

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN47591		
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W0000	<p>This visit was for an investigation of complaint #IN00098580. This visit resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00098580: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W189, W227 and W9999.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 10/17, 10/18, 10/19, 10/20, 10/21 and 10/24/11</p> <p>Facility Number: 002939 Provider Number: 15G689 Aim Number: 200333130</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader Dotty Walton, Medical Surveyor III (10/18/11 to 10/20/11)</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/31/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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

TITLE

(X6) DATE

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

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W0102	<p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C, D) and for 4 additional clients (E, F, G and H), the governing body failed to ensure the facility implemented its policy and procedures to prevent sexual exploitation of a client and to ensure staff immediately reported all concerns and allegations of abuse immediately to the administrator. The governing body failed to ensure the administrative staff reviewed and/or started an investigation immediately for possible abuse in regard to an 10/18/11 reportable incident report involving client G who had a vaginal discharge. The governing body failed to acknowledge the immediacy/possible concern with the incident. The governing body failed to ensure the facility developed a policy and procedure which dealt with staff bathing clients of the opposite sex to ensure client rights, privacy and protection for clients A, B, C, D, E, F, G and H.</p> <p>Findings include:</p> <p>1. The governing body failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (A). The governing body failed to ensure the</p>	W0102	<p>W102</p> <p>Plan of Correction: A policy for bathing consumers will be developed. Staff will be trained on this policy. Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. Administrative staff will be retrained on beginning abuse/neglect investigations immediately, taking immediate action to protect consumers, putting in place additional corrective action measures to prevent any potential abuse of clients and acknowledging the immediacy of abuse/neglect allegations. A thorough investigation will be completed on Client G. Administrative staff will be trained as follows: The following administrative staff will be retrained by November 23, 2011: the Director of Residential Services, the Director of Health Services, the QMRP, the QMRP-D and the Administrative Assistant. These administrative staff will be retrained on the following: beginning abuse/neglect investigations immediately, taking immediate action to protect consumers, putting in place additional corrective measures to prevent potential abuse of clients and</p>	11/23/2011			

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	<p>facility implemented its policy and procedures to prevent neglect and/or exploitation of client A in regard to an inappropriate incident involving staff conduct. The facility failed to ensure facility staff reported allegations of abuse/exploitation to the administrator immediately. Please see W122.</p> <p>2. The governing body failed to ensure the facility developed a policy and procedure in regard to male staff bathing female clients and female staff bathing male clients to ensure the protection of clients A, B, C, D, E, F, G and H.</p> <p>The governing body failed to ensure the facility's administrators immediately addressed a reportable incident report involving client G by initiating an investigation.</p> <p>The governing body failed to ensure the facility implemented its written policies and procedures to prevent abuse/exploitation of client A in regard to an incident involving inappropriate staff conduct/interactions. The governing body failed to ensure facility staff reported all concerns/questionable interactions to the administrator immediately. The governing body failed to ensure the facility put in place additional corrective actions/measures to prevent any potential</p>		<p>acknowledging the immediacy of abuse/neglect allegations. The Vice President of Program Services will first train the staff he directly supervises: the Director of Residential Services and the Director of Health Services. The Director of Residential Services and/or the Director of Health Services will then train the QMRP, QMRP-D's and the Administrative Assistant. The Director of Residential Services and the Director of Health Services fulfill one another's responsibilities when the other is absent. The Residential Chain of Command as far as supervisory responsibilities is as follows (from top level to bottom level): President, Vice President of Program Services, Director of Residential Services, QMRP, QMRP-D/Manager, Assistant Manager, Direct Support Professionals. The Administrative Assistant is trained to act as the Director of Residential Services when she is not available. The Nursing Chain of Command is as follows: President, Vice President of Program Services, Director of Health Services, Nurse/Medical Assistant.</p> <p>The Administrative Assistant is responsible for beginning each investigation and ensuring it gets completed. She is also responsible for ensuring DDRS reports get filed when appropriate. The Director of</p>				

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	<p>abuse of clients to ensure all concerns/allegations would be reported immediately. The governing body failed to ensure facility staff were sufficiently trained to deal with client's behaviors, and/or to ensure the facility addressed identified behavioral needs of a client. The governing body failed to ensure the facility monitored/supervised newly hired staff to prevent potential harm to clients.</p> <p>The governing body failed to ensure the facility staff reported all concerns and/or allegations immediately to the administrator involving client A. Please see W104.</p> <p>This federal tag relates to complaint #IN00098580.</p> <p>9-3-1(a)</p>		<p>Residential Services and the Vice President of Program Services are responsible for identifying the need for an investigation and communicating that need to the Administrative Assistant. The Director of Residential Services and the Vice President of Program Services are responsible for being actively involved in all abuse/neglect investigations. The Direct Support Professionals, Assistant Managers and QMRP/QMRP-D's are responsible for ensuring all allegations/suspensions get reported to the Pager Phone immediately. The person carrying the Pager Phone is responsible for immediately notifying the Director of Residential Services of all reportable incidents except medication errors. These are reported to the Director of Health Services first. The Director of Health Services then reports these errors to the Director of Residential Services. The Director of Residential Services is responsible for ensuring the Vice President of Program Services is aware of all reportable incidents.</p> <p>Preventive Action: A policy for bathing consumers will be developed. Staff will be trained on this policy. Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting</p>		

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W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C, D) and for 4 additional clients	W0104	<p>Procedures. Administrative staff will be retrained on beginning abuse/neglect investigations immediately, taking immediate action to protect consumers, putting in place additional corrective action measures to prevent any potential abuse of clients and acknowledging the immediacy of abuse/neglect allegations. A thorough investigation will be completed on Client G.</p> <p>Monitoring: The QMRP-D, QMRP and/or Assistant Manager will monitor the home at least five days per week. During this time, the QMRP-D, QMRP and/or Assistant Manager will use every opportunity to train staff on reporting appropriately and immediately. The QMRP, QMRP-D and/or Assistant Manager will provide hands-on training to staff.</p> <p>Responsible Party: Vice President of Program Services, Director of Residential Services, QMRP, QMRP-D, Assistant Manager Date to Be Completed by: November 23, 2011</p> <p>Plan of Correction: A policy for bathing consumers will be</p>	11/23/2011	

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	<p>(E, F, G and H), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent sexual exploitation of a client and to ensure staff immediately reported all concerns and allegations of abuse immediately to the administrator. The governing body failed to exercise general policy and operating direction over the facility to ensure the administrative staff reviewed and/or started an investigation immediately for possible abuse in regard to an 10/18/11 reportable incident report involving client G who had a vaginal discharge. The governing body failed to acknowledge the immediacy/possible concern with the incident. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed a policy and procedure which dealt with staff bathing clients of the opposite sex to ensure client rights, privacy and protection for clients A, B, C, D, E, F, G and H.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/17/11 at 3:45 PM. The facility's 10/16/11 reportable incident report indicated "On 10-16-2011, it was</p>		<p>developed. Staff will be trained on this policy. Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. Administrative staff will be retrained on beginning abuse/neglect investigations immediately, taking immediate action to protect consumers, putting in place additional corrective action measures to prevent any potential abuse of clients and acknowledging the immediacy of abuse/neglect allegations. All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior plan. Staff will be retrained on recognizing and reporting new behaviors immediately. A seasoned staff (worked in the home at least 3 months) will be scheduled on each shift when consumers are awake. If a seasoned staff cannot be present, the QMRP or QMRP-D will be present. The QMRP, QMRP-D or Assistant Manager will do at least one unannounced third shift check at least once per month. A thorough investigation will be completed on Client G.</p>				

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	<p>reported to the Director of Residential Services by [staff #2], that [staff #2] had observed [client A] lying on staff [staff #3] on the couch in the living room. [Client A] was reportedly wearing a bra but no shirt. Furthermore, [staff #2] reported that staff [staff #4] observed [client A] lying on staff [staff #3] while [client A] was masturbating. [Staff #4] reportedly attempted to redirect the behavior more than once. [Staff #3] reportedly refused to allow the behavior to be redirected...."</p> <p>The facility's 10/17/11 reportable incident report indicated "Due to an incident that occurred on 10/16/11 (previously reported), it was determined that [client A] should be taken to the ER (emergency room) to be check (sic) for signs of sexual abuse. This was being done simply as a precaution; there was no evidence that [client A] had been touched inappropriately. However, [staff #3] was terminated for inappropriate conduct that involved [client A] having no shirt or bra on in the living room area lying/leaning on [staff #3] without being redirected by [staff #3]...."</p> <p>Interview with staff #2 on 10/17/11 at 6:15 PM and on 10/18/11 at 11:15 AM indicated he had worked at the group home since 8/1/11. Staff #2 indicated he</p>		<p>Preventive Action: A policy for bathing consumers will be developed. Staff will be trained on this policy. Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. Administrative staff will be retrained on beginning abuse/neglect investigations immediately, taking immediate action to protect consumers, putting in place additional corrective action measures to prevent any potential abuse of clients and acknowledging the immediacy of abuse/neglect allegations. All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior plan. Staff will be retrained on recognizing and reporting new behaviors immediately. A seasoned staff (worked in the home at least 3 months) will be scheduled on each shift when consumers are awake. If a seasoned staff cannot be present, the QMRP or QMRP-D will be present. The QMRP, QMRP-D or Assistant Manager will do at least one unannounced third shift check at least once per</p>				

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	<p>worked on 10/16/11 from 4 PM to midnight. Staff #2 indicated he did not feel comfortable performing personal care/bathing female clients, but did it. Staff #2 indicated female and male staff worked during the evening shift (time varies). Staff #2 indicated the male staff who worked at the group home bathed and/or performed personal care of the female clients.</p> <p>Interview with staff #4 on 10/17/11 at 6:37 PM stated she had been having "trouble" with one of the staff (staff #3). Staff #4 indicated staff #3 worked on 10/16/11. Staff #4 indicated staff #3 sat in the recliner and/or on the couch during the entire shift except to give 3 female clients (B, C and H) baths and to feed client C at lunch.</p> <p>Interview with client C on 10/17/11 at 7:15 PM and on 10/18/11 at 11:55 AM indicated client C could answer yes/no questions by nodding her head, saying yes and/or lifting her hand for no. Client C indicated a male staff (staff #3) gave her a shower on 10/16/11.</p> <p>Interview with staff #6 on 10/17/11 at 7:06 PM indicated he performed personal care duties (bathing, toileting etc) of the female clients in the group home.</p>		<p>month. A thorough investigation will be completed on Client G.</p> <p>Monitoring: The QMRP-D, QMRP and/or Assistant Manager will monitor the home at least five days per week. During this time, the QMRP-D, QMRP and/or Assistant Manager will use every opportunity to train staff on reporting appropriately and immediately. The QMRP, QMRP-D and/or Assistant Manager will provide hands-on training to staff. The QMRP and QMRP-D will monitor all scheduling to ensure a seasoned staff or QMRP-D is scheduled.</p> <p>Responsible Party: Vice President of Program Services, Director of Residential Services, QMRP, QMRP-D, Assistant Manager Date to Be Completed by: November 23, 2011</p>		

