

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN 47201
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00174900.</p> <p>Complaint #IN00174900: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154 and W157.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: 6/9, 6/10 and 6/16/15.</p> <p>Facility Number: 000630 Provider Number: 15G090 AIM Number: 100233920</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 2 additional clients (E and F). The governing body failed to ensure clients B and D were not neglected and/or</p>	W 0102	In order to correct this deficiency, body checks have been implemented for clients A, B, C, D, E and F. These checks are done in the morning when the clients enter the day program and in the afternoon when they return from day program. The staff will	07/16/2015

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

TITLE

(X6) DATE

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

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	<p>abused. The facility's governing body failed to ensure the facility developed a written policy and/or procedure which governed how the facility would utilize surveillance cameras, within the group home, to ensure clients were protected from abuse and/or neglect, and to ensure the facility monitored incident reports for patterns and/or trends. The facility's governing body failed to ensure facility staff reported allegations of abuse/neglect immediately to the administrator for client B and conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D and E. The facility's governing body failed to ensure corrective measures were put in place to monitor client B's injury of unknown source.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients A, B, C, D, E and F. The governing body failed to implement its written policy and procedures to prevent abuse and/or neglect of clients. The governing body failed to ensure its staff immediately reported all concerns/allegations of abuse, neglect and/or injuries of unknown source to the</p>		<p>then record any findings in the medical communication log and communicate any findings to the county QIDP and the day program manager. They will note what they found or note that they found nothing. An in-service training for house staff will be held on 7/14/15. The staff will be instructed that any possible allegations of ANE are to be reported to the QIDP or available supervisor within 30 minutes. All QIDPs will be re-trained on DSI's policy and procedures regarding ANE reporting on 7/15/15. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. Also, in order to better track adverse trends within the department, it has been decided that all DSI departments will utilize a real time tracking program that will be available to all program managers. The tracking report will inform any interested party the presence of any trends. Program managers will review the tracking report on a daily basis. DSI regional managers will ensure that the tracking system is accurate by conducting weekly spot audits. Any trend or pattern seen within the tracking report will be investigated immediately. The agency is also in the process of updating our video surveillance system as well as video</p>	

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	<p>administrator immediately. The governing body failed to ensure the facility conducted/documented thorough investigations in regard to all allegations of abuse, neglect and/or injuries of unknown source. The governing body failed to ensure the facility put in place corrective actions for a suspicious injury. The governing body failed to ensure the facility developed policies and procedures in regard to camera usage to prevent abuse/neglect of clients, and to monitor/track specific trends/patterns of incidents. Please see W122.</p> <p>2. The governing body failed to ensure the facility implemented its written policy and procedures to prevent abuse and/or neglect of clients in regard to staff to client abuse. The governing body failed to develop a specific system which monitored for patterns/trends in regard to injuries of unknown source to ensure clients were not being abused across all settings (group home and the facility's owned day program). The governing body failed to develop a written policy and/or procedure which governed how the facility would utilize surveillance cameras, within the group home, to ensure clients were protected from abuse and/or neglect. The governing body failed to implement its written policy and procedures to ensure staff immediately</p>		<p>surveillance review implementation. The improvement will allow approved managers to more easily view the cameras from multiple electronic platforms, including company smart phones. The regional program manager for group homes will create and implement a mandatory observation schedule for QIDPs in the counties that have group homes with video surveillance. The QIDPs will be required to observe portions of each shift per week. The QIDPs will then be required to document what they observed in a shared folder accessible only to relative program managers. The regional program manager will review the documented observations and determine if staff training or other action is appropriate. In order to more effectively back up any ANE findings or any adverse trends, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions/ corrective measures that address the root cause of the investigation. The Quality Assurance Social Service Manager will conduct monthly</p>	

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W 0104 Bldg. 00	<p>reported allegations of abuse and/or neglect to the administrator, and to provide evidence of a thorough investigation in regard to allegations of abuse, neglect and/or clients' injuries of unknown source. The governing body failed to ensure corrective measures were put in place in regard to a suspicious injury for clients A, B, C, D, E and F. The governing body failed to ensure its staff immediately reported all allegations of abuse and/or neglect to the administrator for clients B and D. The governing body failed to conduct a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for client B. The governing body failed to put in place corrective measures/monitor the group home/day program in regard to client B's suspicious injuries for client B. Please see W104.</p> <p>This federal tag relates to complaint #IN00174900.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and</p>	W 0104	<p>inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room in order to better monitor and document staff/client interactions. The house lead, county QIDP or the regional program manager will be present in the home and the day program on a daily basis in order to ensure proper staff/client interaction and to train and direct staff as needed.</p> <p>In order to correct this deficiency, body checks have been</p>	07/16/2015			

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	<p>record review for 4 of 4 sampled clients (A, B, C and D) and for 2 additional clients (E and F), the governing body failed to exercise general policy and operating direction over the facility to ensure clients B and D were not neglected and/or abused. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed a written policy and/or procedure which governed how the facility would utilize surveillance cameras, within the group home, to ensure clients were protected from abuse and/or neglect, and to ensure the facility monitored incident reports for patterns and/or trends. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure facility staff reported allegations of abuse/neglect immediately to the administrator for client B and conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D and E. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure corrective measures were put in place to monitor client B's injury of unknown source.</p> <p>Findings include:</p>		<p>implemented for clients A, B, C, D, E and F. These checks are done in the morning when the clients enter the day program and in the afternoon when they return from day program. The staff will then record any findings in the medical communication log and communicate any findings to the county QIDP and the day program manager. They will note what they found or note that they found nothing. An in-service training for house staff will be held on 7/14/15. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. The staff will be instructed that any possible allegations of ANE are to be reported to the QIDP or available supervisor within 30 minutes. All QIDPs will be re-trained on DSI's policy and procedures regarding ANE reporting on 7/15/15. Also, in order to better track adverse trends within the department, it has been decided that all DSI departments will utilize a real time tracking program that will be available to all program managers. The tracking report will inform any interested party the presence of any trends. Program managers will review the tracking report on a daily basis. DSI regional managers will ensure that the tracking system is accurate by</p>		

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	<p>1. During the 6/10/15 observation period between 6:50 AM and 8:00 AM, the group home had cameras in the living rooms, dining rooms and kitchen areas of the group home where clients A, B, C, D, E and F resided.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 6/9/15 at 1:20 PM. The facility's reportable incident reports and/or investigations indicated the following allegations of abuse and/or neglect of clients at the day program and/or group home (not all inclusive):</p> <p>-5/10/15 "Yesterday two staff were working at Camelot Group Home, [staff #5] and [staff #6]. Near the end of their shift on Sunday 10 10 pm [staff #5] called the QA (Qualified Intellectual Disabilities Assistant) and reported that he'd witnessed [staff #6] being abusive to [client D] earlier in the day. While waiting for [client D] to come back into the med (medication) room to receive his medications [staff #5] alleged he could see on the office camera [staff #6] hit [client D] in the face with an open hand. [Staff #5] reported no hand print was visible when [client D] came back to receive his medication. Both staff's shifts ended at 11 pm. Today the cameras at</p>		<p>conducting weekly spot audits. Any trend or pattern seen within the tracking report will be investigated immediately. The agency is also in the process of updating our video surveillance system as well as video surveillance review implementation. The improvement will allow approved managers to more easily view the cameras from multiple electronic platforms, including company smart phones. The regional program manager for group homes will create and implement a mandatory observation schedule for QIDPs in the counties that have group homes with video surveillance. The QIDPs will be required to observe portions of each shift per week. The QIDPs will then be required to document what they observed in a shared folder accessible only to relative program managers. The regional program manager will review the documented observations and determine if staff training or other action is appropriate. In order to more effectively back up any ANE findings or any adverse trends, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be</p>				

