

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/22/2014
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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W000000	<p>This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00156855.</p> <p>Complaint #IN00156855: Substantiated. Federal/state deficiencies related to the allegations are cited at W102, W104, W122, W125, W149, W153, W154, W156, W157, W159, W186, W189, W259, W407, and W436.</p> <p>This visit was in conjunction with the Post Certification Revisit (PCR) to the investigation of complaint #IN00151850 completed on 7/17/14.</p> <p>Survey Dates: October 6, 7, 8, 14, 15, 16, 17, 20, 21 and 22, 2014.</p> <p>Facility Number: 001209 Provider Number: 15G634 AIM Number: 100240160</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 28, 2014 by Dotty Walton, QIDP.</p>	W000000		

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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise operating direction over the facility by failing to ensure its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B, C, D and E were implemented as written. The governing body failed to ensure thorough investigations were conducted. The governing body failed to ensure the results of investigation were reported to the administrator or designee within 5 working days. The governing body failed to ensure effective corrective actions were implemented to address client to client abuse. The governing body failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to ensure there was sufficient staffing to meet the needs of the clients. The governing body failed to ensure staff received competent training to effectively communicate with client B. The governing body failed to ensure the</p>	W000102	<p>1) Plan of correction: Staff to client ratio will be 3:4 during active treatment and 2:4 during overnights and sleep time (attachment a). Plan of prevention: Staffing office and human resources will prioritize Deckard open shifts (attachment b). Quality monitoring: House manager, coordinator, and director will check in with staffing office daily to make certain these hours are filled. 2) Plan of correction: Staff have been trained on communicating with client B using the training CD and sign language cards in his binder (attachment b). Plan of prevention: Training has been scheduled weekly(attachment c). Quality monitoring: Director will verify that trainings are occurring. 3) Plan of correction: Assessment for client B and D have been completed (attachment Plan of prevention: Coordinator / Qdip has been selected and will start position within the next month. Director will continue monitoring and overseeing the Qdip duties. Quality monitoring: New coordinator– when selected will be trained to complete assessment prior to ISP meeting each year. Director will check to make sure they were completed. 4) Plan of correction:</p>	12/12/2014

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	<p>clients' had the right to due process in regard to the locking of the thermostat and the laundry room door. The governing body failed to ensure a complete and accurate accounting of the clients' funds. The governing body failed to ensure client B was properly placed in regard to his social, behavioral and psychiatric needs. The governing body failed to ensure the carpet was cleaned or replaced, common area walls were repainted, floors not covered by carpet were cleaned, the holes in client E's bedroom were repaired, client B did not store empty soda cans in his bedroom and client B and E's electrical outlet covers were replaced.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 5 of 5 clients living in the group home (A, B, C, D and E), the governing body failed to exercise operating direction over the facility by failing to ensure its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B, C, D and E were implemented as written. The governing body failed to ensure thorough investigations were conducted. The governing body failed to ensure the results of investigation were reported to the administrator or designee within 5 working days. The governing</p>		<p>ISP (IPP) for client B and D have been completed (attachment f). Plan of prevention: The facility's former QDIP /coordinators have resigned and is no longer eligible for employment with StoneBelt. Quality monitoring: New coordinator – when selected will be trained to complete assessment prior to ISP meetings each year. Director will check to make sure they were completed. 5) Plan of correction: Support team will meet each month to discuss client's progress. Plan of prevention: House manager has been trained to facilitate weekly and monthly support team meetings (attachment i). Quality monitoring: Coordinator / QDIP will be trained to oversee that these discussions are occurring. 6) Plan of correction: Support team reviewed client D's audiologist recommendation for a hearing aid. It was determined that due to behaviors and refusals they would not be introduced at this time. Team will review once client D is stable (attachment g) Plan of prevention: Day aid has been trained to follow through with all recommendations and physician orders (attachment h). Quality monitoring: House manager has been trained to monitor outside service reports and that orders have been followed / IDTs held (attachment i). 2 – 1) Plan of correction: IPP has been</p>				

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	<p>body failed to ensure effective corrective actions were implemented to address client to client abuse. The governing body failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to ensure there was sufficient staffing to meet the needs of the clients. The governing body failed to ensure staff received competent training to effectively communicate with client B. The governing body failed to ensure the clients' rights to due process in regard to the locking of the thermostat and the laundry room door. The governing body failed to ensure a complete and accurate accounting of the clients' funds. The governing body failed to ensure client B was properly placed in regard to his social, behavioral and psychiatric needs. The governing body failed to ensure the carpet was cleaned or replaced, common area walls were repainted, floors not covered by carpet were cleaned, the holes in client E's bedroom were repaired, client B did not store empty soda cans in his bedroom and client B and E's electrical outlet covers were replaced.</p> <p>2) Please refer to W122. For 88 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to meet the Condition of</p>		<p>introduced to teachclient b to use temporary communication devise (attachment j) Plan of prevention: QDIP is no longer employed with StoneBelt and is not eligible for rehire. Quality monitoring: House manager has been trained tomonitor outside service reports and that orders have been followed / IDTs held,training plans introduced when needed (attachment i) 3 – Plan of correction:Support team has determined that client b would be served 60 day notice perStone Belt's discharge policy below; (attachment k). Dischargefrom services may occur when: The client/legalguardian chooses to leave services. Services are nolonger appropriate, either because the client has received full benefit orbecause the needs of the client have changed. The client, and/or asapplicable, the family, refuses to participate in available services. The client fails tocontinue to meet admission criteria. A client has presented conduct dangerous to selfor others that is not manageable through behavior intervention techniques,medication and/or environmental adjustments. Funding for servicesis no longer available. Plan of prevention:Admission team will review packets and determine proper placement of eachindividual following visits and team discussion. Information will</p>				

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	<p>Participation: Client Protections. The facility's governing body failed to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations of client to client abuse, and report to incidents to the Bureau of Developmental Disabilities Services (BDDS), within 24 hours, in accordance with state law. The governing body failed to report the results of all investigations to the administrator or designated representative within 5 working days of the incident. The governing body failed to ensure the clients had the right to due process in regard to locking the thermostat and the laundry room door. The governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans as evidenced by: 1) insufficient staffing to implement the clients' program plans, 2) staff received training to communicate effectively with client B, 3) client B and D's comprehensive functional assessments (CFA) were reviewed, at least annually, and updated as needed, 4) client B and D's individual program plans (IPP) were revised at least annually, 5) regular reviews of the clients' progress of their training objectives was not conducted, and 6) there was no review of a</p>		<p>be logged into a data base for accurate data will be kept on each potential client Plan of monitoring:Staffing has been enhanced until client b has been transitioned to another placement.Client b has a new placement and is awaiting CIH waiver to be approved by the state</p>	

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W000104	<p>recommendations made by client D's audiologist for a hearing aid. The governing body failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans. The governing body failed to ensure staff received training to communicate effectively with client B. The governing body failed to ensure client B was properly placed in regards to his social, behavioral and psychiatric needs demonstrated. The governing body failed to ensure client B had a plan to teach him to use a temporary, trial communication device (client B was being assessed for the need of the device).</p> <p>3) Please refer to W407. For 1 of 3 clients in the sample (B), the governing body failed to ensure client B was properly placed in regard to his social, behavioral and psychiatric needs.</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general</p>				

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	<p>policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the governing body failed to exercise operating direction over the facility by failing to ensure its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B, C, D and E were implemented as written. The governing body failed to ensure thorough investigations were conducted. The governing body failed to ensure the results of investigation were reported to the administrator or designee within 5 working days. The governing body failed to ensure effective corrective actions were implemented to address client to client abuse. The governing body failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to ensure there was sufficient staffing to meet the needs of the clients. The governing body failed to ensure staff received competent training to effectively communicate with client B. The governing body failed to ensure the clients' rights to due process in regard to the locking of the thermostat and the laundry room door. The governing body failed to ensure a complete and accurate</p>	W000104	<p>1) Plan of correction: Support team for A, B, C, D, E have determined that locks on laundry room and thermostat would be removed. Plan of prevention: Maintenance department has been trained to not prohibit access without due process initiated by support team. Plan of monitoring: Plan of monitoring: House manager / associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f). . 2) Plan of correction: A, B, C, D, E were reimbursed money that was removed from their account without financial procedures being followed (attachment l). Plan of prevention: House manager and FMPS have been trained by finance department of Stone Belt financial procedures (attachment m). Plan of monitoring: Plan of monitoring: House manager / associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f). 3) Plan of correction: The majority of the 88 of 112 incidents regarding clients A, B, C, D, E occurred between the months of March-August. There has been an 86% decline in incident reports since the change in leadership and support team members (attachment n). The quantity of staff was not increased but</p>	12/12/2014

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	<p>accounting of the clients' funds. The governing body failed to ensure client B was properly placed in regard to his social, behavioral and psychiatric needs. The governing body failed to ensure the carpet was cleaned or replaced, common area walls were repainted, floors not covered by carpet were cleaned, the holes in client E's bedroom were repaired, client B did not store empty soda cans in his bedroom and client B and E's electrical outlet covers were replaced.</p> <p>Findings include:</p> <p>1) Please refer to W125. For 5 of 5 clients living at the group home (A, B, C, D and E), the governing body failed to ensure the clients had the right to due process in regard to locking the thermostat and the laundry room door.</p> <p>2) Please refer to W140. For 5 of 5 clients living at the group home (A, B, C, D and E), the governing body failed to conduct a full and complete accounting of the clients' personal funds.</p> <p>3) Please refer to W149. For 88 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the governing body failed to prevent client to client abuse and staff abuse and neglect, provide sufficient staff to manage and</p>		<p>training of the staff has been prioritized. Plan of prevention: Staff ratios will be 3:4 during sleep time (attachment a). Plan of monitoring: House manager, coordinator, and director will check in with staffing office daily to make certain these hours are filled. 4) Plan of correction: The majority of the 10 of 112 incidents regarding clients A, B, C, D, E that were not reported within 24 hours occurred between the months of March-August (attachment n). Plan of prevention: The staff including; emergency pager, social workers, and behavioral consultant have been trained in reporting incidents within 24 hours in accordance to state law (attachment b). Plan of monitoring: Director will continue to train staff each month at meeting at Shiloh. 5) Plan of correction: The majority of the 15 of 112 incidents regarding clients A, B, C, D, E that were not investigated occurred between the months of March-August (attachment n). Plan of prevention: QDIP will be trained to conduct timely investigations and submit follow up with team and BDDS. Plan of monitoring: Director will continue to train coordinators monthly. 6) Plan of correction: The majority of the 6 of 118 incidents regarding clients A, B, C, D, E that when outcomes were not reported to the</p>	

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	<p>supervise the clients, implement effective corrective actions to address client to client abuse, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conduct investigations of abuse and neglect, and provide the results of investigations to the administrator within 5 working days of the incident.</p> <p>4) Please refer to W153. For 10 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the governing body failed to ensure the facility submitted incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>5) Please refer to W154. For 15 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the governing body failed to ensure the facility conducted thorough investigations of abuse and neglect of the clients.</p> <p>6) Please refer to W156. For 6 of 118 incident/investigative reports reviewed affecting clients, the governing body failed to ensure the facility reported results of all investigations to the administrator or designated representative within 5 working days of</p>		<p>administrator occurred between the months of March-August (attachmentn). Plan of prevention: QDIP will be trained to reportoutcome of investigations within 5 working days of the incident. Plan of monitoring: Director will continue to traincoordinators monthly. 7) Plan of correction: The majority of the 86 of 112incidents regarding clients A, B, C, D, E were associated with client b's maladaptive behavior. Team hasdetermined that a 60 day notice is being provided per agency discharge policy(attachment k). Plan of prevention: QDIP will be trained to implementeffective corrective actions to address client's maladaptive behaviors. Plan of monitoring: Director will continue to traincoordinators monthly. 8) Plan of correction: The majority of the 88 of 112incidents regarding clients A, B, C,D, E occurred between the months of March-August. There has been an 86%decline in incident reports since the change in leadership and support teammembers (attachment n). The quantity of staff was not increased but training ofthe staff has been prioritized. Plan of prevention: Staff ratios will be 3:4 duringactive treatment or 2:4 during sleep time (attachment a). Plan of monitoring: House manager, coordinator, anddirector will check in with</p>	

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	<p>the incident.</p> <p>7) Please refer to W157. For 86 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the governing body failed to ensure the facility implemented effective corrective actions to address the clients' maladaptive behaviors.</p> <p>8) Please refer to W186. For 5 of 5 clients living in the group home (A, B, C, D and E), the governing body failed to ensure the facility provided sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>9) Please refer to W189. For 1 of 3 clients in the sample (B), the governing body failed to ensure the facility provided training to staff to communicate effectively with client B.</p> <p>10) Observations were conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM and 10/7/14 from 6:03 AM to 8:19 AM. On 10/6/14 during the observation, the office area where the staff administered the clients' medications had dark black, brown and gray areas on the floor. During both observations at the group home, the carpet had areas where there were stains</p>		<p>staffing office daily to make certain these hours are filled. 9) Plan of correction: IPP has been introduced to teach client b to use temporary communication devise (attachment j) Plan of prevention: QDIP is no longer employed with StoneBelt and is not eligible for rehire. Quality monitoring: House manager has been trained to monitor outside service reports and that orders have been followed / IDTs held, training plans introduced when needed (attachment i) 10) Plan of correction: All environmental issues listed have been fixed. Including new carpet and new sofa. Plan of prevention: Two overnight staff are scheduled and will be responsible for cleaning the home following a cleaning checklist (attachment o). Quality monitoring: House manager has been trained to submit work orders and copy CFO and director. They have also been trained to provide oversight to the overnight staff and checklist (attachment i)</p>				

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	<p>and discolorations of the carpet. The carpet was matted and torn in some areas. The common areas walls were nicked, scuffed, stained, marked and missing paint in areas throughout the group home. The areas of the floor not covered by carpet were scuffed, marked, and discolored. Client E's bedroom closet had two holes measuring 4 inches by 4 inches, one hole measuring 1 inch by one inch, and one hole measuring 5 inches by 2 inches. Client B and E's bedrooms both had an electrical outlet cover missing from the east wall. Client E's bedroom baseboard trim was torn off the walls throughout his bedroom. During both observations, client B had two garbage bags and several boxes with empty soda cans stored in his bedroom. His bedroom had gnats flying around in the room.</p> <p>On 10/9/14 at 8:15 AM, the Group Home Director indicated in an email, "Closet wall was patched yesterday morning in [client E's] room."</p> <p>On 10/6/14 at 3:19 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the interior of the group home needed to be painted after the scuffs and dings in the walls were repaired. On 10/6/14 at 3:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the group</p>			

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	<p>home was scheduled to have a deep cleaning by a contracted agency on 10/15/14. The QIDP indicated the carpets needed to be cleaned or replaced due to being stained, matted and torn.</p> <p>On 10/7/14 at 6:05 AM, the Group Home Director (GHD) stated the cans in client B's room "have got to go from his room" due to the gnats. The GHD indicated client B was using the bags of cans on 10/6/14 between 9:00 PM to 10:00 PM to disturb the other clients by hitting the bags together trying to wake up the other clients. On 10/8/14 at 3:04 PM, the GHD stated the walls needed to be painted and the floors were "dirty." The GHD indicated the holes in client E's bedroom needed to be repaired. The GHD indicated maintenance would not repair the holes while client E was at home therefore maintenance needed to schedule a time to repair the walls. The GHD indicated clients B and E pulled the electrical outlet covers off in their rooms. The GHD indicated client E's baseboard trim also needed to be repaired.</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-1(a)</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 88 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations of client to client abuse, and report to incidents to the Bureau of Developmental Disabilities Services (BDDS), within 24 hours, in accordance with state law. The facility failed to report the results of all investigations to the administrator or designated representative within 5 working days of the incident. The facility failed to ensure the clients had the right to due process in regard to locking the thermostat and the laundry room door. The facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans as evidenced by: 1) insufficient staffing to implement the clients' program plans, 2) staff received training to communicate effectively with client B, 3) client B and D's comprehensive functional assessments (CFA) were reviewed, at least annually, and updated as needed, 4)</p>	W000122	<p>1) Plan of correction: Locks have been removed. Plan of prevention: Maintenance department has been trained to not prohibit access without due process initiated by support team. Plan of monitoring: Plan of monitoring: House manager /associate manager will conduct daily observations. Coordinator or director will provide daily monitoring (attachment f) to ensure items are not being restricted without due process. 2) Plan of correction: The majority of the 88 of 112 incidents regarding clients A, B, C, D, E occurred between the months of March-August. There has been an 86% decline in incident reports since the change in leadership and support team members (attachment n). Staff ratios will be 3:4 during active treatment or 2:4 during sleep time (attachment a). Plan of monitoring: House manager, coordinator, and director will check in with staffing office daily to make certain these hours are filled. 3) Plan of correction: The majority of the 10 of 112 incidents regarding clients A, B, C, D, E that were not reported within 24 hours occurred between the months of March-August (attachment n). Plan of prevention: The staff including; emergency</p>	12/12/2014

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	<p>client B and D's individual program plans (IPP) were revised at least annually, 5) regular reviews of the clients' progress of their training objectives was not conducted, and 6) there was no review of a recommendations made by client D's audiologist for a hearing aid. The facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans. The facility failed to ensure staff received training to communicate effectively with client B. The facility failed to ensure client B was properly placed in regards to his social, behavioral and psychiatric needs demonstrated. The facility failed to ensure client B had a plan to teach him to use a temporary, trial communication device (client B was being assessed for the need of the device).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Please refer to W125. For 5 of 5 clients living at the group home (A, B, C, D and E), the facility failed to ensure the clients had the right to due process in regard to locking the thermostat and the laundry room door. 2. Please refer to W149. For 88 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the 		<p>pager, social workers, and behavioral consultant have been trained in reporting incidents within 24 hours in accordance to state law (attachment b). Plan of monitoring: Director will continue to train staff each month at Shiloh (attachment AA) 4) Plan of correction: The majority of the 6 of 118 incidents regarding clients A, B, C, D, E that were not investigated occurred between the months of March-August (attachment n). Plan of prevention: QDIP will be trained to report outcome of investigations within 5 working days of the incident. Plan of monitoring: Director will continue to train staff each month at Shiloh (attachment AA) 5) Plan of correction: The majority of the 6 of 118 incidents regarding clients A, B, C, D, E that when outcomes were not reported to the administrator occurred between the months of March-August (attachment n). Plan of prevention: QDIP will be trained to report outcome of investigations within 5 working days of the incident. Plan of monitoring: Director will continue to train coordinators monthly. 6) Plan of correction: The majority of the 86 of 112 incidents regarding clients A, B, C, D, E were associated with client b's maladaptive behavior. Team has determined that a 60 day notice is being provided per agency discharge policy (attachment k). Plan of</p>	

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	<p>facility neglected to implement its policies and procedures to prevent client to client abuse, prevent staff abuse and neglect, provide sufficient staff to manage and supervise the clients, implement effective corrective actions to address client to client abuse, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conduct investigations of abuse and neglect, and provide the results of investigations to the administrator within 5 working days of the incident.</p> <p>3. Please refer to W153. For 10 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>4. Please refer to W154. For 15 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility to conduct thorough investigations of abuse and neglect of the clients.</p> <p>5. Please refer to W156. For 6 of 118 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to report the results of all</p>		<p>prevention: QDIP will be trained to implement effective corrective actions to address client's maladaptive behaviors. Plan of monitoring: Director will continue to train staff each month at Shiloh (attachment AA) 7) Plan of correction: Staff to client ratio will be 3:4 during active treatment and 2:4 during overnights and sleep time (attachments). Plan of prevention: Staffing office and human resources will prioritize Deckard open shifts. Quality monitoring: House manager, coordinator, and director will check in with staffing office daily to make certain these hours are filled. 8) Plan of correction: Staff have been trained on communicating with client B using the training CD and sign language cards in his binder (attachment b). Plan of prevention: Training has been scheduled weekly (attachment c). Quality monitoring: Director will verify that trainings are occurring. 9) Plan of correction: Assessment for client B and D have been completed (attachment d). Plan of prevention: Carmund and Rebecca the former QDIP /coordinators have resigned and is no longer eligible for employment with StoneBelt. Quality monitoring: New coordinator – when selected will be trained to complete assessment prior to ISP meetings each year. Director will check to make sure they were completed.</p>		

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	<p>investigations to the administrator or designated representative within 5 working days of the incident.</p> <p>6. Please refer to W157. For 86 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to implement effective corrective actions to address the clients' maladaptive behaviors.</p> <p>7. Please refer to W159. For 3 of 3 clients in the sample (B, D and E) and two additional clients (A and C), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans as evidenced by: 1) insufficient staffing to implement the clients' program plans affecting clients A, B, C, D and E, 2) staff did not receive training to communicate effectively with client B, 3) client B and D's comprehensive functional assessments (CFA) were not reviewed at least annually and updated as needed, 4) client B and D's individual program plans (IPP) were not revised at least annually, 5) regular reviews of the clients' progress of their training objectives was not conducted, and 6) there was no review of a recommendation made by client D's audiologist for a hearing aid.</p>		<p>10) Plan of correction: ISP (IPP) for client B and D have been completed (attachment f). Plan of prevention: Carmund and Rebecca the former QDIP /coordinators have resigned and is no longer eligible for employment with StoneBelt. Quality monitoring: New coordinator – when selected will be trained to complete assessment prior to ISP meetings each year. Director will check to make sure they were completed.</p> <p>11) Plan of correction: Support will meet each month to discuss client's progress. Plan of prevention: House manager has been trained to facilitate weekly support team meetings (attachment i). Quality monitoring: Coordinator / QDIP will be trained to oversee that these discussions are occurring.</p> <p>12) Plan of correction: Support team reviewed client D's audiologist recommendation for a hearing aid. It was determined that due to behaviors and refusals they would not be introduced at this time. Team will review once client D is stable (attachment g). Plan of prevention: Day aid has been trained to follow through with all recommendations and physician orders (attachment h). Quality monitoring: House manager has been trained to monitor outside service reports and that orders have been followed / IDTs held (attachment i).</p> <p>13) Plan of</p>				

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	<p>8. Please refer to W186. For 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>9. Please refer to W189. For 1 of 3 clients in the sample (B), the facility failed to ensure staff received training to communicate effectively with client B.</p> <p>10. Please refer to W407. For 1 of 3 clients in the sample (B), the facility failed to ensure client B was properly placed in regards to his social, behavioral and psychiatric needs.</p> <p>11. Please refer to W436. For 1 of 3 clients in the sample with adaptive equipment (B), the facility failed to ensure client B had a plan to teach him to use a temporary, trial communication device (client B was being assessed for the need of the device).</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-2(a)</p>		<p>correction: Staff to client ratio will be 3:4 during active treatment and 2:4 during overnights and sleep time (attachment). Plan of prevention: Staffing office and human resources will prioritize Deckard open shifts. Quality monitoring: House manager, coordinator, or director will check in with staffing office daily to make certain these hours are filled. 14) Plan of correction: Staff have been trained on communicating with client B using the training CD and sign language cards in his binder (attachment b). Plan of prevention: Training has been scheduled weekly (attachment c). Quality monitoring: Director will verify that trainings are occurring. 15) Plan of correction: A consultation was obtained from James Wiltz PHD concerning possible environmental changes the facility could introduce to accommodate client b (attachment u). Support team has determined that client b would be served 60 day notice per Stone Belt's discharge policy below; (attachment k). Discharge from services may occur when: The client/legal guardian chooses to leave services. Services are no longer appropriate, either because the client has received full benefit or because the needs of the client have changed. The client, and/or as applicable, the family, refuses to participate in available services. The client fails to continue to</p>		

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W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due		meet admission criteria. Acient has presented conduct dangerous to self or others that is not manageable through behavior intervention techniques, medication and/or environmental adjustments. Funding for services is no longer available. Plan of prevention: Admission team will review packets and determine proper placement of each individual. Visits will be documented and stored in a data base for accuracy in reporting. Plan of monitoring: Staffing has been enhanced until client b has been transitioned to another placement. 10) Plan of correction: ISP (IPP) for client B and D have been completed (attachment f). Plan of prevention: The former facility's former QDIP /coordinator (s) have resigned and are no longer eligible for employment with Stone Belt (attachment w). Quality monitoring: New coordinator – when selected will be trained to complete assessment prior to ISP meetings each year. Director will check to make sure they were completed.	

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	<p>process.</p> <p>Based on observation, record review and interview for 5 of 5 clients living at the group home (A, B, C, D and E), the facility failed to ensure the clients had the right to due process in regard to locking the thermostat and the laundry room door.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM and 10/7/14 from 6:03 AM to 8:19 AM. During the observations, the thermostat had a plastic cover with a lock on it. This affected clients A, B, C, D and E. During the 10/7/14 observation at the group home, the laundry room door was closed and locked. This affected clients A, B, C, D and E. On 10/7/14 at 6:46 AM, client B attempted to access the laundry room. The Group Home Director (GHD) used a key to unlock the door.</p> <p>On 10/6/14 at 4:32 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not sure why the thermostat was locked. The QIDP indicated clients A, B, C, D and E did not have anything in their plans indicating the need for the thermostat to be locked. The QIDP stated it was an "unnecessary restriction." The QIDP indicated the</p>	W000125	<p>Plan of correction: Locks have been removed. Plan of prevention: Maintenance department has been trained to not prohibit access without due process initiated by support team. Plan of monitoring: Coordinator/ Director will provide daily monitoring that ensure that no restrictions are in place that are not in plans. Social workers provide weekly monitoring.</p>	12/12/2014

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	<p>thermostat could only be unlocked with a key the staff had access to.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director (GHD) indicated the locked thermostat was a restriction that was not authorized. The GHD indicated the laundry room was locked due to the chemicals being stored in the room. The GHD indicated the clients access to the washer and dryer should not be restricted.</p> <p>On 10/9/14 at 12:19 PM, the Social Worker indicated in an email to the Group Home Director and the Behavior Specialist, "I'm not sure why the laundry room door is locked, as that is not a current house restriction. Looking back all the way to 2011, I don't find a laundry room restriction for [name of group home]."</p> <p>On 10/9/14 at 2:14 PM, the GHD indicated in an email to the Maintenance Director, "We do not have HRC (Human Rights Committee) approval for the laundry room being locked or restricted at [name of group home]. Please remove door lock and we will need a locking cabinet for all chemicals to store them in the laundry room safely. We are checking to find out if there is HRC approval for the thermostat being locked. At the moment we can not locate any</p>						

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W000140	<p>documentation. So we may also need a cover for it and the lock removed."</p> <p>On 10/9/14 at 3:25 PM, the Maintenance Director indicated in an email to the Group Home Director, "We put a lock on the laundry because of [client C]. I will be out of the office on Friday, but will replace it first thing Monday. The cover is on the thermostat because they break it off the wall."</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 5 of 5 clients living at the group home (A, B, C, D and E), the facility failed to keep a full and complete accounting of the clients' personal funds.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 10/6/14 at 3:20 PM and indicated the following:</p>	W000140	Plan of correction: A, B, C, D, E were reimbursed money that was removed from their account without financial procedures being followed. Money was spent by clients and receipts or money was located. All accounts were reconciled by Financial Coordinator 11/14. Plan of prevention: House manager and FMPS have been trained by finance department of Stone Belt financial procedures (attachment m). House manager	12/12/2014

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	<p>-Client A's personal funds ledger for October 2014 indicated he had \$0.23. Upon counting client A's personal funds, client A had \$1.29.</p> <p>-Client B's personal funds ledger for October 2014 indicated he had no money. On 9/30/14, client B withdrew \$10.00 from the bank. The ledger for September and October 2014 did not account for this money. On 10/6/14 at 3:28 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the \$10.00 should have been added to client B's ledger and the money accounted for with receipts and documentation where client B spent his money.</p> <p>-Client C's personal funds ledger for October 2014 indicated he had \$3.33. Upon counting, client C had \$3.31.</p> <p>-Client D's personal funds ledger for October 2014 indicated he had \$3.04. Upon counting, client D had \$2.37.</p> <p>-Client E's personal funds ledger for October 2014 indicated he had \$0.05. On 9/30/14, client E withdrew \$30.00 from his bank account. The \$30.00 was not added to his ledger and there was no accounting or documentation indicating where client E spent his money. Client</p>		meets monthly with financial coordinator to reconcile accounts Plan of monitoring: Coordinator and/or director will provide daily monitoring.				

