

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2012
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NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
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W0000	<p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00114563 completed on 9/21/12.</p> <p>Complaint #IN00114563: Corrected.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: November 2 and 5, 2012.</p> <p>Facility number: 000823 Provider number: 15G304 AIM number: 100249090</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/13/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the governing body failed to ensure paint was cleaned up/removed from the walls, floors, carpet, trim, doors, stair railings and furniture of the group home.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/2/12 from 1:43 PM to 3:11 PM. During the observations, there was paint on the carpet on the stairs and railings to the upstairs and downstairs, walls and doors in the front door hallway, trim, and floor. There was also paint in the living room on the floor, couch and entertainment center. This affected clients A, B, C, D, E, F, G and H.</p> <p>An interview with the Program Director (PD) was conducted on 11/5/12 at 11:33 AM. The PD indicated the incident occurred on 10/12/12. The PD indicated client A threw a can of paint.</p> <p>An interview with the Area Director (AD) was conducted on 11/5/12 at 10:31 AM. The AD indicated the staff at the home</p>	W0104	<p>The paint in the home on the walls, floors, carpet, trim, doors, stair railings, and furniture has been removed and cleaned up. The staff in the home will be retrained on completing routine and unexpected house cleaning and maintenance on a daily basis. Administrative staff will complete random observations on various shifts on an ongoing basis to monitor that cleaning and maintenance is being completed timely. Staff responsible: Home Manager, Program Director, Area Director</p>	12/05/2012			

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	<p>thought client A was supposed to clean up the paint. The AD indicated when client A refused to clean up the paint, the staff should have cleaned up the paint. The AD indicated there was no maintenance request to clean up the paint.</p> <p>9-3-1(a)</p>			

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 8 incident/investigative reports reviewed affecting client A, the facility neglected to implement its policies and procedures to 1) prevent elopement of client A, 2) failed to report an incident of elopement to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, 3) investigate the use of restraint and 4) conduct thorough investigations of elopement.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/2/12 at 11:07 AM.</p> <p>1 and 2) On 10/10/12 at 4:30 PM, client A eloped from the group home while staff #14 was his 1:1 (one on one) staff. The investigative report, dated 10/15/12, indicated, "[Client A] had an official admission date into the Bloomington Group Home of 8/6/12. [Client A] has a significant history of elopement specifically along with suicidal threats, and other targeted problem behaviors listed in [client A's] Behavior Plan</p>	W0149	<p>Client A's Behavior Support Plan will be completed, guardian and HRC approvals will be obtained , and staff in the home will be trained on the plan by 12/5/12. This plan includes rocedures for staff to prevent elopement of Client A. The Program Director will be retrained on reporting incidents timely to all applicable entities in accordance with state law. The Program Director will be retrained on completing investigations involving client restraints and to complete thorough investigations of incidents including ncidents of elopement. Administrative staff will complete random observations on various shifts on an ongoing basis to monitor that Client A's Behavior Support Plan is implemented correctly to prevent incidents of elopement. The Area Director will monitor incident reporting by the Program Director to ensure timeliness of reporting and will complete corrective action as necessary if there are concerns. The staff involved in the incident of elopement with Client A was terminated from his employment with TSI/Indiana Mentor. Staff responsible: Program Director, Area Director, Behavior Analyst</p>	12/05/2012	

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	<p>Guidelines." The report indicated staff #5 was initially assigned as client A's 1:1 staff however due to "problems" he and staff #14 switched the 1:1 staffing. Staff #14 and client A went to assist staff #2 with dinner prep. Client A assisted with cutting vegetables and then went to the living room. The report indicated, "According to staff, [client A] was never more than 20 feet away from him and was within line of sight throughout the time he was in the living room with the only exception being approximately 20 seconds." The report indicated "[staff #14] stated that he was 'making eye contact with [client A] every few seconds' to ensure that he was in compliance with his plan, noting that he was standing at the pantry/stove area, however, DSP (Direct Support Professional) stated that he now believes that [client A] was watching DSP and right before he eloped, he believes that [client A] became familiar with the fact that DSP was looking up at him every few seconds and took off immediately after this eye contact was made the very last time, giving [client A] approximately 10-20 seconds to get a head start and vacate." The report indicated client A was located "approximately" 2 hours after eloping, unharmed and safe. The report's conclusion indicated, "The evidence supports that [client A] did leave the</p>						

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	<p>group home, however, although staff assigned as his 1:1, [staff #14], did reportedly take his eyes off of [client A], this could have easily been the case if a staff had simply turned their head to speak to another client or to wash his hands, etc. The evidence supports that staff's actions were appropriate at the time of the incident, and that the fact that [client A] did manipulate the situation and vacate the home does not automatically mean that staff's actions were negligent or unreasonable given the circumstances." The report did not include an interview with staff #2 or client A. The BDDS report was submitted on 10/12/12.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 11/2/12 at 11:23 AM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure</p>			