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	<p>the home, which have been HRC (Human Rights Committee) approved, were reviewed during the time mentioned by [staff #5]. It has been confirmed that there was staff aggression as described above by [staff #6] to [client D]...."</p> <p>-5/10/15 "Last evening at 10 pm staff person, [staff #5] called the QA and reported that he felt that [staff #6], a co-worker, had possibly been abusive to [client B]. Today, the film at the home, taken by cameras that have been HRC approved, was examined. Indeed there was a situation during the evening meal when it appears that [staff #6] was impatient with [client B], who is slow eating and leans over his food, at times falling asleep. Per the camera [staff #6] had pushed [client B's] head back repeatedly and hand over hand roughly shoved [client B's] spoon into his mouth. [Staff #6] was suspended today and was told it was due to an allegation of abuse. He is to come into the office on Thursday 5/14/15 around one pm, after our investigation is completed to be informed of the results of the investigation. (He reports he'll be out of town until then)...."</p> <p>An attached 5/10/15 hand written witness statement by staff #5 indicated the following (not all inclusive): While at work today (Sunday, May 10th 2015), I</p>		<p>instructed upon proper investigative techniques and systemic resolutions that address the root cause of the investigation The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room in order to better monitor and document staff/client interactions. The house lead, county QIDP or the regional program manager will be present in the home and the day program on a daily basis in order to ensure proper staff/client interaction and to train and direct staff as needed.</p>				

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	witnessed two instances of physical abuse toward DSI (Developmental Services Inc.) clients, and possibly a third instance. These incidents took place at the Camelot Group Home. The first instance took place in the kitchen between 4 pm and 5 pm...." The witness statement indicated staff #6 "...smack (sic) [client D] on his cheek (or side of his face; it was difficult to tell on the monitor)...The second incident took place in the kitchen while the guys were eating dinner, sometime btw. (between) 6 pm and 7 pm. [Staff #6] walked up behind [client B], who had his plate in front of him, but wasn't eating, grabbed his head with both hands, and moved it roughly around in a circular of figure-eight type pattern. I don't remember [staff #6's] exact words, but he yelled loudly at [client B] to wake up and eat his food. The third possible incident took place between 7 pm and 8 pm. I (staff #5) was passing the evening meds in the office, when I heard some kind of conflict taking place on the couch in the living room between [staff #6] and [client D]. I could tell it was a conflict because [staff #6] was yelling loudly at [client D], [client D] was vocalizing loudly in an agitated tone. I could also tell it was a conflict from the general body language. Since [client D] has a common behavior of not complying with verbal prompts from			

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	<p>staff, I didn't think the conflict was extraordinary, & (and) I turned my attention back to the med sheets in front of me. Shortly thereafter, I heard a loud smack (audible from the living room to the office), which was immediately followed by [staff #6] yelling loudly 'Don't hit me! Don't hit me!' I say this incident is possible, because I didn't see who smacked who. Another staff person, [staff #2], mentioned to me a week or two ago that he doesn't like how [staff #6] 'does' the guys, especially [client D] & [client B]. I didn't ask for details, and he didn't give me any."</p> <p>The facility's 5/14/15 Incident Investigation indicated the facility reviewed the film from the camera on 5/10/15 and found the following instances of staff to client abuse:</p> <p>"14:05:47 (2:05 PM) - [Staff #6] slaps [client D]. 14:07:36 (2:07 PM) - [Staff #6] lifts up [client D's] head. 14:08:10 (2:08 PM) - [Staff #6] slaps [client D]. 14:11:20 (2:11 PM) - [Staff #6] pushes head and attempts to pry open eyes of [client D]. 14:16:20 (2:16 PM) - [Staff #6] smacks [client D]. 20:00:40 (8:00 PM) - [Client D] reaches</p>			

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	<p>for a TV remote. Staff, [staff #6], jumps up and rips the remote from client's hand. Staff then pushes [client D] back down onto couch violently. Staff is then seen yelling at [client D].</p> <p>20:21:45 (8:21 PM) -[Staff #6] hits [client D] to wake him.</p> <p>20:28:19 (8:28 PM) - Staff, [staff #6], slaps [client D].</p> <p>20:28:32 (8:28 PM) - Staff, [staff #6], slaps, pushes, gropes, and shakes [client D]. DSI staff are continuing to review recorded video in order to determine if other instances of abuse occurred..." The facility's investigation indicated the video of the abuse was turned over to the city's police department. The facility's investigation indicated staff #4 also indicated staff #6 would speak in a loud tone and was "rude sounding" when staff #6 would prompt client D to do something. The facility's 5/14/15 witness statement/interview with staff #6 indicated "...He was asked why he'd been abusive as we'd seen on the cameras and he stated that it was too much for him to try to attend to all of their needs at once. It was better for him and the clients would listen better to him when it was one on one. When asked why he didn't call and talk with either the Q or QA or talk with his co-worker he stated that he was afraid to do that. He stated that he felt that in the last 30 days he had been</p>			

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	<p>more physical with the clients."</p> <p>The facility's 5/14/15 investigation in regard to client B indicated the group home's camera/tape was reviewed on 5/11/15. The 5/10/15 tapes indicated the following in regard to client B:</p> <p>"18:54:43 (6:54 PM) - "Staff, [staff #6] shakes [client B's] head up and down with some force. Staff, [staff #6], attempts to force utensil into [client B's] hand and shoves the utensil against client [client B's] body in a seemingly frustrated manner. DSI staffs are continuing to review recorded video in order to determine if other instances of abuse occurred...." The facility's 5/14/15 investigation indicated other staff reported instances of abuse/inappropriate treatment toward client B during the investigation.</p> <p>The facility's investigation indicated "...It has been concluded that upon multiple occasions [staff #6] was physically abusive to [client B] at home. For this reason the staff's person, [staff #6's] employment has been terminated..." The facility failed to review films/tapes from the cameras at the group home, as a preventative measure/routine basis to ensure clients were not being abused and/or neglected.</p>			

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	<p>The facility's reportable incident reports, internal incident reports and/or investigations indicated the following injuries of unknown source:</p> <p>-5/4/15 at 4:45 PM, Client C had an "Unknown bruise appeared on left side lower buttocks 3 cm (centimeters). An investigation will be done...."</p> <p>The facility's 5/7/15 Incident Investigation indicated day program and group home staff were interviewed. The facility's investigation indicated "...Other clients not interviewed as they are non-verbal and cannot respond and [client C] cannot respond as he is non-verbal and not respond to questioning...." The facility's 5/7/15 investigation indicated "...Conclusion/Outcome/Systemic Changes: Unknown bruise could have possible (sic) been caused by sitting down on the hard arm of the chair but there was no visible evidence of that happening. Staff will continue to monitor while in their care to ensure health and safety."</p> <p>-5/4/15 at 7:30 PM, Client B had "4 quarter size bruises along right forearm that vary in size between each of them. An investigation is being done due to being unknown how they were</p>			

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	<p>acquired...."</p> <p>The facility's 5/7/15 Incident Investigation indicated 3 day program and 3 house staff were interviewed. The facility's investigation indicated the staff did not know how client B received the injury. The facility's investigation indicated</p> <p>"...Conclusion/Outcome/Systemic Changes: looks like finger prints but no one saw or could confirm client or staff interaction that could have caused the bruises. Staff will continue to monitor for safety."</p> <p>-6/6/15 "Yesterday while assisting [client E], [staff #9], discovered a bruise on the back of his right arm. The bruise was 1 1/2 inches wide and 2 inches long. It was bluish with yellow in the center. The staff did not notice the bruise when she'd worked on Friday night but on Saturday reported the injury per pager protocol. It is unknown how the client got this bruise but he was on an outing on Saturday and may have received it during the outing somehow. The client is also in the PEP room with another client who pinched three other clients on Friday and reports were done on them. If this were (sic) the case the bruise just either wasn't seen on Friday or didn't come up until Saturday. The Q will investigate to see if possible</p>						