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	<p>E's money pouch contained an envelope with \$5.29. The money in the envelope was not accounted for on the ledger.</p> <p>On 10/6/14 at 3:24 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility should account for the clients' funds to the penny.</p> <p>On 10/7/14 at 6:21 AM, the Group Home Director (GHD) indicated the facility should account for the clients' funds to the penny.</p> <p>On 10/7/14 at 11:10 AM, the facility's Fiscal Coordinator (FC) indicated the facility should account for the clients' funds to the penny. The FC indicated the process should involve the client going to the bank, writing a check, getting cash, logging the deposit for cash on the clients' ledger, and then subtracting the amount on the ledger for money spent. The FC stated, "Have had issues with the funds being off for months." The FC stated it was due to "sloppy accounting."</p> <p>On 10/7/14 at 6:13 AM, the Qualified Intellectual Disabilities Professional (QIDP) informed the Group Home Director that staff #2, who recently took the clients to the bank to withdrawal money, did not document the information</p>						

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W000149	<p>on the clients' financial ledgers.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 88 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility neglected to implement its policies and procedures to prevent client to client abuse, prevent staff abuse and neglect, provide sufficient staff to manage and supervise the clients, implement effective corrective actions to address client to client abuse, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conduct investigations of abuse and neglect, and provide the results of investigations to the administrator within 5 working days of the incident.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/6/14 at 12:31 PM and indicated the following:</p>	W000149	<p>Plan of Correction: Staff #2 was immediately asked to report to directorat 10th street office. His employmentwith Stone Belt was terminated (attachment). Plan of prevention:Leaving clients unattended in vehicles has been trained at monthly Shilohmeeting (attachment EE). Plan of monitoring: Coordinator or director will provide daily monitoring. Plan of correction:The 88 incidents regarding clients A, B, C, D, E were associated with clientb's maladaptive behavior. Team has determined that a 60 day notice is beingprovided per agency discharge policy (attachment k). Staff to client ratio willbe 3:4 during active treatment and 2:4 during overnights and sleep time(attachment a). Plan of prevention:Competency behavior training will be provided by facility BC to each staff(attachment q). Staffing office and human resources</p>	12/12/2014

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	<p>1) An observation was conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM. The surveyor arrived at 2:53 PM and parked in the yard of the group home due to there being no parking spots in the driveway. The surveyor observed staff #2 exit the group home van (parked in the driveway near the front door) and enter the group home. The surveyor walked up to the van, which was running, and observed client C sitting in the front passenger seat. The group home front door was closed. The window to the left of the front door did not have staff observing out of the window. The window to the laundry room and client A's bedroom had the curtains closed. Client C leaned over and started touching the keys. Staff #2 exited the house after two and a half minutes. During the time staff #2 was in the group home, client C was unsupervised in the running group home van.</p> <p>The Investigative Report, dated 10/7/14, indicated, "He (staff #2) admitted leaving [client C] unsupervised in the running group home van. He stated it was the 'middle seat.' Allegation substantiated... Staff was terminated. Email was sent out to all SGL (Supported Group Living) sites stating to never leave clients in vehicle unsupervised."</p>		<p>will prioritize Deckardopen shifts. Plan of monitoring: Director will continue to train coordinators monthly. Director will review competency training is occurring and will ensure it is occurring.</p>				

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	<p>2) On 9/29/14 at 1:50 PM, client E was reading a post card when client D attempted to sit on client E. Client E moved away from client D. Client E went to the kitchen. Client D followed client E and slammed the door. Client D opened the door and threw the trash can lid at client E. Client E had a red mark where the lid hit him on the side. Client E tried to go to his room and client D grabbed his shirt and ripped it. Client D spit at staff. There was no documentation of an investigation.</p> <p>3) On 9/27/14 at 9:00 PM, client B "shoved his way in to the med room between med passes." Client B sat in the middle of the room in a chair. Client B screamed and motioned he was going to break a window for 5 minutes. When client B stood up to go toward the window, staff used a two person transport to assist him to his room. The incident was reported to BDDS on 9/29/14.</p> <p>4) On 9/24/14 at 5:10 PM, client B was sitting in the driveway. As a car drove past, client B threw a rock at the car. Client B entered the house and pointed outside. There was a car parked outside the house. When staff and client B went outside, the car drove off. The car came back and a woman got out of the car and</p>			

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	<p>indicated client B hit her car with a rock, leaving scratches. The woman indicated about one month ago as she passed the group home, someone threw water at her car. The BDDS report, dated 9/25/14, indicated, "Coordinator notified and is investigating." There was no documentation of an investigation.</p> <p>5) On 9/22/14 at 5:00 PM, client B pulled client E's hair as client E was eating. Client E tried to go to his room. Client B ran in front of client E and locked client E's door. Client B slapped client E on the head and kicked him in the shins. Client E was not injured. Client E went into his room and locked the door. Client B went out the back door. Client B walked to a small construction site on the street the group home was located followed by one staff and two clients. Construction workers were digging new gas lines. Client B ignored the cones and staff's prompts and would not move away from the hole. Staff got in between client B and the hole so client B would not fall in. Client B walked down the street and laid in the middle of the street near a curve. Cars were attempting to drive around him and he refused to move. The BDDS report, dated 9/23/14, indicated, in part, "Staff tried to get [client B] to stand up physically by pushing him up and off the</p>			

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	<p>road fearing for [client B's] safety. [Client B] began to walk back toward [name of group home], but each time a car would pass, [client B] would quickly run out in front of the car getting the car to suddenly stop. [Client B] paid no attention to staff; Coordinator and central pager were notified; 911 were (sic) called immediately after. [Client B] apologized and ran inside [name of group home] to hide, but soon came out again. Police arrived at 6:35pm, but left minutes later as [client B] was behaving safely. [Client B] then resumed the behavior and walked out into the street with staff and clients following. Psych (psychiatric) pager was called and [client B] talked to Behaviorist as well. [Client A] also ignored staff's prompts to return to the house. [Client A] trespassed into the backyard of a house which was 'For Sale' and jumped on a trampoline for a few minutes; staff informed [client A] he was trespassing, but [client A] stayed for a little longer. Behaviorist arrived to stay with [client B], and staff returned home with [client A] and other client. Staff never lost sight of any clients." There was no documentation an investigation was conducted.</p> <p>6) On 9/21/14 at 9:00 PM, client B entered a staff's car as a staff was preparing to leave. Client B took a drink</p>			

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	<p>from her car and ran back into the house and locked himself in the bathroom. Staff entered the bathroom to retrieve the drink. When client B exited the bathroom and saw staff with the drink, he attempted to "attack" the staff. Client B was placed in a bear hug. Staff and client B fell to the ground and the hold was released. Client B began head banging and slamming doors. The psychiatric pager staff was contacted. Client B's guardian was notified and client B spoke to his guardian. Client B calmed down, took his medications and went into his room. Client B exited his room and began to engage in self-injurious behavior and aggression. Client B was placed in brief bear holds lasting no longer than one minute on five separate occasions. At 1:00 AM, client B went to bed.</p> <p>7) On 9/20/14 at 1:15 PM, client C approached client E. Client E pushed client C and kicked client C in the hip. Client C stumbled backward and fell to the ground, landing on his buttocks. There was no documentation of an investigation.</p> <p>8) On 9/20/14 at 12:00 PM, client B refused to take his medications.</p> <p>9) On 9/19/14 at 8:00 AM, client B</p>						

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	<p>refused to take his morning medications.</p> <p>10) On 9/18/14 at 3:40 PM and 9:00 PM (incident report documented on 9/19/14), client B grabbed a day program staff's right arm. Client B released his hold and then chased the staff while signing "beautiful." She went into the women's restroom. Client B stood at the door yelling for her to come out for 30 minutes. Staff called client B's guardian who spoke to him about the severity of his decision to grab and trap the staff in the restroom. Client B signed "no" and covered his ears. The Social Worker walked down the hallway and distracted client B long enough for the staff in the restroom to get out. Client B attempted to grab her and he was blocked until she was out of sight. Client B refused to leave the building until 4:30 PM. Client B was transported to his group home. Client B took a nap until 9:00 PM when the Group Home Director was getting ready to leave the house. Client B attempted to wake up his sleeping roommates by hitting on his bag of soda cans (for selling) with a spoon. The Stone Belt Incident Report, dated 9/19/14, indicated, "Team is meeting on 9/20 to discuss possible ESN (Extensive Support Needs) application and other placements to keep [client B] and others safe."</p>			

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	<p>11) On 9/18/14 at 7:25 AM, client A went to the kitchen to prepare breakfast. Client A found a bagel in the refrigerator. Client E entered the kitchen and told client A the bagel was his. Client E approached client A from behind and slapped client A in the back of the head. There was no documentation an investigation was conducted.</p> <p>12) On 9/17/14 at 7:15 AM, client D hit client B in the leg three times after client D hit staff several times while refusing his medications. Client B was not injured. There was no documentation of an investigation.</p> <p>13) On 9/13/14 at 4:00 PM (reported to BDDS on 9/15/14), client D spit on client E and staff. Client D was placed in two basket holds for 30 seconds or less to block his aggression toward client E. Clients D and E hit each other twice with open palms to the face. During the incident, client D attempted to expose himself to client E. There was no documentation of an investigation.</p> <p>14) On 9/12/14 at 12:00 PM (reported to BDDS on 9/15/14), client B refused his morning medications.</p> <p>15) On 9/11/14 at 5:00 PM (reported to</p>			

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	<p>BDDS on 9/13/14), client B went to take his evening medications. Client B then refused to take them. Once the overnight staff arrived, client B began acting in an aggressive manner to the staff, refusing to let them clock in, hitting them, and destroying the staff's glasses. Client B slammed his door repeatedly and began throwing items at staff. Client B left the house at 11:30 PM with staff following. Staff never left client B's vicinity. After two and a half hours of walking around the neighborhood, client B and staff returned to the group home. Client B refused to take his medications.</p> <p>16) On 9/11/14 at 4:00 PM (reported to BDDS on 9/15/14), client B flicked client E's nose and kicked client E's shins. Client E went to his room. Client B kicked and tried to unlock client E's door. Client D was agitated with client B's behavior but was redirected. At 5:00 PM, the behaviorist met with client E in the formal living room. Client D entered the room carrying client B's hat. Client D attempted to close the door and used his body to push the door closed. Client B had his arm in the door and staff was outside of the room prompting client B to remove his arm. Client D took client B's hand and bit it. Behaviorist prompted client D to stop biting client B. Client D released the bite. Client B removed his</p>			

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	<p>hand and client D shut the door. Client B's hand did not have broken skin although the skin was red. There was no documentation of an investigation.</p> <p>17) On 9/9/14 at 12:00 PM, client B refused to take his morning medications.</p> <p>18) On 9/8/14 at 11:45 PM, client B woke up and staff asked him to take his medications. He refused. At 1:00 AM, client B wanted to take his medications. Staff explained it was too late and he would have to wait until morning to take his morning medications. Client B attempted to wake up the other clients by slamming doors, yelling and trying to knock on the other clients' bedroom doors. When staff intervened, there were two instances when client B slapped and punched the staff.</p> <p>19) On 9/8/14 at 5:00 PM, client B repeatedly picked up food off of pans to eat and refused all staff's requests to help set the table. Client D entered the kitchen and mimicked client B's behavior. Client D wanted client B out of the kitchen. Client D pushed client B out of the kitchen multiple times and client B went back in. Client A attempted to enter the kitchen to help with redirecting client D. Client D pulled client A's shirt. Client A tried to charge</p>			

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	<p>at client D but staff stood in front of the two. Client D left the kitchen but then pushed on the door to get back in. Clients A and B were holding the door closed. Client D aggressed on staff. Client D kicked one staff, smacked another in the face and punched a third staff in the shoulder. Client D was then angry at client E who was yelling at client D to stop. Client D followed client E into client E's room. Client D grabbed client E's charging cable and would not let go. Client E attempted to hit client D several times but staff blocked the attempts. Client D was able to kick client E in the stomach. Client D chased client E into the living room. Client D cut his middle knuckle of his right hand during the incident. Client E was not injured.</p> <p>20) On 9/7/14 at 10:30 PM, client A's remote was taken by client B. Clients A and B "wrestled" each other for the remote. Staff broke up the altercation. There was no documentation of an investigation.</p> <p>21) On 9/3/14 at 11:59 PM, client B missed his bedtime medications. On 9/3/14 at 4:00 PM when all the clients were departing the day program, client B refused to leave. Client B did not return home until 9/4/14 at 7:00 AM.</p>						

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	<p>22) On 9/2/14 at 10:00 PM, client B was pounding on the wall between his room and another client's room (client E). Staff prompted client B to stop. Client B took off his shoe and hit the staff with his shoe several times. Staff kept client B in an exclusionary time out in his room for approximately 50 minutes, while standing outside of his doorway using a blocking pad per his behavior plan. Client B made several attempts to hit staff with items from his room. Client B broke a wooden crate in his room. Client B refused to take his medications.</p> <p>23) On 8/26/14 at 12:00 PM, client B refused to take his morning medications. The incident was not reported to BDDS.</p> <p>24) On 8/24/14 at 10:30 PM (reported to BDDS on 8/26/14), staff was working with client C. Clients B and D went into the office area and locked the door. The BDDS report indicated, in part, "Staff could not attend to [client D and client B] because [client C] was being put into his room. [Clients B and D] were each sitting in the office chairs kicking and slapping each other. As soon as staff would separate the two, [client C] would wake up when staff would then attend to [client C]. [Clients B and D] started attacking staff simultaneously with punches, slapping and kicking. [Client</p>			

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	<p>D] was put in a series of 4 bear hugs and 3 basket holds, each lasting a maximum of 10 minutes; and went on for approximately 1 hour." Staff contacted the pager. Client B was screaming/hitting/kicking doors and waking up client C. The report indicated, "[Client C] had fallen due to the force and influence of [client B's] behavior. [Client B] had dumped water on [client C] so [client C] slipped; [client B] slammed a door on [client C] and [client C] was knocked backwards; 2 other occasions where [client C] was exiting his room and fell." Client B pulled the fire alarm while staff was helping client C to bed. Client B blocked the exit for evacuation. The fire department arrived and attempted to re-set the alarm, but the pull appeared broken into the alarm position. Client B attempted to throw things at client C but "staff scooped up [client C] and carried him to the formal room while blocking the door from the inside." Pager contacted again. Things calmed down. The report indicated, "Sometime thereafter, staff called 911 because staff was unable to restrain [client B] or put [client B] in an exclusionary time out as per his BSP, and was unable to continue blocking objects from hitting [client C]. [Client C] was checked for injury as [client C] had some red marks on his shoulders and arms</p>			

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	<p>which may develop into bruises and [client C] will be monitored. Officers arrived at 5:25am and had a chat with [client B] about how the night was going and got him in a more calm space." There was no documentation of an investigation.</p> <p>25) On 8/24/14 at 4:25 PM, client A informed staff he wanted a fountain soda. Staff explained he purchased one on 8/23/14, client A needed to save money, and soda was not healthy. Client A said "fine," took his medications, and went to his room. Staff started passing medications to another client. When staff finished the medication pass, he went to look for client A to see if client A wanted to go on a van ride. Staff was unable to locate client A. The second staff did not know where client A was located and had not observed client A leave the group home. Staff called the pager and the pager informed staff to call 911. The police were given a description of client A. At 4:48 PM, another employee had observed client A walking and stopped to talk to client A in an attempt to stall him. The pager was notified and went to pick up client A. The police arrived to the group home and staff relayed the information to the police. The BDDS report, dated 8/25/14, indicated, "Around 5:15pm, police brought [client A] back to</p>			

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	<p>[name of the group home], carrying a fountain soda he had bought at [name of store]. Client A was very pleased with what he had done, declaring that he was showing his independence. Staff told him that his actions were extremely unsafe and not a choice, nor was it a display of being a responsible adult. [Client A] said that he had really needed a soda, and that it was 'his choice.'" There was no documentation of an investigation.</p> <p>26) On 8/18/14 at 9:40 PM, client B kicked client E's bedroom door. Client B laid in front of client E's room and kicked the bedroom door several times. Client E exited his room a few times and told client B to stop. Client B refused and continued to kick client E's door. Client B stopped once staff told him the staff would have to write an incident report.</p> <p>27) On 8/17/14 at 5:00 PM, client A thought client B had his remote in his bedroom. The former QIDP told client A that client B did not have his remote. The QIDP thought the situation was over. The QIDP heard a commotion from down the hall and went to client B's room. Client D was in client B's room pulling on client B's shirt. Client E was in client B's room trying to take the remote. Client A was in the hallway watching.</p>			

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	<p>Client D was prompted to go to his room. Client A became upset and attempted to go into client B's room. Client A aggressed (kicking and hitting) on the former QIDP trying to get to client B. After the incident, client B admitted to stealing client A's remote and returned it. There was no documentation the incident was reported to BDDS.</p> <p>28) On 8/16/14 at 2:10 AM, client D was prompted to use the restroom due to incontinence. Client D's bed was soaked with urine. Client D took a shower and staff heard a loud noise from the bathroom and heard client D yell for help. Client D was getting up off the bathtub floor. Client D scraped his right cheek during the fall. Staff used hydrogen peroxide to clean the injury. There was no documentation the fall with injury was reported to BDDS. A second incident report, dated 8/16/14, indicated, "Come to find out hours later that the fact the client had fallen in the shower apparently he hit so hard it caused a pipe to burst in the wall causing water to leak into the dining room & living room areas."</p> <p>29) On 8/15/14 at 8:20 PM (reported to BDDS on 8/18/14), client B had been aggressive. At 7:40 PM, he threw an apple off of the apple tree and hit the</p>			

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	<p>group home van. At 8:20 PM, client B hit staff in the back. Client B threw a pen and hit the same staff in the back of the head. Client B was told throwing items was inappropriate and he attempted to aggress on three staff. Client B was put in a baskethold but he spit and kicked at the staff who was attempting to leave. Client B was in the baskethold for 10 minutes. While in a baskethold, client B hit the staff in the chest and attempted to spit on staff. When released, client B grabbed staff's shirt so the staff could not enter the office and tore the staff's shirt. Client B was placed in a bear hug for 30 seconds. Client B yelled and slammed doors once released for 15 minutes.</p> <p>30) On 8/13/14 at 12:00 PM, client B refused to take his morning medications.</p> <p>31) On 8/8/14 at 12:00 AM, client B went to bed early and would not wake up to take his medications. There was no documentation the incident was reported to BDDS.</p> <p>32) On 8/3/14 at 12:00 PM, the incident report indicated, "[Client B] stayed up until very early in the morning displaying unsafe behavior, and fell asleep about 5:30 AM." Client B did not take his morning medications. The incident was not reported to BDDS.</p>			

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	<p>33) On 8/2/14 at 7:00 PM, client B attempted to keep a staff's car from entering the driveway. Client B attempted to keep staff locked in the office after he clocked in and attempted to walk onto the highway next to the house. Client B threw rocks at cars, flipped off drivers from the driveway and crossed the highway at one point. When client B reentered the home around 10:00 PM, client B threatened to throw items at the staff. When client B was asked to take his medications, he started screaming, slamming his bedroom door and kicked the shared wall between his room and client E's room. This continued until 11:30 PM. The overnight staff informed the psychiatric pager staff who had arrived that she could leave. Client B started throwing objects (pillow, laundry basket lid, bottle of Listerine and a bucket) at staff. Client B went into his room and started kicking the wall to client E's room and shouting. At 11:40 PM, client B kicked client E's bedroom door and staff got in between to block. Client B went into his room and threatened to throw items at staff. Client B hit himself in the head with the items. Staff contacted the QIDP. The QIDP informed staff to lock any items used by client B to hit himself with in the office. The items included small metal tin,</p>			

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	<p>several tin cans, larger plastic bins, the laundry basket lid, a small frying pan and a metal mug. Each time staff confiscated an item, client B kicked, scratched, slapped and attempted to bite the staff. Staff blocked client B with a couch cushion. Client B struck the fire detector in the living room and broke it. Staff did not have the alarm box key to disarm the alarm. Client B continued slamming doors, slapping and kicking until around 2:00 AM when he threw the laundry bin at the exposed florescent light tubes in the living room and one fell. Client B swung the tube at the staff but staff blocked it using a brief hold on the ground and preventing him from reaching the tube or laundry bin. Client B attempted to hit additional tubes with a tennis ball and the laundry basket. The psychiatric pager staff returned at 2:20 AM. Client B was calm during her visit but when she left at 3:25 AM, client B began kicking the other clients' bedroom doors, screamed, and slammed his own door until around 4:00 AM. Client B was apologetic. Client C woke up at 4:00 AM and client B apologized to him. Client B was calm until 5:40 AM when client C went back to bed. Client B started kicking the wall in his room and yelling but he was quiet around 6:00 AM. Client B refused to take his bedtime medications.</p>			

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	<p>34) On 8/2/14 at 5:45 PM, client B hit client C with a towel in the head and face. Staff blocked client B's attempts to hit client C. Client B grabbed client C's shirt collar and pulled hard and would not let go. Staff attempted to release client B's grip. Client B jumped through the pass through window and grabbed client C's shirt collar with both hands from the back. Staff attempted to release client B's grip. Client C's face started to turn red. The BDDS report, dated 8/3/14, indicated, "...[client B] was using [client C's] own shirt to choke him. [Client B] was also attempting to bite any staff's arms and hands as they tried to remove [client B's] hands." Staff used a bear hug hold on client B. Client B's grip was released. Client B kicked and spit at client C while pushing against the staff holding him. Client B headbutted the staff's collarbone repeatedly while scratching the staff's arms and hands with his fingernails. When staff attempted to switch due to the first staff's fatigue, client B broke free. Client B threw grill parts and lighter fluid at the house and attempted to kick the window in (the window was already broken). The BDDS report indicated, "Even after attempts to talk to [client B] about why he was angry, plan next day's events, help with cleaning, or go on walks with him, [client</p>			

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	<p>B] continued displaying unsafe behavior for the next 5 hours, including throwing rocks at cars, standing in the middle of [name of streets], and attacking staff. Multiple refusals to talk, and refusals to stop attacking [client C]. [Client B] signed multiple times that he wanted to hit [client C] more and that he wanted to hit staff more, throw rocks and other objects, stand in the road, and break more property... Staff monitored [client C] (housemate) the rest of the night for any adverse effects from the abrasion." The Client to Client Aggression Inquiry, reviewed by the administrator on 8/16/14, indicated, "I recommend that [client B] be placed in a different residential setting that is more appropriate for him. He is becoming a danger to himself and others in the house."</p> <p>35) On 8/2/14 at 12:00 AM (reported to BDDS on 8/4/14), client E refused his medications.</p> <p>36) On 8/1/14 at 7:00 PM (reported to BDDS on 8/3/14), client B got into client A's bedroom. It took until 9:15 PM to get client B to exit client A's bedroom. Client A locked his bedroom door. Client B attempted to stop staff #2 from leaving the group home. Staff #2 was able to leave the group home. Client B, at 9:40 PM, broke his fire detector in his</p>						

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	<p>bedroom. Client B blocked staff from accessing the fire panel. Client E attempted to attack client B while he obstructed the fire panel. Client E struck staff on the left side of the head with his right hand. At 10:00 PM, client B kicked client C's bedroom door and tried to wake up clients C and D who were asleep in their rooms. Client B started slamming his door repeatedly. Client E went to the kitchen to get a drink and client B knocked the drink out of client E's hands. Client B threw milk, juice and water at client E. Client E threw parts of the vacuum at client B. Client B threw utensils, chairs, and a sauce pan at client E. Client B hit client E in the head with a bottle brush and then a small sauce pan. Client E went into a fetal position and started crying. Both clients threw the metal napkin holder at each other until it broke. Client B threw backpacks and chair until he hit one of the plastic light covers in the living room. The cover fell and broke. Client B spit on staff. Client B kicked, slapped and attempted to bite staff. Client B threw chairs, cups of water, tennis balls, laundry basket lid, and utensils at staff. This lasted from 10:00 PM to 2:50 AM. The Stone Belt ARC, Inc. Incident Report indicated, "There were several points where I contacted the emergency pager, [former QIDP], and [former manager] and in</p>			

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	<p>some cases it was because I didn't feel like I could keep the clients safe due to the types of things [client B] was throwing, or that [client E] might have needed medical attention from being hit in the head with a sauce pan." The report indicated, "[Client B] ran out of steam at around 2:50 AM, changed mood drastically and was apologetic and helpful. He helped me do dishes, mop, and do laundry." The investigation, reviewed by the administrator on 8/10/14, indicated, in part, "I recommend that [client B] be placed in a different residential setting that is more appropriate for him. He is becoming a danger to himself and others in the house."</p> <p>37) On 8/1/14 between 12:45 AM and 1:50 AM, client B woke up and started hitting his wall which prevented another client from sleeping. Staff redirected client B but then heard client B throwing a softball. The fire system alarm near the kitchen started going off and client B came running out of his room. Client B either hit the smoke alarm in his room with the ball or unscrewed the cap causing the alarm to go off. Staff was able to get the alarm off but client B was agitated. Client B signed to staff he wanted to hit his smoke detector again. Staff stood in client B's room for most of</p>			

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	<p>an hour trying to redirect client B. Client B threw his shoes at staff and the smoke detector. Client B kicked his window and hit his window with softballs from his room. At 1:30 AM, staff told client B if he did not stop he would put him in a hold. Client B pulled a picture off the wall and grabbed the pin that was holding it up. Client B attempted to poke staff with the pin so staff took it from him and performed a baskethold for 3 minutes. After being released, client B attempted to hit staff with several objects. Client B eventually calmed down.</p> <p>38) On 7/28/14 at 5:30 PM, client B returned to the group home from the grocery store. Client B started bringing in groceries. Client E wanted to assist. Client B tried to close the front door when client E went outside. Clients B and E ran to the van. Client E grabbed some bags and client B hit him on the shoulder. Staff got in between the clients. Client E grabbed another bag and client B reached over the staff and hit client E on the right shoulder. There was no documentation the incident was reported to BDDS. The investigative report was signed as reviewed by the administrator on 8/8/14. The investigative report indicated, in part, "I recommend that either [client E] or [client B] be moved to another residential</p>			

