Manuwas reviewed on PM. The review prohibited/reportion of the Services (BDDS) The QA (Quawill report the stand/or exploitating appropriate contour F. Bureau of Deservices (BDDS) The definitions of follows: "F. NeglectProcedures" 1. Failure to procedure to proce	glect/Exploitation Policy component of the cional Policy and hal (revised 07/02/2012) in January 9, 2013 at 2:05 indicated the agency ted neglect of clients. Ality Assurance) Director aspected abuse, neglect on within 24 hours to the acts, which may include: evelopmental Disabilities (as applicable)" Of neglect were as a cogram (Intervention wide goods and/or rry for the individual to		2013		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G745		A. BUILDING B. WING O COMPLETED 01/17/2013					
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16611 SIMA GRAY RD HENRYVILLE, IN 47126				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	ensure all reporta available for revi PM and again at evidence the abo had been reporte	ce staff #5 was asked to able incidents were sew on 1/10/13 at 1:30 2:45 PM. There was no ve behavioral incident d to BDDS. lates to complaint					

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