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	<p>how the bruise was caused...."</p> <p>The facility's 12/22/11 Standard Operating Procedures (SOP) were reviewed on 6/9/15 at 1:48 PM. The facility's 12/22/11 SOPs indicated the facility did not have a policy which indicated how and when the facility's surveillance cameras/system were to be utilized in regard to conducting investigations, and/or to be reviewed to prevent abuse/neglect of clients.</p> <p>Interview with the Residential Program Manager (RPM) and the Qualified Intellectual Disabilities Professional (QIDP) on 6/10/15 at 11:45 AM indicated they conducted the investigations in regard to client B, C and E's injuries of unknown source when discovered at the group home. When asked why the facility had camera surveillance in the group home, the RPM stated "Due to past problems." The RPM indicated the QIDP and/or RPM had access to the camera data. The RPM stated "We randomly review tapes and go live to see what is going on at the group home." The RPM and QIDP stated the current camera/surveillance system was not "user friendly." The RPM and the QIDP indicated the facility was in the process of trying to update their system which would allow the QIDP and RPM</p>			

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	<p>to review the tapes more often. The QIDP and the RPM indicated the facility had utilized the tapes from the camera to substantiate abuse in the past. The RPM indicated the facility did not have a policy and procedure which specifically indicated how the cameras were to be utilized in regard to investigations, and/or when to randomly review the tapes to prevent clients from being abused and/or neglected by staff.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent abuse and/or neglect of clients in regard to staff to client abuse. The governing body failed to exercise general policy and operating direction over the facility to develop a specific system which monitored for patterns/trends in regard to injuries of unknown source to ensure clients were not being abused across all settings (group home and the facility's owned day program). The governing body failed to exercise general policy and operating direction over the facility to develop a written policy and/or procedure which governed how the facility would utilize surveillance cameras, within the group home, to ensure clients were protected from abuse and/or neglect. The</p>			

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	<p>governing body failed to exercise general policy and operating direction over the facility to implement its written policy and procedures to ensure staff immediately reported allegations of abuse and/or neglect to the administrator, and to provide evidence of a thorough investigation in regard to allegations of abuse, neglect and/or clients' injuries of unknown source. The governing body failed to exercise general policy and operating direction over the facility to ensure corrective measures were put in place in regard to a suspicious injury for clients A, B, C, D, E and F. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure its staff immediately reported all allegations of abuse and/or neglect to the administrator for clients B and D. Please see W153.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations in regard to the allegations of abuse, neglect and/or injuries of unknown source for client B. Please see W154.</p> <p>5. The governing body failed to exercise general policy and operating direction</p>			

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W 0122 Bldg. 00	<p>over the facility to ensure the facility put in place corrective measures/monitor the group home/day program in regard to client B's suspicious injuries for client B. Please see W157.</p> <p>This federal tag relates to complaint #IN00174900.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS 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 4 of 4 sampled clients (A, B, C and D) and for 2 additional clients (E and F). The facility failed to implement its written policy and procedures to prevent abuse and/or neglect of clients. The facility failed to ensure its staff immediately reported all concerns/allegations of abuse, neglect and/or injuries of unknown source to the administrator immediately. The facility failed to conduct /document thorough investigations in regard to all allegations of abuse, neglect and/or injuries of unknown source. The facility failed to ensure it put in place corrective actions for a suspicious injury. The facility failed</p>	W 0122	<p>In order to correct this deficiency and ensure that the clients are provided the rights accorded them without having to claim them, the following actions have been enacted: An in-service training for house staff was conducted on 7/14/2015. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. The staff will be instructed that any possible allegations of ANE are to be reported to the QIDP or available supervisor within 1 hour. All QIDPs will be re-trained on DSI's policy and procedures regarding ANE reporting on 7/15/2015. Day program staff have been trained by the day program manager and all new hires have been made</p>	07/16/2015

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	<p>to develop policies and procedures regarding the use of cameras to prevent abuse/neglect, and to specifically monitor/track specific trends/patterns to ensure clients were not being abused/neglected.</p> <p>Findings include:</p> <p>1. The facility failed to implement its written policy and procedures to prevent abuse and/or neglect of clients in regard to staff to client abuse. The facility failed to develop a specific system which monitored for patterns/trends in regard to injuries of unknown source to ensure clients were not being abused across all settings (group home and the facility's owned day program). The facility failed to develop a written policy and/or procedure which governed how the facility would utilize surveillance cameras, within the group home, to ensure clients were protected from abuse and/or neglect. The facility failed to implement its written policy and procedures to ensure staff immediately reported allegations of abuse and/or neglect to the administrator, and to provide evidence of a thorough investigation in regard to allegations of abuse, neglect and/or clients' injuries of unknown source. The facility also failed to put corrective measures in place in</p>		<p>aware of the critical nature of proper client treatment and reporting. Also, in order to better track adverse trends within the department, it has been decided that all DSI departments will utilize a real time tracking program that will be available to all program managers. The tracking report will inform any interested party the presence of any trends. Program managers will review the tracking report on a daily basis. DSI regional managers will ensure that the tracking system is accurate by conducting weekly spot audits. If any trends are discovered, the program manager will immediately conduct a full and thorough investigation, suspending any party suspected of ANE. The program manager will then allot the staff member a disciplinary action, up to and not excluding termination, according to the severity of findings. The agency is also in the process of updating our video surveillance system as well as video surveillance review implementation. The improvement will allow approved managers to more easily view the cameras from multiple electronic platforms, including company smart phones. The regional program manager for group homes will create and implement a mandatory observation schedule for QIDPs in the counties that have group homes</p>	

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	<p>regard to a suspicious injury. Please see W149.</p> <p>2. The facility failed to ensure its day program and/or group home staff immediately reported allegations of abuse, neglect and/or injuries of unknown source to their administrator immediately for clients B and D. Please see W153.</p> <p>3. The facility failed to document and/or conduct a thorough investigation in regard to allegations of staff to client abuse/neglect, and/or injuries of unknown source for client B. Please see W154.</p> <p>4. The facility failed to put in place corrective measures/monitor the group home/day program in regard to client B's suspicious injuries. Please see W157.</p> <p>This federal tag relates to complaint #IN00174900.</p> <p>9-3-2(a)</p>		<p>with video surveillance. The QIDPs will be required to observe portions of each shift per week. The QIDPs will then be required to document what they observed in a shared folder accessible only to relative program managers. If, during video observations, the QIDP discovers any instances of possible ANE, the QIDP will immediately initiate a full and thorough investigation, suspending any staff suspected of ANE until the investigation is completed. The program manager will then allot the staff member disciplinary action, up to and not excluding termination, according to the severity of findings. In order to back up any ANE findings or any adverse trend, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions/ corrective actions that address the root cause of the investigation. The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house</p>		

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 2 additional clients (E and F), the facility neglected to implement its written policy and procedures to prevent abuse and/or neglect of clients in regard to staff to client abuse. The facility neglected to develop a specific system which monitored for patterns/trends in regard to injuries of unknown source to ensure clients were not being abused across all settings (group home and the facility's owned day program). The facility neglected to develop a written policy			W 0149	meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room in order to better monitor and document staff/client interactions. The house lead, county QIDP or the regional program manager will be present in the home and the day program on a daily basis in order to ensure proper staff/client interaction and to train and direct staff as needed. In order to correct this deficiency, policy has been implemented whose structure will help prevent, identify, investigate and report abuse, neglect and mistreatment of clients. Staff will also be screened and trained through the following policies: body checks have been implemented for clients A, B, C, D, E and F. These checks are done in the morning before the clients enter the day program and in the afternoon when they return from day program. The staff will then record any findings in the medical communication log and communicate any findings to the		07/16/2015