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	<p>setting. This is not an example of an extreme incident, but these situations are too frequent and the abuse that results (as the state calls it peer to peer abuse), is scarring emotionally and psychologically. I do not believe that it is safe to continue supporting both of these clients in this environment."</p> <p>39) On 7/27/14 at 5:00 AM, client C grabbed client E's shirt on his way out of the bathroom. Client E started to choke client C with both hands from the front. Staff pried client E's hands off of client C's neck and put him in a temporary hold for a few seconds. Client C went to bed. Client E wanted an Ensure from the office. Client C exited his room and tried to leave the house through the back door. Client E took four Ensures from the office and was sitting in the living room drinking them. Staff removed one of the Ensures. Client E struck the staff in the back twice with his fist. Staff turned around and client E struck him on the right side of his jaw. Client E dumped an Ensure on the staff. Client C was not injured.</p> <p>40) On 7/25/14 at 9:00 PM, client B attempted to prevent staff from leaving at the end of their shift by standing in front of the staff's car door and getting behind the car and preventing it from backing</p>				

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	<p>out. Staff blocked client B causing him to get more frustrated. At 9:30 PM, client B entered the house and sat on client E's lap while on the couch and would not move. Client E attempted to choke client B with his right arm. Staff blocked the choking attempt. Client B went outside and got into the group home van and started honking the horn at 9:45 PM. Staff called the home manager who instructed the staff to attempt to remove client B from the van since the honking of the horn was disruptive to the neighbors and client B's peers who were trying to sleep. Staff attempted three bear hugs unsuccessfully. Staff used a baskethold to remove him from the van and locked the van's doors. Client B entered the house. At 10:30 PM, client B slammed the kitchen door 4 times and the clock fell off the wall and broke, shattering the glass of the clock. Client B ran from the glass shards and staff blocked him. Staff cleaned up the glass. At 10:40 PM, client B threatened to throw a frying pan at staff. Client B hit the kitchen window. At 10:50 PM, client E walked up to the kitchen to see what was going on and client B threw the frying pan at client E. Staff blocked the frying pan. Staff called the pager. Client B calmed down during the call and put the pan away. After the call, client B got the pan out again. Staff climbed over the</p>			

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	<p>kitchen bar and restrained client B in a bear hug to prevent him from harming himself by breaking the window with the frying pan. Staff prompted client B out of the kitchen. The pager was called again. Client B went to his room from 11:00 PM to 11:20 PM. Client B went outside and stood in the middle of the street outside the house. A car pulled into the neighborhood when client B was still in the road. Staff put client B in a bear hug to remove him from the road. Client B went back inside the house and calmed down.</p> <p>41) On 7/24/14 at 7:00 PM, client B refused to leave client E's bedroom. Client B left client E's room with one of client E's shoes. Client E was standing in front of client B's room demanding his shoe back. Client E was redirected to his room. Client B gave client E his shoe back. Client B attempted to aggress on client C as he exited the medication area. His attempts were blocked. Client C dropped to the floor and client B put his foot on client C. Client B hit the staff in the back and client B was restrained in a standing baskethold. Once released, client B hit the staff again. Client B was restrained again. Once released, client B attempted to aggress on client C. Client C went into the bathroom with staff to take a shower. Client B kicked and</p>			

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	<p>slammed doors. Client B slammed the office door several times repeatedly. Client B started crying and saying he was sorry. The BDDS report, dated 7/25/14, indicated none of the clients were injured. The investigation, dated 7/30/14, indicated, in part, "I recommend that [client B] be moved from [name of group home]. He continues to target [client C] and this (sic) creating an unsafe environment for [client C]. I believe that this targeting will continue."</p> <p>42) On 7/22/14 at 12:00 PM, client B refused his morning medications.</p> <p>43) On 7/21/14 at 7:25 PM, client A was in the kitchen cooking a bowl of cheese in the microwave. Staff #1 went into the kitchen and asked client A if it was a healthy choice. Staff #1 offered fruit or salad instead. Client A "charged" at staff #1 swinging his arms. Staff #1 backed away and client A followed him. Client A "charged" at staff #1 again. Staff #1 attempted to put client A in a baskethold but could not get it applied. Staff #1 did a one man escort toward his room. Client A "turned to me banging on his chest like King Kong and charged at me again, all a long (sic) I was asking him to calm down." Client A went into his room. The report indicated, "He threw a DVD case at me, scraping my arm, and I closed</p>			

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	<p>the door and held it closed while I talked to him asking him to calm down. After a couple of min. (minutes) I open (sic) the door." The Investigative Report, dated 7/24/14, indicated, "In conducting the interviews and reviewing the documentation pertinent to the incident in question, the allegation of abuse is unsubstantiated... Although the client's door was held, and this is a restrictive intervention, it was done so in a manner similar to a blocking technique, rather than for confinement and the duration of 5 minutes noted on the incident report was not corroborated by the interviews of anyone involved. It should also be noted that appropriate protocol was not followed with regards to appropriate interventions when working with acting out clients, as the staff used a hold to act as a transport and did not use appropriate blocking techniques. Similarly, there is indicated that there were client rights violations that occurred during this incident regarding client choice. From the statements that were gathered, it appears as though staff, [staff #1] may be unsure about Stone Belt's policies and procedures surrounding what interventions are appropriate to use, when to use appropriate interventions, and what interventions are not deemed appropriate for use with Stone Belt clients." There was no documentation the incident was</p>			

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	<p>reported to BDDS.</p> <p>44) On 7/12/14 at 12:20 PM, client A asked staff several times throughout the morning if he could get a soda. Staff reminded him of the new house schedule that made time for trips to the store on Sundays but not Saturdays. Client A was reminded the staff would be going to a restaurant for lunch and he could get a soda at that time. Client A agreed to order a value sized soda since he also purchased a milkshake. As he finished his meal, client A asked staff if he could go to the store to get a soda as his current drink was not as large as the one from the store. Client A was reminded of their earlier conversation. Client A started to walk out of the restaurant and staff followed him. Client A indicated he was walking home alone and no one could stop him. Staff attempted to get in front of client A as he was walking toward a road with traffic. Client A raised his arms, closed his eyes, and attempted to strike staff several times. Staff backed away and noticed a car coming. Staff used a brief bear hug in an attempt to calm client A to get him out of the road. After 2 seconds, client A calmed down and walked out of the road.</p> <p>45) On 7/10/14 from 10-10:30 PM, client B threw items at staff. Client E</p>						

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	<p>observed client B enter the kitchen for some grapes. Client E yelled, "The kitchen is closed." Client B responded, "Nuh uh." This lasted for 10 minutes. Client E was prompted to ignore client B. Client E was yelling "no." Client C woke up. The staff left the kitchen area to attend to client C, who appeared unstable (gait). Clients B and E were in the kitchen yelling at each other. Staff was assisting client C to the table, client E ran to client B and choked and shook him. Staff removed client E's hands from client B and escorted client E to the front room. Client E attempted to hit staff. Clients B and E calmed down. The investigation, dated 7/17/14 did not have a signature indicating the report was reviewed by the administrator. The investigation indicated, in part, "I do not believe that [name of group home] is an appropriate setting for both [client B and client E]. It is becoming increasingly more and more difficult to support both clients in this setting. These incidents are most dangerous overnight when there is only one staff."</p> <p>46) On 7/9/14 at 2:15 PM, client E entered the office and sat down. He had dried blood on his forehead. He indicated he did not know where the blood came from. Staff cleaned the blood and there was a knot on his forehead. Client E</p>			

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	<p>indicated he fell in his bedroom and hit his head on the bed. When asked how he fell he did not know. The BDDS report, dated 7/10/14, indicated, "A (sic) Injury of Unknown Origin Inquiry will be conducted." There was no documentation of an investigation.</p> <p>47) On 7/7/14 at 10:15 AM, client B was in his room when a repair company arrived to repair client C's broken door to his bathroom. Client B became upset when they finished. Client B attempted to follow the repairmen outside and then attempted to break the new door. Client B grabbed the back of client C's shirt but let go when prompted. Client B spit on staff and threw a shoe at staff. Client B hit staff and pulled the staff's shirt. Client B was placed in a baskethold to escort him to his room. Client B dropped to the floor in the hallway. Client B ran outside and sat in the driveway. There was no documentation the incident was reported to BDDS.</p> <p>48) On 7/5/14 at 10:30 PM, client B attempted to lie down on top of client E. Client B attempted to nudge and shove client E. Client E attempted to hit and kick client B. Client E started ignoring client B. Client B went outside to throw cups of water at passing cars. Client B threw a cup of water at a car with the</p>			

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	<p>window open. The car stopped and client B ran inside the house and watched as the car waited for about 5 minutes. At 10:50 PM, client E got up to use the restroom and client B took his spot on the couch. When client E returned, he got aggravated and attempted to hit, kick and throw his shoes at client B. Client E sat on the couch with client B. Client B started pulling client E's hair and staff sat in between the clients. Client B attempted to reach around the staff. While blocking client B, client B grabbed the staff's right hand and shook it and staff felt a sharp pain on his ring finger. The investigation, dated 7/8/14, indicated, in part, "[Client E] has refused all medications for more than a week. The team believes that his guardian has encouraged [client E] to not take his medication and that is why this string of refusals have continued despite staff prompting [client E] and despite the team encouraging [client E] to take medications. Many of these client to client incidents are happening at night when one staff is present. Considering [client E's] current psychiatric state and [client B's] predisposition to bother and intentionally disturb [client B], I do not think that it is appropriate for these two individuals to live together. It is exceptionally challenging to support two such individuals in this setting. Once</p>						

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	<p>[client E's] psychiatric condition stabilizes, this recommendation might not be necessary."</p> <p>49) On 6/30/14 (no time indicated), the investigative report (there was no facility incident report or BDDS reports to review), dated 7/1/14, indicated, in part, "[Client B] was quite upset and was standing outside of [client E's] door banging on it and yelling. [Client E] was in his room and was awake. The other guys were not awake. I made sure that [client C] was not hurt when [client B] hit him on the back of the head. [Client C] fell, but not as a result of [client B] hitting him. [Client C] was okay. I stayed with [client C] for as long as he was up. We went to the dining room table and had a snack. [Client B] followed but I stayed with [client C] and [client B] did not do anything else." The recommendations section indicated, "[Name of a former staff] completed training with me about the importance of ensuring that bedroom doors are locked when arriving at work. [Former staff] understood how important that is. I do not believe that any other training is necessary at this time."</p> <p>50) On 6/29/14-6/30/14 (no time indicated), the investigative report (there was no facility incident report or BDDS</p>			

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	<p>reports to review), dated 7/1/14, indicated, in part, "[Client C] had gotten up. [Client B] was yelling loudly after he stopped banging on [client E's] door. [Client E] was awake but in his room. I got [client C] to sit down at the table and I was sitting next to him... It happened so fast. I was sitting on the other side of the table from [client B] who was yelling. [Client E] came pretty quickly out of his room and slapped [client B] and then went... [Client E] ran to his room right as I was telling him that he couldn't hit [client B]. They ended up in two different rooms and there was no further contact for the evening." Client B was not injured.</p> <p>51) On 6/28/14 at 2:30 PM, client B was involved in a prior incident where he bit a roommate and drew blood. Client B was taken to the emergency room for lab work.</p> <p>52) On 6/27/14 at 6:35 PM, client B was eating dinner and got up to get the empty bottles client E threw into the trash can. Client B threw the bottles into the backyard. Client E jumped up to get the bottles. Client E came inside, wet (due to rain) and cursed at client B. Client E threw the bottles away again. Client B took the bottles out of the trash can and threw them outside. Client E grabbed</p>						

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	<p>client B's shirt by the collar with both hands. Client B bit down on client E's left forearm, resulting in a puncture. Client E backed away. Later in the evening, client D was agitated with client B's behavior (loud noises and encroaching on personal space). Client D moved past staff to sit between clients B and E who were on the couch. Client D grabbed client B's hat and crushed his drink can. Client B pushed and grabbed client D. Client D grabbed the phone and remote from client E and attempted to block client E from seeing the television. Client E attempted to grab and hit client D. Client E threw the remote at client D and client D threw the broken pieces of the remote at client E. Client D continued to display aggressive behavior toward clients B and E for 20 minutes. The BDDS report, dated 6/28/14, indicated, "No serious injuries were incurred by the clients." The BDDS report did not indicate who was injured and what the injuries consisted of. The investigation, dated 7/1/14, indicated, "I recommend that [client B] and his guardian pursue a CIH (Community Integration and Habilitation) waiver. This incident is another example of how [client B's] anxiety and aptness for intentionally upsetting his housemates has resulted in an incident. While I recognize that this tendency is not new to</p>			

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	<p>[client B], my concern, and hence my initial statement, arises from the increase in this behavior especially directed towards [client E], who also exhibits high anxiety and an inability to regulate responses on his own. [Client E] had made improvements in this area and ought not regress. I believe that two clients with such extreme anxiety in one house is too much. We will use new strategies developed by [Social Worker] to assist in calming [client B] in an attempt to reduce anxiety and redirect him during these situations."</p> <p>53) On 6/22/14 at 5:00 PM, client B entered the home yelling. Client B told the staff they could no longer work with client C. Staff explained he was working with client C. Client B threatened to bite, hit, kick and spit at client C. Client C and staff walked away. Client B followed them and continued to threaten client C. Client B hit client C but it was partially blocked. Client D walked into the room at the time client B hit client C. Client D attempted to hit client B. Client D followed client B around the house while client B yelled he was going to hurt client C. The Stone Belt ARC, Inc. Incident Report, dated 6/22/14, indicated, "[Staff] was at this point preparing to get [clients C and D] out of the violent and stressful environment, grabbing [client</p>			

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	<p>C's] backpack off of the coat rack in the living room." Clients C and D were trying to leave and client B blocked their exit. Client D leaned and charged from the living room to the kitchen area and shoved client B down pushing him into the door. Client B fell to the floor. No one was injured.</p> <p>54) On 6/5/14 at 4:45 PM, client A received a phone call on the group home phone. Client B became agitated and wanted the telephone. Client B threatened to hit client A. Client A left to go on a walk. Client B threw items at the staff who left with client A. Client A went on his walk and client B followed. Client B attempted to hit the staff. Client A pushed client B. Client C had arrived in the van. Client C's staff decided to leave with client C after seeing client B agitated. Client B held onto the van's mirror in an attempt to keep the van from leaving. Staff redirected client B. Client B went into the group home and started throwing objects at the staff. Client B went into his room and threw objects at staff. The Social Worker attempted to take client D into the staff office but client B rushed in and would not leave. The Social Worker and client D left the area. Client C returned to the home and laid on the floor. Client B laid on top of client C. Client B, with prompting, got</p>			

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	<p>off of client C. The incident report, dated 6/5/14, indicated at 9:00 PM at the time the incident report was written, client B was in his room pounding on client E's wall.</p> <p>On 6/5/14 (no time indicated), the Client to Client Inquiry, dated 6/11/14, indicated client B was preventing client C from taking a shower. Eventually client C got into the bathroom. Client B banged on the door. Client D came down the hall and grabbed client B and put him in a headlock. Client D released the hold when prompted. Client B was not injured. The investigation, dated 6/11/14, was not signed by an administrator as having received the report. The investigation indicated, in part, "I recommend that [client B] be moved from [name of group home] as soon as possible. I fear for his long term safety. It is becoming increasingly more difficult for us to protect [client B] with [client D] feeling emboldened and recognizing that his interventions are calming [client B]. [Client D] is stronger than most staff, quick and not easily restrained. I fear that [client B's] continued presence in the house will result in a serious injury or abuse. I recommend that the Director seek an emergency waiver for [client B]."</p> <p>55) On 5/18/14 at 9:45 PM, client D</p>				

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	<p>gorged on client E's breadsticks. Client E ran to client D and client D smacked client E's face. Client E was screaming due to being hit hard by client D. Client E had a dark red area on his face. Client D took 5 breadsticks and went to his room. Client E went to client D's room and banged on the door. Staff prompted clients A and B to go to their rooms and lock their doors for their protection. Client D exited his room screaming and ran toward staff. Client D ran and attempted to hit client E but it was prevented. Client E ran to the dining room and client D tore his own shirt in half. Client D hit staff several times and ran toward client E. Client E ran to his room and locked his door. Client D hit staff again. Client D took his penis out of his pants and threatened to urinate on staff. Client B opened his door and said "pee pee." Client B ran to the bathroom and closed the door. Client D attempted to open the door but client B was holding the door closed. Client B ran out of the bathroom to his room. Client D attempted to run after client B but the staff restrained client D in a baskethold. After 2-3 minutes, client D was released. He attempted to hit staff several times and pulled his penis out and threatened to urinate on staff. Client D went to his room and came out with 2 breadsticks. Client D indicated he wanted to say he</p>			

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	<p>was sorry to client E. Client E refused to come out of his room. Client D said he was sorry to client A and they hugged. The report indicated, "[Client D] ate some of [client E's] bread sticks and [client E] was hit in the face. Everyone in the house was scared of [client D]."</p> <p>56) On 5/15/14 and 5/16/14, there was an allegation of verbal and emotional abuse made concerning facility-operated day program staff #2 employee involving client B. The allegation indicated staff #2 would not allow client B to talk with another staff. The allegation indicated staff #2 shut the van door so client B could not talk to another staff. The Investigative Report, dated 5/23/14, indicated, in part, "Allegation involving [client B] substantiated for Client Rights Violation." The Statement of Findings indicated, in part, "Although there are some discrepancies in the accounts of the four incidents investigated, it appears that [former day program staff #2] has made multiple statements to clients which have been disrespectful, and intended to restrict clients' choices, and to intervene with client behavior in a punitive and domineering manner. [Former day program staff #2] by her own admission, is unfamiliar with client behavior plans and risk plans. She perceives interactions with clients as necessitating dominance,</p>			

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	<p>and she lacks insight into her own tone, and demeanor. While it is not likely that [former day program staff #2] is intentionally being abusive to clients, her actions, statements and manipulative interactions have cause clients to feel negatively." Former day program staff #2 was terminated on 5/28/14.</p> <p>57) On 5/13/14 from 9:50 PM to 11:00 PM, client B blocked the office door so the staff could not get in. Client C went to the office door and gave staff a hug. Client B grabbed client C's shirt collar and client B refused to let go. Staff prompted client B but refused to let go. Staff removed client B's grip, finger by finger, from client C's shirt. Client B went into client C's room. Client C attempted to crawl into bed where client B was sitting. Client B grabbed client C's shirt collar again and held it. Client B released his grip and went to bed. Client C was not injured. The investigation, dated 5/16/14, indicated, "I strongly recommend that [client B] be moved to another residential location. It is not safe for him to be in a house with this set of clients. [Client B] has been involved in 11 client to client incidents since the beginning of April."</p> <p>58) On 5/12 to 5/13/14 from 10:30 PM to 12:00 AM, client B went to client C's</p>			

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	<p>room and woke him up by being loud in the hallway and knocking on client C's door. Client C exited his room and client B went in and sat on client C's dresser. As staff attempted to get client B to leave client C's room, client B laid on client C's bed. Client C walked up several times to go back to bed. The Stone Belt ARC, Inc. Incident Report, dated 5/15/14, indicated, in part, "After this happened for awhile I let [client C] attempt to crawl into his bed. [Client B] grabbed hold of [client C's] shirt by the collar so I asked him to let go of [client C] but I eventually had to pull [client B's] hand off of [client C's] shirt. [Client B] then sat up in bed while [client C] was half on the bed...". Staff asked client B if he needed an escort to his own room and client B said, "Nuh uh." Staff told client B he was going to have to call the pager. Client B eventually got up and left client C's room. Staff locked client C's door and escorted client B to the hallway. Client B went to his room but stayed awake all night. The investigation, dated 5/16/14, indicated, "I strongly recommend that [client B] be moved to another residential location. It is not safe for him to be in a house with this set of clients. [Client B] has been involved in 11 client to client incidents since the beginning of April."</p> <p>59) On 5/9/14 at 7:00 PM, clients B, D</p>			

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	<p>and E were getting ready to return from dinner in the van. Clients B and E got into a disagreement about what radio station to listen to. Client E cursed at client B and hit him on the left arm. Client D hit client E on his right arm. Client E hit client D on his left arm. Everyone calmed. When they returned home, client E pushed client D in the back. The investigation, dated 5/13/14, indicated, "I strongly recommend that [client B] receive alternate residential placement. [Clients B and E] can not live together safely. There has (sic) been 8 incidents of peer to peer abuse between these two clients in the past 5 weeks. [Client B] is a more appropriate candidate for waiver placement than [client E], which is why I recommend that he be moved instead of [client E]."</p> <p>60) On 4/28/14 at 7:45 AM, client D was sitting at the table eating. Client E was in the living room. Client E walked into the dining room with his shoes in his hands and asked client D if he was going to the day program. Client D shouted "NO" and client E hit client D in the back of the head and ran to his room. There was no documentation of an investigation.</p> <p>61) On 4/22/14 at 2:00 AM, client B turned client E's bedroom light on and off. For two hours, client B attempted to</p>			

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	"pester" client E by turning his light off and on and hitting and kicking his door and wall. Client B put his feet into client E's room. Client B threw a magazine, paper towels and sodas into client E's bedroom. Staff stayed in between the clients. Client B woke up client C. Staff called the pager and was told there was no one to come and help. Client C walked to the entryway and attempted to leave the house. When staff got to the hallway, client E was bent over client B. Client B was on the floor and client E was punching him in the face. Staff prompted client E to stop. Client B returned to turning the lights off and on and hitting client E's door and wall. Client B threatened to run away. Client B walked outside and stood outside for an hour. The report indicated there were no injuries. The investigation, dated 4/28/14, indicated, "I recommend that [client B] be moved out of [name of group home]. While we will continue to support [clients B and E] at the same residence for as long as they are both here, it is now clear that this is not a healthy environment for these two clients. If we want to see true, continued and further development with [client B], he needs intensive supports in an environment where he does not have targets for his frustration. While that might sound unreasonable, it is not			

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	<p>reasonable or safe to subject other highly anxious, volatile clients to behaviors that are unsolicited. I will continue to make this singular recommendation if client to client aggression between these two clients continues."</p> <p>62) On 4/10/14, the Client to Client Aggression Inquiry, dated 4/16/14, indicated, "[Client C] was wandering around. [Client B] went into [client E's] room and would not leave. [Client D] was in his own room. [Client C] went outside about 20 minutes into the incident. [Client E] immediately got angry when [client B] would not leave his room. [Client B] tried to throw a shoe at [client E]. I was in between the two clients the entire time... In the midst of them trying to hit each other, I reminded the guys [clients B and E] about the house meeting that they had with [Social Worker] where they discussed civility and not hurting each other. I then asked [client E] if he would come into the office with me to calm down. I needed to go in there anyway to clean up the scrape on his knee from [client B] throwing a shoe at him. The shoe (hit) [client E's] knee. After [client B] went into the office came out and started to upset [client E] again, [client D] seemed to have had enough. When [client D] got involved, despite my redirections, I</p>			

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	<p>decided that I had to call the police or someone was going to get hurt. (It should be noted that [staff] called the Central Pager first and [name of group home] Coordinator was carrying the Central Pager. He picked up another client and staff that were elsewhere before coming to [name of group home]. When [client E] left his room and went with me to the office, [client B] calmed down and left [client E's] bedroom. Unfortunately, when [client E] left the office and returned to his bedroom, [client B] went back into the bedroom and [client E] got upset all over again. Eventually, I got [client B] to go with me to the office to talk, which also de-escalated the situation. He was fine for that time, but once he left the office, he resumed his behavior. He knew that it was going to get a rise out of [client E] and that [client E] would not stop yelling and would eventually try to hurt [client B]. Once I called the police, everyone calmed down. They all wanted to talk and I asked them to give me a moment before we started talking again. They all needed a break to relax and compose themselves."</p> <p>63) Client E's 4/10/14 Support Team Review Form indicated, in part, "[Group Home Director - GHD] and [Qualified Intellectual Disabilities Professional - QIDP] will review a recent incident</p>			

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	<p>where a non CPI (Crisis Prevention Institute) restraint was used." There was no documentation of an investigation.</p> <p>64) On 4/9/14 at 5:30 PM, client C hugged client A. During the hug, client C bit client A's right shoulder, breaking the top layer of his skin.</p> <p>65) On 4/8/14 at 3:00 PM, client E wanted milk. Client E threw his glass of milk at staff #1. As client E passed client C, client C grabbed client E's shirt collar. Client E tried to remove client C's fingers. Client E open hand slapped client C on the forehead twice. Staff pulled client E's hand away from slapping client C again and staff removed client C's hand from client E's shirt. The investigation, dated 4/11/14, indicated, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of Supervised Group Living...".</p> <p>66) On 4/8/14 at 2:45 PM, client E ate an 11 ounce box of vanilla wafers and drank a large glass of milk. Client E got another glass of milk and another box of vanilla wafers. Staff #1 asked client E to make a healthier choice. Client E hit staff in the side of the face and threw the glass of milk at staff. Client E punched the walls. Client E threw a shoe and a</p>			

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	<p>basketball at staff #1. Client E slammed his bedroom door.</p> <p>67) On 4/6/14 at 7:00 PM, client B returned to the group home. Client B slammed client E's open bedroom door against the wall. Client E yelled at client B. Client B screamed at client E. Client B threw his wallet and watch at client E. Staff approached and client B slammed client E's door shut. Client E locked his door. Client B kicked client E's door. Client B attempted to use a quarter to unlock client E's door. Staff blocked the attempt. Client D exited his room screaming, pulling his hair and hit the walls. Client D slammed the fire door closed. Client B continued to kick client E's door while screaming. Client B hit staff in the face repeatedly. Client D opened the fire door, screaming and attempted to charge at client B. Client B went into the dining room and threw a ketchup bottle and cups at client C. Client B lunged over the table trying to hit client C. Staff called 911. Client B continued to scream and threaten to hurt client C. Staff informed client B the police were called. He continued to scream and pace through the house but no longer threatened his roommates. The police arrived and spoke to client B about the consequences of hurting others. Client B remained calm. The</p>			

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	<p>investigation, dated 4/11/14, indicated, in part, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of Supervised Group Living...".</p> <p>68) On 4/6/14 at 11:30 AM, client B returned to the group home. Client E was asleep in his bed. Client B slapped client E's open door with his hand. Client E woke up and asked client B to stop. Client B screamed "No" and continued to slap the door. Client E asked client B to stop for 15 minutes. Client B started throwing clothes at client E. Client B grabbed one of client E's shirts and ran to his room. Client E followed him. Client B locked his door. Client B screamed through the door and client E pounded on client B's door. Client D returned to his room and client B left his room to scream at client E from client E's doorway. Client D lunged at client B and grabbed the medallion he had received the day before and ripped it off of client B's neck. Client B and E exchanged slaps and pushes around the staff in between them. Client E "became violently aggressive attempting to punch [client B] and a rear bear hug was used to stop the attack." Client B attempted to hit client C but the staff blocked his attempts. The Stone Belt ARC, Inc. Incident Report, dated 4/6/14, indicated, "[Client D] repeatedly</p>			

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W000153	<p>left his room to express his excruciating emotional and physical stress from hearing and witnessing the events... [Client D] expressed multiple times he wanted to fight with [client B], but staff was able to talk to him about appropriate outlets for his anger." The investigation, dated 4/11/14, indicated, in part, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of Supervised Group Living..."</p> <p>69) On 4/4/14 at 7:45 PM, client D was getting a snack and client E told client D it was not snack time yet. Client D continued to eat and client E attempted to grab the cereal clie 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 10 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p>	W000153	<p>Plan of correction: Staff responsible for late reporting was provided training along with a performance action plan (attachment dd - writeup). Plan of prevention: Staff was trained on incident reporting before the end of their shift when possible. Training will continue each month during Shiloh meeting</p>	12/12/2014			