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	<p>Interview with staff #8 on 10/18/11 at 1:38 PM indicated she worked from 6 AM to 11 AM on 10/16/11. Staff #8 indicated she had worked with staff #3 on 10/15/11. Staff #8 stated staff #3 did not know what to do and "He would sit back and wait until we told him what to do." Staff #8 indicated staff #3 was told to give client C a shower on 10/15/11.</p> <p>Interview with administrative staff #2 on 10/18/11 at 10:24 AM indicated the facility did not have a policy in regard to staff bathing clients of the opposite sex. Administrative staff #2 stated "It is client choice." Administrative staff #2 also stated "We get a lot of male staff here."</p> <p>Interview with administrative staff #1 and staff #2 on 10/18/11 at 3:20 PM indicated the male staff bathed and/or assisted female clients with personal hygiene care at the group home. Administrative staff #2 indicated the facility did not have a policy and/or procedure which addressed staff bathing clients of the opposite sex. Administrative staff #1 indicated the facility should have a policy.</p> <p>Interview with staff #9 and #10 on 10/21/11 at 7:45 AM indicated male and female staff bathed and/or assisted clients A, B, C, D, E, F, G and H to bathe/shower. Staff #9 and #10 stated</p>				

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	<p>"We all chip in to help out." Staff #9 and #10 indicated they were not aware of a policy in regard to bathing clients.</p> <p>The facility's policy and procedures were reviewed on 10/17/11 at 2:15 PM. The facility did have and/or provide documentation of a policy in regard to staff bathing clients of the opposite sex to ensure the rights of clients, privacy and/or protection.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 10/21/11 at 10:10 AM. The facility's 10/18/11 reportable incident report indicated "[Client G] was sent to the ER (emergency room) with vaginal discharge and itching. The hospital did not give any medications and [client G] is to follow-up with family doctor for OB (obstetric and gynecological) consult and to return if any problems. The staff will follow the instructions of the hospital and report any changes to the nurse."</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/17/11 at 3:45 PM. The facility's 10/16/11 reportable incident report indicated "On 10-16-2011, it was reported to the Director of Residential Services by [staff #2], that [staff #2] had observed [client A] lying on staff [staff #3] on the</p>				

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	<p>couch in the living room. [Client A] was reportedly wearing a bra but no shirt. Furthermore, [staff #2] reported that staff [staff #4] observed [client A] lying on staff [staff #3] while [client A] was masturbating. [Staff #4] reportedly attempted to redirect the behavior more than once. [Staff #3] reportedly refused to allow the behavior to be redirected. Consumer [client E] reportedly observed the behavior. However he is nonverbal and unable to give a statement. Staff [staff #3] was immediately removed from all contact with consumers pending the outcome of an investigation. Staff [staff #3] will be terminated today because 2 staff witnessed the behavior...."</p> <p>The facility's 10/17/11 reportable incident report indicated "Due to an incident that occurred on 10/16/11 (previously reported), it was determined that [client A] should be taken to the ER (emergency room) to be check (sic) for signs of sexual abuse. This was being done simply as a precaution; there was no evidence that [client A] had been touched inappropriately. However, [staff #3] was terminated for inappropriate conduct that involved [client A] having no shirt or bra on in the living room area lying/leaning on [staff #3] without being redirected by [staff #3]....."</p>			

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	<p>The facility's above mentioned 10/18/11 reportable incident report did not indicate the governing body/administrative staff initiated an investigation in regard to client G's vaginal discharge due to the circumstance and/or inappropriate staff conduct due to the 10/17/11 incident with client A.</p> <p>Client G's record was reviewed on 10/21/11 at 10:15 AM. Client G's 9/11, 8/11 and 7/11 nurse notes and/or record did not indicate client G had a history of having problems with vaginal discharge.</p> <p>Client G's 10/18/11 hospital records indicated client G was released with a diagnosis of "Vaginal Discharge" on 10/18/11. Client G's 10/18/11 Patient Information sheet indicated "Follow up to family doctor for OB consult. No new meds. Return (with) problems." The 10/18/11 sheet indicated an appointment was to be obtained "ASAP (as soon as possible)."</p> <p>Client G's 10/18/11 Treatment/Procedures sheet indicated client G was found to have a vaginal discharge when examined in the ER. Client G's 10/18/11 Emergency Physician Record indicated the doctor was "unable to get a full pelvic exam due to poor cooperation. Pt (patient) will need (unreadable word) sedation for full pelvic exam. It probably shall be done by GYN</p>			

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	<p>(gynecologist)...." The ER record indicated client G's urinalysis was normal and the client did not have any signs of infection.</p> <p>Interview with staff #4 on 10/17/11 at 6:37 PM stated she had been having "trouble" with one of the staff (staff #3). Staff #4 indicated staff #3 and #5 also worked on 10/16/11. Staff #4 indicated staff #3 sat in the recliner and/or on the couch during the entire shift except to give 3 female clients (B, C and H) baths and to feed client C at lunch.</p> <p>Interview with client C on 10/17/11 at 7:15 PM and on 10/18/11 at 11:55 AM indicated client C could answer yes/no questions by nodding her head, saying yes and/or lifting her hand for no. Client C indicated a male staff (staff #3) gave her a shower on 10/16/11.</p> <p>Interview with LPN #1 and #2 on 10/21/11 at 10:40 AM and at 2:16 PM, by phone, indicated client G did not have a history/problems with vaginal discharge. LPN #1 stated she (LPN #1) went to the group home to assess client G and the client had "1 teaspoon" of clear discharge with no odor. LPN #1 stated the vaginal discharge was "a lot." LPN #1 indicated client G was not sexually active. LPN #1 indicated she did not feel the discharge</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
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	<p>meant anything, but she sent the client to ER due to the 10/17/11 incident which occurred in the home. LPN #1 indicated the doctor did not indicate/document there was any concern in regard to trauma and/or abuse.</p> <p>Interview with administrative staff #2 on 10/21/11 at 9:50 AM and at 11:40 AM indicated she (administrative staff#2) had been told client G was being sent out to the hospital due to vaginal discharge on 10/18/11. Administrative staff #2 stated "I knew she went to ER but I did not know the facts about it until today (10/21/11). Administrative staff #2 indicated they had learned through investigation of the 10/17/11 incident, the alleged perpetrator had bathed all the female clients at the home at one point. When asked if the facility was conducting an investigation in regard to the 10/18/11 incident, administrative staff #2 stated "I did not think about it. I did not make the connection. We will start one now."</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policies and procedures to prevent abuse/exploitation of client A in regard to an incident involving inappropriate staff conduct/interactions. The governing body</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
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	<p>failed to exercise general policy and operating direction over the facility to ensure facility staff reported all concerns/questionable interactions to the administrator immediately. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility put in place additional corrective actions/measures to prevent any potential abuse of clients to ensure all concerns/allegations would be reported immediately. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff were sufficiently trained to deal with client's behaviors, and/or to ensure the facility addressed identified behavioral needs of a client. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility monitored/supervised newly hired staff to prevent potential harm to clients. Please see W149.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility staff reported all concerns and/or allegations immediately to the administrator involving client A. Please see W153.</p> <p>This federal tag relates to complaint #IN00098580.</p>				

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN47591
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W0122	<p>9-3-1(a)</p> <p>The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (A). The facility failed to implement its written policies and procedures to prevent abuse/exploitation of a client in regard to an incident involving inappropriate staff conduct/interactions. This non-compliance resulted in an Immediate Jeopardy as the facility failed to ensure staff reported all concerns/questionable interactions to the administrator immediately; failed to put in place additional corrective actions/measures to prevent any potential abuse of clients; failed to ensure facility staff were sufficiently trained to deal with client's behaviors, and/or failed to address identified behavioral needs of a client. The facility failed to monitor/supervise newly hired staff to prevent potential harm to clients. The Immediate Jeopardy was identified on 10/18/11 at 5:10 PM. The Vice President of Program Services and the Director of Residential Services were notified of the Immediate Jeopardy on 10/18/11 at 5:55 PM. The Immediate Jeopardy began on 10/16/11. The facility</p>	W0122	<p>W122</p> <p>Plan of Correction: Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. Administrative staff will be retrained on putting in place additional corrective action measures to prevent any potential abuse of clients. All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior plan. Staff will be retrained on recognizing and reporting new behaviors immediately. A seasoned staff (worked in the home at least 3 months) will be scheduled on each shift when consumers are awake. If a seasoned staff cannot be present, the QMRP or QMRP-D will be present. The QMRP, QMRP-D or Assistant Manager will do at least one unannounced third shift check at least once per month. The staff who did not report immediately has been disciplined and has received</p>	11/23/2011

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	submitted a plan of removal for the Immediate Jeopardy on 10/19/11 at 4:10 PM. The facility's 10/19/11 plan of removal indicated the staff who failed to immediately report the incident was disciplined and would receive hands on training during each shift for the next 2 weeks by an individual who has at least one year's experience in group home management or Qualified Mental Retardation Professional/Designee (QMRP/QMRP-D). The facility's plan of removal indicated all facility staff would be retrained in regard to the abuse/neglect policy, consumer rights and reporting. The facility's 10/19/11 plan of removal indicated the staff person was removed from the schedule on 10/19 and 10/20/11. The facility's plan of removal indicated the staff who was watching the TV was terminated and "seasoned staff" would be present during all hours at the group home to "...ensuring that all staff receive appropriate consumer specific training prior to being responsible for any consumers in the home. 7. All staff will receive consumer specific training on each consumer in the home...." The 10/19/11 plan of removal indicated client A's behavior would be updated to address the client's removal of clothes and masturbation in public, and then staff would be trained and the plan implemented once the guardian and		hands-on retraining for two weeks with an individual who has at least one year QMRP/QMRP-D and/or Group Home Management experience and at least 2 years of group home experience. An evaluation has been completed using our 70-day evaluation form. She met expectations on all performance criteria. It was determined she was ready to work without constant supervision but will be supervised by someone meeting the above requirements for at least two partial shifts per week until it is determined the staff no longer requires this level of supervision due to her improved performance. Preventive Action: A policy for bathing consumers will be developed. Staff will be trained on this policy. Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. Administrative staff will be retrained on putting in place additional corrective action measures to prevent any potential abuse of clients. All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior		