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	<p>and/or procedure which governed how the facility would utilize surveillance cameras, within the group home, to ensure clients were protected from abuse and/or neglect. The facility neglected to implement its written policy and procedures to ensure staff immediately reported allegations of abuse and/or neglect to the administrator, and to provide evidence of a thorough investigation in regard to allegations of abuse, neglect and/or clients' injuries of unknown source. The facility also failed to put corrective measures in place in regard to a suspicious injury.</p> <p>Findings include:</p> <p>1. During the 6/9/15 observation period between 11:02 AM and 12:45 PM, at the day program, clients A, B, C, D, E and F were in the PEP (Personal Enhancement Program) room. Clients A, B, C, D, E and F stayed in the PEP room sitting down at the table and/or in the sensory area sitting in lounge chairs. At times, client B would stand up and walk around in a small area. Client B was bent over and blind, but client B did not bump and/or hit any items with his body. Clients A, B, C, D, E and F did not display any inappropriate behaviors. The clients stayed with staff and did not leave the area.</p>		<p>county QIDP and the day program manager. They will note what they found or note that they found nothing. The county QIDP will review multiple times a week the documented checks in order to ensure staff are performing effective checks. An in-service training for house staff will be conducted on 7/14/2015. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. The staff will be instructed that any possible allegation of ANE is to be reported to the QIDP or available supervisor within 30 minutes. Any staff who fail to comply with this directive in the future will receive a disciplinary action or terminated. All QIDPs will be re-trained on DSI's policy and procedures regarding ANE reporting on 7/15/2015. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. Also, in order to better track adverse trends within the department, it has been decided that all DSI departments will utilize a real time tracking program that will be available to all program managers. The tracking report will inform any interested party the presence of any trends. Program managers</p>		

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	<p>During the 6/10/15 observation period between 6:50 AM and 8:00 AM the group home had cameras in the living rooms, dining rooms and kitchen areas of the group home where clients A, B, C, D, E and F resided.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 6/9/15 at 1:20 PM. The facility's reportable incident reports and/or investigations indicated the following allegations of abuse and/or neglect of clients at the day program and/or group home (not all inclusive):</p> <p>-5/10/15 "Yesterday two staff were working at Camelot Group Home, [staff #5] and [staff #6]. Near the end of their shift on Sunday 10 10 pm [staff #5] called the QA (Qualified Intellectual Disabilities Assistant) and reported that he'd witnessed [staff #6] being abusive to [client D] earlier in the day. While waiting for [client D] to come back into the med (medication) room to receive his medications [staff #5] alleged he could see on the office camera [staff #6] hit [client D] in the face with an open hand. [Staff #5] reported no hand print was visible when [client D] came back to receive his medication. Both staff's shifts</p>		<p>will review the tracking report on a daily basis. DSI regional managers will ensure that the tracking system is accurate by conducting weekly spot audits. If a program manager is unable to perform weekly checks due to illness or time off, the regional manager or QA (if applicable) will perform the required checks and documentation. If any trends are discovered, the program manager will immediately conduct a full and thorough investigation, suspending any party suspected of ANE. The program manager will then allot the staff member a disciplinary action, up to and not excluding termination, according to the severity of findings. The agency is also in the process of updating our video surveillance system as well as video surveillance review implementation. The improvement will allow approved managers to more easily view the cameras from multiple electronic platforms, including company smart phones. The regional program manager for group homes will create and implement a mandatory observation schedule for QIDPs in the counties that have group homes with video surveillance. The QIDPs will be required to observe portions of each shift per week. If the QIDPs are unable to perform video observations, the regional manager or QA (if applicable) will perform the observations and</p>		

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	<p>ended at 11 pm. Today the cameras at the home, which have been HRC (Human Rights Committee) approved, were reviewed during the time mentioned by [staff #5]. It has been confirmed that there was staff aggression as described above by [staff #6] to [client D]. This staff, [staff #6] was called and told that he was suspended immediately due to the allegation of abuse. The investigation into this situation continues. [Staff #6] is to come in on Thurs. (Thursday) 5/14 at around 1 pm after the investigation of the incident is completed (he states he will be out of town until then) and we will inform him of all results of the investigation at that time. [Client D] has no visible marks on him at this point and has shown no ill effects from this situation that this Q (Qualified Intellectual Disabilities Professional) is aware of...[The Residential Program Manager] (RPM) has viewed the camera footage as above and is involved in the rest of the investigation as well."</p> <p>-5/10/15 "Last evening at 10 pm staff person, [staff #5] called the QA and reported that he felt that [staff #6], a co-worker, had possibly been abusive to [client B]. Today, the film at the home, taken by cameras that have been HRC approved, was examined. Indeed there was a situation during the evening meal</p>		<p>required documentation. The QIDPs will then be required to document what they observed in a shared folder accessible only to relative program managers. If, during video observations, the QIDP discovers any instances of possible ANE, the QIDP will immediately initiate a full and through investigation, suspending any staff suspected of ANE until the investigation is completed. The program manager will then allot the staff member disciplinary action, up to and not excluding termination, according to the severity of findings. In order to back up any ANE findings or any adverse trend, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions/corrective actions that address the root cause of the investigation. The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The</p>	

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	<p>when it appears that [staff #6] was impatient with [client B], who is slow eating and leans over his food, at times falling asleep. Per the camera [staff #6] had pushed [client B's] head back repeatedly and hand over hand roughly shoved [client B's] spoon into his mouth. [Staff #6] was suspended today and was told it was due to an allegation of abuse. He is to come into the office on Thursday 5/14/15 around one pm, after our investigation is completed to be informed of the results of the investigation. (He reports he'll be out of town until then). [Client B] currently has no visible marks on him and has shown no ill effects from this situation that this Q is aware of... [The RPM] has reviewed the camera films today and is actively investigating the situation."</p> <p>An attached 5/10/15 hand written witness statement by staff #5 indicated the following (not all inclusive): While at work today (Sunday, May 10th 2015), I witnessed two instances of physical abuse toward DSI (Developmental Services Inc.) clients, and possibly a third instance. These incidents took place at the Camelot Group Home. The first instance took place in the kitchen between 4 pm and 5 pm...." The witness statement indicated staff #6 "...smack (sic) [client D] on his cheek (or side of</p>		RPM will continue to review incident reports and conduct investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room in order to better monitor and document staff/client interactions. The house lead, county QIDP or the regional program manager will be present in the home and the day program on a daily basis in order to ensure proper staff/client interaction and to train and direct staff as needed.				