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	<p>A review of the facility's incident/investigative reports was conducted on 10/6/14 at 12:31 PM and indicated the following:</p> <p>1) On 9/13/14 at 4:00 PM, client D spit on client E and staff. Client D was placed in two basket holds for 30 seconds or less to block his aggression toward client E. Clients D and E hit each other twice with open palms to the face. During the incident, client D attempted to expose himself to client E. The incident was reported to BDDS on 9/15/14.</p> <p>2) On 9/11/14 at 4:00 PM, client B flicked client E's nose and kicked client E's shins. Client E went to his room. Client B kicked and tried to unlock client E's door. Client D was agitated with client B's behavior but was redirected. At 5:00 PM, the behaviorist met with client E in the formal living room. Client D entered the room carrying client B's hat. Client D attempted to close the door and used his body to push the door closed. Client B had his arm in the door and staff was outside of the room prompting client B to remove his arm. Client D took client B's hand and bit it. Behaviorist prompted client D to stop biting client B. Client D released the bite. Client B removed his hand and client D shut the</p>		<p>(attachment ee). Plan of monitoring: Director will continue to train coordinators monthly to monitor incident reporting and continue supporting staff.</p>	

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	<p>door. Client B's hand did not have broken skin although the skin was red. The incident was reported to BDDS on 9/15/14.</p> <p>3) On 8/24/14 at 10:30 PM, staff was working with client C. Clients B and D went into the office area and locked the door. The BDDS report indicated, in part, "Staff could not attend to [client D and client B] because [client C] was being put into his room. [Clients B and D] were each sitting in the office chairs kicking and slapping each other. As soon as staff would separate the two, [client C] would wake up when staff would then attend to [client C]. [Clients B and D] started attacking staff simultaneously with punches, slapping and kicking. [Client D] was put in a series of 4 bear hugs and 3 basket holds, each lasting a maximum of 10 minutes; and went on for approximately 1 hour." Staff contacted the pager. Client B was screaming/hitting/kicking doors and waking up client C. The report indicated, "[Client C] had fallen due to the force and influence of [client B's] behavior. [Client B] had dumped water on [client C] so [client C] slipped; [client B] slammed a door on [client C] and [client C] was knocked backwards; 2 other occasions where [client C] was exiting his room and fell." Client B pulled the</p>			

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	<p>fire alarm while staff was helping client C to bed. Client B blocked the exit for evacuation. The fire department arrived and attempted to re-set the alarm, but the pull appeared broken into the alarm position. Client B attempted to throw things at client C but "staff scooped up [client C] and carried him to the formal room while blocking the door from the inside." Pager contacted again. Things calmed down. The report indicated, "Sometime thereafter, staff called 911 because staff was unable to restrain [client B] or put [client B] in an exclusionary time out as per his BSP (behavior support plan), and was unable to continue blocking objects from hitting [client C]. [Client C] was checked for injury as [client C] had some red marks on his shoulders and arms which may develop into bruises and [client C] will be monitored. Officers arrived at 5:25am and had a chat with [client B] about how the night was going and got him in a more calm space." The incident was reported to BDDS on 8/26/14.</p> <p>4) On 8/17/14 at 5:00 PM, client A thought client B had his remote in his bedroom. The former Qualified Intellectual Disabilities Professional (QIDP) told client A that client B did not have his remote. The QIDP thought the situation was over. The QIDP heard a</p>						

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	<p>commotion from down the hall and went to client B's room. Client D was in client B's room pulling on client B's shirt. Client E was in client B's room trying to take the remote. Client A was in the hallway watching. Client D was prompted to go to his room. Client A became upset and attempted to go into client B's room. Client A agressed (kicking and hitting) on the former QIDP trying to get to client B. After the incident, client B admitted to stealing client A's remote and returned it. There was no documentation the incident was reported to BDDS.</p> <p>5) On 8/1/14 at 7:00 PM, client B got into client A's bedroom. It took until 9:15 PM to get client B to exit client A's bedroom. Client A locked his bedroom door. Client B attempted to stop staff #2 from leaving the group home. Staff #2 was able to leave the group home. Client B, at 9:40 PM, broke his fire detector in his bedroom. Client B blocked staff from accessing the fire panel. Client E attempted to attack client B while he obstructed the fire panel. Client E struck staff on the left side of the head with his right hand. At 10:00 PM, client B kicked client C's bedroom door and tried to wake up clients C and D who were asleep in their rooms. Client B started slamming his door repeatedly. Client E went to the</p>			

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	<p>kitchen to get a drink and client B knocked the drink out of client E's hands. Client B threw milk, juice and water at client E. Client E threw parts of the vacuum at client B. Client B threw utensils, chairs, and a sauce pan at client E. Client B hit client E in the head with a bottle brush and then a small sauce pan. Client E went into a fetal position and started crying. Both clients threw the metal napkin holder at each other until it broke. Client B threw backpacks and chair until he hit one of the plastic light covers in the living room. The cover fell and broke. Client B spit on staff. Client B kicked, slapped and attempted to bite staff. Client B threw chairs, cups of water, tennis balls, laundry basket lid, and utensils at staff. This lasted from 10:00 PM to 2:50 AM. The Stone Belt ARC, Inc. Incident Report indicated, "There were several points where I contacted the emergency pager, [former QIDP], and [former manager] and in some cases it was because I didn't feel like I could keep the clients safe due to the types of things [client B] was throwing, or that [client E] might have needed medical attention from being hit in the head with a sauce pan." The report indicated, "[Client B] ran out of steam at around 2:50 AM, changed mood drastically and was apologetic and helpful. He helped me do dishes, mop,</p>			

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	<p>and do laundry." The investigation, reviewed by the administrator on 8/10/14, indicated, in part, "I recommend that [client B] be placed in a different residential setting that is more appropriate for him. He is becoming a danger to himself and others in the house." The incident was reported to BDDS on 8/3/14.</p> <p>6) On 7/28/14 at 5:30 PM, client B returned to the group home from the grocery store. Client B started bringing in groceries. Client E wanted to assist. Client B tried to close the front door when client E went outside. Clients B and E ran to the van. Client E grabbed some bags and client B hit him on the shoulder. Staff got in between the clients. Client E grabbed another bag and client B reached over the staff and hit client E on the right shoulder. The investigative report indicated, in part, "I recommend that either [client E] or [client B] be moved to another residential setting. This is not an example of an extreme incident, but these situations are too frequent and the abuse that results (as the state calls it peer to peer abuse), is scarring emotionally and psychologically. I do not believe that it is safe to continue supporting both of these clients in this environment." There was no documentation the incident was reported</p>						

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	<p>to BDDS.</p> <p>7) On 7/21/14 at 7:25 PM, client A was in the kitchen cooking a bowl of cheese in the microwave. Staff #1 went into the kitchen and asked client A if it was a healthy choice. Staff #1 offered fruit or salad instead. Client A "charged" at staff #1 swinging his arms. Staff #1 backed away and client A followed him. Client A "charged" at staff #1 again. Staff #1 attempted to put client A in a baskethold but could not get it applied. Staff #1 did a one man escort toward his room. Client A "turned to me banging on his chest like King Kong and charged at me again, all a long (sic) I was asking him to calm down." Client A went into his room. The report indicated, "He threw a DVD case at me, scraping my arm, and I closed the door and held it closed while I talked to him asking him to calm down. After a couple of min. (minutes) I open (sic) the door." The Investigative Report, dated 7/24/14, indicated, "In conducting the interviews and reviewing the documentation pertinent to the incident in question, the allegation of abuse is unsubstantiated... Although the client's door was held, and this is a restrictive intervention, it was done so in a manner similar to a blocking technique, rather than for confinement and the duration of 5 minutes noted on the incident report</p>						

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	<p>was not corroborated by the interviews of anyone involved. It should also be noted that appropriate protocol was not followed with regards to appropriate interventions when working with acting out clients, as the staff used a hold to act as a transport and did not use appropriate blocking techniques. Similarly, there is indicated that there were client rights violations that occurred during this incident regarding client choice. From the statements that were gathered, it appears as though staff, [staff #1] may be unsure about Stone Belt's policies and procedures surrounding what interventions are appropriate to use, when to use appropriate interventions, and what interventions are not deemed appropriate for use with Stone Belt clients." There was no documentation the incident was reported to BDDS.</p> <p>8) On 7/7/14 at 10:15 AM, client B was in his room when a repair company arrived to repair client C's broken door to his bathroom. Client B became upset when they finished. Client B attempted to follow the repairmen outside and then attempted to break the new door. Client B grabbed the back of client C's shirt but let go when prompted. Client B spit on staff and threw a shoe at staff. Client B hit staff and pulled the staff's shirt. Client B was placed in a baskethold to</p>			

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	<p>escort him to his room. Client B dropped to the floor in the hallway. Client B ran outside and sat in the driveway. There was no documentation the incident was reported to BDDS.</p> <p>9) On 6/30/14 (no time indicated), the investigative report (there was no facility incident report or BDDS reports to review), dated 7/1/14, indicated, in part, "[Client B] was quite upset and was standing outside of [client E's] door banging on it and yelling. [Client E] was in his room and was awake. The other guys were not awake. I made sure that [client C] was not hurt when [client B] hit him on the back of the head. [Client C] fell, but not as a result of [client B] hitting him. [Client C] was okay. I stayed with [client C] for as long as he was up. We went to the dining room table and had a snack. [Client B] followed but I stayed with [client C] and [client B] did not do anything else." The recommendations section indicated, "[Name of a former staff] completed training with me about the importance of ensuring that bedroom doors are locked when arriving at work. [Former staff] understood how important that is. I do not believe that any other training is necessary at this time." There was no documentation the incident was reported to BDDS.</p>			

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	<p>10) On 6/29/14-6/30/14 (no time indicated), the investigative report (there were no facility incident reports or BDDS reports to review), dated 7/1/14, indicated, in part, "[Client C] had gotten up. [Client B] was yelling loudly after he stopped banging on [client E's] door. [Client E] was awake but in his room. I got [client C] to sit down at the table and I was sitting next to him... It happened so fast. I was sitting on the other side of the table from [client B] who was yelling. [Client E] came pretty quickly out of his room and slapped [client B] and then went... [Client E] ran to his room right as I was telling him that he couldn't hit [client B]. They ended up in two different rooms and there was no further contact for the evening." Client B was not injured. There was no documentation the incident was reported to BDDS.</p> <p>On 10/6/14 at 2:14 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated BDDS reports should be submitted within 24 hours of the incident.</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 15 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to conduct thorough investigations of abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/6/14 at 12:31 PM and indicated the following:</p> <p>1) On 9/29/14 at 1:50 PM, client E was reading a post card when client D attempted to sit on client E. Client E moved away from client D. Client E went to the kitchen. Client D followed client E and slammed the door. Client D opened the door and threw the trash can lid at client E. Client E had a red mark where the lid hit him on the side. Client E tried to go to his room and client D grabbed his shirt and ripped it. Client D spit at staff. There was no documentation of an investigation.</p>	W000154	<p>1) Plan of correction: Investigations were completed. Plan of prevention: Investigator was trained in completing and submitting investigations in a timely manner. Quality monitoring: Director was acting Qdip and was trained in reviewing investigations in a timely manner.</p> <p>1. Plan of correction: Investigations were completed. Plan of prevention: Investigator was trained in completing and submitting investigations in a timely manner.</p> <p>Quality monitoring: Director was acting Qdip and was trained in reviewing investigations in a timely manner.</p>	12/12/2014

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	<p>2) On 9/24/14 at 5:10 PM, client B was sitting in the driveway. As a car drove past, client B threw a rock at the car. Client B entered the house and pointed outside. There was a car parked outside the house. When staff and client B went outside, the care drove off. The car came back and a woman got out of the car and indicated client B hit her car with a rock, leaving scratches. The woman indicated about one month ago as she passed the group home, someone threw water at her car. The Bureau of Developmental Disabilities Services (BDDS) report, dated 9/25/14, indicated, "Coordinator notified and is investigating." There was no documentation of an investigation.</p> <p>3) On 9/22/14 at 5:00 PM, client B pulled client E's hair as client E was eating. Client E tried to go to his room. Client B ran in front of client E and locked client E's door. Client B slapped client E on the head and kicked him in the shins. Client E was not injured. Client E went into his room and locked the door. Client B went out the back door. Client B walked to a small construction site on the street the group home was located. Construction workers were digging new gas lines. Client B ignored the cones and staff's prompts and would not move away from the hole. Staff got in between client B and the hole</p>			

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	<p>so client B would not fall in. Client B walked down the street and laid in the middle of the street near a curve. Cars were attempting to drive around him and he refused to move. The BDDS report, dated 9/23/14, indicated, in part, "Staff tried to get [client B] to stand up physically by pushing him up and off the road fearing for [client B's] safety. [Client B] began to walk back toward [name of group home], but each time a car would pass, [client B] would quickly run out in front of the car getting the car to suddenly stop. [Client B] paid no attention to staff; Coordinator and central pager were notified; 911 were called immediately after. [Client B] apologized and ran inside [name of group home] to hide, but soon came out again. Police arrived at 6:35pm, but left minutes later as [client B] was behaving safely. [Client B] then resumed the behavior and walked out into the street with staff and clients following. Psych (psychiatric) pager was called and [client B] talked to Behaviorist as well. [Client A] also ignored staff's prompts to return to the house. [Client A] trespassed into the backyard of a house which was 'For Sale' and jumped on a trampoline for a few minutes; staff informed [client A] he was trespassing, but [client A] stayed for a little longer. Behaviorist arrived to stay with [client B], and staff returned home with [client</p>			

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	<p>A] and other client. Staff never lost sight of any clients." There was no documentation an investigation was conducted.</p> <p>4) On 9/20/14 at 1:15 PM, client C approached client E. Client E pushed client C and kicked client C in the hip. Client C stumbled backward and fell to the ground, landing on his buttocks. There was no documentation of an investigation.</p> <p>5) On 9/18/14 at 7:25 AM, client A went to the kitchen to prepare breakfast. Client A found a bagel in the refrigerator. Client E entered the kitchen and told client A the bagel was his. Client E approached client A from behind and slapped client A in the back of the head. There was no documentation an investigation was conducted.</p> <p>6) On 9/17/14 at 7:15 AM, client D hit client B in the leg three times after client D hit staff several times while refusing his medications. Client B was not injured. There was no documentation of an investigation.</p> <p>7) On 9/13/14 at 4:00 PM (reported to BDDS on 9/15/14), client D spit on client E and staff. Client D was placed in two basket holds for 30 seconds or less to</p>			

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	<p>block his aggression toward client E. Clients D and E hit each other twice with open palms to the face. During the incident, client D attempted to expose himself to client E. There was no documentation of an investigation.</p> <p>8) On 9/7/14 at 10:30 PM, client A's remote was taken by client B. Clients A and B "wrestled" each other for the remote. Staff broke up the altercation. There was no documentation of an investigation.</p> <p>9) On 8/24/14 at 10:30 PM (reported to BDDS on 8/26/14), staff was working with client C. Clients B and D went into the office area and locked the door. The BDDS report indicated, in part, "Staff could not attend to [client D and client B] because [client C] was being put into his room. [Clients B and D] were each sitting in the office chairs kicking and slapping each other. As soon as staff would separate the two, [client C] would wake up when staff would then attend to [client C]. [Clients B and D] started attacking staff simultaneously with punches, slapping and kicking. [Client D] was put in a series of 4 bear hugs and 3 basket holds, each lasting a maximum of 10 minutes; and went on for approximately 1 hour." Staff contacted the pager. Client B was</p>			

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	<p>screaming/hitting/kicking doors and waking up client C. The report indicated, "[Client C] had fallen due to the force and influence of [client B's] behavior. [Client B] had dumped water on [client C] so [client C] slipped; [client B] slammed a door on [client C] and [client C] was knocked backwards; 2 other occasions where [client C] was exiting his room and fell." Client B pulled the fire alarm while staff was helping client C to bed. Client B blocked the exit for evacuation. The fire department arrived and attempted to re-set the alarm, but the pull appeared broken into the alarm position. Client B attempted to throw things at client C but "staff scooped up [client C] and carried him to the formal room while blocking the door from the inside." Pager contacted again. Things calmed down. The report indicated, "Sometime thereafter, staff called 911 because staff was unable to restrain [client B] or put [client B] in an exclusionary time out as per his BSP (behavior support plan), and was unable to continue blocking objects from hitting [client C]. [Client C] was checked for injury as [client C] had some red marks on his shoulders and arms which may develop into bruises and [client C] will be monitored. Officers arrived at 5:25am and had a chat with [client B] about how the night was going and got him in a</p>			

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	<p>more calm space." There was no documentation of an investigation.</p> <p>10) On 8/24/14 at 4:25 PM, client A informed staff he wanted a fountain soda. Staff explained he purchased one on 8/23/14, client A needed to save money, and soda was not healthy. Client A said "fine," took his medications, and went to his room. Staff started passing medications to another client. When staff finished the medication pass, he went to look for client A to see if client A wanted to go on a van ride. Staff was unable to locate client A. The second staff did not know where client A was located and had not observed client A leave the group home. Staff called the pager and the pager informed staff to call 911. The police were given a description of client A. At 4:48 PM, another employee had observed client A walking and stopped to talk to client A in an attempt to stall him. The pager was notified and went to pick up client A. The police arrived to the group home and staff relayed the information to the police. The BDDS report, dated 8/25/14, indicated, "Around 5:15pm, police brought [client A] back to [name of the group home], carrying a fountain soda he had bought at [name of store]. Client A was very pleased with what he had done, declaring that he was showing his independence. Staff told</p>			

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	<p>him that his actions were extremely unsafe and not a choice, nor was it a display of being a responsible adult. [Client A] said that he had really needed a soda, and that it was 'his choice.'" There was no documentation of an investigation.</p> <p>11) On 7/9/14 at 2:15 PM, client E entered the office and sat down. He had dried blood on his forehead. He indicated he did not know where the blood came from. Staff cleaned the blood and there was a knot on his forehead. Client E indicated he fell in his bedroom and hit his head on the bed. When asked how he fell he did not know. The BDDS report, dated 7/10/14, indicated, "A (sic) Injury of Unknown Origin Inquiry will be conducted." There was no documentation of an investigation.</p> <p>12) On 4/28/14 at 7:45 AM, client D was sitting at the table eating. Client E was in the living room. Client E walked into the dining room with his shoes in his hands and asked client D if he was going to the day program. Client D shouted "NO" and client E hit client D in the back of the head and ran to his room. There was no documentation of an investigation.</p> <p>13) Client E's 4/10/14 Support Team</p>						

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	<p>Review Form indicated, in part, "[Group Home Director - GHD] and [Qualified Intellectual Disabilities Professional - QIDP] will review a recent incident where a non CPI (Crisis Prevention Institute) restraint was used." There was no documentation of an investigation.</p> <p>14) Client D's Support Team Review Form, dated 2/3/14, indicated, "[Client D] was held (put in a hold) on 1/31/14. The team is going to review this incident (1/31) further a Support Team on Wednesday, 5 February. There are some inconsistencies in the reporting." There was no documentation of an investigation.</p> <p>15) Client E's Nursing Consultation, dated 12/23/13, indicated, "Staff at Life Long Learning (Stone Belt day program) alerted nurse that [client E] had put his hands through a glass window resulting in the glass breaking causing a laceration on his hand. Nurse saw [client E] who was in the men's bathroom sitting in a chair with staff by his side, staff was applying pressure to the inside of [client E's] right wrist with a cloth. Upon assessment nurse noted the following: deep laceration noted to the inside of R (right) wrist (approximately) 1/2 inch long and 2/3 inches wide, (approximately) 1/3 of an inch deep.</p>			

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	<p>Blood flowing at a moderate rate but not pulsating - upon closer inspection no artery was involved. Also laceration noted to R tricep (approximately) 5 inches long and 1/2 inch wide, (approximately) 1/8 inch in depth, area bleeding slightly. Nurse applied pressure with sterile gauze to laceration on wrist, area on tricep was cleansed periodically with gauze. When nurse inquired what happened [client E] stated that he had been running and lost his footing (shoe got momentarily stuck to the floor) and lost his balance causing him to fall forward - [client E] put his arms out to help cushion fall and contacted a glass window. 911 was called by day staff personnel before nurse had evaluated [client E], once paramedics arrived they proceeded to wrap [client E's] wounds in gauze and were going to transport him to the ER (emergency room) for treatment. House manager was present when paramedics arrived and was going to follow ambulance to the ER. At (sic) last minute [client E] did not want to go (sic) the hospital despite encouragement from staff, eventually SGL (Supported Group Living) Director was able to convince [client E] to go (sic) the hospital for treatment - [client E] was taken to the hospital by the SGL Director followed by the ambulance." On 12/23/13, a Nursing Consultation Note indicated, "[Client E]</p>			

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W000156	<p>was seen at [name of group home] after being discharged from [name of hospital] when [client E] received 25 staples to R upper arm and 5 to wrist. [Client E] stated he felt okay and was really tired. He was wrapped in a comforter in his room." There was no documentation of an investigation.</p> <p>On 10/8/14 at 3:10 PM, the Group Home Director (GHD) indicated the facility should conduct investigations of client to client abuse and neglect.</p> <p>On 10/6/14 at 2:14 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated incidents of client to client abuse should be investigated.</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 6 of 112 incident/investigative reports</p>	W000156	<p>Plan of correction: Investigations were completed. Plan of prevention: Investigator</p>	12/12/2014			

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	<p>reviewed affecting clients A, B, C, D and E, the facility failed to report the results of all investigations to the administrator or designated representative within 5 working days of the incident.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/6/14 at 12:31 PM and indicated the following:</p> <p>1) On 8/2/14 at 5:45 PM, client B hit client C with a towel in the head and face. Staff blocked client B's attempts to hit client C. Client B grabbed client C's shirt collar and pulled hard and would not let go. Staff attempted to release client B's grip. Client B jumped through the pass through window and grabbed client C's shirt collar with both hands from the back. Staff attempted to release client B's grip. Client C's face started to turn red. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/3/14, indicated, "...[client B] was using [client C's] own shirt to choke him. [Client B] was also attempting to bite any staff's arms and hands as they tried to remove [client B's] hands." Staff used a bear hug hold on client B. Client B's grip was released. Client B kicked and spit at client C while pushing against the staff</p>		<p>was trained in completing and submitting investigations in atimely manner.</p> <p>Quality monitoring: Director was acting Qdip and was trained in reviewing investigations in a timely manner.</p>	

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	holding him. Client B headbutted the staff's collarbone repeatedly while scratching the staff's arms and hands with his fingernails. When staff attempted to switch due to the first staff's fatigue, client B broke free. Client B threw grill parts and lighter fluid at the house and attempted to kick the window in (the window was already broken). The BDDS report indicated, "Even after attempts to talk to [client B] about why he was angry, plan next day's events, help with cleaning, or go on walks with him, [client B] continued displaying unsafe behavior for the next 5 hours, including throwing rocks at cars, standing in the middle of [name of streets], and attacking staff. Multiple refusals to talk, and refusals to stop attacking [client C]. [Client B] signed multiple times that he wanted to hit [client C] more and that he wanted to hit staff more, throw rocks and other objects, stand in the road, and break more property... Staff monitored [client C] (housemate) the rest of the night for any adverse effects from the abrasion." The Client to Client Aggression Inquiry, reviewed by the administrator on 8/16/14, indicated, "I recommend that [client B] be placed in a different residential setting that is more appropriate for him. He is becoming a danger to himself and others in the house."			