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	<p>Human Rights Committee reviewed and approved. The facility's plan of removal indicated the group home's QMRP-D would be moved to a direct care staff position until "...he gains enough experience and maturity to demonstrate capability in a position other than direct care...13. The Director of Residential Services, Director of Health Services or Vice President of Program Services will be present in the home while consumers are present at least 3 times per week and then continue the usual practice of spot checking the group homes on a weekly basis." The facility submitted a plan of removal via e-mail on 10/19/11 at 4:10 PM.</p> <p>The Immediate Jeopardy was removed on 10/24/11 at 12:40 PM through observation, interview and record review. It was determined the facility implemented a plan of action to remove the Immediate Jeopardy, and the steps taken removed the immediacy of the problem. During the 10/21/11 observation period between 6:08 AM and 7:45 AM, at the group home, there were 4 staff to 8 clients present in the group home. Staff #6, #9 and #11 were the seasoned staff who worked in the group home while staff #10 was a new staff who was helping out from another group home. During the observation period,</p>		<p>plan. Staff will be retrained on recognizing and reporting new behaviors immediately. A seasoned staff (worked in the home at least 3 months) will be scheduled on each shift when consumers are awake. If a seasoned staff cannot be present, the QMRP or QMRP-D will be present. The QMRP, QMRP-D or Assistant Manager will do at least one unannounced third shift check at least once per month. The staff who did not report immediately has been disciplined and has received hands-on retraining for two weeks with an individual who has at least one year QMRP/QMRP-D and/or Group Home Management experience and at least 2 years of group home experience. An evaluation has been completed using our 70-day evaluation form. She met expectations on all performance criteria. It was determined she was ready to work without constant supervision but will be supervised by someone meeting the above requirements for at least two partial shifts per week until it is determined the staff no longer requires this level of supervision due to her improved performance.</p> <p>Monitoring: The QMRP-D, QMRP and/or Assistant Manager will monitor the home at least five days per week. During this time,</p>		

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN47591			
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	<p>staff #10 got client C and E's liquid consistency mixed up. Staff #11, a seasoned staff who was at the dining room table with staff #10, redirected and trained staff on the proper consistencies (honey thick and nectar thick) clients C and E received. During the 10/21/11 observation period, staff to client interactions/conduct were appropriate.</p> <p>The facility's inservice training records were reviewed on 10/20/11 at 3:08 PM and on 10/21/11 at 10:00 AM. The facility's 10/20/11 and 10/21/11 Employee Training Records indicated all facility staff who worked in the group home had been retrained in regard to reporting allegations of abuse/neglect/exploitation. The training records indicated facility staff were re-trained on consumer supervision, Risk Plans, program plan and behavior plans. The facility's 10/20/11 Employee Training Record indicated QMRPs and QMRP-Ds were trained in regard to "Seasoned staff must be present during all awake hours & (and) must ensure that all staff receive consumer specific training prior to being responsible for consumers. Adjust schedules immediately."</p> <p>The facility staffs' schedule was reviewed on 10/21/11 at 12:26 PM and on 10/24/11 at 12:05 PM. The 10/2011 schedule</p>		<p>the QMRP-D, QMRP and/or Assistant Manager will use every opportunity to train staff on reporting appropriately and immediately. The QMRP, QMRP-D and/or Assistant Manager will provide hands-on training to staff. The QMRP and QMRP-D will monitor all scheduling to ensure a seasoned staff or QMRP-D is scheduled.</p> <p>Responsible Party: Vice President of Program Services, Director of Residential Services, QMRP, QMRP-D, Assistant Manager Date to Be Completed by: November 23, 2011</p>				

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN47591			
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	<p>indicated on Saturday 10/22/11, seasoned staff #8, #9 and #11 worked at the group home for each shift. The facility's 10/29/11 schedule also indicated QMRP #2 worked and was present in the group home from 6 AM to 2:00 PM. On 10/23/11 (Sunday), a seasoned staff person (staff #2, #7, #8, #9 and #11) worked on each shift in the group home. Staff #4 worked on 10/22/11 from 6:00 AM to 2:00 PM with the QMRP-D during staff #4's shift.</p> <p>Staff #4's Record of Disciplinary Action was reviewed on 10/21/11 at 12:35 PM. The facility's 10/18/11 disciplinary record indicated staff #4 received a verbal warning for inappropriate conduct as staff #4 failed "...to report suspicion of abuse/neglect/exploitation immediately to the pager phone...." The 10/21/11 disciplinary action record indicated staff #4 would be retrained on reporting, abuse, neglect and client consumer rights, pager policy and etc.</p> <p>The facility's administrative typed notes of observations in the group home were reviewed on 10/21/11 at 10:37 AM and on 10/24/11 at 12:03 PM. The typed notes indicated administrative and/or QMRP-Ds were present in the group home to monitor/supervise on 10/19/11 (Wednesday evening), 10/20/11, 10/21/11</p>						

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN47591		
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	<p>at 5:30 PM, 10/22/11 at 4:00 PM, and on 10/23/11 at 9:45 AM.</p> <p>Client A's record was reviewed on 10/24/11 at 12:12 PM. Client A's 10/20/11 Behavior Support Plan (BSP) indicated the client's identified need of taking clothes off in public and masturbating in public had been added to the BSP.</p> <p>Interview with staff #9 on 10/21/11 at 6:40 AM indicated she had worked in the group home for a year. Staff #9 indicated she received retraining on the facility's abuse/neglect/exploitation policy and reporting on 10/20/11. Staff #9 stated "I will not allow anyone to abuse these consumers."</p> <p>Interview with staff #10 on 10/21/11 at 7:24 AM indicated this was only her second time working in the group home for breakfast. Staff #10 indicated she had received retraining in regard to reporting and abuse and neglect on 10/20/11. Staff #10 indicated she also received consumer specific training on 10/20/11.</p> <p>Interview with staff #6 and #11 on 10/21/11 at 7:45 AM indicated they had worked in the group home for over a year. Staff #6 and #11 indicated they had been retrained in regard to</p>				

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN47591			
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	<p>abuse/neglect/exploitation and reporting on 10/20/11.</p> <p>While the Immediate Jeopardy was removed on 10/24/11, the facility remained out of compliance at the Condition level in that the facility needed to train and implement client A's Behavior Support Plan in regard to masturbation and removing clothes in public. The facility needed to further monitor and supervise the facility staff to ensure the effectiveness of its plan or removal to ensure clients were protected from abuse, neglect and/or exploitation.</p> <p>Findings include:</p> <p>1. The facility failed to implement its written policies and procedures to prevent abuse/exploitation of client A in regard to an incident involving inappropriate staff conduct/interactions. The facility failed to ensure facility staff reported all concerns/questionable interactions to the administrator immediately. The facility failed to ensure additional corrective actions/measures were put in place to prevent any potential abuse of clients to ensure all concerns/allegations would be reported immediately. The facility failed to ensure facility staff were sufficiently trained to deal with client's behaviors, and/or to ensure the facility addressed</p>						

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN47591		
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W0149	<p>identified behavioral needs of a client. The facility failed to ensure newly hired staff were monitored to prevent potential harm to clients. Please see W149.</p> <p>2. The facility failed to ensure facility staff reported all concerns and/or allegations immediately to the administrator involving client A. Please see W153.</p> <p>This federal tag relates to complaint #IN00098580.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility neglected to implement its written policies and procedures to prevent abuse/exploitation of a client in regard to an incident involving inappropriate staff conduct/interactions. The facility neglected to implement its policy and procedures to ensure facility staff reported all concerns/questionable interactions to the administrator immediately. The facility neglected to put in place additional corrective actions/measures to prevent any potential abuse of clients to ensure all concerns/allegations would be</p>	W0149	<p>W149</p> <p>Plan of Correction: A policy for bathing consumers will be developed. Staff will be trained on this policy. Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. Administrative staff will be retrained on beginning abuse/neglect investigations immediately, taking immediate action to protect consumers, putting in place additional corrective action measures to prevent any potential abuse of clients and acknowledging the</p>	11/23/2011	

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	<p>reported immediately. The facility neglected to ensure facility staff were sufficiently trained to deal with client's behaviors, and/or neglected to address identified behavioral needs of a client. The facility neglected to monitor/supervise newly hired staff to prevent potential harm to clients.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/17/11 at 3:45 PM. The facility's 10/16/11 reportable incident report indicated "On 10-16-2011, it was reported to the Director of Residential Services by [staff #2], that [staff #2] had observed [client A] lying on staff [staff #3] on the couch in the living room. [Client A] was reportedly wearing a bra but no shirt. Furthermore, [staff #2] reported that staff [staff #4] observed [client A] lying on staff [staff #3] while [client A] was masturbating. [Staff #4] reportedly attempted to redirect the behavior more than once. [Staff #3] reportedly refused to allow the behavior to be redirected. Consumer [client E] reportedly observed the behavior. However he is nonverbal and unable to give a statement. Staff [staff #3] was immediately removed from all contact with consumers pending the outcome of</p>		<p>immediacy of abuse/neglect allegations. All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior plan. Staff will be retrained on recognizing and reporting new behaviors immediately. A seasoned staff (worked in the home at least 3 months) will be scheduled on each shift when consumers are awake. If a seasoned staff cannot be present, the QMRP or QMRP-D will be present. The QMRP, QMRP-D or Assistant Manager will do at least one unannounced third shift check at least once per month. A thorough investigation will be completed on Client G. The staff who did not report immediately has been disciplined and has received hands-on retraining for two weeks with an individual who has at least one year QMRP/QMRP-D and/or Group Home Management experience and at least 2 years of group home experience. An evaluation has been completed using our 70-day evaluation form. She met expectations on all performance criteria. It was determined she was ready to work without constant supervision but will be supervised by someone meeting the above requirements for at least two</p>		

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN47591			
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	<p>an investigation. Staff [staff #3] will be terminated today because 2 staff witnessed the behavior. The Director of Residential Services has already attempted to contact APS (Adult Protective Services) by phone and left a message."</p> <p>The facility's 10/17/11 reportable incident report indicated "Due to an incident that occurred on 10/16/11 (previously reported), it was determined that [client A] should be taken to the ER (emergency room) to be check (sic) for signs of sexual abuse. This was being done simply as a precaution; there was no evidence that [client A] had been touched inappropriately. However, [staff #3] was terminated for inappropriate conduct that involved [client A] having no shirt or bra on in the living room area lying/leaning on [staff #3] without being redirected by [staff #3]. Another staff did attempt redirection. [Client A] was seen by an ER physician at approximately 1:00 p.m. on 10/17/11. It was determined that [client A] would have to be given gas to put her to sleep in order for the rape kit and assessment to be completed. This was done at approximately 6 p.m. on 10/17/11. It was determined by the physician that [client A] had not engaged in complete sexual intercourse. Fluids were taken anyway as a precaution. No results have</p>		<p>partial shifts per week until it is determined the staff no longer requires this level of supervision due to her improved performance.</p> <p>Preventive Action: A policy for bathing consumers will be developed. Staff will be trained on this policy. Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. Administrative staff will be retrained on beginning abuse/neglect investigations immediately, taking immediate action to protect consumers, putting in place additional corrective action measures to prevent any potential abuse of clients and acknowledging the immediacy of abuse/neglect allegations. All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior plan. Staff will be retrained on recognizing and reporting new behaviors immediately. A seasoned staff (worked in the home at least 3 months) will be scheduled on each shift when consumers are awake. If a seasoned staff cannot be present, the QMRP or QMRP-D will be present. The QMRP,</p>				