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	<p>the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights."</p> <p>A review of client A's Supervision Guidelines, undated, was conducted on 11/2/12 at 11:37 AM. The plan indicated, "[Client A] requires one on one supervision, which refers to the ratio of one staff to one client, [client A]. One on one supervision is more intense than regular active treatment supervision, where the ratio for this house is normally 3 staff to 8 clients. One on one supervision is more intense than 15 minute checks because it requires the client to be supervised 'round the clock.' When a client is under one on one supervision, this means that there must be a staff who is monitoring the designated client at all times. Where ever the client goes, the staff should go as well...". The plan indicated vacating was a targeted behavior. The plan indicated, "Vacating will be defined to occur only at times when [client A] is schedules to be in to a specified environment (e.g., group home, day program) as outlined within [client A's] program plan. Vacating is defined as</p>			

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	<p>leaving without informing staff or leaving a program area and not returning when called."</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 11/2/12 at 11:12 AM. The QAD indicated reportable incidents should be submitted within 24 hours.</p> <p>An interview with the Program Director (PD) was conducted on 11/5/12 at 11:41 AM. The PD indicated reportable incidents should be submitted to BDDS within 24 hours. The PD indicated elopement should not occur since client A received 1:1 staffing. The PD indicated client A's plan for elopement should be implemented as written.</p> <p>An interview with the Area Director (AD) was conducted on 11/2/12 at 10:44 AM. The AD indicated staff #14 did not implement client A's plan, as written, for 1:1 supervision. The AD indicated staff #14 did not keep client A within the parameters of the plan. The AD indicated although the investigation did not recommend termination of staff #14, the AD was recommending staff #14 be terminated. The AD indicated client A's plan for elopement should be implemented as written.</p>			

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	<p>3) On 10/11/12 at 8:30 AM, client A was restrained on 2 separate occasions after attempting to assault staff on duty to elope from the group home. The BDDS report, dated 10/12/12, did not indicated the type of restraint used or if the staff implemented his plan, as written. The facility did not provide an investigation to review.</p> <p>A review of client A's record was conducted on 11/2/12 at 11:57 AM. Client A's Supervision Guidelines, undated, indicated he had targeted behaviors of verbal abuse, manipulative behavior/lying, temper outbursts, physical assault, vacating, property destruction, suicidal talk, self-injurious behavior, type 1 resistance (failure to adequately complete any task or scheduled appointments), and blocking others. For physical assault, the plan indicated, in part, "3. If he pursues and reinitiates physical assault, use the minimum amount of physical guidance necessary to stop the aggression; use techniques taught in your agency approved program." For elopement/vacating, the plan indicated, in part, "2. If staff observe [client A] attempting to leave, ask him to remain within the program area and remind him that per his plan, he is to be stopped from leaving the area using the least restrictive agency approved intervention. 4. *If staff</p>			

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	<p>fear that [client A] is leaving and may harm himself by going onto the highway, etc. staff should block him from leaving the home using the minimum amount of physical intervention necessary to keep him inside and safe."</p> <p>An interview with the AD was conducted on 11/5/12 at 10:42 AM. The AD indicated an investigation was not conducted for this incident. The AD indicated the facility should have conducted an investigation due to the use of restraint to ensure staff implemented the plan appropriately.</p> <p>4) On 10/11/12 at 1:00 PM, client A eloped from the group home. Client A was located "approximately" 35 minutes later. The incident report indicated client A's staff was following the plan for his 1:1 however client A was able to "overpower" through physical assault and take off running. The facility did not provide an investigation to review.</p> <p>On 10/28/12 at 8:47 PM, client A eloped from the group home. The report indicated the staff member working 1:1 with client A was outside with client A when client A took off on foot. The staff followed client A until client A was out of sight. Client A was gone for "approximately" one hour. When client A</p>				

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	<p>returned to the group home, he began making suicidal threats and stated he was going to "jump off the balcony." Client A was taken to the emergency room and admitted to the Stress Care unit on 10/29/12. The facility did not provide an investigation to review.</p> <p>An interview with the Program Director (PD) was conducted on 11/5/12 at 11:41 AM. The PD indicated investigations should have been conducted within 5 business days.</p> <p>An interview with the AD was conducted on 11/5/12 at 10:42 AM. The AD indicated incidents of elopement should be investigated. The AD indicated the facility did not investigate the incident on 10/11/12 and was in the process of investigating the incident from 10/28/12. The AD indicated investigations should be conducted with 5 business days.</p> <p>9-3-2(a)</p>				