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	<p>his face; it was difficult to tell on the monitor)...The second incident took place in the kitchen while the guys were eating dinner, sometime btw. (between) 6 pm and 7 pm. [Staff #6] walked up behind [client B], who had his plate in front of him, but wasn't eating, grabbed his head with both hands, and moved it roughly around in a circular of figure-eight type pattern. I don't remember [staff #6's] exact words, but he yelled loudly at [client B] to wake up and eat his food. The third possible incident took place between 7 pm and 8 pm. I (staff #5) was passing the evening meds in the office, when I heard some kind of conflict taking place on the couch in the living room between [staff #6] and [client D]. I could tell it was a conflict because [staff #6] was yelling loudly at [client D], [client D] was vocalizing loudly in an agitated tone. I could also tell it was a conflict from the general body language. Since [client D] has a common behavior of not complying with verbal prompts from staff, I didn't think the conflict was extraordinary, & (and) I turned my attention back to the med sheets in front of me. Shortly thereafter, I heard a loud smack (audible from the living room to the office), which was immediately followed by [staff #6] yelling loudly 'Don't hit me! Don't hit me!' I say this incident is possible, because I didn't see</p>			

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	<p>who smacked who. Another staff person, [staff #2], mentioned to me a week or two ago that he doesn't like how [staff #6] 'does' the guys, especially [client D] & [client B]. I didn't ask for details, and he didn't give me any."</p> <p>The facility's 5/14/15 Incident Investigation indicated the facility reviewed the film from the camera on 5/10/15 and found the following instances of staff to client abuse:</p> <p>"14:05:47 (2:05 PM) -[Staff #6] slaps [client D]. 14:07:36 (2:07 PM) - [Staff #6] lifts up [client D's] head. 14:08:10 (2:08 PM) - [Staff #6] slaps [client D]. 14:11:20 (2:11 PM) - [Staff #6] pushes head and attempts to pry open eyes of [client D]. 14:16:20 (2:16 PM) - [Staff #6] smacks [client D]. 20:00:40 (8:00 PM) - [Client D] reaches for a TV remote. Staff, [staff #6], jumps up and rips the remote from client's hand. Staff then pushes [client D] back down onto couch violently. Staff is then seen yelling at [client D]. 20:21:45 (8:21 PM) -[Staff #6] hits [client D] to wake him. 20:28:19 (8:28 PM) - Staff, [staff #6], slaps [client D].</p>			

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	20:28:32 (8:28 PM) - Staff, [staff #6], slaps, pushes, gropes, and shakes [client D]. DSI staff are continuing to review recorded video in order to determine if other instances of abuse occurred..." The facility's investigation indicated the video of the abuse was turned over to the city's police department. The facility's investigation indicated staff #4 also indicated staff #6 would speak in a loud tone and was "rude sounding" when staff #6 would prompt client D to do something. The facility's 5/14/15 witness statement/interview with staff #6 indicated "...He was asked why he'd been abusive as we'd seen on the cameras and he stated that it was too much for him to try to attend to all of their needs at once. It was better for him and the clients would listen better to him when it was one on one. When asked why he didn't call and talk with either the Q or QA or talk with his co-worker he stated that he was afraid to do that. He stated that he felt that in the last 30 days he had been more physical with the clients." The facility's 5/14/15 investigation indicated "...It has been concluded that upon several occasions [staff #6] was physically abusive to [client D] at home. For this reason the staff person, [staff #6's] employment has been terminated. Staff at the home have been retrained regarding what could be considered abuse			

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	<p>and under what circumstances supervisors should be notified of staff's suspicions. Additionally, the timeliness of reporting of these circumstances was reviewed...."</p> <p>The facility's 5/14/15 investigation in regard to client B indicated the group home's camera/tape was reviewed on 5/11/15. The 5/10/15 tapes indicated the following in regard to client B:</p> <p>"18:54:43 (6:54 PM) - "Staff, [staff #6] shakes [client B's] head up and down with some force. Staff, [staff #6], attempts to force utensil into [client B's] hand and shoves the utensil against client [client B's] body in a seemingly frustrated manner. DSI staffs are continuing to review recorded video in order to determine if other instances of abuse occurred...." The facility's 5/14/15 investigation indicated other staff reported instances of abuse/inappropriate treatment toward client B during the investigation.</p> <p>The facility's investigation indicated "...It has been concluded that upon multiple occasions [staff #6] was physically abusive to [client B] at home. For this reason the staff's person, [staff #6's] employment has been terminated. Staff at the home have been retrained regarding what could be considered abuse</p>			

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	<p>and under what circumstances supervisors should be notified of staff's suspicions. Additionally, the timeliness of reporting of these circumstances was reviewed with all staff."</p> <p>The facility neglected to ensure facility staff immediately reported abuse, concerns and/or mistreatment of clients in a timely manner to prevent further abuse of clients B and D. The facility neglected to review films/tapes from the cameras at the group home, as a preventative measure/routine basis to ensure clients were not being abused and/or neglected.</p> <p>-5/29/15 at 12:00 PM, "The second staff in the PEP room reported that staff prompted [client B] to eat his lunch one time before throwing the food in the trash. Client [client B] often requires hand over hand assistance and supervision while eating. Both staff were suspended pending investigation. Investigation was completed 6/2/2015. The reporting staff was counseled and retrained on reporting practices on 6/2/2015. The staff that was alleged neglectful will be terminated on 6/3/15 with a disciplinary action based on DSI (Developmental Services Incorporated) policy. Staff will maintain health and safety." The facility's 5/29/15 reportable</p>			

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	<p>incident report indicated the facility did not have documentation of an investigation.</p> <p>-5/29/15 at 3:27 PM, "Day Program Manager was notified by the Group Home Manager that [client B] had scraped his head. Unaware of the serious nature of the incident and having not received any reports from staff, Day Program Manager did not originally file the Incident Report. In Monday, 6/1/15 Day Program Manager received a report that [client B] had to seek treatment at [name of medical facility] to get the wound glued. Day Program Manager began an internal investigation to find out the cause of the injury. Staff (staff #7) called in to report that the other staff (staff #8) who was working with [client B] redirected him away from the door...Staff (staff #8) left the reporting staff (staff #7) in the room alone with 9 clients without notice to use the restroom. Residential staff came to pick up [client B] and found him bent over looking out the door with blood running down his arm. Residential staff reported to Group Home Manager that staff told him he was responsible for reporting it and was unaware of what took place to cause the injury...." The facility's 5/29/15 reportable incident report indicated the neglectful staff (staff #8) was terminated</p>			

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	<p>and staff #7 was counseled and retrained on reporting on 6/2/15. The facility's reportable incident report did not indicate any additional documentation/evidence of an investigation.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations indicated the following injuries of unknown source:</p> <p>-5/1/15 "Right after getting out of group home van after arriving home from his day program (sic) it was noticed by staff that client (client C) had a dime sized bruise on his left inside of his arm between his wrist and elbow. One of the group home staff, [staff #9], filled out a medical incident report. The QA, [name of QA] questioned staff from the day program, but at this time it has not been determined how the bruise happened. An investigation has been started and will be completed and turned in."</p> <p>The facility's 5/5/15 Incident Investigation indicated group home staff and day program staff were interviewed. The facility's investigation indicated "...Conclusion/Outcome/Systemic Changes: The conclusion is that the cause of the bruise is still unknown. It most likely happened in the day program and could possibly been the result of one</p>			

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	<p>of the other clients pinching him, but that could not be substantiated.</p> <p>-5/4/15 at 4:45 PM, Client C had an "Unknown bruise appeared on left side lower buttocks 3 cm (centimeters). An investigation will be done...."</p> <p>The facility's 5/7/15 Incident Investigation indicated day program and group home staff were interviewed. The facility's investigation indicated "...Other clients not interviewed as they are non-verbal and cannot respond and [client C] cannot respond as he is non-verbal and not respond to questioning...." The facility's 5/7/15 investigation indicated "...Conclusion/Outcome/Systemic Changes: Unknown bruise could have possible (sic) been caused by sitting down on the hard arm of the chair but there was no visible evidence of that happening. Staff will continue to monitor while in their care to ensure health and safety."</p> <p>-5/4/15 at 7:30 PM, Client B had "4 quarter size bruises along right forearm that vary in size between each of them. An investigation is being done due to being unknown how they were acquired...."</p>			