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	<p>2) On 8/1/14 at 7:00 PM, client B got into client A's bedroom. It took until 9:15 PM to get client B to exit client A's bedroom. Client A locked his bedroom door. Client B attempted to stop staff #2 from leaving the group home. Staff #2 was able to leave the group home. Client B, at 9:40 PM, broke his fire detector in his bedroom. Client B blocked staff from accessing the fire panel. Client E attempted to attack client B while he obstructed the fire panel. Client E struck staff on the left side of the head with his right hand. At 10:00 PM, client B kicked client C's bedroom door and tried to wake up clients C and D who were asleep in their rooms. Client B started slamming his door repeatedly. Client E went to the kitchen to get a drink and client B knocked the drink out of client E's hands. Client B threw milk, juice and water at client E. Client E threw parts of the vacuum at client B. Client B threw utensils, chairs, and a sauce pan at client E. Client B hit client E in the head with a bottle brush and then a small sauce pan. Client E went into a fetal position and started crying. Both clients threw the metal napkin holder at each other until it broke. Client B threw backpacks and chair until he hit one of the plastic light covers in the living room. The cover fell and broke. Client B spit on staff. Client B kicked, slapped and attempted to bite</p>			

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	<p>staff. Client B threw chairs, cups of water, tennis balls, laundry basket lid, and utensils at staff. This lasted from 10:00 PM to 2:50 AM. The Stone Belt ARC, Inc. Incident Report indicated, "There were several points where I contacted the emergency pager, [former Qualified Intellectual Disabilities Professional (QIDP)], and [former manager] and in some cases it was because I didn't feel like I could keep the clients safe due to the types of things [client B] was throwing, or that [client E] might have needed medical attention from being hit in the head with a sauce pan." The report indicated, "[Client B] ran out of steam at around 2:50 AM, changed mood drastically and was apologetic and helpful. He helped me do dishes, mop, and do laundry." The investigation, reviewed by the administrator on 8/10/14, indicated, in part, "I recommend that [client B] be placed in a different residential setting that is more appropriate for him. He is becoming a danger to himself and others in the house."</p> <p>3) On 7/28/14 at 5:30 PM, client B returned to the group home from the grocery store. Client B started bringing in groceries. Client E wanted to assist. Client B tried to close the front door when client E went outside. Clients B</p>			

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	<p>and E ran to the van. Client E grabbed some bags and client B hit him on the shoulder. Staff got in between the clients. Client E grabbed another bag and client B reached over the staff and hit client E on the right shoulder. The investigative report was signed as reviewed by the administrator on 8/8/14. The investigative report indicated, in part, "I recommend that either [client E] or [client B] be moved to another residential setting. This is not an example of an extreme incident, but these situations are too frequent and the abuse that results (as the state calls it peer to peer abuse), is scarring emotionally and psychologically. I do not believe that it is safe to continue supporting both of these clients in this environment."</p> <p>4) On 7/10/14 from 10-10:30 PM, client B threw items at staff. Client E observed client B enter the kitchen for some grapes. Client E yelled, "The kitchen is closed." Client B responded, "Nuh uh." This lasted for 10 minutes. Client E was prompted to ignore client B. Client E was yelling "no." Client C woke up. The staff left the kitchen area to attend to client C, who appeared unstable (gait). Clients B and E were in the kitchen yelling at each other. Staff was assisting client C to the table, client E ran to client B and choked and shook him. Staff</p>			

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	<p>removed client E's hands from client B and escorted client E to the front room. Client E attempted to hit staff. Clients B and E calmed down. The investigation, dated 7/17/14 did not have a signature indicating the report was reviewed by the administrator. The investigation indicated, in part, "I do not believe that [name of group home] is an appropriate setting for both [client B and client E]. It is becoming increasingly more and more difficult to support both clients in this setting. These incidents are most dangerous overnight when there is only one staff."</p> <p>5) On 3/2/14 at 4:30 PM, client E arrived home and went straight to client A's room to take his television remote. Client E used the remote to turn the television client B was watching in the living room. Client E lunged at client B and client B slapped client E in the face. Client E went into the kitchen. Client B took client E's soda to his room. Client E went after client B. Client B stayed in his room. Client E attempted to hit the staff. Client E threw a pepper shaker. Client E slammed the toaster down and it broke. Client E started to pick up a chair but was redirected. Client E spit on staff. Client E tried to pick up the chair and was restrained using a rear bear hug for 15 seconds until he calmed down. Client E</p>			

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W000157	<p>had red marks on his cheek requiring first aid. The investigation was signed by the administrator on 3/10/14.</p> <p>6) On 3/1/14 at 1:00 PM, client B scratched client E's face on his left eye after client E threw a water bottle at client B. The water bottle missed. Client B picked up the water bottle and threw it at client E's soda. Client E's soda spilled on the floor. Client E went to get his eye checked and once finished, he and client B called each other names through the doorway. The investigation was signed by the administrator on 3/10/14.</p> <p>On 10/6/14 at 2:14 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the timeframe for getting the results of investigations to the administrator was 5 days.</p> <p>This federal tag relates to complaint #IN00156855.</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 record review and interview for 86 of 112 incident/investigative reports reviewed affecting clients A, B, C, D and</p>	W000157	<p>Plan of correction: All 68 out of 86 incidents (79%) when an alleged violation was verified</p>	12/12/2014			

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	<p>E, the facility failed to implement effective corrective actions to address the clients' maladaptive behaviors.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/6/14 at 12:31 PM and indicated the following:</p> <p>1) On 9/29/14 at 1:50 PM, client E was reading a post card when client D attempted to sit on client E. Client E moved away from client D. Client E went to the kitchen. Client D followed client E and slammed the door. Client D opened the door and threw the trash can lid at client E. Client E had a red mark where the lid hit him on the side. Client E tried to go to his room and client D grabbed his shirt and ripped it. Client D spit at staff.</p> <p>2) On 9/27/14 at 9:00 PM, client B "shoved his way in to the med room between med passes." Client B sat in the middle of the room in a chair. Client B screamed and motioned he was going to break a window for 5 minutes. When client B stood up to go toward the window, staff used a two person transport to assist him to his room.</p>		<p>but appropriate corrective action was not taken involved client b. Client b is being presented a 90 day notice (attachment k). 10 our of the remaining 18 incidents were involving client a has received a CIH waiver and was discharged 10/31. Appropriate placement has been found and his BDDScaseworker is awaiting CIH waiver approval from the state. (attachment r).</p> <p>Plan of prevention: SGLDirector has been trained to conduct support team meetings within 48 hours following allegation of abuse and neglect including client on client to discuss appropriate corrective action (attachment s).</p> <p>Quality monitoring: New coordinator – when selected will be trained to complete investigations and the outcome to director within the 5 day window. SGL Director has been trained to monitor that appropriate corrective action is being sought and facilitated (attachment s).</p>				

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	<p>3) On 9/24/14 at 5:10 PM, client B was sitting in the driveway. As a car drove past, client B threw a rock at the car. Client B entered the house and pointed outside. There was a car parked outside the house. When staff and client B went outside, the care drove off. The car came back and a woman got out of the car and indicated client B hit her car with a rock, leaving scratches. The woman indicated about one month ago as she passed the group home, someone threw water at her car.</p> <p>4) On 9/22/14 at 5:00 PM, client B pulled client E's hair as client E was eating. Client E tried to go to his room. Client B ran in front of client E and locked client E's door. Client B slapped client E on the head and kicked him in the shins. Client E was not injured. Client E went into his room and locked the door. Client B went out the back door. Client B walked to a small construction site on the street the group home was located. Construction workers were digging new gas lines. Client B ignored the cones and staff's prompts and would not move away from the hole. Staff got in between client B and the hole so client B would not fall in. Client B walked down the street and laid in the middle of the street near a curve. Cars were attempting to drive around him and</p>			

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	<p>he refused to move. The Bureau of Developmental Disabilities Services (BDDS) report, dated 9/23/14, indicated, in part, "Staff tried to get [client B] to stand up physically by pushing him up and off the road fearing for [client B's] safety. [Client B] began to walk back toward [name of group home], but each time a car would pass, [client B] would quickly run out in front of the car getting the car to suddenly stop. [Client B] paid no attention to staff; Coordinator and central pager were notified; 911 were called immediately after. [Client B] apologized and ran inside [name of group home] to hide, but soon came out again. Police arrived at 6:35pm, but left minutes later as [client B] was behaving safely. [Client B] then resumed the behavior and walked out into the street with staff and clients following. Psych (psychiatric) pager was called and [client B] talked to Behaviorist as well. [Client A] also ignored staff's prompts to return to the house. [Client A] trespassed into the backyard of a house which was 'For Sale' and jumped on a trampoline for a few minutes; staff informed [client A] he was trespassing, but [client A] stayed for a little longer. Behaviorist arrived to stay with [client B], and staff returned home with [client A] and other client. Staff never lost sight of any clients."</p>			

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	<p>5) On 9/21/14 at 9:00 PM, client B entered a staff's car as a staff was preparing to leave. Client B took a drink from her car and ran back into the house and locked himself in the bathroom. Staff entered the bathroom to retrieve the drink. When client B exited the bathroom and saw staff with the drink, he attempted to "attack" the staff. Client B was placed in a bear hug. Staff and client B fell to the ground and the hold was released. Client B began head banging and slamming doors. The psychiatric pager staff was contacted. Client B's guardian was notified and client B spoke to his guardian. Client B calmed down, took his medications and went into his room. Client B exited his room and began to engage in self-injurious behavior and aggression. Client B was placed in brief bear holds lasting no longer than one minute on five separate occasions. At 1:00 AM, client B went to bed.</p> <p>6) On 9/20/14 at 1:15 PM, client C approached client E. Client E pushed client C and kicked client C in the hip. Client C stumbled backward and fell to the ground, landing on his buttocks.</p> <p>7) On 9/20/14 at 12:00 PM, client B refused to take his medications.</p>			

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	<p>8) On 9/19/14 at 8:00 AM, client B refused to take his morning medications.</p> <p>9) On 9/18/14 at 3:40 PM and 9:00 PM (incident report documented on 9/19/14), client B grabbed a day program staff's right arm. Client B released his hold and then chased the staff while signing "beautiful." She went into the women's restroom. Client B stood at the door yelling for her to come out for 30 minutes. Staff called client B's guardian who spoke to him about the severity of his decision to grab and trap the staff in the restroom. Client B signed "no" and covered his ears. The Social Worker walked down the hallway and distracted client B long enough for the staff in the restroom to get out. Client B attempted to grab her and he was blocked until she was out of sight. Client B refused to leave the building until 4:30 PM. Client B was transported to his group home. Client B took a nap until 9:00 PM when the Group Home Director was getting ready to leave the house. Client B attempted to wake up his sleeping roommates by hitting on his cans with a spoon. The Stone Belt Incident Report, dated 9/19/14, indicated, "Team is meeting on 9/20 to discuss possible ESN (Extensive Support Needs) application and other placements to keep [client B] and others safe."</p>						

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	<p>10) On 9/18/14 at 7:25 AM, client A went to the kitchen to prepare breakfast. Client A found a bagel in the refrigerator. Client E entered the kitchen and told client A the bagel was his. Client E approached client A from behind and slapped client A in the back of the head.</p> <p>11) On 9/17/14 at 7:15 AM, client D hit client B in the leg three times after client D hit staff several times while refusing his medications. Client B was not injured.</p> <p>12) On 9/13/14 at 4:00 PM (reported to BDDS on 9/15/14), client D spit on client E and staff. Client D was placed in two basket holds for 30 seconds or less to block his aggression toward client E. Clients D and E hit each other twice with open palms to the face. During the incident, client D attempted to expose himself to client E.</p> <p>13) On 9/12/14 at 12:00 PM (reported to BDDS on 9/15/14), client B refused his morning medications.</p> <p>14) On 9/11/14 at 5:00 PM (reported to BDDS on 9/13/14), client B went to take his evening medications. Client B then refused to take them. Once the overnight staff arrived, client B began acting in an</p>			

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	<p>aggressive manner to the staff, refusing to let them clock in, hitting them, and destroying the staff's glasses. Client B slammed his door repeatedly and began throwing items at staff. Client B left the house at 11:30 PM with staff following. Staff never left client B's vicinity. After two and a half hours of walking around the neighborhood, client B and staff returned to the group home. Client B refused to take his medications.</p> <p>15) On 9/11/14 at 4:00 PM (reported to BDDS on 9/15/14), client B flicked client E's nose and kicked client E's shins. Client E went to his room. Client B kicked and tried to unlock client E's door. Client D was agitated with client B's behavior but was redirected. At 5:00 PM, the behaviorist met with client E in the formal living room. Client D entered the room carrying client B's hat. Client D attempted to close the door and used his body to push the door closed. Client B had his arm in the door and staff was outside of the room prompting client B to remove his arm. Client D took client B's hand and bit it. Behaviorist prompted client D to stop biting client B. Client D released the bite. Client B removed his hand and client D shut the door. Client B's hand did not have broken skin although the skin was red.</p>			

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	<p>16) On 9/9/14 at 12:00 PM, client B refused to take his morning medications.</p> <p>17) On 9/8/14 at 11:45 PM, client B woke up and staff asked him to take his medications. He refused. At 1:00 AM, client B wanted to take his medications. Staff explained it was too late and he would have to wait until morning to take his morning medications. Client B attempted to wake up other clients by slamming doors, yelling and trying to knock on other clients' bedroom doors. When staff intervened, there were two instances when client B slapped and punched the staff.</p> <p>18) On 9/8/14 at 5:00 PM, client B repeatedly picked up food off of pans to eat and refused all staff's requests to help set the table. Client D entered the kitchen and mimicked client B's behavior. Client D wanted client B out of the kitchen. Client D pushed client B out of the kitchen multiple times and client B went back in. Client A attempted to enter the kitchen to help with redirecting client D. Client D pulled client A's shirt. Client A tried to charge at client D but staff stood in front of the two. Client D left the kitchen but then pushed on the door to get back in. Clients A and B were holding the door closed. Client D aggressed on staff.</p>			

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	<p>Client D kicked one staff, smacked another in the face and punched a third staff in the shoulder. Client D was then angry at client E who was yelling at client D to stop. Client D followed client E into client E's room. Client D grabbed client E's charging cable and would not let go. Client E attempted to his client D several times but staff blocked the attempts. Client D was able to kick client E in the stomach. Client D chased client E into the living room. Client D cut his middle knuckle of his right hand during the incident. Client E was not injured.</p> <p>19) On 9/7/14 at 10:30 PM, client A's remote was taken by client B. Clients A and B "wrestled" each other for the remote. Staff broke up the altercation.</p> <p>20) On 9/3/14 at 11:59 PM, client B missed his bedtime medications. On 9/3/14 at 4:00 PM when all the clients were departing the day program, client B refused to leave. Client B did not return home until 9/4/14 at 7:00 AM.</p> <p>21) On 9/2/14 at 10:00 PM, client B was pounding on the wall between his room and another client's room (client E). Staff prompted client B to stop. Client B took off his shoe and hit the staff with his shoe several times. Staff kept client B in an exclusionary time out in his room for</p>			

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	<p>approximately 50 minutes, while standing outside of his doorway using a blocking pad per his behavior plan. Client B made several attempts to hit staff with items from his room. Client B broke a wooden crate in his room. Client B refused to take his medications.</p> <p>22) On 8/26/14 at 12:00 PM, client B refused to take his morning medications.</p> <p>23) On 8/24/14 at 10:30 PM, staff was working with client C. Clients B and D went into the office area and locked the door. The BDDS report indicated, in part, "Staff could not attend to [client D and client B] because [client C] was being put into his room. [Clients B and D] were each sitting in the office chairs kicking and slapping each other. As soon as staff would separate the two, [client C] would wake up when staff would then attend to [client C]. [Clients B and D] started attacking staff simultaneously with punches, slapping and kicking. [Client D] was put in a series of 4 bear hugs and 3 basket holds, each lasting a maximum of 10 minutes; and went on for approximately 1 hour." Staff contacted the pager. Client B was screaming/hitting/kicking doors and waking up client C. The report indicated, "[Client C] had fallen due to the force and influence of [client B's] behavior.</p>			

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	<p>[Client B] had dumped water on [client C] so [client C] slipped; [client B] slammed a door on [client C] and [client C] was knocked backwards; 2 other occasions where [client C] was exiting his room and fell." Client B pulled the fire alarm while staff was helping client C to bed. Client B blocked the exit for evacuation. The fire department arrived and attempted to re-set the alarm, but the pull appeared broken into the alarm position. Client B attempted to throw things at client C but "staff scooped up [client C] and carried him to the formal room while blocking the door from the inside." Pager contacted again. Things calmed down. The report indicated, "Sometime thereafter, staff called 911 because staff was unable to restrain [client B] or put [client B] in an exclusionary time out as per his BSP (behavior support plan), and was unable to continue blocking objects from hitting [client C]. [Client C] was checked for injury as [client C] had some red marks on his shoulders and arms which may develop into bruises and [client C] will be monitored. Officers arrived at 5:25am and had a chat with [client B] about how the night was going and got him in a more calm space."</p> <p>24) On 8/24/14 at 4:25 PM, client A informed staff he wanted a fountain soda.</p>			

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	<p>Staff explained he purchased one on 8/23/14, client A needed to save money, and soda was not healthy. Client A said "fine," took his medications, and went to his room. Staff started passing medications to another client. When staff finished the medication pass, he went to look for client A to see if client A wanted to go on a van ride. Staff was unable to locate client A. The second staff did not know where client A was located and had not observed client A leave the group home. Staff called the pager and the pager informed staff to call 911. The police were given a description of client A. At 4:48 PM, another employee had observed client A walking and stopped to talk to client A in an attempt to stall him. The pager was notified and went to pick up client A. The police arrived to the group home and staff relayed the information to the police. The BDDS report, dated 8/25/14, indicated, "Around 5:15pm, police brought [client A] back to [name of the group home], carrying a fountain soda he had bought at [name of store]. Client A was very pleased with what he had done, declaring that he was showing his independence. Staff told him that his actions were extremely unsafe and not a choice, nor was it a display of being a responsible adult. [Client A] said that he had really needed a soda, and that it was 'his choice.'"</p>			

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	<p>25) On 8/18/14 at 9:40 PM, client B kicked client E's bedroom door. Client B laid in front of client E's room and kicked the bedroom door several times. Client E exited his room a few times and told client B to stop. Client B refused and continued to kick client E's door. Client B stopped once staff told him the staff would have to write an incident report.</p> <p>26) On 8/17/14 at 5:00 PM, client A thought client B had his remote in his bedroom. The former Qualified Intellectual Disabilities Professional (QIDP) told client A that client B did not have his remote. The QIDP thought the situation was over. The QIDP heard a commotion from down the hall and went to client B's room. Client D was in client B's room pulling on client B's shirt. Client E was in client B's room trying to take the remote. Client A was in the hallway watching. Client D was prompted to go to his room. Client A became upset and attempted to go into client B's room. Client A agressed (kicking and hitting) on the former QIDP trying to get to client B. After the incident, client B admitted to stealing client A's remote and returned it.</p> <p>27) On 8/16/14 at 2:10 AM, client D was prompted to use the restroom due to</p>			

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	<p>incontinence. Client D's bed was soaked with urine. Client D took a shower and staff heard a loud noise from the bathroom and heard client D yell for help. Client D was getting up off the bathtub floor. Client D scraped his right cheek during the fall. Staff used hydrogen peroxide to clean the injury. There was no documentation the fall with injury was reported to BDDS. A second incident report, dated 8/16/14, indicated, "Come to find out hours later that the fact the client had fallen in the shower apparently he hit so hard it caused a pipe to burst in the wall causing water to leak into the dining room & living room areas."</p> <p>28) On 8/15/14 at 8:20 PM (reported to BDDS on 8/18/14), client B had been aggressive. At 7:40 PM, he threw an apple off of the apple tree and hit the group home van. At 8:20 PM, client B hit staff in the back. Client B threw a pen and hit the same staff in the back of the head. Client B was told throwing items was inappropriate and he attempted to aggress on three staff. Client B was put in a baskethold but he spit and kicked at the staff who was attempting to leave. Client B was in the baskethold for 10 minutes. While in a baskethold, client B hit the staff in the chest and attempted to spit on staff. When released, client B</p>						

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	<p>grabbed staff's shirt so the staff could not enter the office and tore the staff's shirt. Client B was placed in a bear hug for 30 seconds. Client B yelled and slammed doors once released for 15 minutes.</p> <p>29) On 8/13/14 at 12:00 PM, client B refused to take his morning medications.</p> <p>30) On 8/8/14 at 12:00 AM, client B went to bed early and would not wake up to take his medications.</p> <p>31) On 8/3/14 at 12:00 PM, the incident report indicated, "[Client B] stayed up until very early in the morning displaying unsafe behavior, and fell asleep about 5:30 AM." Client B did not take his morning medications.</p> <p>32) On 8/2/14 at 7:00 PM, client B attempted to keep a staff's car from entering the driveway. Client B attempted to keep staff locked in the office after he clocked in and attempted to walk onto the highway next to the house. Client B threw rocks at cars, flipped off drivers from the driveway and crossed the highway at one point. When client B reentered the home around 10:00 PM, client B threatened to throw items at the staff. When client B was asked to take his medications, he started screaming, slamming his bedroom door</p>				

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	<p>and kicked the shared wall between his room and client E's room. This continued until 11:30 PM. The overnight staff informed the psychiatric pager staff who had arrived that she could leave. Client B started throwing objects (pillow, laundry basket lid, bottle of Listerine and a bucket) at staff. Client B went into his room and started kicking the wall to client E's room and shouting. At 11:40 PM, client B kicked client E's bedroom door and staff got in between to block. Client B went into his room and threatened to throw items at staff. Client B hit himself in the head with the items. Staff contacted the former QIDP. The QIDP informed staff to lock any items used by client B to hit himself with in the office. The items included small metal tin, several tin cans, larger plastic bins, the laundry basket lid, a small frying pan and a metal mug. Each time staff confiscated an item, client B kicked, scratched, slapped and attempted to bite the staff. Staff blocked client B with a couch cushion. Client B struck the fire detector in the living room and broke it. Staff did not have the alarm box key to disarm the alarm. Client B continued slamming doors, slapping and kicking until around 2:00 AM when he threw the laundry bin at the exposed florescent light tubes in the living room and one fell. Client B swung the tube at the staff</p>			

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	<p>but staff blocked it using a brief hold on the ground and preventing him from reaching the tube or laundry bin. Client B attempted to hit additional tubes with a tennis ball and the laundry basket. The psychiatric pager staff returned at 2:20 AM. Client B was calm during her visit but when she left at 3:25 AM, client B began kicking the other clients' bedroom doors, screamed, and slammed his own door until around 4:00 AM. Client B was apologetic. Client C woke up at 4:00 AM and client B apologized to him. Client B was calm until 5:40 AM when client C went back to bed. Client B started kicking the wall in his room and yelling but he was quiet around 6:00 AM. Client B refused to take his bedtime medications.</p> <p>33) On 8/2/14 at 5:45 PM, client B hit client C with a towel in the head and face. Staff blocked client B's attempts to hit client C. Client B grabbed client C's shirt collar and pulled hard and would not let go. Staff attempted to release client B's grip. Client B jumped through the pass through window and grabbed client C's shirt collar with both hands from the back. Staff attempted to release client B's grip. Client C's face started to turn red. The BDDS report, dated 8/3/14, indicated, "...[client B] was using [client C's] own shirt to choke him. [Client B]</p>						

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	<p>was also attempting to bite any staff's arms and hands as they tried to remove [client B's] hands." Staff used a bear hug hold on client B. Client B's grip was released. Client B kicked and spit at client C while pushing against the staff holding him. Client B headbutted the staff's collarbone repeatedly while scratching the staff's arms and hands with his fingernails. When staff attempted to switch due to the first staff's fatigue, client B broke free. Client B threw grill parts and lighter fluid at the house and attempted to kick the window in (the window was already broken). The BDDS report indicated, "Even after attempts to talk to [client B] about why he was angry, plan next day's events, help with cleaning, or go on walks with him, [client B] continued displaying unsafe behavior for the next 5 hours, including throwing rocks at cars, standing in the middle of [name of streets], and attacking staff. Multiple refusals to talk, and refusals to stop attacking [client C]. [Client B] signed multiple times that he wanted to hit [client C] more and that he wanted to hit staff more, throw rocks and other objects, stand in the road, and break more property... Staff monitored [client C] (housemate) the rest of the night for any adverse effects from the abrasion." The Client to Client Aggression Inquiry, reviewed by the administrator on 8/16/14,</p>			

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	<p>indicated, "I recommend that [client B] be placed in a different residential setting that is more appropriate for him. He is becoming a danger to himself and others in the house."</p> <p>34) On 8/2/14 at 12:00 AM (reported to BDDS on 8/4/14), client E refused his medications.</p> <p>35) On 8/1/14 at 7:00 PM (reported to BDDS on 8/3/14), client B got into client A's bedroom. It took until 9:15 PM to get client B to exit client A's bedroom. Client A locked his bedroom door. Client B attempted to stop staff #2 from leaving the group home. Staff #2 was able to leave the group home. Client B, at 9:40 PM, broke his fire detector in his bedroom. Client B blocked staff from accessing the fire panel. Client E attempted to attack client B while he obstructed the fire panel. Client E struck staff on the left side of the head with his right hand. At 10:00 PM, client B kicked client C's bedroom door and tried to wake up clients C and D who were asleep in their rooms. Client B started slamming his door repeatedly. Client E went to the kitchen to get a drink and client B knocked the drink out of client E's hands. Client B threw milk, juice and water at client E. Client E threw parts of the vacuum at client B. Client B threw</p>			

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	utensils, chairs, and a sauce pan at client E. Client B hit client E in the head with a bottle brush and then a small sauce pan. Client E went into a fetal position and started crying. Both clients threw the metal napkin holder at each other until it broke. Client B threw backpacks and chair until he hit one of the plastic light covers in the living room. The cover fell and broke. Client B spit on staff. Client B kicked, slapped and attempted to bite staff. Client B threw chairs, cups of water, tennis balls, laundry basket lid, and utensils at staff. This lasted from 10:00 PM to 2:50 AM. The Stone Belt ARC, Inc. Incident Report indicated, "There were several points where I contacted the emergency pager, [former QIDP], and [former manager] and in some cases it was because I didn't feel like I could keep the clients safe due to the types of things [client B] was throwing, or that [client E] might have needed medical attention from being hit in the head with a sauce pan." The report indicated, "[Client B] ran out of steam at around 2:50 AM, changed mood drastically and was apologetic and helpful. He helped me do dishes, mop, and do laundry." The investigation, reviewed by the administrator on 8/10/14, indicated, in part, "I recommend that [client B] be placed in a different residential setting that is more			

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	<p>appropriate for him. He is becoming a danger to himself and others in the house."</p> <p>36) On 8/1/14 between 12:45 AM and 1:50 AM, client B woke up and started hitting his wall which prevented another client from sleeping. Staff redirected client B but then heard client B throwing a softball. The fire system alarm near the kitchen started going off and client B came running out of his room. Client B either hit the smoke alarm in his room with the ball or unscrewed the cap causing the alarm to go off. Staff was able to get the alarm off but client B was agitated. Client B signed to staff he wanted to hit his smoke detector again. Staff stood in client B's room for most of an hour trying to redirect client B. Client B threw his shoes at staff and the smoke detector. Client B kicked his window and hit his window with softballs from his room. At 1:30 AM, staff told client B if he did not stop he would put him in a hold. Client B pulled a picture off the wall and grabbed the pin that was holding it up. Client B attempted to poke staff with the pin so staff took it from him and performed a baskethold for 3 minutes. After being released, client B attempted to hit staff with several objects. Client B eventually calmed down.</p>						

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	<p>37) On 7/28/14 at 5:30 PM, client B returned to the group home from the grocery store. Client B started bringing in groceries. Client E wanted to assist. Client B tried to close the front door when client E went outside. Clients B and E ran to the van. Client E grabbed some bags and client B hit him on the shoulder. Staff got in between the clients. Client E grabbed another bag and client B reached over the staff and hit client E on the right shoulder. There was no documentation the incident was reported to BDDS. The investigative report was signed as reviewed by the administrator on 8/8/14. The investigative report indicated, in part, "I recommend that either [client E] or [client B] be moved to another residential setting. This is not an example of an extreme incident, but these situations are too frequent and the abuse that results (as the state calls it peer to peer abuse), is scarring emotionally and psychologically. I do not believe that it is safe to continue supporting both of these clients in this environment."</p> <p>38) On 7/27/14 at 5:00 AM, client C grabbed client E's shirt on his way out of the bathroom. Client E started to choke client C with both hands from the front. Staff pried client E's hands off of client C's neck and put him in a temporary hold</p>						

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	<p>for a few seconds. Client C went to bed. Client E wanted an Ensure from the office. Client C exited his room and tried to leave the house through the back door. Client E took four Ensures from the office and was sitting in the living room drinking them. Staff removed one of the Ensures. Client E struck the staff in the back twice with his fist. Staff turned around and client E struck him on the right side of his jaw. Client E dumped an Ensure on the staff. Client C was not injured.</p> <p>39) On 7/25/14 at 9:00 PM, client B attempted to prevent staff from leaving at the end of their shift by standing in front of the staff's car door and getting behind the car and preventing it from backing out. Staff blocked client B causing him to get more frustrated. At 9:30 PM, client B entered the house and sat on client E's lap while on the couch and would not move. Client E attempted to choke client B with his right arm. Staff blocked the choking attempt. Client B went outside and got into the group home van and started honking the horn at 9:45 PM. Staff called the home manager who instructed the staff to attempt to remove client B from the van since the honking of the horn was disruptive to the neighbors and client B's peers who were trying to sleep. Staff attempted three</p>						

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	<p>bear hugs unsuccessfully. Staff used a baskethold to remove him from the van and locked the van's doors. Client B entered the house. At 10:30 PM, client B slammed the kitchen door 4 times and the clock fell off the wall and broke, shattering the glass of the clock. Client B ran from the glass shards and staff blocked him. Staff cleaned up the glass. At 10:40 PM, client B threatened to throw a frying pan at staff. Client B hit the kitchen window. At 10:50 PM, client E walked up to the kitchen to see what was going on and client B threw the frying pan at client E. Staff blocked the frying pan. Staff called the pager. Client B calmed down during the call and put the pan away. After the call, client B got the pan out again. Staff climbed over the kitchen bar and restrained client B in a bear hug to prevent him from harming himself by breaking the window with the frying pan. Staff prompted client B out of the kitchen. The pager was called again. Client B went to his room from 11:00 PM to 11:20 PM. Client B went outside and stood in the middle of the street outside the house. A car pulled into the neighborhood when client B was still in the road. Staff put client B in a bear hug to remove him from the road. Client B went back inside the house and calmed down.</p>			