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	<p>been given at this point. [Name of APS representative] and the Sheriff's department were informed of the ER visit due to the nature of the previous incident...."</p> <p>An attached 10/17/11 email indicated a police report was filed with the local sheriff's department on 10/17/11. An attached 10/17/11 Voluntary Statement by staff #2 indicated "Arrived at work around 4 pm and as soon as I walked into the door I saw [client A] without a shirt on sitting on the couch and leaning on [staff #3]. Before I could say or do anything [staff #4] took me outside to fill me in on what had/was happening. She, [staff #4] then proceeded to tell me that [client A] had started to strip, which is not uncommon for her to do, and also started to touch herself while sitting on the couch leaned up next to [staff #3]. [Staff #4] then said she tried to redirect [client A] back to her room to get clothes on her but that [staff #3] had said no and the (sic) he could handle it and doesn't mind what [client A] was doing. After [staff #4] finished telling me what happened I walked back inside, saw that [client A] and [staff #3] had not moved, put my stuff up in the kitchen and then went to confront [staff #3]. When I went to confront [staff #3] he had already gotten up and took [client A] to the back and</p>		<p>QMRP-D or Assistant Manager will do at least one unannounced third shift check at least once per month. A thorough investigation will be completed on Client G. All new hires/transfers will receive consumer specific training prior to being responsible for consumers in the home. Human Resources will be retrained on obtaining at least one work reference on each individual who is hired (in addition to two personal references).</p> <p>Monitoring: The QMRP-D, QMRP and/or Assistant Manager will monitor the home at least five days per week. During this time, the QMRP-D, QMRP and/or Assistant Manager will use every opportunity to train staff on reporting appropriately and immediately. The QMRP, QMRP-D and/or Assistant Manager will provide hands-on training to staff. The QMRP and QMRP-D will monitor all scheduling to ensure a seasoned staff or QMRP-D is scheduled.</p> <p>Responsible Party: Vice President of Program Services, Director of Residential Services, QMRP, QMRP-D, Assistant Manager Date to Be Completed by: November 23, 2011</p>		

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	<p>proceeded to get her dressed. From that point on I made sure [client A] was not around him and in my eyesight as I communicated with [administrative staff #2] over the phone what all happened (sic)."</p> <p>The facility's 10/17/11 attached witness statement by staff #3 indicated client A had sat down next to staff #3 on the couch and placed her (client A's) hands down inside her pants. Staff #3's witness statement indicated he asked staff #4 what he should do. The witness statement indicated staff #3 indicated staff #4 tried to redirect client A to her bedroom. The 10/17/11 witness statement indicated "...She did take her bra off repeatedly and her shirt. Finally, I just left her bra on. I more or less asked the staff is that ok and it seemed okay." An attached 10/17/11 note written by administrative staff #2 indicated staff #3 admitted staff #4 prompted client A to go to her bedroom. The note indicated staff #3 "...Says happens all the time. [Client A] fell asleep laying on him. She (client A) just wanted attention."</p> <p>The facility's Record of Disciplinary Action was reviewed on 10/17/11 at 3:45 PM. The disciplinary action indicated staff #3 was terminated on 10/17/11 for "inappropriate conduct."</p>				

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	<p>During the 10/17/11 observation period between 5:17 PM and 8:20 PM at the group home, client A was at the hospital being evaluated due to the 10/16/11 incident. Client A returned to the group home at 7:55 PM on 10/17/11. During the above mentioned observation period, staff #4 was working in the group home.</p> <p>Client A's record was reviewed on 10/17/11 at 3:25 PM. Client A's 10/17/11 Emergency Room or Outpatient Information Form indicated client A was taken to the hospital for "Suspected sexual abuse...." The 10/17/11 form indicated blood work "results pending." An attached outpatient form indicated client A had received general anesthesia.</p> <p>Client A's 6/10/11 Individual Program Plan (IPP) indicated client A's diagnoses included, but were not limited to, Profound Mental Retardation and Speech and Language Disorder.</p> <p>Client A's 6/4/11 Sexuality and Vulnerability Assessment indicated client A "Will allow others to take advantage of him/her." Client A's 5/23/11 Functional Assessment indicated client A "Masturbates or touches his/her genitals only in private." The 5/23/11 assessment indicated client A would sometimes</p>				

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	<p>"expose herself" and refuse to wear clothing. The assessment indicated "N" (No) was checked for "Masturbates in inappropriate situations." Client A's 6/10/11 IPP and/or 6/8/11 Behavior Plan indicated the facility neglected to address client A's identified need of removing her clothes/exposing herself.</p> <p>Interview with administrative staff #2 on 10/17/11 at 4:38 PM and on 10/18/11 at 10:12 AM and 10:24 AM indicated the sheriff/police was at the facility due to an incident involving staff #3 and client A on 10/16/11. Administrative staff #2 indicated the facility was in the process of conducting an investigation in regard to sexual abuse regarding an incident on 10/16/11. Administrative staff #2 indicated the facility terminated staff #3 on 10/17/11 after two staff saw client A without a shirt and/or bra masturbating while laying/leaning on staff #3. Administrative staff #2 indicated staff #3 did not redirect the client to stop and refused to allow staff #4 to redirect client A to her bedroom. Administrative staff #2 indicated client A did not have a history of masturbating in public/common areas. The administrative staff indicated client A masturbated in her bedroom alone. Administrative staff #3 indicated three staff were working at the time the incident occurred on 10/16/11. One staff</p>						

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	<p>was at the back of the house and did not see anything, and the perpetrator was sitting on the couch with client A while the other staff was attempted to redirect client A and watch the other clients in the group home. When asked how long the incident occurred before staff called administrative staff, administrative staff #2 stated "Occurred with a half hour period from start to finish."</p> <p>Administrative staff #2 indicated staff #4 did not report the inappropriate conduct of staff but did tell the next staff who came on duty who called her (administrative staff #2). Administrative staff #2 stated the facility did not take client A to the hospital on 10/16/11 to be examined as "There was no allegation of inappropriate touching." Administrative staff #2 indicated after speaking with staff #3 on the morning of 10/17/11, she became concerned and spoke with APS for direction. Administrative staff #3 indicated staff #3 did not see anything wrong with what he did on 10/16/11 as the staff person admitted client A was leaning/laying on him masturbating. Administrative staff #2 indicated staff #3 got upset when he was being interviewed. Administrative staff #3 stated "He was ready to come across the table at me." Administrative staff #2 indicated she asked a male administrative staff to come in and assist her. Administrative staff #2</p>				

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	<p>stated staff #3 indicated he was going to "confront" staff #4 and was advised not to return to the facility/group home. Administrative staff #2 indicated staff #3 was a new hire to the group home as the staff person had worked on the waiver side in the past. Administrative staff #2 indicated staff #4 did not report staff #3's conduct/behavior until the evening shift staff came in at 4:00 PM. Administrative staff #2 indicated staff #4 then informed staff #2, her peer. Administrative staff #2 stated staff #4 did not call anyone as she was "very shook up." Administrative staff #2 stated she "informally" counseled staff #4 about reporting all concerns/allegations to the administrator immediately. Administrative staff #2 indicated staff #4 stated "I should have called." The administrative staff indicated the facility had not formally retrained staff #4 on reporting. Administrative staff #2 indicated all staff at the group home would be retrained on abuse and neglect when the investigation was completed. Administrative staff #2 indicated the facility had neglected to put in place any additional measures to ensure staff #4 would call/report any concerns and allegations to prevent potential harm to clients as the staff continued to work in the group home after the 10/16/11 incident. Administrative staff #2 indicated the administrative staff went to</p>			

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	<p>the hospital for client A's procedure/rape exam. Administrative staff #2 indicated the doctor stated client A's "Hymen was intact" and the doctor did not feel intercourse had occurred. Administrative staff #2 indicated staff #5 was moved to group home 101 from another group home. Administrative staff #2 stated staff #5 was "upset and did not work. So she kept to herself as she had been moved from [name of group home]."</p> <p>Administrative staff #2 stated "She (staff #5) was mad at me." Administrative staff #2 indicated the staff should have been helping/assisting with the clients in the group home.</p> <p>Interview with staff #2 on 10/17/11 at 6:15 PM and on 10/18/11 at 11:15 AM indicated he had worked at the group home since 8/1/11. Staff #2 indicated he worked on 10/16/11 from 4 PM to midnight. Staff #2 indicated he arrived at the group home at 4:00 PM. Staff #2 stated "As soon as I walked into the house, [client A] had her shirt off and was sitting on the couch." Staff #2 stated he did not think that was "unusual" as client A would remove her shirt if it was wet. Staff #2 indicated client A was sitting on the couch next to staff #3. Staff #2 indicated staff #4 asked to speak with him outside. Staff #2 indicated staff #4 told staff him (staff #2) she had tried to</p>				

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	<p>redirect client A to her bedroom as client A was masturbating and laying on staff #3. Staff #2 indicated staff #4 stated staff #3 told her it was "ok" and he would not let her redirect client A to the the client's bedroom. Staff #2 indicated he told staff #4 he would talk with staff #3. Staff #2 indicated he returned inside the house to put his things up and to speak with staff #3. Staff #2 indicated client A and staff #3 were still sitting on the couch with client A leaning on staff #3. The client did not have a shirt on. Staff #2 stated "There was no urgency for [staff #3] to put shirt on her and redirect her. He (staff #3) was just chilling." Staff #2 indicated when he came out of the kitchen, client A had gone to the back of the house with staff #3 to get dressed. When asked how long staff #3 was with client A at the back of the house staff #2 stated "a couple of minutes. No more than 3 to 4 minutes." Staff #2 indicated when he got to the back of the house, client A met him in the hallway and she had a shirt on. Staff #2 indicated he then directed staff #4 to leave and he kept client A with him and called administrative staff #2. Staff #2 indicated he did not say anything to staff #3 as "I was really mad." When asked where were the rest of the clients, staff #2 stated all the clients were in the living room (where client A and staff #3 were located) except client F who could have been "roaming."</p>				

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	<p>Staff #2 indicated he did not know when the inappropriate conduct/incident started. Staff #2 stated "I hope not very long." Staff #2 indicated client A would remove her shirt if wet wanting staff to get her another one. Staff #2 indicated client A responded to redirection. Staff #2 indicated client A would put her hand down her pants but remove it with redirection. Staff #2 stated client A did not like to be touched and was "surprised" she sat close/leaned on staff #3. Staff #2 stated "I have never seen staff let her lay on anyone else. I have never seen a situation where staff just let her lean on them and masturbate." Staff #2 indicated staff #3 went to the back of the group home to pass the client's medications and he kept client A in the kitchen with him. Staff #2 indicated staff #3 received a phone call from administrative staff #2. Staff #2 indicated when he went to the back of the house, staff #3 had left the group home. Staff #2 indicated the staff left clients' medications out on the counter and the medications unlocked. Staff #2 indicated he (staff #3) did not tell anyone he had left the group home. Staff #2 indicated staff #3 had recently started working at the group home as he came from another group home. Staff #2 stated staff #3 was "a little odd." Staff #2 indicated he did not know staff #5 was in the group home when he arrived, as the</p>			