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	<p>The facility's 5/7/15 Incident Investigation indicated 3 day program and 3 house staff were interviewed. The facility's investigation indicated the staff did not know how client B received the injury. The facility's investigation indicated</p> <p>"...Conclusion/Outcome/Systemic Changes: looks like finger prints but no one saw or could confirm client or staff interaction that could have caused the bruises. Staff will continue to monitor for safety." The facility's 5/7/15 investigation indicated the facility neglected to put any corrective actions/measures in place to monitor client B to ensure the client was not being abused.</p> <p>-6/6/15 "Yesterday while assisting [client E], [staff #9], discovered a bruise on the back of his right arm. The bruise was 1 1/2 inches wide and 2 inches long. It was bluish with yellow in the center. The staff did not notice the bruise when she'd worked on Friday night but on Saturday reported the injury per pager protocol. It is unknown how the client got this bruise but he was on an outing on Saturday and may have received it during the outing somehow. The client is also in the PEP room with another client who pinched three other clients on Friday and reports were done on them. If this was the case</p>			

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	<p>the bruise just either wasn't seen on Friday or didn't come up until Saturday. The Q will investigate to see if possible how the bruise was caused...."</p> <p>The facility's above mentioned investigations in regard to client B, C and E's injuries of unknown source indicated the facility neglected to address and/or look at the injuries of unknown source, at the day program and/or group home, to ensure clients were not potentially being abused and/or neglected. The facility neglected to develop a system which specifically monitored for patterns and/or trends to prevent abuse and/or neglect of clients.</p> <p>Staff #8's personnel record was reviewed on 6/10/15 at 10:00 AM. Staff #8's personnel record indicated the staff worked in the facility's day program. Staff #8's personnel record also indicated staff #8's 6/3/15 Counseling Memorandum which indicated staff #8 was terminated on 6/8/15 for neglect and abuse of clients at the day program.</p> <p>The facility's inservice/training records were reviewed on 6/10/15 at 11:20 AM. The facility's 5/21/15 Staff Training Report indicated facility staff were retrained on recognizing abuse, reporting and prevention of abuse/neglect on</p>			

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	<p>5/21/15.</p> <p>The facility's policy and procedures were reviewed on 6/9/15 at 11:00 AM. The facility's 4/12/06 policy entitled Identifying and Reporting Suspected Abuse and Neglect indicated the following "...Definitions:</p> <p>1. Physical Abuse: Knowingly or intentionally touching another person in a rude, insolent or angry manner; punishment with resulting physical harm or pain; unnecessary physical or chemical restraints.</p> <p>2. Verbal/Emotional Abuse: Includes oral, written, and/or gestured language that includes disparaging or derogatory remarks. Also includes demeaning tones or harsh language. Includes unreasonable confinements, intimidation or humiliation...</p> <p>4. Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care, food, medical care, shelter, or supervision...." The facility's 4/12/06 policy indicated the facility defined "...Injuries of Unknown Origin: Any significant injury of unknown origin should be investigated as potential abuse or neglect. Description of significant injury include large bruising; burns, unusual marks on the skin; any area that</p>			

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	<p>is visibly swollen or red; finger like bruising (as if grabbed); any unusual complaints of pain by the client with no known medical reason...." The facility's policy and procedures indicated facility staff were to "...immediately report this suspicion within one hour of discovery to their supervisor/QMRP or the emergency response system..." The facility's 4/12/06 policy indicated "...The Department Manager and/or Program Director will conduct a full internal investigation in cooperation with responsible authorities such as: Indiana State Police, Child or Adult Protective Services, Bureau of Quality Improvement Services, Indiana State Board of health, etc...."</p> <p>The facility's 12/22/11 Standard Operating Procedures (SOP) were reviewed on 6/9/15 at 1:48 PM. The facility's SOPs indicated the facility neglected to develop a system which monitored and specifically tracked injuries of unknown source in regard to patterns and trends. The facility's 12/22/11 SOPs also indicated the facility neglected to indicate how and when the facility's surveillance cameras/system were to be utilized in regard to conducting investigations, and/or to be reviewed to prevent abuse/neglect of clients.</p>			

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	<p>Interview with DPM on 6/9/15 at 12:45 PM and on 6/10/15 at 9:15 AM indicated the day program had terminated staff in the past several months for abuse and/or neglect of clients. The DPM indicated she (DPM) was having to work in the PEP room as there was only 1 regular staff left to work in the PEP room where clients A, B, C and D attended during the day. The DPM stated staff #8 "did not have a history of abuse but had personal issues." The DPM stated the "Team Lead" was not in the room when the 5/29/15 incidents occurred. The DPM stated "It is hard to keep staff in that room." When asked if she had been aware of any injuries of unknown source regarding the clients in the PEP room, the DPM stated "No other injuries which would indicate any additional abuse at this time." The DPM indicated staff #7 did not report the allegation of abuse and/or neglect with clients B and C until 6/1/15. The DPM indicated she counseled staff #7 in regard to the late reporting and reminded the staff allegations of abuse and/or neglect should be reported immediately. The DPM indicated staff #7 should have reported the allegations within a half hour of the incident occurring. The DPM indicated if staff #7 had reported the first allegation of abuse to the DPM on</p>			

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	<p>5/29/15 at 12:00 PM the other incidents which occurred on 5/29/15 could have been prevented. The DPM indicated when she spoke with staff #8, staff #8 was undergoing some personal issues at home which appeared to affect staff #8's ability to do her job. The DPM indicated she conducted the investigation in regard to client B's allegations of abuse/neglect on 5/29/15. The DPM indicated she had not written/typed up the 5/29/15 investigation as she had been working in the PEP room. The DPM indicated she spoke with the day program staff who worked in the PEP room. The DPM stated she did not interview any clients as the clients would not be able to give "an accurate account of what happened." The DPM indicated staff #8 was terminated for abuse and neglect in regard to the 5/29/15 allegations.</p> <p>Interview with the Residential Program Manager (RPM) and the Qualified Intellectual Disabilities Professional (QIDP) on 6/10/15 at 11:45 AM indicated the DPM had conducted the investigation in regard to the 5/29/15 allegations of abuse/neglect involving client B. The RPM and the QIDP indicated staff #7 had been terminated in regard to the 5/29/15 allegations. The RPM and the QIDP indicated they conducted the investigations in regard to</p>			

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	<p>client B, C and E's injuries of unknown source when discovered at the group home. The RPM and/or the QIDP indicated they and/or the DPM may not have included documentation to ensure all injuries of unknown source were thoroughly investigated. When asked if the facility had looked at and/or reviewed the number of incidents involving injuries of unknown source as a whole for the group home to rule out abuse, the RPM and the QIDP stated "No." The RPM indicated the facility had a system in place which looked for patterns and trends. The RPM and the QIDP indicated they were not aware of any patterns and/or trends in regard to injuries of unknown source. The RPM stated his supervisor (administrative staff #1) tracked "Trends of Incident Reports Analysis." The RPM stated administrative staff #1 only tracked the number of injuries of unknown source by "county and quarters." The RPM stated there had been 5 incidents of unknown source for "[Name] County" for the months of January 2015 to March 2015. The RPM indicated in the quarter of (October 2015 to December 2014) there were 3 incidents of injuries of unknown source in the county. The RPM indicated from July 2014 to September 2014, there were also 3 incidents of unknown origin in the county. The RPM and the QIDP</p>			

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	<p>indicated [name] county's data would include two group homes within that county of which Camelot was one of the group homes. The RPM and the QIDP indicated the facility's current tracking of patterns and trends was not specific in regard to group home, clients, shifts and/or staff who worked with clients at the Camelot group home. When asked why the facility had camera surveillance in the group home, the RPM stated "Due to past problems." The RPM indicated the QIDP and/or RPM had access to the camera data. The RPM stated "We randomly review tapes and go live to see what is going on at the group home." The RPM and QIDP stated the current camera/surveillance system was not "user friendly." The RPM and the QIDP indicated the facility was in the process of trying to update their system which would allow the QIDP and RPM to review the tapes more often. The QIDP and the RPM indicated the facility had utilized the tapes from the camera to substantiate abuse in the past. The RPM indicated the facility did not have a policy and procedure which indicated how the cameras were to be utilized in regard to investigations and/or when to randomly review to ensure clients were not being neglected and/or abused by staff.</p>			