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	<p>40) On 7/24/14 at 7:00 PM, client B refused to leave client E's bedroom. Client B left client E's room with one of client E's shoes. Client E was standing in front of client B's room demanding his shoe back. Client E was redirected to his room. Client B gave client E his shoe back. Client B attempted to aggress on client C as he exited the medication area. His attempts were blocked. Client C dropped to the floor and client B put his foot on client C. Client B hit the staff in the back and client B was restrained in a standing baskethold. Once released, client B hit the staff again. Client B was restrained again. Once released, client B attempted to aggress on client C. Client C went into the bathroom with staff to take a shower. Client B kicked and slammed doors. Client B slammed the office door several times repeatedly. Client B started crying and saying he was sorry. The BDDS report, dated 7/25/14, indicated none of the clients were injured. The investigation, dated 7/30/14, indicated, in part, "I recommend that [client B] be moved from [name of group home]. He continues to target [client C] and this (sic) creating an unsafe environment for [client C]. I believe that this targeting will continue."</p> <p>41) On 7/22/14 at 12:00 PM, client B</p>			

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	<p>refused his morning medications.</p> <p>42) On 7/21/14 at 7:25 PM, client A was in the kitchen cooking a bowl of cheese in the microwave. Staff #1 went into the kitchen and asked client A if it was a healthy choice. Staff #1 offered fruit or salad instead. Client A "charged" at staff #1 swinging his arms. Staff #1 backed away and client A followed him. Client A "charged" at staff #1 again. Staff #1 attempted to put client A in a baskethold but could not get it applied. Staff #1 did a one man escort toward his room. Client A "turned to me banging on his chest like King Kong and charged at me again, all a long (sic) I was asking him to calm down." Client A went into his room. The report indicated, "He threw a DVD case at me, scraping my arm, and I closed the door and held it closed while I talked to him asking him to calm down. After a couple of min. (minutes) I open (sic) the door." The Investigative Report, dated 7/24/14, indicated, "In conducting the interviews and reviewing the documentation pertinent to the incident in question, the allegation of abuse is unsubstantiated... Although the client's door was held, and this is a restrictive intervention, it was done so in a manner similar to a blocking technique, rather than for confinement and the duration of 5 minutes noted on the incident report</p>			

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	<p>was not corroborated by the interviews of anyone involved. It should also be noted that appropriate protocol was not followed with regards to appropriate interventions when working with acting out clients, as the staff used a hold to act as a transport and did not use appropriate blocking techniques. Similarly, there is indicated that there were client rights violations that occurred during this incident regarding client choice. From the statements that were gathered, it appears as though staff, [staff #1] may be unsure about Stone Belt's policies and procedures surrounding what interventions are appropriate to use, when to use appropriate interventions, and what interventions are not deemed appropriate for use with Stone Belt clients."</p> <p>43) On 7/12/14 at 12:20 PM, client A asked staff several times throughout the morning if he could get a soda. Staff reminded him of the new house schedule that made time for trips to the store on Sundays but not Saturdays. Client A was reminded the staff would be going to a restaurant for lunch and he could get a soda at that time. Client A agreed to order a value sized soda since he also purchased a milkshake. As he finished his meal, client A asked staff if he could go to the store to get a soda as his current drink was not as large as the one from the</p>			

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	<p>store. Client A was reminded of their earlier conversation. Client A started to walk out of the restaurant and staff followed him. Client A indicated he was walking home alone and no one could stop him. Staff attempted to get in front of client A as he was walking toward a road with traffic. Client A raised his arms, closed his eyes, and attempted to strike staff several times. Staff backed away and noticed a car coming. Staff used a brief bear hug in an attempt to calm client A to get him out of the road. After 2 seconds, client A calmed down and walked out of the road.</p> <p>44) On 7/10/14 from 10-10:30 PM, client B threw items at staff. Client E observed client B enter the kitchen for some grapes. Client E yelled, "The kitchen is closed." Client B responded, "Nuh uh." This lasted for 10 minutes. Client E was prompted to ignore client B. Client E was yelling "no." Client C woke up. The staff left the kitchen area to attend to client C, who appeared unstable (gait). Clients B and E were in the kitchen yelling at each other. Staff was assisting client C to the table, client E ran to client B and choked and shook him. Staff removed client E's hands from client B and escorted client E to the front room. Client E attempted to hit staff. Clients B and E calmed down. The investigation,</p>			

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	<p>dated 7/17/14 did not have a signature indicating the report was reviewed by the administrator. The investigation indicated, in part, "I do not believe that [name of group home] is an appropriate setting for both [client B and client E]. It is becoming increasingly more and more difficult to support both clients in this setting. These incidents are most dangerous overnight when there is only one staff."</p> <p>45) On 7/9/14 at 2:15 PM, client E entered the office and sat down. He had dried blood on his forehead. He indicated he did not know where the blood came from. Staff cleaned the blood and there was a knot on his forehead. Client E indicated he fell in his bedroom and hit his head on the bed. When asked how he fell he did not know. The BDDS report, dated 7/10/14, indicated, "A (sic) Injury of Unknown Origin Inquiry will be conducted." There was no documentation of an investigation.</p> <p>46) On 7/7/14 at 10:15 AM, client B was in his room when a repair company arrived to repair client C's broken door to his bathroom. Client B became upset when they finished. Client B attempted to follow the repairmen outside and then attempted to break the new door. Client B grabbed the back of client C's shirt but</p>			

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	<p>let go when prompted. Client B spit on staff and threw a shoe at staff. Client B hit staff and pulled the staff's shirt. Client B was placed in a baskethold to escort him to his room. Client B dropped to the floor in the hallway. Client B ran outside and sat in the driveway. There was no documentation the incident was reported to BDDS.</p> <p>47) On 7/5/14 at 10:30 PM, client B attempted to lie down on top of client E. Client B attempted to nudge and shove client E. Client E attempted to hit and kick client B. Client E started ignoring client B. Client B went outside to throw cups of water at passing cars. Client B threw a cup of water at a car with the window open. The car stopped and client B ran inside the house and watched as the car waited for about 5 minutes. At 10:50 PM, client E got up to use the restroom and client B took his spot on the couch. When client E returned, he got aggravated and attempted to hit, kick and throw his shoes at client B. Client E sat on the couch with client B. Client B started pulling client E's hair and staff sat in between the clients. Client B attempted to reach around the staff. While blocking client B, client B grabbed the staff's right hand and shook it and staff felt a sharp pain on his ring finger. The investigation, dated 7/8/14,</p>						

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	<p>indicated, in part, "[Client E] has refused all medications for more than a week. The team believes that his guardian has encouraged [client E] to not take his medication and that is why this string of refusals have continued despite staff prompting [client E] and despite the team encouraging [client E] to take medications. Many of these client to client incidents are happening at night when one staff is present. Considering [client E's] current psychiatric state and [client B's] predisposition to bother and intentionally disturb [client B], I do not think that it is appropriate for these two individuals to live together. It is exceptionally challenging to support two such individuals in this setting. Once [client E's] psychiatric condition stabilizes, this recommendation might not be necessary."</p> <p>48) On 6/30/14 (no time indicated), the investigative report (there was no facility incident report or BDDS reports to review), dated 7/1/14, indicated, in part, "[Client B] was quite upset and was standing outside of [client E's] door banging on it and yelling. [Client E] was in his room and was awake. The other guys were not awake. I made sure that [client C] was not hurt when [client B] hit him on the back of the head. [Client C] fell, but not as a result of [client B]</p>			

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	<p>hitting him. [Client C] was okay. I stayed with [client C] for as long as he was up. We went to the dining room table and had a snack. [Client B] followed but I stayed with [client C] and [client B] did not do anything else." The recommendations section indicated, "[Name of a former staff] completed training with me about the importance of ensuring that bedroom doors are locked when arriving at work. [Former staff] understood how important that is. I do not believe that any other training is necessary at this time."</p> <p>49) On 6/29/14-6/30/14 (no time indicated), the investigative report (there was no facility incident report or BDDS reports to review), dated 7/1/14, indicated, in part, "[Client C] had gotten up. [Client B] was yelling loudly after he stopped banging on [client E's] door. [Client E] was awake but in his room. I got [client C] to sit down at the table and I was sitting next to him... It happened so fast. I was sitting on the other side of the table from [client B] who was yelling. [Client E] came pretty quickly out of his room and slapped [client B] and then went... [Client E] ran to his room right as I was telling him that he couldn't hit [client B]. They ended up in two different rooms and there was no further contact for the evening." Client B was</p>			

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	<p>not injured.</p> <p>50) On 6/28/14 at 2:30 PM, client B was involved in a prior incident where he bit a roommate and drew blood. Client B was taken to the emergency room for lab work.</p> <p>51) On 6/27/14 at 6:35 PM, client B was eating dinner and got up to get the empty bottles client E threw into the trash can. Client B threw the bottles into the backyard. Client E jumped up to get the bottles. Client E came inside, wet (due to rain) and cursed at client B. Client E threw the bottles away again. Client B took the bottles out of the trash can and threw them outside. Client E grabbed client B's shirt by the collar with both hands. Client B bit down on client E's left forearm, resulting in a puncture. Client E backed away. Later in the evening, client D was agitated with client B's behavior (loud noises and encroaching on personal space). Client D moved past staff to sit between clients B and E who were on the couch. Client D grabbed client B's hat and crushed his drink can. Client B pushed and grabbed client D. Client D grabbed the phone and remote from client E and attempted to block client E from seeing the television. Client E attempted to grab and hit client D. Client E threw the remote at client D</p>			

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	<p>and client D threw the broken pieces of the remote at client E. Client D continued to display aggressive behavior toward clients B and E for 20 minutes. The BDDS report, dated 6/28/14, indicated, "No serious injuries were incurred by the clients." The BDDS report did not indicate who was injured and what the injuries consisted of. The investigation, dated 7/1/14, indicated, "I recommend that [client B] and his guardian pursue a CIH (Community Integration and Habilitation) waiver. This incident is another example of how [client B's] anxiety and aptness for intentionally upsetting his housemates has resulted in an incident. While I recognize that this tendency is not new to [client B], my concern, and hence my initial statement, arises from the increase in this behavior especially directed towards [client E], who also exhibits high anxiety and an inability to regulate responses on his own. [Client E] had made improvements in this area and ought not regress. I believe that two clients with such extreme anxiety in one house is too much. We will use new strategies developed by [Social Worker] to assist in calming [client B] in an attempt to reduce anxiety and redirect him during these situations."</p> <p>52) On 6/22/14 at 5:00 PM, client B</p>						

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	<p>entered the home yelling. Client B told the staff they could no longer work with client C. Staff explained he was working with client C. Client B threatened to bite, hit, kick and spit at client C. Client C and staff walked away. Client B followed them and continued to threaten client C. Client B hit client C but it was partially blocked. Client D walked into the room at the time client B hit client C. Client D attempted to hit client B. Client D followed client B around the house while client B yelled he was going to hurt client C. The Stone Belt ARC, Inc. Incident Report, dated 6/22/14, indicated, "[Staff] was at this point preparing to get [clients C and D] out of the violent and stressful environment, grabbing [client C's] backpack off of the coat rack in the living room." Clients C and D were trying to leave and client B blocked their exit. Client D leaned and charged from the living room to the kitchen area and shoved client B down pushing him into the door. Client B fell to the floor. No one was injured.</p> <p>53) On 6/5/14 at 4:45 PM, client A received a phone call on the group home phone. Client B became agitated and wanted the telephone. Client B threatened to hit client A. Client A left to go on a walk. Client B threw items at the staff who left with client A. Client A</p>			

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	<p>went on his walk and client B followed. Client B attempted to hit the staff. Client A pushed client B. Client C had arrived in the van. Client C's staff decided to leave with client C after seeing client B agitated. Client B held onto the van's mirror in an attempt to keep the van from leaving. Staff redirected client B. Client B went into the group home and started throwing objects at the staff. Client B went into his room and threw objects at staff. The Social Worker attempted to take client D into the staff office but client B rushed in and would not leave. The Social Worker and client D left the area. Client C returned to the home and laid on the floor. Client B laid on top of client C. Client B, with prompting, got off of client C. The incident report, dated 6/5/14, indicated at 9:00 PM at the time the incident report was written, client B was in his room pounding on client E's wall.</p> <p>On 6/5/14 (no time indicated), the Client to Client Inquiry, dated 6/11/14, indicated client B was preventing client C from taking a shower. Eventually client C got into the bathroom. Client B banged on the door. Client D came down the hall and grabbed client B and put him in a headlock. Client D released the hold when prompted. Client B was not injured. The investigation, dated 6/11/14,</p>			

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	<p>was not signed by an administrator as having received the report. The investigation indicated, in part, "I recommend that [client B] be moved from [name of group home] as soon as possible. I fear for his long term safety. It is becoming increasingly more difficult for us to protect [client B] with [client D] feeling emboldened and recognizing that his interventions are calming [client B]. [Client D] is stronger than most staff, quick and not easily restrained. I fear that [client B's] continued presence in the house will result in a serious injury or abuse. I recommend that the Director seek an emergency waiver for [client B]."</p> <p>54) On 5/18/14 at 9:45 PM, client D gorged on client E's breadsticks. Client E ran to client D and client D smacked client E's face. Client E was screaming due to being hit hard by client D. Client E had a dark red area on his face. Client D took 5 breadsticks and went to his room. Client E went to client D's room and banged on the door. Staff prompted clients A and B to go to their rooms and lock their doors for their protection. Client D exited his room screaming and ran toward staff. Client D ran and attempted to hit client E but it was prevented. Client E ran to the dining room and client D tore his own shirt in half. Client D hit staff several times and</p>			

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	<p>ran toward client E. Client E ran to his room and locked his door. Client D hit staff again. Client D took his penis out of his pants and threatened to urinate on staff. Client B opened his door and said "pee pee." Client B ran to the bathroom and closed the door. Client D attempted to open the door but client B was holding the door closed. Client B ran out of the bathroom to his room. Client D attempted to run after client B but the staff restrained client D in a baskethold. After 2-3 minutes, client D was released. He attempted to hit staff several times and pulled his penis out and threatened to urinate on staff. Client D went to his room and came out with 2 breadsticks. Client D indicated he wanted to say he was sorry to client E. Client E refused to come out of his room. Client D said he was sorry to client A and they hugged. The report indicated, "[Client D] ate some of [client E's] bread sticks and [client E] was hit in the face. Everyone in the house was scared of [client D]."</p> <p>55) On 5/13/14 from 9:50 PM to 11:00 PM, client B blocked the office door so the staff could not get in. Client C went to the office door and gave staff a hug. Client B grabbed client C's shirt collar and client B refused to let go. Staff prompted client B but refused to let go. Staff removed client B's grip, finger by</p>			

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	<p>finger, from client C's shirt. Client B went into client C's room. Client C attempted to crawl into bed where client B was sitting. Client B grabbed client C's shirt collar again and held it. Client B released his grip and went to bed. Client C was not injured. The investigation, dated 5/16/14, indicated, "I strongly recommend that [client B] be moved to another residential location. It is not safe for him to be in a house with this set of clients. [Client B] has been involved in 11 client to client incidents since the beginning of April."</p> <p>56) On 5/12 to 5/13/14 from 10:30 PM to 12:00 AM, client B went to client C's room and woke him up by being loud in the hallway and knocking on client C's door. Client C exited his room and client B went in and sat on client C's dresser. As staff attempted to get client B to leave client C's room, client B laid on client C's bed. Client C walked up several times to go back to bed. The Stone Belt ARC, Inc. Incident Report, dated 5/15/14, indicated, in part, "After this happened for awhile I let [client C] attempt to crawl into his bed. [Client B] grabbed hold of [client C's] shirt by the collar so I asked him to let go of [client C] but I eventually had to pull [client B's] hand off of [client C's] shirt. [Client B] then sat up in bed while [client C] was half on the bed..."</p>			

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	<p>Staff asked client B if he needed an escort to his own room and client B said, "Nuh uh." Staff told client B he was going to have to call the pager. Client B eventually got up and left client C's room. Staff locked client C's door and escorted client B to the hallway. Client B went to his room but stayed awake all night. The investigation, dated 5/16/14, indicated, "I strongly recommend that [client B] be moved to another residential location. It is not safe for him to be in a house with this set of clients. [Client B] has been involved in 11 client to client incidents since the beginning of April."</p> <p>57) On 5/9/14 at 7:00 PM, clients B, D and E were getting ready to return from dinner in the van. Clients B and E got into a disagreement about what radio station to listen to. Client E cursed at client B and hit him on the left arm. Client D hit client E on his right arm. Client E hit client D on his left arm. Everyone calmed. When they returned home, client E pushed client D in the back. The investigation, dated 5/13/14, indicated, "I strongly recommend that [client B] receive alternate residential placement. [Clients B and E] can not live together safely. There has (sic) been 8 incidents of peer to peer abuse between these two clients in the past 5 weeks. [Client B] is a more appropriate candidate</p>			

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	<p>for waiver placement than [client E], which is why I recommend that he be moved instead of [client E]."</p> <p>58) On 4/28/14 at 7:45 AM, client D was sitting at the table eating. Client E was in the living room. Client E walked into the dining room with his shoes in his hands and asked client D if he was going to the day program. Client D shouted "NO" and client E hit client D in the back of the head and ran to his room.</p> <p>59) On 4/22/14 at 2:00 AM, client B turned client E's bedroom light on and off. For two hours, client B attempted to "pester" client E by turning his light off and on and hitting and kicking his door and wall. Client B put his feet into client E's room. Client B threw a magazine, paper towels and sodas into client E's bedroom. Staff stayed in between the clients. Client B woke up client C. Staff called the pager and was told there was no one to come and help. Client C walked to the entryway and attempted to leave the house. When staff got to the hallway, client E was bent over client B. Client B was on the floor and client E was punching him in the face. Staff prompted client E to stop. Client B returned to turning the lights off and on and hitting client E's door and wall. Client B threatened to run away. Client B</p>			

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	<p>walked outside and stood outside for an hour. The report indicated there were no injuries. The investigation, dated 4/28/14, indicated, "I recommend that [client B] be moved out of [name of group home]. While we will continue to support [clients B and E] at the same residence for as long as they are both here, it is now clear that this is not a healthy environment for these two clients. If we want to see true, continued and further development with [client B], he needs intensive supports in an environment where he does not have targets for his frustration. While that might sound unreasonable, it is not reasonable or safe to subject other highly anxious, volatile clients to behaviors that are unsolicited. I will continue to make this singular recommendation if client to client aggression between these two clients continues."</p> <p>60) On 4/10/14, the Client to Client Aggression Inquiry, dated 4/16/14, indicated, "[Client C] was wandering around. [Client B] went into [client E's] room and would not leave. [Client D] was in his own room. [Client C] went outside about 20 minutes into the incident. [Client E] immediately got angry when [client B] would not leave his room. [Client B] tried to throw a shoe at [client E]. I was in between the two</p>						

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	clients the entire time... In the midst of them trying to hit each other, I reminded the guys [clients B and E] about the house meeting that they had with [Social Worker] where they discussed civility and not hurting each other. I then asked [client E] if he would come into the office with me to calm down. I needed to go in there anyway to clean up the scrape on his knee from [client B] throwing a shoe at him. The shoe (hit) [client E's] knee. After [client B] went into the office came out and started to upset [client E] again, [client D] seemed to have had enough. When [client D] got involved, despite my redirections, I decided that I had to call the police or someone was going to get hurt. (It should be noted that [staff] called the Central Pager first and [name of group home] Coordinator was carrying the Central Pager. He picked up another client and staff that were elsewhere before coming to [name of group home]. When [client E] left his room and went with me to the office, [client B] calmed down and left [client E's] bedroom. Unfortunately, when [client E] left the office and returned to his bedroom, [client B] went back into the bedroom and [client E] got upset all over again. Eventually, I got [client B] to go with me to the office to talk, which also de-escalated the situation. He was fine for that time, but			

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	<p>once he left the office, he resumed his behavior. He knew that it was going to get a rise out of [client E] and that [client E] would not stop yelling and would eventually try to hurt [client B]. Once I called the police, everyone calmed down. They all wanted to talk and I asked them to give me a moment before we started talking again. They all needed a break to relax and compose themselves."</p> <p>61) Client E's 4/10/14 Support Team Review Form indicated, in part, "[Group Home Director - GHD] and [Qualified Intellectual Disabilities Professional - QIDP] will review a recent incident where a non CPI (Crisis Prevention Institute) restraint was used."</p> <p>62) On 4/9/14 at 5:30 PM, client C hugged client A. During the hug, client C bit client A's right shoulder, breaking the top layer of his skin.</p> <p>63) On 4/8/14 at 3:00 PM, client E wanted milk. Client E threw his glass of milk at staff #1. As client E passed client C, client C grabbed client E's shirt collar. Client E tried to remove client C's fingers. Client E open hand slapped client C on the forehead twice. Staff pulled client E's hand away from slapping client C again and staff removed client C's hand from client E's shirt. The</p>			

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	<p>investigation, dated 4/11/14, indicated, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of Supervised Group Living..."</p> <p>64) On 4/8/14 at 2:45 PM, client E ate an 11 ounce box of vanilla wafers and drank a large glass of milk. Client E got another glass of milk and another box of vanilla wafers. Staff #1 asked client E to make a healthier choice. Client E hit staff in the side of the face and threw the glass of milk at staff. Client E punched the walls. Client E threw a shoe and a basketball at staff #1. Client E slammed his bedroom door.</p> <p>65) On 4/6/14 at 7:00 PM, client B returned to the group home. Client B slammed client E's open bedroom door against the wall. Client E yelled at client B. Client B screamed at client E. Client B threw his wallet and watch at client E. Staff approached and client B slammed client E's door shut. Client E locked his door. Client B kicked client E's door. Client B attempted to use a quarter to unlock client E's door. Staff blocked the attempt. Client D exited his room screaming, pulling his hair and hit the walls. Client D slammed the fire door closed. Client B continued to kick client E's door while screaming. Client B hit</p>			

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	<p>staff in the face repeatedly. Client D opened the fire door, screaming and attempted to charge at client B. Client B went into the dining room and threw a ketchup bottle and cups at client C. Client B lunged over the table trying to hit client C. Staff called 911. Client B continued to scream and threaten to hurt client C. Staff informed client B the police were called. He continued to scream and pace through the house but no longer threatened his roommates. The police arrived and spoke to client B about the consequences of hurting others. Client B remained calm. The investigation, dated 4/11/14, indicated, in part, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of Supervised Group Living..."</p> <p>66) On 4/6/14 at 11:30 AM, client B returned to the group home. Client E was asleep in his bed. Client B slapped client E's open door with his hand. Client E woke up and asked client B to stop. Client B screamed "No" and continued to slap the door. Client E asked client B to stop for 15 minutes. Client B started throwing clothes at client E. Client B grabbed one of client E's shirts and ran to his room. Client E followed him. Client B locked his door. Client B screamed through the door and client E pounded on</p>			

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	<p>client B's door. Client D returned to his room and client B left his room to scream at client E from client E's doorway. Client D lunged at client B and grabbed the medallion he had received the day before and ripped it off of client B's neck. Client B and E exchanged slaps and pushes around the staff in between them. Client E "became violently aggressive attempting to punch [client B] and a rear bear hug was used to stop the attack." Client B attempted to hit client C but the staff blocked his attempts. The Stone Belt ARC, Inc. Incident Report, dated 4/6/14, indicated, "[Client D] repeatedly left his room to express his excruciating emotional and physical stress from hearing and witnessing the events... [Client D] expressed multiple times he wanted to fight with [client B], but staff was able to talk to him about appropriate outlets for his anger." The investigation, dated 4/11/14, indicated, in part, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of Supervised Group Living...".</p> <p>67) On 4/4/14 at 7:45 PM, client D was getting a snack and client E told client D it was not snack time yet. Client D continued to eat and client E attempted to grab the cereal client D was eating. Clients D and E yelled at each other and</p>						

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	<p>pushed each other. Staff attempted to separate the clients. Clients D and E punched each other. Client E took client D's lunch box outside the house. Client D went outside to get his lunch box. Client E hit the window next to the back door. After the third bang, the double paned window broke out from the inside. Client D received superficial scratches on his right hand requiring first aid.</p> <p>68) On 3/26/14 at 10:05 AM, client E entered the office where client C was receiving his medications and demanded to use the phone. Client E was reminded of privacy during a medication pass and client E punched staff #1 in the left eye with his right hand. Staff #1's glasses were broken. Client E exited the office and picked up a calculator and threw it against the wall breaking it.</p> <p>69) On 3/24/14 at 7:50 PM, client B ran out of the living room and into client E's room. He laid on the floor and would not leave. Client E went to his room and sat on his bed. Client E hit client B in the face with an open hand twice yelling for him to get out of his room. Client E continued to yell at client B. Client E reached over and slapped client B in the face. Client E hand was removed and prevented from further aggression. Client E went to take his medications. Client E</p>			

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	<p>returned and started yelling at client B. Client B was lying on the floor. Client E pushed the staff out of the way and jumped on client B. Client E pushed client B's head into a pile of clothes on the floor. Staff attempted to pull client E off of client B. Client E stopped and got up. Clients B and E were not injured.</p> <p>70) On 3/21/14 at 4:30 PM, client D reached around staff and shoved client B. Clients B and D went to the dining room. Client D shoved client B again. Client A pushed client D. When asked why client A pushed client D, client A said, "I'm helping." Client A attempted to hit staff. Client A ripped staff's shirt. Client A attempted to hit and kick staff and fell on his buttocks two times while doing so. No injury was indicated on the incident report.</p> <p>71) On 3/7/14 at 5:30 PM, client C grabbed client E's shirt. Client E hit client C on the top of the head. Client C was not injured.</p> <p>72) On 3/4/14 at 9:45 AM at the facility-operated day program, client B asked client E to have a turn playing a video game. Client E refused. Client B asked a second time. Client E shoved client B. Client B was not injured.</p>						

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	<p>73) On 3/3/14 at 8:05 PM, client E was lying in his bed. Client E wanted the hallway light off so he could sleep. Client B covered the light switch so the lights would stay on. Client E started calling client B names. Client E picked up a fork and threw it at client B but missed. Client E attempted to throw his soda on client B but missed. Client E spilled his drink all over himself. Client E yelled at client B for making him spill his soda. Client E attempted to hit client B but staff stayed in between the clients. Client B punched client E's right side. Client E had small scratches on his right hand requiring first aid.</p> <p>74) On 3/3/14 at 9:20 AM at the facility-operated day program, client A grabbed and twisted client E's arm behind his back. Staff intervened and client A hit staff in the back of the head. During the incident, client A shoved a microwave off a table and onto the floor, breaking the microwave. Client E had a red mark on the back of his neck from the incident.</p> <p>75) On 3/2/14 at 4:30 PM, client E arrived home and went straight to client A's room to take his television remote. Client E used the remote to turn the television client B was watching in the living room. Client E lunged at client B</p>						