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	<p>staff person was in the small TV room near the back of the house.</p> <p>Interview with staff #4 on 10/17/11 at 6:37 PM stated she had been having "trouble" with one of the staff (staff #3). Staff #4 indicated staff #3 and #5 also worked on 10/16/11. Staff #4 indicated staff #3 sat in the recliner and/or on the couch during the entire shift except to give 3 female clients (B, C and H) baths and to feed client C at lunch. Staff #4 indicated staff #5 stayed in the small TV room and did not assist with any client care. Staff #4 indicated all the clients were in the living room except client F who was in bed taking a nap after lunch. Staff #4 indicated client G was gone out with her parents. Staff #4 indicated client A was sitting on the couch leaning over with her eyes closed on the arm of the couch. Staff #4 indicated she prompted client A to sit up or go lay down in her bed to sleep. Staff #4 indicated client A sat up for 1 to 2 minutes when staff #3 got up out the recliner and went to sit next to client A on the couch. Staff #4 stated "She (client A) was ok and then all of sudden she laid over on him. I have never seen her do that. She was moving her face up and down his arm. He did not stop her. I tried to redirect her to her room. He said she was fine." Staff #4 indicated she then went into the kitchen as</p>			

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	<p>client B was getting into things in the kitchen. Staff #4 indicated she gave clients A and B a snack (cookies). Staff #4 stated once client A finished her cookies, the client "laid back down on him. She put her hands down her pants and started masturbating. He gave me a funny look. He did not redirect her." Staff #4 stated client A laid her head down near staff #3's elbow area and continued to "play with herself. She (client A) sits back up. Really going to town with masturbating and rubbing his arm with her free hand. I told him she really needs to go to her room. He said nothing." Staff #4 indicated client A then took her shirt off and she put the shirt back on the client. Staff #4 indicated she then had to go to the kitchen to get client B who was going through items in the kitchen. Staff #4 indicated client A got up and went to the back of the house on her own and staff #4 returned to the recliner. Staff #4 indicated client A came back to the front of the house with no shirt and/or bra on. Staff #4 indicated she redirected client A to put her bra on but client A walked into the living room and sat down on the couch before she could get her shirt on. Staff #4 indicated she went back to the kitchen as client B was back in the kitchen. Staff #4 indicated when she returned to the living room, staff #3 got up from the recliner and went sat next to</p>			

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	<p>client A on the couch who had a bra on but did not have her shirt on. Staff #4 stated she walked over to client A to assist the client to go back to her bedroom when staff #3 "puts his arm up to stop me and told me she was fine." When asked how staff #3 stopped her, staff #4 demonstrated the action. Staff #4 lifted her arm and moved it in a swaying motion from left to right. When asked where staff #5 was, staff #3 indicated the staff was in the small TV room. Staff #4 indicated she told staff #5 she needed help at one point. Staff #4 stated "She (staff #5) never came out of the room." Staff #4 stated "I was very uncomfortable and did not know what to do." Staff #4 stated client A "laid" on staff #3 when the staff person came and sat next to her on the couch the second time. When asked how client A laid on staff #3, staff #4 stated, "She laid her head over on staff #3's lap near his abdomen area "like a pillow." Staff #4 stated she told staff #3 to redirect client A to her bedroom "2 to 4 times." Staff #4 stated "He (staff #3) just giggled or laughed." Staff #4 stated "He was comfortable with it (client A laying on him and masturbating)." Staff #4 indicated staff #3 came in at 11:00 AM to work. When asked when all this took place, staff #4 indicated it was after lunch around 2:00 PM. Staff #4 indicated she was due to leave at 3:00 PM. Staff #4</p>				

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	<p>indicated she told staff #2 what happened when he came in to work at 3:00 PM. Staff #4 indicated she thought the incident lasted about 45 minutes to 1 hour before staff #2 came into work. Staff #4 stated "I was relieved to see him (staff #2)." Staff #4 indicated client A would remove her clothes in her room and not in front of others. Staff #4 indicated the other clients were present in the living room when the incident/inappropriate conduct occurred. Staff #4 indicated client A did not like to be touched. When asked why she did not call anyone when this was going on, staff #4 stated "I was dumbfounded. I was the only one here with 3 staff. I had no help. I tried to monitor clients. I could not leave to use the phone and go out. I was so in shock at what I saw. I was brain dead." Staff #4 indicated she should have called someone when it occurred. Staff #4 indicated staff #2 called the office after he came into work.</p> <p>Interview with client C on 10/17/11 at 7:15 PM and on 10/18/11 at 11:55 AM indicated client C could answer yes/no questions by nodding her head, saying yes and/or lifting her hand for no. Client C indicated client C was in the living room on 10/16/11. Client C indicated client A was sitting on the couch next to staff #3. Client C indicated she saw client A remove her shirt in the living room.</p>				

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	<p>Client C indicated a male staff (staff #3) gave her a shower on 10/16/11.</p> <p>Interview with staff #6 on 10/17/11 at 7:06 PM indicated he did not work on 10/16/11. Staff #6 indicated he had worked at the group home since 4/11. Staff #6 stated client A "normally likes to be by herself. Will occasionally sit on the couch." Staff #6 indicated client A would remove her shirt in her bedroom but not out in common areas of the group home. Staff #6 indicated client A would remove her shirt if had something on it or got wet.</p> <p>Interview with staff #1 on 10/17/11 at 7:50 PM and on 10/18/11 at 5:10 PM indicated staff #3 used to work at another group home. Staff #1 stated staff #3 was moved to group home 101 "due to personality clash of staff here (group home 101)." Staff #1 indicated he was not aware of client A acting in this manner before. Staff #1 stated "If clothes wet, will strip in a moments notice. Wants something dry on." When asked if client A removed her bra, staff #1 stated, "Only if wet. She will put clothes back on." Staff #1 stated client A masturbated "behind closed doors and not in public." Staff #1 indicated client A did not remove her clothes/shirt to his knowledge when he was in the group home on 10/16/11. "Easily redirects." Staff #1 indicated he</p>				

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	<p>was the on-call Qualified Mental Retardation Professional-Designee (QMRP-D) on 10/16/11. Staff #1 indicated he was at the group home on 10/16/11 from 11 AM to 1:30 PM and then went to one of the other group homes (across the street) from 1:30 PM to 3:00 PM. Staff #1 indicated 3 staff were in the group home when he left, staff #3, #4 and staff #5. Staff #1 indicated it was staff #5's first day at the group home and he was told to find her some hours to work at one of the group homes. Staff #1 indicated staff #5 came into work at 1:00 PM and he reviewed the clients' IPPs with her before he left. Staff #1 stated staff #5 should have "shadowed staff." Staff #1 indicated staff #3 had only worked 2 to 3 weeks in the group home, staff #4 had just worked 3 to 4 shifts in the group home and it was staff #5's first day at the group home. When asked if working all new staff was a good idea, staff #1 indicated staff #2 was coming in at 4:00 PM and he did not think there would be any problems for the short period they were left alone. Staff #1 indicated he was new to the position of QMRP-D and still being trained. Staff #1 did not know what time the inappropriate behavior/conduct started.</p> <p>Interview with administrative staff #3 and #4 on 10/18/11 at 9:50 AM indicated the</p>				

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	<p>facility terminated staff #3 on 10/17/11. Administrative staff #3 and #4 indicated staff #3 was first hired in 2/3/11 for a waived home. Administrative staff #4 indicated the staff was terminated in 5/11 due to an accident and no FMLA (Family Medical Leave). The administrative staff indicated staff #3 was rehired on 9/27/11. Administrative staff #4 indicated staff #3 did not have any work references just personal references.</p> <p>Interview with staff #8 on 10/18/11 at 1:38 PM indicated she worked from 6 AM to 11 AM on 10/16/11. Staff #8 indicated she had worked with staff #3 on 10/15/11. Staff #8 stated staff #3 did not know what to do and "He would sit back and wait until we told him what to do." Staff #8 indicated staff #3 sat in the recliner in the living room and did not get up to get clients when they went to the door. Staff #8 indicated staff #3 was told to give client C a shower on 10/15/11. Staff #8 stated "He was right behind me when I was washing dishes. Felt uncomfortable." Staff #8 stated staff #3 was "too close."</p> <p>Interview with staff #7 on 10/18/11 at 2:22 PM indicated he had worked with client A for over 4 years. Staff #7 indicated client A would remove her clothes if they were wet or she had</p>				

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	<p>something on her clothes. Staff #7 indicated client A did not masturbate in public places only in her bedroom. Staff #7 stated "[Client A] does not intentionally try to lay on anybody."</p> <p>Interview with staff #5 on 10/18/11 at 2:38 PM indicated she worked on 10/16/11 from 1 PM to 11 PM. Staff #5 indicated 10/16/11 was her first day working at the group home. Staff #5 indicated she was in the back room with client F watching football on TV. Staff #5 indicated she also did 8 to 10 loads of laundry while working. Staff #5 indicated she did not know what was going on in the living room of the group home as she was in the TV room. When asked if staff #5 saw client A without a shirt and/or bra, staff #5 indicated she saw client A come from the back of the house without a shirt, but a staff took the client back to her room to put the shirt on. Staff #5 indicated staff #4 did not ask her for assistance.</p> <p>Interview with administrative staff #1 and staff #2 on 10/18/11 at 3:20 PM indicated they had learned through interviews other clients were present in the living room besides client E when staff #3 did not redirect client A's behavior and allowed the client to lay/lean on him and masturbate. Administrative staff #1 and #2 indicated the facility had terminated</p>				

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	<p>staff #3 and placed a second staff on the night shift due to the staff's threats against staff #4 to ensure staff and the clients' protection. Administrative staff #1 and #2 indicated the facility had not put any additional measures in place to monitor/supervise staff to ensure the staff performed their duties to prevent potential harm to clients as all 3 staff were new to the group home (one behaving in an inappropriate manner, one did not know what to do and the other was disgruntled and refusing to work). Administrative staff #1 and #2 indicated staff #3, #4 and #5 were new staff to the group home and the facility should have had a "seasoned" staff working with them. The administrative staff indicated staff #4 had not been formally retrained and the facility did not have documentation the staff was verbally retrained by administrative staff #2. Administrative staff #1 and #2 indicated no facility staff had been retrained on reporting concerns/abuse/neglect. Administrative staff #2 stated staff #5 should have been "shadowing staff" on 10/16/11. Administrative staff #1 and #2 indicated client A's 6/11 IPP and/or BSP indicated the facility neglected to address the client's identified need of disrobing/removal of clothes. Administrative staff #2 indicated staff #3 was trained by the QMRP-D on client</p>			