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W 0153 Bldg. 00	<p>2. The facility failed to ensure its staff immediately reported all allegations of abuse and/or neglect to the administrator for clients B and D. Please see W153.</p> <p>3. The facility failed to conduct a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for client B. Please see W154.</p> <p>4. The facility failed to put in place corrective measures/monitor the group home/day program in regard to client B's suspicious injuries for client B. Please see W157.</p> <p>This federal tag relates to complaint #IN00174900.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 4 of 10 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure its day program and/or group home staff</p>	W 0153	In order to correct this deficiency, the following policies have been implemented in order to facilitate greater awareness of how to document and discover injuries of unknown origin as well as how	07/16/2015			

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	<p>immediately reported allegations of abuse, neglect and/or injuries of unknown source to their administrator immediately for clients B and D.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 6/9/15 at 1:20 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-5/10/15 "Yesterday two staff were working at Camelot Group Home, [staff #5] and [staff #6]. Near the end of their shift on Sunday 10 10 pm [staff #5] called the QA (Qualified Intellectual Disabilities Professional Assistant) and reported that he'd witnessed [staff #6] being abusive to [client D] earlier in the day. While waiting for [client D] to come back into the med (medication) room to receive his medications [staff #5] alleged he could see on the office camera [staff #6] hit [client D] in the face with an open hand. [Staff #5] reported no hand print was visible when [client D] came back to receive his medication. Both staff's shifts ended at 11 pm. Today the cameras at the home, which have been HRC (Human Rights Committee)</p>		<p>staff should respond when discovery of an injury of unknown origin is discovered: body checks have been implemented for clients B and D (as well as all other group home clients). These checks are done in the morning before the clients enter the day program and in the afternoon before they return from day program. This practice will help shorten the lag time on reporting on injuries of unknown source</p> <p>This practice will help isolate instances of injuries of unknown origin. The staff will then record any findings in the medical communication log and communicate any findings to the county QIDP and the day program manager. They will note what they found or note that they found nothing. An in-service training for day program and house staff will be conducted on 7/14/15. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. The staff are to be instructed that any possible allegation of ANE were to be reported to the QIDP or available supervisor immediately. The manager reported to will then be expected to decide the appropriate course to take according to DSi's standard operating procedure. Staff are to observe the chain of command when reporting an injury, ensuring</p>				

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	<p>approved, were reviewed during the time mentioned by [staff #5]. It has been confirmed that there was staff aggression as described above by [staff #6] to [client D]...." The facility's 5/10/15 reportable incident report indicated facility staff did not immediately report/notify the administrator when they observed the abuse of client D.</p> <p>-5/10/15 "Last evening at 10 pm staff person, [staff #5] called the QA and reported that he felt that [staff #6], a co-worker, had possibly been abusive to [client B]. Today, the film at the home, taken by cameras that have been HRC approved, was examined. Indeed there was a situation during the evening meal when it appears that [staff #6] was impatient with [client B], who is slow eating and leans over his food, at times falling asleep. Per the camera [staff #6] had pushed [client B's] head back repeatedly and hand over hand roughly shoved [client B's] spoon into his mouth. [Staff #6] was suspended today and was told it was due to an allegation of abuse. He is to come into the office on Thursday 5/14/15 around one pm, after our investigation is completed to be informed of the results of the investigation. (He reports he'll be out of town until then). [Client B] currently has no visible marks on him and has shown no ill effects from</p>		<p>that the incident is reported in a timely manner. The QIDP will continue to make monthly observations of staff/client interactions. The QIDP and day program manager will ensure through weekly visits to the pep room that staff/client interactions are appropriate and that staff are properly reporting unknown injuries. The county QIDP and regional program manager will ensure that weekly, unannounced visits to the county group homes are conducted and documented. The day program manager, QIDP and RPM will make weekly visits to the PEP room in order to better monitor and document staff/client interactions.</p>	

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	<p>this situation that this Q is aware of... [The RPM] has reviewed the camera films today and is actively investigating the situation." The facility's 5/10/15 reportable incident report indicated the facility staff failed to immediately report the allegations of abuse/neglect to ensure the clients were protected.</p> <p>-5/29/15 at 12:00 PM, "The second staff in the PEP (Personal Performance Program) room reported that staff prompted [client B] to eat his lunch one time before throwing the food in the trash. Client [client B] often requires hand over hand assistance and supervision while eating. Both staff were suspended pending investigation. Investigation was completed 6/2/2015. The reporting staff was counseled and retrained on reporting practices on 6/2/2015. The staff that was alleged neglectful will be terminated on 6/3/15 with a disciplinary action based on DSI (Developmental Services Incorporated) policy. Staff will maintain health and safety." The facility's reportable incident report indicated staff #7 did not report the allegation of neglect until 6/1/15.</p> <p>-5/29/15 at 3:27 PM, "Day Program Manager was notified by the Group Home Manager that [client B] had scraped his head. Unaware of the serious</p>			

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	<p>nature of the incident and having not received any reports from staff, Day Program Manager did not originally file the Incident Report. In Monday, 6/1/15 Day Program Manager received a report that [client B] had to seek treatment at [name of medical facility] to get the wound glued. Day Program Manager began an internal investigation to find out the cause of the injury. Staff (staff #7) called in to report that the other staff (staff #8) who was working with [client B] redirected him away from the door...Staff (staff #8) left the reporting staff (staff #7) in the room alone with 9 clients without notice to use the restroom. Residential staff came to pick up [client B] and found him bent over looking out the door with blood running down his arm. Residential staff reported to Group Home Manager that staff told him he was responsible for reporting it and was unaware of what took place to cause the injury...." The facility's 5/29/15 reportable incident report indicated staff #7 did not report the 5/25/15 incident until 6/1/15.</p> <p>Interview with DPM on 6/9/15 at 12:45 PM and on 6/10/15 at 9:15 AM indicated the day program had terminated staff in the past several months for abuse and/or neglect of clients. The DPM indicated staff #7 did not report the allegation of</p>			

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W 0154 Bldg. 00	<p>abuse and/or neglect with clients B and C until 6/1/15. The DPM indicated she counseled staff #7 in regard to the late reporting and reminded the staff allegations of abuse and/or neglect should be reported immediately. The DPM indicated staff #7 should have reported the allegations within a half hour of the incident occurring.</p> <p>Interview with the Residential Program Manager (RPM) and the Qualified Intellectual Disabilities Professional (QIDP) on 6/10/15 at 11:20 AM indicated facility staff did not immediately report staff #6 on 5/10/15 until the shift was almost over. The RPM indicated if staff #5 would have reported the staff sooner, clients B and D would not have experienced additional abuse by staff #6.</p> <p>This federal tag relates to complaint #IN00174900.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 2 of 10 allegations of abuse, neglect</p>	W 0154	In order to back up any ANE findings or any adverse trend, the agency will develop an agency	07/16/2015			

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	<p>and/or injuries of unknown source reviewed, the facility failed to document and/or conduct a thorough investigation in regard to allegations of staff to client abuse/neglect, and/or injuries of unknown source for client B.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 6/9/15 at 1:20 PM. The facility's reportables and/or investigations indicated the following (not all inclusive):</p> <p>-5/29/15 at 12:00 PM, "The second staff in the PEP room reported that staff prompted [client B] to eat his lunch one time before throwing the food in the trash. Client [client B] often requires hand over hand assistance and supervision while eating. Both staff were suspended pending investigation. Investigation was completed 6/2/2015. The reporting staff was counseled and retrained on reporting practices on 6/2/2015. The staff that was alleged neglectful will be terminated on 6/3/15 with a disciplinary action based on DSI (Developmental Services Incorporated) policy. Staff will maintain health and safety." The facility's 5/29/15 reportable incident report indicated the facility did</p>		<p>investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions that address the root cause of the investigation. They will be instructed upon the proper collection of interviews, statements, physical evidence and any pertinent maps, pictures or diagrams. This team will also be asked to attend INARF's incident investigation and recommendations training on 8/11/2015. The RPM will review all completed investigations in order to determine if the corrective actions are adequate and in line with state regulations. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and request investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room in order to better monitor and document staff/client interactions.</p>		