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client A, the facility failed to report an allegation of neglect regarding elopement to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/2/12 at 11:07 AM.</p> <p>On 10/10/12 at 4:30 PM, client A eloped from the group home while staff #14 was his 1:1 (one on one) staff. The investigative report of possible neglect, dated 10/15/12, indicated, "[Client A] had an official admission date into the Bloomington Group Home of 8/6/12. [Client A] has a significant history of elopement specifically along with suicidal threats, and other targeted problem behaviors listed in [client A's] Behavior Plan Guidelines." The report indicated</p>	W0153	The Program Director will be retrained on reporting incidents timely to all applicable entities in accordance with state law. The Area Director will monitor incident reporting by the Program Director to ensure timeliness of reporting and will complete corrective action as necessary if there are concerns. Staff responsible: Program Director, Area Director	12/05/2012			

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	<p>staff #5 was initially assigned as client A's 1:1 staff however due to "problems" he and staff #14 switched the 1:1 staffing. Staff #14 and client A went to assist staff #2 with dinner prep. Client A assisted with cutting vegetables and then went to the living room. The report indicated, "According to staff, [client A] was never more than 20 feet away from him and was within line of sight throughout the time he was in the living room with the only exception being approximately 20 seconds." The report indicated staff #14 was "making eye contact with [client A] every few seconds" to ensure that he was in compliance with his plan, noting that he was standing at the pantry/stove area, however, DSP (Direct Support Professional) stated that he now believes that [client A] was watching DSP and right before he eloped, he believes that [client A] became familiar with the fact that DSP was looking up at him every few seconds and took off immediately after this eye contact was made the very last time, giving [client A] approximately 10-20 seconds to get a head start and vacate. The report indicated client A was located "approximately" 2 hours after eloping, unharmed and safe. The report's conclusion indicated, "The evidence supports that [client A] did leave the group home, however, although staff assigned as his 1:1, [staff #14], did</p>			

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	<p>reportedly take his eyes off of [client A], this could have easily been the case if a staff had simply turned their head to speak to another client or to wash his hands, etc. The evidence supports that staff's actions were appropriate at the time of the incident, and that the fact that [client A] did manipulate the situation and vacate the home does not automatically mean that staff's actions were negligent or unreasonable given the circumstances." The BDDS report was submitted on 10/12/12.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 11/2/12 at 11:12 AM. The QAD indicated reportable incidents should be submitted within 24 hours.</p> <p>An interview with the Program Director (PD) was conducted on 11/5/12 at 11:41 AM. The PD indicated reportable incidents should be submitted to BDDS within 24 hours.</p> <p>9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 3 of 8 incident/investigative reports reviewed affecting client A, the facility failed to conduct thorough investigations of elopement and the use of restraint.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/2/12 at 11:07 AM.</p> <p>1) On 10/11/12 at 8:30 AM, client A was restrained on 2 separate occasions after attempting to assault staff on duty to elope from the group home. The BDDS report, dated 10/12/12, did not indicated the type of restraint used or if the staff implemented his plan, as written. The facility did not provide an investigation to review.</p> <p>A review of client A's record was conducted on 11/2/12 at 11:57 AM. Client A's Supervision Guidelines, undated, indicated he had targeted behaviors of verbal abuse, manipulative behavior/lying, temper outbursts, physical assault, vacating, property destruction, suicidal talk, self-injurious behavior, type</p>	W0154	The Program Director will be retrained on completing investigations involving client restraints and to complete thorough investigations of incidents including incidents of elopement. The Area Director will monitor incidents requiring investigations by the Program Director to ensure investigations are completed involving restraints and the thoroughness of investigations and will complete corrective action as necessary if there are concerns. Staff responsible: Program Director, Area Director	12/05/2012

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	<p>1 resistance (failure to adequately complete any task or scheduled appointments), and blocking others. For physical assault, the plan indicated, in part, "3. If he pursues and reinitiates physical assault, use the minimum amount of physical guidance necessary to stop the aggression; use techniques taught in your agency approved program." For elopement/vacating, the plan indicated, in part, "2. If staff observe [client A] attempting to leave, ask him to remain within the program area and remind him that per his plan, he is to be stopped from leaving the area using the least restrictive agency approved intervention. 4. *If staff fear that [client A] is leaving and may harm himself by going onto the highway, etc. staff should block him from leaving the home using the minimum amount of physical intervention necessary to keep him inside and safe."</p> <p>An interview with the AD was conducted on 11/5/12 at 10:42 AM. The AD indicated an investigation was not conducted for this incident. The AD indicated, on 11/5/12 at 11:22 AM, the facility should have conducted an investigation due to the use of restraint to ensure staff implemented the plan appropriately.</p> <p>2) On 10/11/12 at 1:00 PM, client A</p>						