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	<p>specific training/goals/plans.</p> <p>Administrative staff #2 indicated they did not have documentation of the training as a generic training was located in the staff's training record with no name and/or date of training documented on the form.</p> <p>Interview with the Director of Nursing on 10/18/11 at 4:50 PM indicated client A's Hymen was still intact.</p> <p>Interview with the guardian on 10/19/11 at 5:08 PM indicated client A did not masturbate with others. Client A's guardian stated client A was not a "touchy person so this concerned her." Client A's guardian indicated client A did not disrobe as "sexual behavior" but only when her clothes were wet. Client A's guardian was concerned about the staff's conduct and interactions with client A.</p> <p>Personnel records were reviewed on 10/18/11 at 9:10 AM. Staff #3's personnel record indicated the facility neglected to obtain work references for staff #3 as only 3 personal references had been obtained. Staff #3's personnel record indicated the staff was re-hired on 9/27/11.</p> <p>The facility's 10/11 Time schedules/records were reviewed on 10/18/11 at 11:46 AM. The facility's</p>				

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	<p>10/11 time records indicated staff #3 had worked in the group home on 10/12/11 (3 PM to 10 PM), 10/13/11 (3 PM to 9 PM), 10/14/11 (3 PM to 9 PM), 10/15/11 (10 AM to 10 PM) and on 10/16/11 (10 AM to 8 PM). The facility's 10/11 time schedules/records did not indicate staff #5 was scheduled and/or worked in the home on 10/16/11.</p> <p>The facility's training records were reviewed on 10/18/11 at 4:05 PM. The facility's Employee Training Records indicated the facility had neglected to train staff #3 on each client's IPPs and/or behavior plans. Staff #4's training records indicated the facility staff was trained on reporting allegations of abuse/neglect/concerns on 9/12/11.</p> <p>The facility's policy and procedures were reviewed on 10/17/11 at 2:15 PM. The facility's 10/1/11 policy entitled Neglect, Abuse, Battery, Exploitation Policy and Incident Reporting/Investigatory Procedure indicated the purpose of the policy was "To provide all staff, employees and volunteers with an understanding of abuse, and with guidelines to follow in the event abuse, neglect, battery or exploitation is suspected." The 10/1/11 policy indicated "...Neglect, abuse, battery or exploitation of any KCARC (Knox County</p>				

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	Association for Retarded Citizens) consumer by any person will not be tolerated...Any involvement in perpetrating battery, exploitation, material abuse, neglect, physical abuse, psychological abuse, self-neglect or sexual abuse...or any failure to report, in accordance to the following requirements, may be grounds for disciplinary action up to and/or termination...." The 10/1/11 policy indicated "...Any staff, employee or volunteer who suspects or knows or to whom a consumer has made an allegation that neglect, abuse, battery, exploitation has occurred or identifies an injury of unknown origin, shall report immediately, either by telephone or in person to the home's pager phone, or QMRP designee. Reports of allegations after office hours are reported to the designated phone number. Persons answering the pager will notify the QMRP, who will notify upper management personnel deemed necessary. When any level of management is not available to receive a report, the witness/supervisor reporting is to report to the next level of authority. The top level of authority or designee will report the incident to BDDS (Bureau of Developmental Disabilities Services) immediately and to Adult Protective Services...as appropriate...." The 10/1/11 policy defined "Abuse refers to the ill treatment, violation, to speak abusively,				

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	<p>slandorous defamation, exploitation and/or otherwise disregard of a consumer, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator...." The facility's policy indicated the following behaviors constituted abuse (not all inclusive):</p> <p>"...j. Purposely and continually ignoring a consumer who needs assistance/supervision...Failing to implement and document Individual Program Plans including training/behavioral objectives and behavioral programs...Failure to intervene when indicated (i.e., neglect)...Monitoring systems that are absent or are inadequate to prevent such incidents;...Staff who have knowledge of any questionable activity, MUST report the activity to a member of the management staff immediately...."</p> <p>2. The facility failed to ensure the staff reported all concerns and/or allegations immediately to the administrator involving client A. Please see W153.</p> <p>This federal tag relates to complaint #IN00098580.</p> <p>9-3-2(a)</p>				

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W0153	<p>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.</p> <p>Based on interview and record review for 1 of 4 allegations of abuse and/or neglect reviewed for client A, the facility failed to ensure staff reported all concerns and/or allegations immediately to the administrator in accordance with state law.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/17/11 at 3:45 PM. The facility's 10/16/11 reportable incident report indicated "On 10-16-2011, it was reported to the Director of Residential Services by [staff #2], that [staff #2] had observed [client A] lying on staff [staff #3] on the couch in the living room. [Client A] was reportedly wearing a bra but no shirt. Furthermore, [staff #2] reported that staff [staff #4] observed [client A] lying on staff [staff #3] while [client A] was masturbating. [Staff #4] reportedly attempted to redirect the behavior more than once. [Staff #3] reportedly refused to allow the behavior to be redirected. Consumer [client E] reportedly observed the behavior...."</p>	W0153	<p>W153</p> <p>Plan of Correction: Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. The staff who did not report immediately has been disciplined and has received hands-on retraining for two weeks with an individual who has at least one year QMRP/QMRP-D and/or Group Home Management experience and at least 2 years of group home experience. An evaluation has been completed using our 70-day evaluation form. She met expectations on all performance criteria. It was determined she was ready to work without constant supervision but will be supervised by someone meeting the above requirements for at least two partial shifts per week until it is determined the staff no longer requires this level of supervision due to her improved performance.</p> <p>Preventive Action: Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting</p>	11/23/2011	

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	An attached 10/17/11 email indicated a police report was filed with the local sheriff's department on 10/17/11. An attached 10/17/11 Voluntary Statement by staff #2 indicated "Arrived at work around 4 pm and as soon as I walked into the door I saw [client A] without a shirt on sitting on the couch and leaning on [staff #3]. Before I could say or do anything [staff #4] took me outside to fill me in on what had/was happening. She, [staff #4] then proceeded to tell me that [client A] had started to strip, which is not uncommon for her to do, and also started to touch herself while sitting on the couch leaned up next to [staff #3]. [Staff #4] then said she tried to redirect [client A] back to her room to get clothes on her but that [staff #3] had said no and the (sic) he could handle it and doesn't mind what [client A] was doing. After [staff #4] finished telling me what happened I walked back inside, saw that [client A] and [staff #3] had not moved, put my stuff up in the kitchen and then went to confront [staff #3]. When I went to confront [staff #3] he had already gotten up and took [client A] to the back and proceeded to get her dressed. From that point on I made sure [client A] was not around him and in my eyesight as I communicated with [administrative staff #2] over the phone what all happened		<p>Procedures. The staff who did not report immediately has been disciplined and has received hands-on retraining for two weeks with an individual who has at least one year QMRP/QMRP-D and/or Group Home Management experience and at least 2 years of group home experience. An evaluation has been completed using our 70-day evaluation form. She met expectations on all performance criteria. It was determined she was ready to work without constant supervision but will be supervised by someone meeting the above requirements for at least two partial shifts per week until it is determined the staff no longer requires this level of supervision due to her improved performance.</p> <p>Monitoring: The QMRP-D, QMRP and/or Assistant Manager will monitor the home at least five days per week. During this time, the QMRP-D, QMRP and/or Assistant Manager will use every opportunity to train staff on reporting appropriately and immediately. The QMRP, QMRP-D and/or Assistant Manager will provide hands-on training to staff.</p> <p>Responsible Party: Vice President of Program Services, Director of Residential Services, QMRP, QMRP-D, Assistant</p>	

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	(sic)." Interview with administrative staff #2 on 10/17/11 at 4:38 PM and on 10/18/11 at 10:12 AM and 10:24 AM indicated the sheriff/police was at the facility due to an incident involving staff #3 and client A on 10/16/11. Administrative staff #2 indicated the facility was in the process of conducting an investigation in regard to sexual abuse regarding an incident on 10/16/11. Administrative staff #2 indicated the facility terminated staff #3 on 10/17/11 after two staff saw client A without a shirt and/or bra masturbating while laying/leaning on staff #3. Administrative staff #2 indicated staff #3 did not redirect the client to stop and refused to allow staff #4 to redirect client A to her bedroom. When asked how long the incident occurred before staff called administrative staff, administrative staff #2 stated "Occurred with a half hour period from start to finish." Administrative staff #2 indicated staff #4 did not report the inappropriate conduct of staff but did tell the next staff who came on duty who called her (administrative staff #2). Administrative staff #2 indicated staff #4 did not report staff #3's conduct/behavior until the evening shift staff came in at 4:00 PM. Administrative staff #2 indicated staff #4 then informed staff #2, her peer. Administrative staff #2		Manager Date to Be Completed by: November 23, 2011		

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	<p>stated staff #4 did not call anyone as she was "very shook up." Administrative staff #2 stated she "informally" counseled staff #4 about reporting all concerns/allegations to the administrator immediately. Administrative staff #2 indicated staff #4 stated "I should have called."</p> <p>Interview with staff #4 on 10/17/11 at 6:37 PM stated she had been having "trouble" with one of the staff (staff #3). Staff #4 indicated staff #3 and #5 also worked on 10/16/11. Staff #4 indicated staff #3 sat in the recliner and/or on the couch during the entire shift except to give 3 female clients (B, C and H) baths and to feed client C at lunch. Staff #4 indicated staff #5 stayed in the small TV room and did not assist with any client care. Staff #4 indicated all the clients were in the living room except client F who was in bed taking a nap after lunch. Staff #4 indicated client G was gone out with her parents. Staff #4 indicated client A was sitting on the couch leaning over with her eyes closed on the arm of the couch. Staff #4 indicated she prompted client A to sit up or go lay down in her bed to sleep. Staff #4 indicated client A sat up for 1 to 2 minutes when staff #3 got up out the recliner and went to sit next to client A on the couch. Staff #4 stated "She (client A) was ok and then all of</p>				

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	sudden she laid over on him. I have never seen her do that. She was moving her face up and down his arm. He did not stop her. I tried to redirect her to her room. He said she was fine." Staff #4 indicated she then went into the kitchen as client B was getting into things in the kitchen. Staff #4 indicated she gave clients A and B a snack (cookies). Staff #4 stated once client A finished her cookies, the client "laid back down on him. She put her hands down her pants and started masturbating. He gave me a funny look. He did not redirect her." Staff #4 stated client A laid her head down near staff #3's elbow area and continued to "play with herself. She (client A) sits back up. Really going to town with masturbating and rubbing his arm with her free hand. I told him she really needs to go to her room. He said nothing." Staff #4 indicated client A then took her shirt off and she put the shirt back on the client. Staff #4 indicated she then had to go to the kitchen to get client B who was going through items in the kitchen. Staff #4 indicated client A got up and went to the back of the house on her own and staff #4 returned to the recliner. Staff #4 indicated client A came back to the front of the house with no shirt and/or bra on. Staff #4 indicated she redirected client A to put her bra on but client A walked into the living room and sat down			