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W000159	<p>and client B slapped client E in the face. Client E went into the kitchen. Client B took client E's soda to his room. Client E went after client B. Client B stayed in his room. Client E attempted to hit the staff. Client E threw a pepper shaker. Client E slammed the toast</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 3 of 3 clients in the sample (B, D and E) and two additional clients (A and C), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans as evidenced by: 1) insufficient staffing to implement the clients' program plans affecting clients A, B, C, D and E, 2) staff did not receive training to communicate effectively with client B, 3) client B and D's comprehensive functional assessments (CFA) were reviewed at least annually and updated as needed, 4) client B and D's individual program plans (IPP) were revised at least annually, 5) regular reviews of the clients' progress of their training objectives was not conducted, and 6) there was no review of a recommendation made by client D's audiologist for a hearing aid.</p>	W000159	<p>1) Plan of correction: Staff to client ratio will be 3:4 during active treatment and 2:4 during overnights and sleep time (attachmenta). Plan of prevention: Staffing office and human resources will prioritize Deckard open shifts. Quality monitoring: House manager, coordinator, or director will check in with staffing office daily to make certain these hours are filled.</p> <p>2) Plan of correction: Facility and LL Staff have been trained on communicating with client B using the training CD and sign language cards in his binder (attachment b). Plan of prevention: Training has been scheduled weekly (attachment c). Quality monitoring: Director will verify that trainings are occurring (attachment s).</p> <p>3) Plan of correction: Assessment</p>	12/12/2014

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	<p>Findings include:</p> <p>1) Please refer to W186. For 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>2) Please refer to W189. For 1 of 3 clients in the sample (B), the facility failed to ensure staff received training to communicate effectively with client B.</p> <p>3) Please refer to W259. For 2 of 3 clients in the sample (B and D), the facility failed to ensure the clients' comprehensive functional assessments (CFA) were reviewed at least annually and updated as needed.</p> <p>4) Please refer to W260. For 2 of 3 clients in the sample (B and D), the facility failed to ensure the clients' individual program plans (IPP) were revised at least annually.</p> <p>5) A review of client B's record was conducted on 10/7/14 at 12:39 PM. Client B's most recent quarterly review of his progress toward completing his training objectives was dated March to May 2014. There was no documentation</p>		<p>for client B and D havebeen completed (attachment d). Plan of prevention: Carmund and Rebecca the former QDIP /coordinators have resigned and is no longer eligible for employment with StoneBelt. Quality monitoring: New coordinator – when selected willbe trained to complete assessment prior to ISP meetings each year. New directorwill check to make sure CFA are reviewed annually (attachment s). 4)Plan of correction: ISP (IPP) for client B and D havebeen completed (attachment f). Plan of prevention: Carmund and Rebecca the former QDIP /coordinators have resigned and are no longer eligible for employment with StoneBelt. Quality monitoring: New coordinator – when selected willbe trained to complete assessment prior to ISP meetings each year. Directorwill check to make sure they were completed (attachment s). 5) Plan of correction: Support team will meet each month,quarter, and annually to discuss client's progress. Plan of prevention: Carmund and Rebecca the former QDIP /coordinators have resigned and are no longer eligible for employment with StoneBelt. Quality monitoring: New coordinator – when selected willbe trained to complete assessment prior to ISP meetings</p>				

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	<p>the QIDP reviewed client B's progress of his training objectives from June 2014 to October 2014.</p> <p>A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's most recent quarterly review of his progress toward completing his training objectives was dated March to May 2014. There was no documentation the QIDP reviewed client D's progress of his training objectives from April 2014 to October 2014.</p> <p>A review of client E's record was conducted on 10/8/14 at 12:48 PM. Client E's most recent quarterly review of his progress toward completing his training objectives was dated March to May 2014. There was no documentation the QIDP reviewed client E's progress of his training objectives from April 2014 to October 2014.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director (GHD) indicated the clients' progress toward completing their training objectives should be completed quarterly (every 90 days).</p> <p>6) A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's most recent hearing exam, dated 5/6/14, indicated, in part, "Right</p>		<p>each year. Director will check to make sure QDIP complete quarterly and annual reviews (attachments).</p> <p>6) Plan of correction: Support team reviewed client D's audiologist recommendation for a hearing aid. It was determined that due to behaviors and refusals they would not be introduced at this time. Team will review once client D is stable (attachment g).</p> <p>Plan of prevention: Day aid has been trained to follow through with all recommendations and physician orders (attachment h).</p> <p>Quality monitoring: House manager has been trained to monitor outside service reports and that orders have been followed / IDTs held (attachment i).</p>	

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W000186	<p>ear good, left ear slight hearing loss in high frequency. Hearing aid recommended for left ear although not medically necessary yet." There was no documentation the facility's nurse or client D's interdisciplinary team (IDT) reviewed and addressed the recommendation in client D's record.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated the nurse and IDT should have addressed the recommendation made by client D's audiologist.</p> <p>On 10/15/14 at 12:43 PM, the Nurse Manager (NM) indicated he thought client D had hearing aids in the past and refused to wear them. The NM indicated he could not locate documentation the nurse or the support team discussed the recommendation. The NM indicated there should be documentation in client D's record regarding a discussion of the recommendation.</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-3(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct</p>						

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	<p>care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM. The surveyor arrived and parked in the yard of the group home due to there being no parking spots in the driveway. The surveyor observed staff #2 exit the group home van (parked in the driveway near the front door) and enter the group home. The surveyor walked up to the van, which was running, and observed client C sitting in the front passenger seat. The group home front door was closed. The window to the left of the front door did not have staff observing out of the window. The window to the laundry room and client A's bedroom had the curtains closed.</p>	W000186	<p>Plan of correction: Staff to client ratio will be 3:4 during activetreatment and 2:4 during overnights and sleep time (attachment a).</p> <p>Plan of prevention: Staffing office and human resources will prioritize Deckard open shifts.</p> <p>Quality monitoring: House manager, coordinator, or director will check in with staffing officedaily to make certain these hours are filled (attachment t).</p>	12/12/2014

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	<p>Client C leaned over and started touching the keys. Staff #2 exited the house after two and a half minutes. During the time staff #2 was in the group home, client C was unsupervised in the running group home van.</p> <p>During the evening observation on 10/6/14, the Group Home Director indicated she was staying to work the overnight shift due to the lack of staffing at the group home.</p> <p>An observation was conducted at the group home on 10/7/14 from 6:03 AM to 8:19 AM. On 10/7/14 at 6:03 AM, the Group Home Director was working at the group home with no additional staff. The Qualified Intellectual Disabilities Professional (QIDP) arrived on 10/7/14 at 6:06 AM. At 6:46 AM, staff #3 (substitute staff) arrived to work. At 7:22 AM, staff #5 (substitute staff) arrived to work. At 8:05 AM, client B's one on one day program staff (day program staff #1) arrived.</p> <p>On 10/7/14 at 1:54 PM, client A's Behavioral Support Plan, dated 6/11/14, indicated he had the following maladaptive behaviors targeted in his plan: out of bounds, poor interpersonal/sexual boundaries, improper telephone etiquette, and</p>			

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	<p>physical aggression.</p> <p>On 10/7/14 at 12:39 PM, client B's Behavioral Support Plan, dated 8/6/14, indicated he had the following maladaptive behaviors targeted in his plan: disruptive behaviors, physical aggression, stealing, inappropriate refusals, self-injurious behaviors, and elopement.</p> <p>On 10/7/14 at 1:43 PM, client C's Behavioral Support Plan, dated 4/29/14, indicated he had the following maladaptive behaviors targeted in his plan: physical aggression, PICA (ingestion of non-nutritive items), task avoidance, out of bounds and head and hand banging.</p> <p>On 10/8/14 at 11:22 AM, client D's Behavioral Support Plan, dated 7/25/14, indicated he had the following maladaptive behaviors targeted in his plan: refusals, tantrums, physical aggression, out of bounds/inappropriate touch, skin picking, and symptoms of depression.</p> <p>On 10/8/14 at 12:48 PM, client E's Behavioral Support Plan, dated 7/21/14, indicated he had the following maladaptive behaviors targeted in his plan: physical aggression, property</p>				

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	<p>destruction, inappropriate sexual behavior, compulsive behavior, and symptoms of bi-polar disorder.</p> <p>A review of the facility's incident/investigative reports was conducted on 10/6/14 at 12:31 PM and indicated the following:</p> <p>1) On 4/6/14 at 7:00 PM, client B returned to the group home. Client B slammed client E's open bedroom door against the wall. Client E yelled at client B. Client B screamed at client E. Client B threw his wallet and watch at client E. Staff approached and client B slammed client E's door shut. Client E locked his door. Client B kicked client E's door. Client B attempted to use a quarter to unlock client E's door. Staff blocked the attempt. Client D exited his room screaming, pulling his hair and hit the walls. Client D slammed the fire door closed. Client B continued to kick client E's door while screaming. Client B hit staff in the face repeatedly. Client D open the fire door, screaming and attempted to charge at client B. Client B went into the dining room and threw a ketchup bottle and cups at client C. Client B lunged over the table trying to hit client C. Staff called 911. Client B continued to scream and threaten to hurt client C. Staff informed client B the</p>			

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	<p>police were called. He continued to scream and pace through the house but no longer threatening his roommates. The police arrived and spoke to client B about the consequences of hurting others. Client B remained calm. The investigation, dated 4/11/14, indicated, in part, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of Supervised Group Living...".</p> <p>2) On 4/6/14 at 11:30 AM, client B returned to the group home. Client E was asleep in his bed. Client B slapped client E's open door with his hand. Client E woke up and asked client B to stop. Client B screamed "No" and continued to slap the door. Client E asked client B to stop for 15 minutes. Client B started throwing clothes at client E. Client B grabbed one of client E's shirts and ran to his room. Client E followed him. Client B locked his door. Client B screamed through the door and client E pounded on client B's door. Client D returned to his room and client B left his room to scream at client E from client E's doorway. Client D lunged at client B and grabbed the medallion he had received the day before and ripped it off of client B's neck. Client B and E exchanged slaps and pushes around the staff in between them. Client E "became violently aggressive</p>			

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	<p>attempting to punch [client B] and a rear bear hug was used to stop the attack." Client B attempted to hit client C but the staff blocked his attempts. The Stone Belt ARC, Inc. Incident Report, dated 4/6/14, indicated, "[Client D] repeatedly left his room to express his excruciating emotional and physical stress from hearing and witnessing the events... [Client D] expressed multiple times he wanted to fight with [client B], but staff was able to talk to him about appropriate outlets for his anger." The investigation, dated 4/11/14, indicated, in part, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of Supervised Group Living...".</p> <p>3) On 7/10/14 from 10-10:30 PM, client B threw items at staff. Client E observed client B enter the kitchen for some grapes. Client E yelled, "The kitchen is closed." Client B responded, "Nuh uh." This lasted for 10 minutes. Client E was prompted to ignore client B. Client E was yelling "no." Client C woke up. The staff left the kitchen area to attend to client C, who appeared unstable (gait). Clients B and E were in the kitchen yelling at each other. Staff was assisting client C to the table, client E ran to client B and choked and shook him. Staff removed client E's hands from client B</p>			

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	<p>and escorted client E to the front room. Client E attempted to hit staff. Clients B and E calmed down. The investigation, dated 7/17/14, indicated, in part, "I do not believe that [name of group home] is an appropriate setting for both [client B and client E]. It is becoming increasingly more and more difficult to support both clients in this setting. These incidents are most dangerous overnight when there is only one staff."</p> <p>4) On 7/5/14 at 10:30 PM, client B attempted to lie down on top of client E. Client B attempted to nudge and shove client E. Client E attempted to hit and kick client B. Client E started ignoring client B. Client B went outside to throw cups of water at passing cars. Client B threw a cup of water at a car with the window open. The car stopped and client B ran inside the house and watched as the car waited for about 5 minutes. At 10:50 PM, client E got up to use the restroom and client B took his spot on the couch. When client E returned, he got aggravated and attempted to hit, kick and throw his shoes at client B. Client E sat on the couch with client B. Client B started pulling client E's hair and staff sat in between the clients. Client B attempted to reach around the staff. While blocking client B, client B grabbed the staff's right hand and shook it and</p>			

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	<p>staff felt a sharp pain on his ring finger. The investigation, dated 7/8/14, indicated, in part, "Many of these client to client incidents are happening at night when one staff is present."</p> <p>5) On 8/24/14 at 10:30 PM (reported to BDDS on 8/26/14), one staff was working at the group home. Staff was working with client C. Clients B and D went into the office area and locked the door. The BDDS report indicated, in part, "Staff could not attend to [client D and client B] because [client C] was being put into his room. [Clients B and D] were each sitting in the office chairs kicking and slapping each other. As soon as staff would separate the two, [client C] would wake up when staff would then attend to [client C]. [Clients B and D] started attacking staff simultaneously with punches, slapping and kicking. [Client D] was put in a series of 4 bear hugs and 3 basket holds, each lasting a maximum of 10 minutes; and went on for approximately 1 hour." Staff contacted the pager. Client B was screaming/hitting/kicking doors and waking up client C. The report indicated, "[Client C] had fallen due to the force and influence of [client B's] behavior. [Client B] had dumped water on [client C] so [client C] slipped; [client B] slammed a door on [client C] and [client</p>			

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	<p>C] was knocked backwards; 2 other occasions where [client C] was exiting his room and fell." Client B pulled the fire alarm while staff was helping client C to bed. Client B blocked the exit for evacuation. The fire department arrived and attempted to re-set the alarm, but the pull appeared broken into the alarm position. Client B attempted to throw things at client C but "staff scooped up [client C] and carried him to the formal room while blocking the door from the inside." Pager contacted again. Things calmed down. The report indicated, "Sometime thereafter, staff called 911 because staff was unable to restrain [client B] or put [client B] in an exclusionary time out as per his BSP (behavior support plan), and was unable to continue blocking objects from hitting [client C]. [Client C] was checked for injury as [client C] had some red marks on his shoulders and arms which may develop into bruises and [client C] will be monitored. Officers arrived at 5:25am and had a chat with [client B] about how the night was going and got him in a more calm space."</p> <p>Client B's Support Team Review Form, dated 11/6/13, indicated, in part, "[Qualified Intellectual Disabilities Professional (QIDP)] and the team believes that [client B] needs 24/7</p>			

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	<p>staffing. His behavior overnight necessitates extra staffing in the 10P-6A hours...".</p> <p>On 10/6/14 at 11:41 AM, the Group Home Director (GHD) indicated the group home did not have two overnight staff. The GHD stated the facility stopped using two overnight staff and placed one "competent" staff in the position. The GHD indicated client B will not leave the group home during the overnight with one staff present since client B knew one staff could not follow him. The GHD indicated the group home had one permanent staff. The GHD indicated every weekend position was open. The GHD indicated the current Qualified Intellectual Disabilities Professional (QIDP) had been in the position for one week. The previous QIDP was given the choice to quit or be terminated. The previous QIDP quit. The former Home Manager left and went to work at the day program. Several group home staff also left to work at the day program. The GHD indicated the former overnight staff needed a second staff to work with him.</p> <p>On 10/6/14 at 3:01 PM, staff #1 (the only full-time, permanent staff working at the group home) indicated one staff was not sufficient to supervise the clients during</p>						

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	<p>the overnight shift. Staff #1 indicated client B needed one on one staff. Staff #1 indicated client C needed one on one supervision. Staff #1 indicated client E, at times, needed one on one supervision. Staff #1 indicated in September 2014, client B left the group home and walked to a place miles from the group home. Staff #1 indicated there were two staff working that night. At 3:15 PM, staff #1 indicated two staff was not sufficient during the morning shift. Staff #1 indicated there needed to be at least three staff due to the clients' behaviors and client C needing one on one due to falls. Staff #1 stated there have been "numerous" times when the morning shift had two staff.</p> <p>On 10/14/14 at 11:56 AM, the Social Worker (SW) indicated there were times when client B was up during the night shift for hours and hours. The SW stated it was "impossible" for the overnight staff to do anything else besides supervise client B. The SW indicated having two overnight staff would allow the night shift to go better much. The SW indicated there were a few recent weeks with two overnight staff. The SW stated, "More staff is better." The SW stated if any of the other clients were awake when client B was awake, one staff could not attend to two people at once due to client</p>			

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	<p>B "demanding" the staff's attention. If client B did not receive the attention he wanted, he would do something to get the staff's attention. The SW indicated client B usually engaged in maladaptive behaviors (aggression) to get the staff's attention.</p> <p>On 10/6/14 at 2:14 PM, the QIDP indicated there were times when two staff worked at the group home. The QIDP indicated clients B and C needed one on one staffing leaving three people unsupervised. The QIDP indicated there should be at least three staff during waking hours. The QIDP indicated there was one staff during the overnight shift. The QIDP stated there needed to be "at least" two overnight shift staff. The QIDP stated, "Insufficient staff to implement the clients' plans."</p> <p>On 10/15/14 at 1:10 PM, the Human Resources Staffing Coordinator (SC) indicated the clients were not receiving the proper care and programming they should have due to a staffing shortage at the agency. The SC indicated there was one permanent staff at the group home. The SC indicated the group home should have four staff in the mornings and evenings. The SC indicated the overnight shift was being staffed by one staff. The SC indicated one staff was not</p>				

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W000189	<p>sufficient during the overnight shift.</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM 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.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (B), the facility failed to ensure staff received training to communicate effectively with client B.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM and 10/7/14 from 6:03 AM to 8:19 AM. During the observations, client B was not offered and did not use his communication device. During the observations, client B's communication device was hanging in the office area of the group home. On 10/7/14 at 7:44 AM, client B attempted to get staff #3 to tell him who was taking him to the day program. Client B, attempted several</p>	W000189	<p>Plan of correction: Facility and LL Staff have been trained oncommunicating with client B using the training CD and sign language cards inhis binder (attachment b).</p> <p>Plan of prevention: Training has been scheduled weekly (attachment c).</p> <p>Quality monitoring: Director will verify that trainings are occurring (attachment s).</p>	11/14/2014

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	<p>times, to get staff #3 to tell him who was taking him to the day program. Staff #3 did not appear to understand what client B wanted to know. Staff #3 did not prompt client B to get or use his communication device. Client B continued to ask who was taking him to the day program. Client B was getting louder and appeared anxious due to his body movements and rapid speech. At 7:49 AM, client B was moaning and grunting trying to get staff #3 to tell him who was coming in to take him to the day program. Staff #3 did not appear to understand his questions as evidenced by her lack of response. Staff #5 told client B his one on one staff would be at the group home in 11 minutes. Client B immediately calmed down. On 10/7/14 at 8:08 AM, client B was getting ready to leave the group home for the day. Client B had the communication device hanging around his neck from a neck strap.</p> <p>On 10/7/14 at 8:08 AM, client B's day program staff #1 stated client B "reluctantly" used the communication device. Staff #1 stated client B's use of his communication device was, "never on his own accord." Staff #1 indicated the speech therapist will decide at client B's next appointment if client B could keep the device since it was loaned to client B to see if he would use it. Staff #1</p>			

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	<p>indicated client B had the device for awhile. Staff #1 indicated the trial period had been extended a few time in order to get client B to use the device more often.</p> <p>A review of the facility's incident/investigative reports was conducted on 10/6/14 at 12:31 PM and indicated the following: On 12/22/13 at 2:00 PM, client B called out to client C in a friendly manner. As client C approached client B, client B kicked client C in the abdomen. Client B threw items and spit at client C. Client C was not injured. The investigation, dated 12/30/13, indicated, "[Client B] needs to be seen by a professional sign language therapist for assessment so that they can prevent/assist (to) us with how best to use sign language to communicate with [client B]. This will go a long way towards helping him to reduce frustration that leads to aggression."</p> <p>A review of client B's record was conducted on 10/7/14 at 12:39 PM. Client B's 8/7/13 Individual Support Plan did not address the use of the communication device. There was no documentation in client B's record indicating there was a plan to teach client B to use his device. Client B's Behavioral Support Plan (BSP), dated 8/6/14, indicated in the General Proactive</p>						

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	<p>Strategies section, in part, "6. Actively communicate with [client B] whenever possible. [Client B] enjoys being around and talking with a wide variety of people; he has a lot of ideas and interests and is excited to share them. Use sign language as much as possible and encourage [client B] to take time to sign and communicate with others. Encourage [client B] to communicate using full sentences, as this has been shown to help [client B] reduce his anxiety and communicate more clearly...".</p> <p>Client B's Support Team Review Form, dated 3/5/14, indicated, in part, "The Social Work team is going to be working with [client B] two days a week on a new loaner program iPad to see if the app (application) on the loaner will be good for [client B]. [Social Worker] is going to work with [Life Long Learning Coordinator] about the prospect of [Coordinator's] employees working with [client B] during LL (Life Long Learning) hours."</p> <p>Client B's Support Team Review Form, dated 5/22/14, indicated, in part, "[Social Worker] is working with IT (Information Technology) and Social Work Services to complete the sign language DVDs (digital video discs) that will be used to train staff on [client B's] sign language."</p>			

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	<p>Client B's Support Team Review Form, dated 6/9/14, indicated, in part, "[Social Worker] will follow up with IT and [name of IT Director] about [client B's] sign language DVDs. IT is working on HIPAA (Health Insurance Portability and Accountability Act) concerns. [Social Worker] is following up on the assistive communication device. The [name of university] professional responsible is waiting on prior authorization."</p> <p>Client B's Support Team Review Form, dated 8/13/14, indicated, in part, "[Social Worker] will follow [name of staff] as it relates to the AAC (Augmentative and Alternative Communication) device, program and scheduling appointments."</p> <p>On 10/8/14 at 1:55 PM, the Behavior Specialist (BS) indicated he had recent concerns about how substitute staff (subs) were being trained. The BS stated the "Subs received limited training." The BS indicated he trained the Home Manager and Coordinator (Qualified Intellectual Disabilities Professional) and the HM and Coordinator should be training the staff. The BS stated, "Training in general (is) a concern."</p> <p>On 10/15/14 at 2:08 PM, the Group Home Director (GHD) sent an email with</p>			

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	<p>training documentation regarding client B's communication device. The Staff Training Form, dated 8/8/14, indicated three former staff and the GHD received the training. There was no documentation day program staff #1 received the training. There was no documentation the substitute staff received the training. There was no documentation staff #1 (the one permanent, full time staff working in the group home) received the training.</p> <p>On 10/15/14 at 2:08 PM, the Group Home Director (GHD) sent an email with training documentation regarding client B's sign language DVD. The Staff Training Form, dated 10/10/14 (after the start of the survey), indicated the GHD, Behavior Specialist and the Qualified Intellectual Disabilities Professional received the training. There was no documentation day program staff #1 received the training. There was no documentation the substitute staff received the training. There was no documentation staff #1 (the one permanent, full time staff working in the group home) received the training.</p> <p>On 10/14/14 at 2:39 PM, the Social Worker (SW) indicated client B met with an intern through the Social Work office. The intern recorded a video with client B</p>						

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	<p>using his personalized sign language in order to increase the staff's ability to communicate with client B. One of the DVDs was at the group home and one was at the day program. The SW indicated he was unclear if the staff were trained using the DVDs. The SW indicated the DVDs were helpful to increase the staff's ability to communicate with client B. The DVDs would decrease his frustration with attempting to communicate his wants and needs. The SW indicated the first DVD sent to the group home could not be located so it was replaced last week. The SW indicated client B currently had a loaned communication device for a trial period. The SW indicated there was a tracking sheet and staff were supposed to be encouraging client B to use the device regularly to get him to communication effectively. The SW indicated the day program staff who took client B to his appointments with the Speech Therapist were supposed to train the group home staff on how to use the device with client B. The SW indicated he was unclear if the day program staff trained the group home staff to use the device with client B.</p> <p>This federal tag relates to complaint #IN00156855.</p>						

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W000249	<p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 2 of 3 clients in the sample (B and D) and one additional client (C), the facility failed to ensure staff implemented the clients' program plans as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 10/7/14 from 6:03 AM to 8:19 AM. At 7:53 AM, client B was eating his breakfast in the dining room. There was no staff in the dining room for 2 minutes.</p> <p>A review of client B's record was conducted on 10/7/14 at 12:39 PM. Client B's Aspiration Plan, dated June 2014, indicated, in part, "[Client B] has a history of occasionally choking due to the way in which and rate at which he eats.</p>	W000249	<p>1) Planof correction: Staff trained on following client b's dining plan. Plan of prevention: All staff were trained on client b'sdining plan during staff meeting 11/14 (attachment b). Plan of monitoring: Day aid, house manager, associatehouse manager one of which will be monitoring each meal.</p> <p>2) Plan of correction: Staff trained on following clientd's 1800 calorie diet. Plan of prevention: All staff were trained on client d's1800 calorie diet and the fmps to shop for the proper food (attachment b).There is a right's restriction to restrict access from the kitchen. Client willreach inside counter window and unlock door from inside kitchen. The doorhandle has been switched to prevent his free-access to food. Plan of monitoring: Day aid,</p>	12/05/2014			

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	<p>[Client B's] most recent Swallow Study indicates that he does have Mild Dysphagia, however, the therapist recommended a regular diet with regular liquids. Recommendation made for [client B] to eat small bites, and he is to be encouraged to take small sips of liquids instead of gulping them." The plan indicated, "[Client B] is capable of feeding himself but should be in line of site of staff when he is eating."</p> <p>On 10/7/14 at 2:10 PM, the Nurse Manager indicated client B's plan for line of sight while eating should be implemented as written.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated client B's plan should be implemented as written.</p> <p>2) An observation was conducted at the group home on 10/7/14 from 6:03 AM to 8:19 AM. At 8:02 AM, client D started to eat his breakfast. Client D had eggs, bacon, biscuit and oatmeal. At 8:08 AM, staff #3 served client D another plate with a second biscuit and more oatmeal. At 8:16 AM, staff #3 served client D more oatmeal while in the kitchen. Client D took the leftover food from client E's plate, which was located on the counter, and ate it while standing in the kitchen. Client D ate client E's eggs off</p>		<p>house manager, associatehouse manager one of which will be monitoring each meal.</p> <p>3) Plan of correction: Facility and LL Staff have beentrained on communicating with client B using the training CD and sign languagecards in his binder (attachment b). Plan of prevention: Training has been scheduled weekly(attachment c). Quality monitoring: Director will verify that trainings areoccurring (attachment s).</p> <p>4) Plan ofcorrection: Client b's medication training object was updated to focus on onegoal / ipp (attachment t).</p> <p>Plan of prevention:Staff were trained to implement goal/ipp and active treatment(attachment b).</p> <p>Plan of monitoring:House manager, associate manager, or day aid will be present during each medadmin. A director will conduct random and frequent observations.</p> <p>5) Plan of correction:Client c's is scheduled for an ot/pt evaluation on 11/19 and referred to aspecialist for further consultation to determine the usage of gait belt and touupdate fall plan if needed.</p> <p>Plan of prevention:Client c's fall plan was reviewed at staff</p>				

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	<p>of his plate. Staff #3 stated to client D, "You gonna eat all that?" Staff #3 did not redirect client D from eating off client E's plate. Staff #3 did not prompt client D to follow his diet.</p> <p>A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's most recent Group Home Nutrition Review, dated 4/30/14, indicated his current diet order was a 1500 calorie and fruit and vegetables only for seconds. The current weight on the review indicated 221. Client D's ideal body weight was 130 - 169.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated the staff should encourage and prompt client D to follow his diet order.</p> <p>On 10/15/14 at 12:43 PM, the Nurse Manager indicated the staff should encourage, teach and train client D to follow his diet order.</p> <p>3) Observations were conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM and 10/7/14 from 6:03 AM to 8:19 AM. During the observations, client D's communication device was hanging in the office area of the group home. Client D's communication device did not turn on and was not able to be used by</p>		<p>meeting and it was clarified thatgait belt was only to be used prn while he was having tremors (attachment b).</p> <p>Plan of monitoring: Adirector will conduct random and frequent observations.</p>	