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	<p>eloped from the group home. Client A was located "approximately" 35 minutes later. The incident report indicated client A's staff was following the plan for his 1:1 however client A was able to "overpower" through physical assault and take off running. The facility did not provide an investigation to review.</p> <p>3) On 10/28/12 at 8:47 PM, client A eloped from the group home. The report indicated the staff member working 1:1 with client A was outside with client A when client A took off on foot. The staff followed client A until client A was out of sight. Client A was gone for "approximately" one hour. When client A returned to the group home, he began making suicidal threats and stated he was going to "jump off the balcony." Client A was taken to the emergency room and admitted to the Stress Care unit on 10/29/12. The facility did not provide an investigation to review.</p> <p>An interview with the Program Director (PD) was conducted on 11/5/12 at 11:41 AM. The PD indicated investigations should have been conducted within 5 business days.</p> <p>An interview with the AD was conducted on 11/5/12 at 10:42 AM. The AD indicated incidents of elopement should</p>						

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	<p>be investigated. The AD indicated the facility did not investigate the incident on 10/11/12 and was in the process of investigating the incident from 10/28/12. The AD indicated investigations should be conducted with 5 business days.</p> <p>9-3-2(a)</p>			

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W0295	<p>483.450(d)(1)(i) PHYSICAL RESTRAINTS The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (A), the facility failed to ensure the client's program plan included specific physical restraint techniques for staff to follow.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 11/2/12 at 11:57 AM. Client A's Supervision Guidelines, undated, indicated he had targeted behaviors of verbal abuse, manipulative behavior/lying, temper outbursts, physical assault, vacating, property destruction, suicidal talk, self-injurious behavior, type 1 resistance (failure to adequately complete any task or scheduled appointments), and blocking others. For physical assault, the plan indicated, in part, "3. If he pursues and reinitiates physical assault, use the minimum amount of physical guidance necessary to stop the aggression; use techniques taught in your agency approved program." For elopement/vacating, the plan indicated, in part, "2. If staff observe [client A]</p>	W0295	<p>Client A's Behavior Support Plan will be completed, guardian and HRC approvals will be obtained, and staff in the home will be trained on the plan by 12/5/12. This plan includes specific physical restraint techniques for staff to follow. Administrative staff will complete random observations on various shifts on an ongoing basis to monitor that Client A's Behavior Support Plan is implemented correctly. Staff responsible: Program Director, Area Director, Behavior Analyst</p>	12/05/2012			

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	<p>attempting to leave, ask him to remain within the program area and remind him that per his plan, he is to be stopped from leaving the area using the least restrictive agency approved intervention. 4. *If staff fear that [client A] is leaving and may harm himself by going onto the highway, etc. staff should block him from leaving the home using the minimum amount of physical intervention necessary to keep him inside and safe." The plan for property destruction indicated, in part, "2. Get between [client A] and the object of the destruction. Use the blocking technique approved by the agency to prevent further destruction. 3. If blocking is ineffective, use the containment techniques approved by your agency and continue containment until [client A] is calm." For self-injurious behavior, the plan indicated, in part, "3a. If this behavior cannot be redirected and may cause moderate or more serious injury, use the minimum amount of physical guidance necessary to stop the behavior (use agency approved physical intervention techniques.)."</p> <p>An interview with the Program Director (PD) was conducted on 11/5/12 at 11:41 AM. The PD indicated client A's plan should include the specific techniques for staff to implement to address maladaptive behaviors.</p>			

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	<p>An interview with the Area Director (AD) was conducted on 11/5/12 at 10:42 AM. The AD indicated client A's plan should include the specific techniques within the plan staff were to implement.</p> <p>9-3-5(a)</p>			

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division (15. A fall resulting in injury, regardless of the severity of the severity of the injury.).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client F, the facility failed to ensure a fall with injury was reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was</p>	W9999	The Program Director will be retrained on reporting incidents timely to all applicable entities in accordance with state law. The Area Director will monitor incident reporting by the Program Director to ensure timeliness of reporting and will complete corrective action as necessary if there are concerns. Staff responsible: Program Director, Area Director	12/05/2012	

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	<p>conducted on 11/2/12 at 11:07 AM.</p> <p>On 10/6/12 at 7:30 PM, client F tripped and fell cutting his shin requiring first aid. The incident was reported to BDDS on 10/8/12.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 11/2/12 at 11:12 AM. The QAD indicated reportable incidents should be submitted within 24 hours.</p> <p>An interview with the Program Director (PD) was conducted on 11/5/12 at 11:41 AM. The PD indicated reportable incidents should be submitted to BDDS within 24 hours.</p> <p>9-3-1(b)</p>				