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	<p>on the couch before she could get her shirt on. Staff #4 indicated she went back to the kitchen as client B was back in the kitchen. Staff #4 indicated when she returned to the living room, staff #3 got up from the recliner and went sat next to client A on the couch who had a bra on but did not have her shirt on. Staff #4 stated she walked over to client A to assist the client to go back to her bedroom when staff #3 "puts his arm up to stop me and told me she was fine." When asked how staff #3 stopped her, staff #4 demonstrated the action. Staff #4 lifted her arm and moved it in a swaying motion from left to right. When asked where staff #5 was, staff #3 indicated the staff was in the small TV room. Staff #4 indicated she told staff #5 she needed help at one point. Staff #4 stated "She (staff #5) never came out of the room." Staff #4 stated "I was very uncomfortable and did not know what to do." Staff #4 stated client A "laid" on staff #3 when the staff person came and sat next to her on the couch the second time. When asked how client A laid on staff #3, staff #4 stated, "She laid her head over on staff #3's lap near his abdomen area "like a pillow." Staff #4 stated she told staff #3 to redirect client A to her bedroom "2 to 4 times." Staff #4 stated "He (staff #3) just giggled or laughed." Staff #4 stated "He was comfortable with it (client A laying on</p>				

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	<p>him and masturbating)." Staff #4 indicated staff #3 came in at 11:00 AM to work. When asked when all this took place, staff #4 indicated it was after lunch around 2:00 PM. Staff #4 indicated she was due to leave at 3:00 PM. Staff #4 indicated she told staff #2 what happened when he came in to work at 3:00 PM. Staff #4 indicated she thought the incident lasted about 45 minutes to 1 hour before staff #2 came into work. Staff #4 stated "I was relieved to see him (staff #2)." Staff #4 indicated client A would remove her clothes in her room and not in front of others. Staff #4 indicated the other clients were present in the living room when the incident/inappropriate conduct occurred. Staff #4 indicated client A did not like to be touched. When asked why she did not call anyone when this was going on, staff #4 stated "I was dumbfounded. I was the only one here with 3 staff. I had no help. I tried to monitor clients. I could not leave to use the phone and go out. I was so in shock at what I saw. I was brain dead." Staff #4 indicated she should have called someone when it occurred. Staff #4 indicated staff #2 called the office after he came into work.</p> <p>This federal tag relates to complaint #IN00098580.</p> <p>9-3-2(a)</p>			

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W0189	<p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to ensure staff were re-trained to report all concerns and/or allegations to the administrator immediately to prevent abuse, neglect and/or exploitation, and/or to ensure all staff were trained in regard to clients' program plans/behavior plans prior to working with clients.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/17/11 at 3:45 PM. The facility's 10/16/11 reportable incident report indicated "On 10-16-2011, it was reported to the Director of Residential Services by [staff #2], that [staff #2] had observed [client A] lying on staff [staff #3] on the couch in the living room. [Client A] was reportedly wearing a bra but no shirt. Furthermore, [staff #2] reported that staff [staff #4] observed [client A] lying on staff [staff #3] while [client A] was masturbating. [Staff #4] reportedly attempted to redirect the behavior more than once. [Staff #3] reportedly refused to</p>	W0189	<p>W189</p> <p>Plan of Correction: A policy for bathing consumers will be developed. Staff will be trained on this policy. Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. Administrative staff will be retrained on beginning abuse/neglect investigations immediately, taking immediate action to protect consumers, putting in place additional corrective action measures to prevent any potential abuse of clients and acknowledging the immediacy of abuse/neglect allegations. All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior plan. Staff will be retrained on recognizing and reporting new behaviors immediately. A seasoned staff (worked in the home at least 3 months) will be scheduled on each shift when consumers are awake. If a seasoned staff cannot be present, the QMRP or QMRP-D</p>	11/23/2011

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	<p>allow the behavior to be redirected....."</p> <p>An attached 10/17/11 email indicated a police report was filed with the local sheriff's department on 10/17/11. An attached 10/17/11 Voluntary Statement by staff #2 indicated "Arrived at work around 4 pm and as soon as I walked into the door I saw [client A] without a shirt on sitting on the couch and leaning on [staff #3]. Before I could say or do anything [staff #4] took me outside to fill me in on what had/was happening. She, [staff #4] then proceeded to tell me that [client A] had started to strip, which is not uncommon for her to do, and also started to touch herself while sitting on the couch leaned up next to [staff #3]. [Staff #4] then said she tried to redirect [client A] back to her room to get clothes on her but that [staff #3] had said no and the (sic) he could handle it and doesn't mind what [client A] was doing. After [staff #4] finished telling me what happened I walked back inside, saw that [client A] and [staff #3] had not moved, put my stuff up in the kitchen and then went to confront [staff #3]. When I went to confront [staff #3] he had already gotten up and took [client A] to the back and proceeded to get her dressed. From that point on I made sure [client A] was not around him and in my eyesight as I communicated with [administrative staff</p>		<p>will be present. The QMRP, QMRP-D or Assistant Manager will do at least one unannounced third shift check at least once per month. A thorough investigation will be completed on Client G. The staff who did not report immediately has been disciplined and has received hands-on retraining for two weeks with an individual who has at least one year QMRP/QMRP-D and/or Group Home Management experience and at least 2 years of group home experience. An evaluation has been completed using our 70-day evaluation form. She met expectations on all performance criteria. It was determined she was ready to work without constant supervision but will be supervised by someone meeting the above requirements for at least two partial shifts per week until it is determined the staff no longer requires this level of supervision due to her improved performance.</p> <p>Preventive Action: A policy for bathing consumers will be developed. Staff will be trained on this policy. Staff will be retrained on the Abuse/Neglect/Exploitation policy, Consumer Rights Policy, and Reportable Incident Reporting Procedures. Administrative staff will be retrained on beginning abuse/neglect investigations immediately, taking immediate</p>				

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	<p>#2] over the phone what all happened (sic)."</p> <p>During the 10/17/11 observation period between 5:17 PM and 8:20 PM at the group home, staff #4 was working in the group home.</p> <p>Interview with administrative staff #2 on 10/17/11 at 4:38 PM and on 10/18/11 at 10:12 AM and 10:24 AM indicated the sheriff/police was at the facility due to an incident involving staff #3 and client A on 10/16/11. Administrative staff #2 indicated the facility was in the process of conducting an investigation in regard to sexual abuse regarding an incident on 10/16/11. Administrative staff #2 indicated the facility terminated staff #3 on 10/17/11 after two staff saw client A without a shirt and/or bra masturbating while laying/leaning on staff #3. Administrative staff #2 indicated staff #3 did not redirect the client to stop and refused to allow staff #4 to redirect client A to her bedroom. Administrative staff #2 indicated client A did not have a history of masturbating in public/common areas. The administrative staff indicated client A masturbated in her bedroom alone. Administrative staff #3 indicated three staff were working at the time the incident occurred on 10/16/11. One staff was at the back of the house and did not</p>		<p>action to protect consumers, putting in place additional corrective action measures to prevent any potential abuse of clients and acknowledging the immediacy of abuse/neglect allegations. All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior plan. Staff will be retrained on recognizing and reporting new behaviors immediately. A seasoned staff (worked in the home at least 3 months) will be scheduled on each shift when consumers are awake. If a seasoned staff cannot be present, the QMRP or QMRP-D will be present. The QMRP, QMRP-D or Assistant Manager will do at least one unannounced third shift check at least once per month. A thorough investigation will be completed on Client G. All new hires/transfers will receive consumer specific training prior to being responsible for consumers in the home. KCARC has a standard of retraining on Consumer Rights, Abuse/Neglect etc annually and as deemed necessary. KCARC will continue this standard.</p> <p>Monitoring: The QMRP-D, QMRP and/or Assistant Manager will monitor the home at least five</p>				

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	<p>see anything, and the perpetrator was sitting on the couch with client A while the other staff was attempted to redirect client A and watch the other clients in the group home. When asked how long the incident occurred before staff called administrative staff, administrative staff #2 stated "Occurred with a half hour period from start to finish."</p> <p>Administrative staff #2 indicated staff #4 did not report the inappropriate conduct of staff but did tell the next staff who came on duty who called her (administrative staff #2). Administrative staff #2 indicated staff #4 did not report staff #3's conduct/behavior until the evening shift staff came in at 4:00 PM. Administrative staff #2 indicated staff #4 then informed staff #2, her peer. Administrative staff #2 stated staff #4 did not call anyone as she was "very shook up." Administrative staff #2 stated she "informally" counseled staff #4 about reporting all concerns/allegations to the administrator immediately. Administrative staff #2 indicated staff #4 stated "I should have called." The administrative staff indicated the facility had not formally retrained staff #4 on reporting. Administrative staff #2 indicated all staff at the group home would be retrained on abuse and neglect when the investigation was completed.</p> <p>The facility's training records were</p>		<p>days per week. During this time, the QMRP-D, QMRP and/or Assistant Manager will use every opportunity to train staff on reporting appropriately and immediately. The QMRP, QMRP-D and/or Assistant Manager will provide hands-on training to staff. The QMRP and QMRP-D will monitor all scheduling to ensure a seasoned staff or QMRP-D is scheduled.</p> <p>Responsible Party: Vice President of Program Services, Director of Residential Services, QMRP, QMRP-D, Assistant Manager Date to Be Completed by: November 23, 2011</p>				

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W0227	<p>reviewed on 10/18/11 at 4:05 PM. The facility's Employee Training Records indicated the facility did not train staff #3 on each client's IPPs and/or behavior plans. Staff #4's training records indicated the facility staff was trained on reporting allegations of abuse/neglect/concerns on 9/12/11. Staff #4's training records did not indicate the facility documented and/or retrained staff #4 on reporting allegations and/or concerns immediately.</p> <p>This federal tag relates to complaint #IN00098580.</p> <p>9-3-3(a)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review for 1 of 4 sampled clients (A), the client's Individual Support Plan (IPP) failed to address the client's identified behavioral/training need.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/17/11 at 3:45 PM. The facility's 10/16/11 reportable incident report</p>	W0227	<p>W227</p> <p>Plan of Correction: All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior plan. Staff will be retrained on recognizing and reporting new behaviors immediately. The QRMP-D and QMRP will be</p>	11/23/2011			