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	<p>not have documentation of an investigation.</p> <p>-5/29/15 at 3:27 PM, "Day Program Manager was notified by the Group Home Manager that [client B] had scraped his head. Unaware of the serious nature of the incident and having not received any reports from staff, Day Program Manager did not originally file the Incident Report. In Monday, 6/1/15 Day Program Manager received a report that [client B] had to seek treatment at [name of medical facility] to get the wound glued. Day Program Manager began an internal investigation to find out the cause of the injury. Staff (staff #7) called in to report that the other staff (staff #8) who was working with [client B] redirected him away from the door...Staff (staff #8) left the reporting staff (staff #7) in the room alone with 9 clients without notice to use the restroom. Residential staff came to pick up [client B] and found him bent over looking out the door with blood running down his arm. Residential staff reported to Group Home Manager that staff told him he was responsible for reporting it and was unaware of what took place to cause the injury...." The facility's 5/29/15 reportable incident report indicated the neglectful staff (staff #8) was terminated and staff #7 was counseled and retrained</p>			

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	<p>on reporting on 6/2/15. The facility's reportable incident report did not indicate any additional documentation/evidence of an investigation.</p> <p>Interview with DPM on 6/9/15 at 12:45 PM and on 6/10/15 at 9:15 AM indicated the day program had terminated staff in the past several months for abuse and/or neglect of clients. The DPM indicated she conducted the investigation in regard to client B's allegations of abuse/neglect on 5/29/15. The DPM indicated she had not written/typed up the 5/29/15 investigation as she had been working in the PEP room. The DPM indicated she spoke with the day program staff who worked in the PEP room. The DPM stated she did not interview any clients as the clients would not be able to give "an accurate account of what happened." The DPM indicated staff #8 was terminated for abuse and neglect in regard to the 5/29/15 allegations.</p> <p>Interview with the Residential Program Manager (RPM) and the Qualified Intellectual Disabilities Professional (QIDP) on 6/10/15 at 11:45 AM indicated the DPM had conducted the investigation in regard to the 5/29/15 allegations of abuse/neglect involving client B. The RPM indicated the facility did not have a copy of the investigation.</p>			

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W 0157 Bldg. 00	<p>This federal tag relates to complaint #IN00174900.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 10 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to put in place corrective measures/monitor the group home/day program in regard to client B's suspicious injuries.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 6/9/15 at 1:20 PM. The facility's 5/4/15 reportable incident report indicated Client B had "4 quarter size bruises along right forearm that vary in size between each of them. An investigation is being done due to being unknown how they were acquired...."</p> <p>The facility's 5/7/15 Incident Investigation indicated the staff did not know how client B received the injury.</p>	W 0157	In order to implement effective corrective actions for any ANE findings or any adverse trend, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions that address the root cause of the investigation. They will be instructed upon the proper collection of interviews, statements, physical evidence and any pertinent maps, pictures or diagrams. In addition to training provided by DSI, this team will also be asked to attend INARF's incident investigation and recommendations training on 8/11/2015. County QIDPs will be trained on 7/15/15 how to identify and implement proper corrective actions that will prevent future	07/16/2015

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W 0267 Bldg. 00	<p>The facility's investigation indicated "...Conclusion/Outcome/Systemic Changes: looks like finger prints but no one saw or could confirm client or staff interaction that could have caused the bruises. Staff will continue to monitor for safety." The facility's 5/7/15 investigation indicated the facility neglected to put any corrective actions/measures in place to monitor client B to ensure the client was not being abused.</p> <p>Interview with the Residential Program Manager (RPM) and the Qualified Intellectual Disabilities Professional (QIDP) on 6/10/15 at 11:45 AM indicated staff had been terminated from the group home and the day program due to abuse of clients. The QIDP indicated the facility was not able to determine how client B received the bruises on 5/4/15. The QIDP and the RPM indicated the facility did not address client B's suspicious injury of 5/4/15.</p> <p>This federal tag relates to complaint #IN00174900.</p> <p>9-3-2(a)</p> <p>483.450(a)(1) CONDUCT TOWARD CLIENT The facility must develop and implement</p>		instances of ANE. The RPM will review all completed investigations in order to determine in the corrective actions are adequate and in line with state regulations. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and request investigations if they meet the criteria.		

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	<p>written policies and procedures for the management of conduct between staff and clients.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure a staff person did not use inappropriate language when working around clients at the day program.</p> <p>Findings include:</p> <p>During the 6/9/15 observation period between 11:02 AM and 12:45 PM, at the day program, staff #1 wheeled a client into the PEP (Personal Enhancement Program) room. Staff #4 stated to staff #1 "We are revoking your vacation." Staff #1 replied/stated in a loud tone "B....., I'm still going." After staff #1 made his statement, staff #3 said "sh sh" and looked in the surveyor's direction. Staff #1 turned around to see who staff #3 was looking at. Staff #1 turned back around and left the PEP room. Clients A, B, C and D were present when staff #1 made the statement. The Day Program Manager (DPM), staff #3 and #4 were also present in the area/PEP room.</p> <p>Interview with staff #3 on 6/9/15 at 1:00 PM stated facility staff should not use "inappropriate language" in front of clients.</p>	W 0267	<p>In order to correct this deficiency, the staff in question was issued a counseling memorandum regarding the proper use of language when clients are present. An in-service will be held on 7/14/15 to address the expectation of proper discourse between staff and clients and staff to staff. Staff are to maintain a professional demeanor while working and strive to set a good example as a mentor. Staff are expected to act (language, action, discipline, rules etc.) in a way that promotes the clients' quality of life. The QIDP will use monthly observations as well as weekly unannounced visits to ensure that staff are using appropriate language. The day program manager, QIDP and RPM will make weekly visits to the PEP room in order to better monitor and document staff/client interactions. The day program manager, QIDP and RPM will make multiple weekly visits to the PEP room in order to ensure staff are interacting with the clients in a positive and uplifting manner.</p>	07/16/2015	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Interview with administrative staff #3 on 6/9/15 at 1:09 PM indicated facility staff should not curse/use inappropriate language around clients. When asked if the facility had a policy and procedure in regard to staff to client interactions, administrative staff #3 indicated she would check to see. Administrative staff #3 indicated the staff to client interactions were a part of facility's staff training the facility provided when staff were hired.</p> <p>Interview with the Residential Program Manager (RPM) on 6/9/15 at 1:11 PM when told what happened in the PEP room, stated "Definitely inappropriate." The RPM indicated staff to client interactions and conduct were a part of the facility's Standard Operating Procedures manual.</p> <p>Interview with the DPM on 6/10/15 at 9:15 AM indicated she heard staff #1's statement on 6/9/15. The DPM indicated staff #1 should not have used that kind of language in front of clients. The DPM indicated she was not staff #1's supervisor as the staff person, who was assisting the client, was from a group home. The DPM indicated she reported the incident to staff #1's supervisor.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2015
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN 47201		
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	The facility's 12/22/11 Standard Operating Procedures (SOP) were reviewed on 6/9/15 at 1:48 PM. The facility's SOP indicated in regard to clients' rights, facility staff were not to swear and/or use "name calling" when around clients. 9-3-5(a)				