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	<p>indicated "On 10-16-2011, it was reported to the Director of Residential Services by [staff #2], that [staff #2] had observed [client A] lying on staff [staff #3] on the couch in the living room. [Client A] was reportedly wearing a bra but no shirt. Furthermore, [staff #2] reported that staff [staff #4] observed [client A] lying on staff [staff #3] while [client A] was masturbating. [Staff #4] reportedly attempted to redirect the behavior more than once. [Staff #3] reportedly refused to allow the behavior to be redirected...."</p> <p>The facility's 10/17/11 attached witness statement by staff #3 indicated client A had sat down next to staff #3 on the couch and placed her (client A's) hands down inside her pants. Staff #3's witness statement indicated he asked staff #4 what he should do. The witness statement indicated staff #3 indicated staff #4 tried to redirect client A to her bedroom. The 10/17/11 witness statement indicated "...She did take her bra off repeatedly and her shirt. Finally, I just left her bra on. I more or less asked the staff is that ok and it seemed okay."</p> <p>Interview with staff #2 on 10/17/11 at 6:15 PM and on 10/18/11 at 11:15 AM indicated he had worked at the group home since 8/1/11. Staff #2 indicated he worked on 10/16/11 from 4 PM to</p>		<p>retrained on addressing all concerns identified in the functional assessments or that arise after the completion of the functional assessments. These concerns will be addressed in each individual's plan. Client A's behavior plan has been revised to include taking her clothes off and masturbating in public. All targeted behaviors will be added to Client A's IPP.</p> <p>Preventive Action: All behavior plans will be reviewed/revise to ensure that all targeted behaviors are addressed. Staff will be retrained on all consumer behavior plans. The QMRP/QMRP-D will be retrained on recognizing when it is appropriate to revise a behavior plan. Staff will be retrained on recognizing and reporting new behaviors immediately. The QRMP-D and QMRP will be retrained on addressing all concerns identified in the functional assessments or that arise after the completion of the functional assessments. These concerns will be addressed in each individual's plan.</p> <p>Monitoring: The QMRP-D, QMRP and/or Assistant Manager will monitor the home at least five days per week. During this time, the QMRP-D, QMRP and/or Assistant Manager will use every opportunity to train staff on reporting appropriately and</p>		

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	<p>midnight. Staff #2 indicated he arrived at the group home at 4:00 PM. Staff #2 stated "As soon as I walked into the house, [client A] had her shirt off and was sitting on the couch." Staff #2 stated he did not think that was "unusual" as client A would remove her shirt if it was wet.</p> <p>Interview with staff #4 on 10/17/11 at 6:37 PM indicated client A was sitting on the couch leaning over with her eyes closed on the arm of the couch. Staff #4 indicated she prompted client A to sit up or go lay down in her bed to sleep. Staff #4 indicated client A sat up for 1 to 2 minutes when staff #3 got up out the recliner and went to sit next to client A on the couch. Staff #4 stated "She (client A) was ok and then all of sudden she laid over on him. I have never seen her do that. She was moving her face up and down his arm. He did not stop her. I tried to redirect her to her room. He said she was fine." Staff #4 indicated she then went into the kitchen as client B was getting into things in the kitchen. Staff #4 indicated she gave clients A and B a snack (cookies). Staff #4 stated once client A finished her cookies, the client "laid back down on him. She put her hands down her pants and started masturbating. He gave me a funny look. He did not redirect her." Staff #4 stated client A laid her head down near staff #3's elbow area and</p>		<p>immediately. The QMRP, QMRP-D and/or Assistant Manager will provide hands-on training to staff (including training on identifying new behaviors and/or other issues that need to be reported to the QMRP/QMRP-D). The QMRP and QMRP-D will monitor all scheduling to ensure a seasoned staff or QMRP-D is scheduled.</p> <p>Responsible Party: Vice President of Program Services, Director of Residential Services, QMRP, QMRP-D, Assistant Manager Date to Be Completed by: November 23, 2011</p>		

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	<p>continued to "play with herself. She (client A) sits back up. Really going to town with masturbating and rubbing his arm with her free hand. I told him she really needs to go to her room. He said nothing." Staff #4 indicated client A then took her shirt off and she put the shirt back on the client. Staff #4 indicated she then had to go to the kitchen to get client B who was going through items in the kitchen. Staff #4 indicated client A got up and went to the back of the house on her own and staff #4 returned to the recliner. Staff #4 indicated client A came back to the front of the house with no shirt and/or bra on. Staff #4 indicated she redirected client A to put her bra on but client A walked into the living room and sat down on the couch before she could get her shirt on. Staff #4 indicated she went back to the kitchen as client B was back in the kitchen. Staff #4 indicated when she returned to the living room, staff #3 got up from the recliner and went sat next to client A on the couch who had a bra on but did not have her shirt on.</p> <p>Interview with client C on 10/17/11 at 7:15 PM and on 10/18/11 at 11:55 AM indicated client C could answer yes/no questions by nodding her head, saying yes and/or lifting her hand for no. Client C indicated client C was in the living room on 10/16/11. Client C indicated she saw</p>				

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN47591		
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	<p>client A remove her shirt in the living room.</p> <p>Interview with staff #6 on 10/17/11 at 7:06 PM indicated client A would remove her shirt in her bedroom but not out in common areas of the group home. Staff #6 indicated client A would remove her shirt if had something on it or got wet.</p> <p>Interview with staff #1 on 10/17/11 at 7:50 PM and on 10/18/11 at 5:10 PM stated "If clothes wet, will strip in a moments notice (client A). Wants something dry on." When asked if client A removed her bra, staff #1 stated, "Only if wet. She will put clothes back on." Staff #1 stated client A masturbated "behind closed doors and not in public. Staff #1 indicated client A did not remove her clothes/shirt to his knowledge when he was in the group home on 10/16/11. "Easily redirects."</p> <p>Interview with staff #7 on 10/18/11 at 2:22 PM indicated client A would remove her clothes if they were wet or she had something on her clothes. Staff #7 indicated client A did not masturbate in public places only in her bedroom.</p> <p>Interview with staff #5 on 10/18/11 at 2:38 PM indicated she saw client A come from the back of the house without a shirt,</p>				

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W0331	<p>but a staff took the client back to her room to put the shirt on.</p> <p>Interview with administrative staff #1 and staff #2 on 10/18/11 at 3:20 PM indicated client A's 6/11 IPP and/or Behavior Support Plan (BSP) did not address the client's identified need of disrobing/removal of clothes.</p> <p>Interview with the guardian on 10/19/11 at 5:08 PM indicated client A did not masturbate with others. Client A's guardian indicated client A did not disrobe as "sexual behavior" but only when her clothes were wet.</p> <p>Client A's record was reviewed on 10/17/11 at 3:25 PM. Client A's 5/23/11 Functional Assessment indicated client A would sometimes "expose herself" and refuse to wear clothing. Client A's 6/10/11 IPP and/or 6/8/11 Behavior Plan indicated the facility did not address client A's identified need of removing her clothes/exposing herself.</p> <p>This federal tag relates to complaint #IN00098580.</p> <p>9-3-4(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p>				

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	<p>Based on interview and record review for 1 additional client G, the facility's nursing services failed to document an assessment of the client timely. The nursing services also failed to ensure the client's record contained updated nurse monthly notes of the client's health status.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/21/11 at 10:10 AM. The facility's 10/18/11 reportable incident report indicated "[Client G] was sent to the ER (emergency room) with vaginal discharge and itching. The hospital did not give any medications and [client G] is to follow-up with family doctor for OB (obstetric and gynecological) consult and to return if any problems. The staff will follow the instructions of the hospital and report any changes to the nurse."</p> <p>Client G's record was reviewed on 10/21/11 at 10:15 AM. Client G's record indicated the last nurse monthly review of the client's health status in the chart was dated 6/2011. Client G's record did not indicate any recent assessments and/or notes in regard to the client's health status.</p> <p>Interview with LPN #1 and LPN #2 on 10/21/11 at 10:40 AM indicated client G</p>			W0331	<p>W331</p> <p>Plan of Correction: The nursing department will be retrained on completing/filing nursing notes and assessments in a timely manner. The Medical Assistants will be trained to file these documents appropriately and in a timely manner.</p> <p>Preventive Action: The nursing department will be retrained on completing/filing nursing notes and assessments in a timely manner</p> <p>Monitoring: The Director of Health Services will monitor that nursing notes and assessments are completed in a timely manner. The Medical Assistants will monitor that they are filed in a timely manner. The Director of Health Services will be trained to monitor that nursing notes and assessments are completed in a timely manner by meeting with her staff on a daily basis (5 days per week) to review any health-related issues. The Director of Health Services will monitor the completion of nursing notes and assessments at this time. The Medical Assistants will be trained to file these documents appropriately and in a timely manner. The Director of Health Services will do spot checks of files to ensure proper procedures are being followed when filing nursing notes and assessments.</p>		11/23/2011

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W9999	<p>did not have a history/problem with vaginal discharge. LPN #1 stated she (LPN #1) went to the group home to assess client G and the client had "1 teaspoon" of clear discharge with no odor. LPN #1 stated the vaginal discharge was "a lot." When asked where LPN #1 documented her 10/18/11 assessment of client G, LPN #1 indicated she had not yet documented her 10/18/11 assessment of the client as of 10/21/11. LPN #1 indicated she did not feel the discharge meant anything, but she sent the client to ER (emergency room) due to the 10/17/11 incident which occurred in the home with client A. LPN #1 indicated client G had nurse monthly reviews for 7/11, 8/11 and 9/11. LPN #1 indicated she did not know why client G's monthly nurse reviews were not in the client's record.</p> <p>Interview with administrative staff #2 on 10/21/11 at 10:47 AM indicated client G's nursing notes/monthlies may be waiting to be scanned into the computer. Administrative staff #2 indicated client G's monthly notes should have been in the client's record.</p> <p>9-3-6(a)</p> <p>STATE FINDINGS:</p>	W9999	<p>Responsible Party: Director of Health Services, Nurse, Medical Assistant Date to Be Completed by: November 23, 2011</p>	11/23/2011	

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	<p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met. 460 IAC 9-3-2 Resident Protections</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC. 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on interview and record review for 1 of 4 personnel records reviewed (staff #3), the facility failed to obtain a reference in regard to a staff's employment/work as the staff only had 3 personal references.</p> <p>Findings include:</p> <p>Personnel records were reviewed on 10/18/11 at 9:10 AM. Staff #3's personnel record indicated the facility neglected to obtain work references for staff #3 as only 3 personal references had</p>		<p>Plan of Correction: Human Resources will be retrained on ensuring they have at least on work reference in addition to two personal references prior to hiring a new staff. Human Resources will be retrained on recognizing that mere verification of employment dates by previous employers does not constitute a reference in compliance with this section.</p> <p>Preventive Action: Human Resources will be retrained on ensuring they have at least on work reference in addition to two personal references prior to hiring a new staff. Human Resources will be retrained on recognizing that mere verification of employment dates by previous employers does not constitute a reference in compliance with this section.</p> <p>Monitoring: The Director of Human Resources will monitor the completion of appropriate reference checks.</p> <p>Responsible Party: Director of Residential Services, Director of Human Resources Date to Be Completed by: November 23, 2011</p>		

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	<p>been obtained. Staff #3's personnel record indicated the staff was re-hired on 9/27/11.</p> <p>Interview with administrative staff #3 and #4 on 10/18/11 at 9:50 AM indicated the facility terminated staff #3 on 10/17/11. Administrative staff #3 and #4 indicated staff #3 was first hired in 2/3/11 for a waived home. Administrative staff #4 indicated the staff was terminated in 5/11 due to an accident and no FMLA (Family Medical Leave). The administrative staff indicated staff #3 was rehired on 9/27/11. Administrative staff #4 indicated staff #3 did not have any work references just personal references.</p> <p>This state rule relates to complaint #IN00098580.</p> <p>9-3-2(c)</p>				