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	<p>client D. During the observations, client D was not offered and did not use his communication device.</p> <p>A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's record did not contain documentation of the assessment/evaluation indicating the need for the communication device. Client D's Individual Support Plan (ISP), dated 7/26/13, included a training objective to increase the use of his communication device. The ISP indicated, in part, "Staff Instructions: [Client D] currently has several methods through which to communicate, including but not limited to an abbreviated sign language, a communication box and picture schedules/choice books. Encourage [client D] to communicate his wants and needs utilizing any of the above mentioned tools... Staff should also encourage [client D] to use his picture schedule or communication box when making choices or communicating preferences." Client D's Nurse Quarterly Physicals, dated 10/30/13, 2/26/14, 5/19/14 and 8/20/14 indicated, in part, "Has a communication device but he does not choose to use it very often."</p> <p>On 10/6/14 at 3:38 PM, staff #4 (substitute) indicated she had not</p>			

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	<p>observed client D to use his communication device. Staff #4 indicated she had never attempted to get client D to use his communication device. Staff #4 indicated she had not observed other staff prompt client D to use his communication device.</p> <p>On 10/8/14 at 1:55 PM, the Behavior Specialist indicated client D communicated enough to get his point across. The BS indicated he was not aware of a plan for client D to use a communication device. The BS indicated client D needed another evaluation regarding the use of the device.</p> <p>On 10/8/14 at 3:04 PM, the Group Home Director indicated client D needed a plan to use his communication device.</p> <p>On 10/6/14 at 3:19 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she had worked at the group home for one week and she had not observed client D to use the communication device. The QIDP indicated client D had a plan to use the communication device and the staff should implement the plan as written.</p> <p>4) a) An observation was conducted at the group home on 10/7/14 from 6:03 AM to 8:19 AM. At 6:42 AM, client B</p>			

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	<p>received his medications from the Qualified Intellectual Disabilities Professional (QIDP). The QIDP did not prompt client B to choose which medications he will take and the order. The QIDP did not ask client B to identify the purpose of the medication and how many tablets should be dispensed. The QIDP did not prompt client B to complete the medication log.</p> <p>A review of client B's record was conducted on 10/7/14 at 12:39 PM. Client B's Individual Support Plan (ISP), dated 8/7/13, indicated client B had a training objective to increase his ability to administer his medications. The training objective indicated, in part, "Staff Instructions: Staff will assist [client B] in all parts of the medication pass. Staff will prompt [client B] to choose which medications he will take and in what order. Staff will ask [client B] to identify the purpose of the medication and how many tablets should be dispensed for consumption during the medication pass. Staff will then assist [client B] to ensure that the correct number of pills have been dispensed, and that the medication log has been completed appropriately."</p> <p>b) An observation was conducted at the group home on 10/7/14 from 6:03 AM to</p>						

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	<p>8:19 AM. At 7:05 AM, client D received his medications from the QIDP. The QIDP did not ask client D what time he takes his medications. The QIDP did not prompt client D to select each medication bottle as they were being prepared. The QIDP did not prompt client D to sign the first letter of each of his medications. The QIDP did not prompt client D to sign his line in the medication book.</p> <p>A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's ISP, dated 7/26/13, indicated client D had a training objective to increase his ability to administer his medications. The training objective indicated, in part, "Staff Instructions: [Client D] will indicate what time his meds are taken. [Client D] will then select each med bottle as you ask. [Client D] should also sign the first letter of each of his meds. Then [client D] will sign his own line in the med book. Staff will also sign their line...".</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated the clients' medication administration training objectives should be implemented at every medication pass.</p> <p>5) Observations were conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM and 10/7/14 from 6:03 AM to</p>						

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	<p>8:19 AM. During the observations, client C was wearing a gait belt. Staff #2, staff #3, staff #5, and QIDP held onto client C's gait belt and used the gait belt to have client C walk in a direction they wanted him to go. There were numerous times throughout the survey when client C was leaned over and trying to move in a direction and the staff were holding onto the gait belt to direct his movement.</p> <p>Client C's record was reviewed on 10/16/14 at 10:28 AM. Client C's Fall Risk Plan, dated June 2014, indicated, in part, "[Client C] is at risk for falls due to his history and diagnosis. [Client C] has been seen by his neurologist who feels that the falls are not related to [client C's] seizure disorder or seizure activity. It is possible that the falls are related to his diagnosis of Anglemans (sic) Syndrome...</p> <p>1. Staff will use a gait belt with [client C] (around waist) PRN (as needed) when [client C's] gait is unsteady or his is having severe tremors. 2. Gait belt is to be used to help steady [client C's] gait and to prevent falls. Staff should NEVER pull on gait belt to encourage [client C] to walk in a particular direction. Staff should walk beside [client C] and let him lead the way."</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director (GHD) indicated the staff should</p>				

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W000259	<p>walk side by side with client C. The GHD indicated the gait belt should not be used to restrict his movement.</p> <p>On 10/7/14 at 2:20 PM, the Nurse Manager (NM) indicated client C's gait belt should be used when client C was having tremors. The NM indicated the gait belt should not be used to guide or direct client C's movement. The NM indicated the purpose of the gait belt was to protect him from falling. On 10/16/14 at 10:31 AM, the Nurse Manager (NM) indicated client C's plan should be implemented as written.</p> <p>On 10/8/14 at 1:55 PM, the Behavior Specialist (BS) indicated the intent of the gait belt was to protect client C from falling. The BS indicated the gait belt should not be used to guide or direct client C's movement. The BS indicated the staff should walk side by side to support client C's gait.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for</p>	W000259	Plan of correction: Assessment for client B and D havebeen	11/28/2014			

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W000260	<p>2 of 3 clients in the sample (B and D), the facility failed to ensure the clients' comprehensive functional assessments (CFA) were reviewed, at least annually, and updated as needed.</p> <p>Findings include:</p> <p>A review of client B's record was conducted on 10/7/14 at 12:39 PM. Client B's most recent CFA was dated 8/28/12. There was no documentation client B's CFA was reviewed and updated since 8/28/12.</p> <p>A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's most recent CFA was dated 6/30/12. There was no documentation client D's CFA was reviewed and updated since 6/30/12.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated the clients' CFAs should be reviewed quarterly and updated annually.</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-4(a)</p> <p>483.440(f)(2)</p>		<p>completed (attachment d). Plan of prevention: New coordinator / qdip has been selected. Quality monitoring: New coordinator – when selected will be trained to complete assessment prior to ISP meetings each year. New director will check to make sure CFA are reviewed annually (attachment s).</p>				

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W000331	<p>PROGRAM MONITORING & CHANGE</p> <p>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (B and D), the facility failed to ensure the clients' individual program plans (IPP) were revised at least annually.</p> <p>Findings include:</p> <p>A review of client B's record was conducted on 10/7/14 at 12:39 PM. Client B's most recent IPP was dated 8/7/13. There was no documentation in client B's record indicating his IPP was revised since 8/7/13.</p> <p>A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's most recent IPP was dated 7/26/13. There was no documentation in client D's record indicating his IPP was revised since 7/26/13.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated the clients' IPPs should be revised at least annually.</p> <p>9-3-4(a)</p> <p>483.460(c)</p>	W000260	<p>Plan of correction: ISP (IPP) for client B and D have been completed(attachment f).</p> <p>Plan of prevention:Carmund and Rebecca the former QDIP / coordinators have resigned and are nolonger eligible for employment with Stone Belt.</p> <p>Quality monitoring:New coordinator – when selected will be trained to complete assessment prior toISP meetings each year. Director will check to make sure they were completed(attachment s).</p>	12/05/2014			

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	<p>NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 3 of 3 clients in the sample (B, D and E), the facility's nursing services failed to ensure: 1) client B's follow-up neurology appointment was held as recommended, 2) client D's recommendation for a hearing aid was addressed, 3) client E's dental appointment was held timely, 4) client E's hearing evaluation follow up was completed as recommended, and 5) client E's psychiatrist appointment was held timely.</p> <p>Findings include:</p> <p>1) A review of client B's record was conducted on 10/7/14 at 12:39 PM. Client B's most recent neurologist appointment was conducted on 10/29/13. The Outside Services Report (OSR), dated 10/29/13, indicated, client B was to return for a follow-up visit in 6 months. There was no documentation the follow-up appointment was held.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated client B should have had a follow-up appointment with his neurologist as recommended.</p> <p>On 10/15/14 at 12:43 PM, the Nurse</p>	W000331	<p>1) Plan of correction: Client b frequently refuses medical treatment and appointments. A neuro appointment was made for the next available date. Clientb has a desensitization plan.</p> <p>Plan of prevention:Day aid has been trained to follow up all recommendations, including follow up visits. When a client refuses an appointment then an OSR will be completed and the refusal documented.</p> <p>Quality of monitoring: Nursing manager and team will be notified when any appointments are missed due to refusals.</p> <p>2) Plan of correction: Support team reviewed client D's audiologist recommendation for a hearing aid. It was determined that due to behaviors and refusals they would not be introduced at this time. Team will review once client D is stable (attachment g).</p> <p>Plan of prevention:Day aid has been trained to follow through with all recommendations and physician orders (attachment h).</p> <p>Quality monitoring:House manager has been trained to monitor outside service reports</p>	12/05/2014

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	<p>Manager (NM) indicated an appointment should have been held as recommended. The NM indicated client B had a seizure disorder and took medications for seizures. The NM indicated client B may have refused the appointment but the NM was unable to locate documentation regarding a refusal to attend an appointment.</p> <p>2) A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's most recent hearing exam, dated 5/6/14, indicated, in part, "Right ear good, left ear slight hearing loss in high frequency. Hearing aid recommended for left ear although not medically necessary yet." There was no documentation the facility's nurse reviewed and addressed the recommendation in client D's record.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated the nurse should have addressed the recommendation made by client D's audiologist.</p> <p>On 10/15/14 at 12:43 PM, the Nurse Manager (NM) indicated he thought client D had hearing aids in the past and refused to wear them. The NM indicated he could not locate documentation the nurse or the support team discussed the recommendation. The NM indicated</p>		<p>and that orders have been followed / IDTs held (attachment i).</p> <p>3) Plan of correction: Client E frequently refuses medical treatment and appointments. He has refused to leave for home visits or to go on outings for several months. A dentist apt was made for the next available.</p> <p>Plan of prevention: Day aid has been trained to follow up all recommendations, including follow up visits. When a client refuses an appointment then an OSR will be completed and the refusal documented.</p> <p>Quality of monitoring: Nursing manager and team will be notified when any appointments are remissed due to refusals.</p> <p>4) Plan of correction: Client E frequently refuses medical treatment and appointments. He has refused to leave for home visits or to go on outings for several months. An apt was made for the next available to discuss ear cleaning with pcp.</p> <p>Plan of prevention: Day aid has been trained to follow up all recommendations, including follow up visits. When a client refuses an appointment then an</p>	

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	<p>there should be documentation in client D's record regarding a discussion of the recommendation.</p> <p>3) A review of client E's record was conducted on 10/8/14 at 12:48 PM. Client E's most recent dental appointment, dated 4/3/14, indicated a return visit in 3 months. Client E's next dental appointment was held on 9/4/14. There was no documentation of an appointment between 4/3/14 and 9/4/14.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated a follow-up appointment should have been held as recommended by the dentist.</p> <p>On 10/15/14 at 12:43 PM, the Nurse Manager (NM) indicated the appointment held on 9/4/14 was late. The NM indicated client E refused a lot of his medical appointments however there should be documentation in the record of the refusals. The NM indicated he was unable to locate documentation of client E's refusals to attend his 3 month follow up appointment. The NM indicated refusals to go to appointments should be documented in the record.</p> <p>4) A review of client E's record was conducted on 10/8/14 at 12:48 PM. Client E's most recent hearing evaluation</p>		<p>OSR will be completed and the refusal documented.</p> <p>Quality of monitoring: Nursing manager and team will be notified when any appointments are missed due to refusals.</p> <p>5) Plan of correction: Client E frequently refuses medical treatment and appointments. He has refused to leave for home visits or to go on outings for several months. He has since seen the psych. She was on vacation and had changed the appointment on 8/13/14.</p> <p>Plan of prevention: Day aid has been trained to follow up all recommendations, including follow up visits. When a client refuses an appointment then an OSR will be completed and the refusal documented.</p> <p>Quality of monitoring: Nursing manager and team will be notified when any appointments are missed due to refusals.</p>				

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	<p>was completed on 6/27/13. The Outside Services Report, dated 6/27/13, indicated, in part, "Ear wax build up in both ears. Hearing looks worse in high (frequency) R (right) & L (left) (results may have been confounded by wax). Have earwax removed and return for continued testing. Return following earwax removal." The Audiologic Evaluation, dated 6/27/13, indicated, in part, "Since [client E] did have a large amount of cerumen bilaterally, it is difficult to determine whether high frequency thresholds are reliable. It is recommended that [client E] see a physician for cerumen (earwax) management then return to the clinic for further testing. This was discussed with his caregiver and he had an appointment to return to this clinic on July 29, 2013." There was no documentation in client E's record indicating a follow-up appointment was conducted as recommended.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated the recommendations from the audiologist should have been completed as ordered.</p> <p>On 10/15/14 at 12:43 PM, the Nurse Manager (NM) indicated there was no documentation a follow up appointment was held. The NM indicated there should be documentation, if client E refused to</p>			

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W000407	<p>go to the appointment, in client E's record. The NM indicated client E should have returned for a follow up appointment as recommended.</p> <p>5) A review of client E's record was conducted on 10/8/14 at 12:48 PM. Client E's most recent psychiatric appointment, dated 8/13/14, indicated he was to return in one month. There was no documentation in client E's record indicating a follow up appointment was conducted.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated client E should have had a follow up appointment as ordered.</p> <p>On 10/15/14 at 12:43 PM, the Nurse Manager (NM) indicated the appointment was not held as recommended due to client E's psychiatrist taking a leave of absence for 4 to 5 weeks. The NM indicated there should be documentation in client E's record explaining why an appointment was not held as recommended.</p> <p>9-3-6(a)</p> <p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and</p>				

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	<p>social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (B), the facility failed to ensure client B was properly placed in regard to his social, behavioral and psychiatric needs.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/6/14 at 12:31 PM and indicated the following:</p> <p>1) On 9/29/14 at 1:50 PM, client E was reading a post card when client D attempted to sit on client E. Client E moved away from client D. Client E went to the kitchen. Client D followed client E and slammed the door. Client D opened the door and threw the trash can lid at client E. Client E had a red mark where the lid hit him on the side. Client E tried to go to his room and client D grabbed his shirt and ripped it. Client D spit at staff.</p> <p>2) On 9/27/14 at 9:00 PM, client B "shoved his way in to the med room between med passes." Client B sat in the middle of the room in a chair. Client B screamed and motioned he was going to</p>	W000407	<p>Plan of correction: A consultation was obtained from James Wiltz PHD concerning possible environmental changes the facility could introduce to accommodate client b (attachment u). Support team determined that client b would be served 60 day notice (attachment k) per Stone Belt's discharge policy below. Last projected day at facility January 11, 2014. <i>Discharge from services may occur when: The client/legal guardian chooses to leave services. Services are no longer appropriate, either because the client has received full benefit or because the needs of the client have changed. The client, and/or as applicable, the family, refuses to participate in available services. The client fails to continue to meet admission criteria. A client has presented conduct dangerous to self or others that is not manageable through behavior intervention techniques, medication and/or environmental adjustments.</i></p> <p><i>Funding for services is no longer available.</i> Plan of prevention: Admission team will review packets and determine proper placement of each individual. Plan of monitoring: Staffing has been enhanced until client b has been transitioned to another placement.</p>	11/14/2014			

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	<p>break a window for 5 minutes. When client B stood up to go toward the window, staff used a two person transport to assist him to his room.</p> <p>3) On 9/24/14 at 5:10 PM, client B was sitting in the driveway. As a car drove past, client B threw a rock at the car. Client B entered the house and pointed outside. There was a car parked outside the house. When staff and client B went outside, the care drove off. The car came back and a woman got out of the car and indicated client B hit her car with a rock, leaving scratches. The woman indicated about one month ago as she passed the group home, someone threw water at her car. The BDDS report, dated 9/25/14, indicated, "Coordinator notified and is investigating."</p> <p>4) On 9/22/14 at 5:00 PM, client B pulled client E's hair as client E was eating. Client E tried to go to his room. Client B ran in front of client E and locked client E's door. Client B slapped client E on the head and kicked him in the shins. Client E was not injured. Client E went into his room and locked the door. Client B went out the back door. Client B walked to a small construction site on the street the group home was located followed by one staff and two clients. Construction workers</p>			

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	<p>were digging new gas lines. Client B ignored the cones and staff's prompts and would not move away from the hole. Staff got in between client B and the hole so client B would not fall in. Client B walked down the street and laid in the middle of the street near a curve. Cars were attempting to drive around him and he refused to move. The BDDS report, dated 9/23/14, indicated, in part, "Staff tried to get [client B] to stand up physically by pushing him up and off the road fearing for [client B's] safety. [Client B] began to walk back toward [name of group home], but each time a car would pass, [client B] would quickly run out in front of the car getting the car to suddenly stop. [Client B] paid no attention to staff; Coordinator and central pager were notified; 911 were called immediately after. [Client B] apologized and ran inside [name of group home] to hide, but soon came out again. Police arrived at 6:35pm, but left minutes later as [client B] was behaving safely. [Client B] then resumed the behavior and walked out into the street with staff and clients following. Psych (psychiatric) pager was called and [client B] talked to Behaviorist as well. [Client A] also ignored staff's prompts to return to the house. [Client A] trespassed into the backyard of a house which was 'For Sale' and jumped on a trampoline for a few minutes; staff</p>			

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	<p>informed [client A] he was trespassing, but [client A] stayed for a little longer. Behaviorist arrived to stay with [client B], and staff returned home with [client A] and other client. Staff never lost sight of any clients."</p> <p>5) On 9/21/14 at 9:00 PM, client B entered a staff's car as a staff was preparing to leave. Client B took a drink from her car and ran back into the house and locked himself in the bathroom. Staff entered the bathroom to retrieve the drink. When client B exited the bathroom and saw staff with the drink, he attempted to "attack" the staff. Client B was placed in a bear hug. Staff and client B fell to the ground and the hold was released. Client B began head banging and slamming doors. The psychiatric pager staff was contacted. Client B's guardian was notified and client B spoke to his guardian. Client B calmed down, took his medications and went into his room. Client B exited his room and began to engage in self-injurious behavior and aggression. Client B was placed in brief bear holds lasting no longer than one minute on five separate occasions. At 1:00 AM, client B went to bed.</p> <p>6) On 9/20/14 at 12:00 PM, client B refused to take his medications.</p>				

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	<p>7) On 9/19/14 at 8:00 AM, client B refused to take his morning medications.</p> <p>8) On 9/18/14 at 3:40 PM and 9:00 PM (incident report documented on 9/19/14), client B grabbed a day program staff's right arm. Client B released his hold and then chased the staff while signing "beautiful." She went into the women's restroom. Client B stood at the door yelling for her to come out for 30 minutes. Staff called client B's guardian who spoke to him about the severity of his decision to grab and trap the staff in the restroom. Client B signed "no" and covered his ears. The Social Worker walked down the hallway and distracted client B long enough for the staff in the restroom to get out. Client B attempted to grab her and he was blocked until she was out of sight. Client B refused to leave the building until 4:30 PM. Client B was transported to his group home. Client B took a nap until 9:00 PM when the Group Home Director was getting ready to leave the house. Client B attempted to wake up his sleeping roommates by hitting on his cans with a spoon. The Stone Belt Incident Report, dated 9/19/14, indicated, "Team is meeting on 9/20 to discuss possible ESN (Extensive Support Needs) application and other placements to keep [client B]</p>			

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	<p>and others safe."</p> <p>9) On 9/12/14 at 12:00 PM (reported to BDDS on 9/15/14), client B refused his morning medications.</p> <p>10) On 9/11/14 at 5:00 PM, client B went to take his evening medications. Client B then refused to take them. Once the overnight staff arrived, client B began acting in an aggressive manner to the staff, refusing to let them clock in, hitting them, and destroying the staff's glasses. Client B slammed his door repeatedly and began throwing items at staff. Client B left the house at 11:30 PM with staff following. Staff never left client B's vicinity. After two and a half hours of walking around the neighborhood, client B and staff returned to the group home. Client B refused to take his medications.</p> <p>11) On 9/11/14 at 4:00 PM (reported to BDDS on 9/15/14), client B flicked client E's nose and kicked client E's shins. Client E went to his room. Client B kicked and tried to unlock client E's door. Client D was agitated with client B's behavior but was redirected. At 5:00 PM, the behaviorist met with client E in the formal living room. Client D entered the room carrying client B's hat. Client D attempted to close the door and used his body to push the door closed. Client B</p>			

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	<p>had his arm in the door and staff was outside of the room prompting client B to remove his arm. Client D took client B's hand and bit it. Behaviorist prompted client D to stop biting client B. Client D released the bite. Client B removed his hand and client D shut the door. Client B's hand did not have broken skin although the skin was red.</p> <p>12) On 9/9/14 at 12:00 PM, client B refused to take his morning medications.</p> <p>13) On 9/8/14 at 11:45 PM, client B woke up and staff asked him to take his medications. He refused. At 1:00 AM, client B wanted to take his medications. Staff explained it was too late and he would have to wait until morning to take his morning medications. Client B attempted to wake up other clients by slamming doors, yelling and trying to knock on other clients' bedroom doors. When staff intervened, there were two instances when client B slapped and punched the staff.</p> <p>14) On 9/8/14 at 5:00 PM, client B repeatedly picked up food off of pans to eat and refused all staff's requests to help set the table. Client D entered the kitchen and mimicked client B's behavior. Client D wanted client B out of the kitchen. Client D pushed client B</p>			

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	<p>out of the kitchen multiple times and client B went back in. Client A attempted to enter the kitchen to help with redirecting client D. Client D pulled client A's shirt. Client A tried to charge at client D but staff stood in front of the two. Client D left the kitchen but then pushed on the door to get back in. Clients A and B were holding the door closed. Client D aggressed on staff. Client D kicked one staff, smacked another in the face and punched a third staff in the shoulder. Client D was then angry at client E who was yelling at client D to stop. Client D followed client E into client E's room. Client D grabbed client E's charging cable and would not let go. Client E attempted to his client D several times but staff blocked the attempts. Client D was able to kick client E in the stomach. Client D chased client E into the living room. Client D cut his middle knuckle of his right hand during the incident. Client E was not injured.</p> <p>15) On 9/7/14 at 10:30 PM, client A's remote was taken by client B. Clients A and B "wrestled" each other for the remote. Staff broke up the altercation.</p> <p>16) On 9/3/14 at 11:59 PM, client B missed his bedtime medications. On 9/3/14 at 4:00 PM when all the clients were departing the day program, client B</p>				

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	<p>refused to leave. Client B did not return home until 9/4/14 at 7:00 AM.</p> <p>17) On 9/2/14 at 10:00 PM, client B was pounding on the wall between his room and another client's room (client E). Staff prompted client B to stop. Client B took off his shoe and hit the staff with his shoe several times. Staff kept client B in an exclusionary time out in his room for approximately 50 minutes, while standing outside of his doorway using a blocking pad per his behavior plan. Client B made several attempts to hit staff with items from his room. Client B broke a wooden crate in his room. Client B refused to take his medications.</p> <p>18) On 8/26/14 at 12:00 PM, client B refused to take his morning medications.</p> <p>19) On 8/24/14 at 10:30 PM (reported to BDDS on 8/26/14), staff was working with client C. Clients B and D went into the office area and locked the door. The BDDS report indicated, in part, "Staff could not attend to [client D and client B] because [client C] was being put into his room. [Clients B and D] were each sitting in the office chairs kicking and slapping each other. As soon as staff would separate the two, [client C] would wake up when staff would then attend to [client C]. [Clients B and D] started</p>			

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	<p>attacking staff simultaneously with punches, slapping and kicking. [Client D] was put in a series of 4 bear hugs and 3 basket holds, each lasting a maximum of 10 minutes; and went on for approximately 1 hour." Staff contacted the pager. Client B was screaming/hitting/kicking doors and waking up client C. The report indicated, "[Client C] had fallen due to the force and influence of [client B's] behavior. [Client B] had dumped water on [client C] so [client C] slipped; [client B] slammed a door on [client C] and [client C] was knocked backwards; 2 other occasions where [client C] was exiting his room and fell." Client B pulled the fire alarm while staff was helping client C to bed. Client B blocked the exit for evacuation. The fire department arrived and attempted to re-set the alarm, but the pull appeared broken into the alarm position. Client B attempted to throw things at client C but "staff scooped up [client C] and carried him to the formal room while blocking the door from the inside." Pager contacted again. Things calmed down. The report indicated, "Sometime thereafter, staff called 911 because staff was unable to restrain [client B] or put [client B] in an exclusionary time out as per his BSP (behavior support plan), and was unable to continue blocking objects from hitting</p>			

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	<p>[client C]. [Client C] was checked for injury as [client C] had some red marks on his shoulders and arms which may develop into bruises and [client C] will be monitored. Officers arrived at 5:25am and had a chat with [client B] about how the night was going and got him in a more calm space."</p> <p>20) On 8/18/14 at 9:40 PM, client B kicked client E's bedroom door. Client B laid in front of client E's room and kicked the bedroom door several times. Client E exited his room a few times and told client B to stop. Client B refused and continued to kick client E's door. Client B stopped once staff told him the staff would have to write an incident report.</p> <p>21) On 8/17/14 at 5:00 PM, client A thought client B had his remote in his bedroom. The former Qualified Intellectual Disabilities Professional (QIDP) told client A that client B did not have his remote. The QIDP thought the situation was over. The QIDP heard a commotion from down the hall and went to client B's room. Client D was in client B's room pulling on client B's shirt. Client E was in client B's room trying to take the remote. Client A was in the hallway watching. Client D was prompted to go to his room. Client A became upset and attempted to go into</p>			

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	<p>client B's room. Client A aggressed (kicking and hitting) on the former QIDP trying to get to client B. After the incident, client B admitted to stealing client A's remote and returned it.</p> <p>22) On 8/15/14 at 8:20 PM, client B had been aggressive. At 7:40 PM, he threw an apple off of the apple tree and hit the group home van. At 8:20 PM, client B hit staff in the back. Client B threw a pen and hit the same staff in the back of the head. Client B was told throwing items was inappropriate and he attempted to aggress on three staff. Client B was put in a baskethold but he spit and kicked at the staff who was attempting to leave. Client B was in the baskethold for 10 minutes. While in a baskethold, client B hit the staff in the chest and attempted to spit on staff. When released, client B grabbed staff's shirt so the staff could not enter the office and tore the staff's shirt. Client B was placed in a bear hug for 30 seconds. Client B yelled and slammed doors once released for 15 minutes.</p> <p>23) On 8/13/14 at 12:00 PM, client B refused to take his morning medications.</p> <p>24) On 8/8/14 at 12:00 AM, client B went to bed early and would not wake up to take his medications.</p>			

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	<p>25) On 8/3/14 at 12:00 PM, the incident report indicated, "[Client B] stayed up until very early in the morning displaying unsafe behavior, and fell asleep about 5:30 AM." Client B did not take his morning medications.</p> <p>26) On 8/2/14 at 7:00 PM, client B attempted to keep a staff's car from entering the driveway. Client B attempted to keep staff locked in the office after he clocked in and attempted to walk onto the highway next to the house. Client B threw rocks at cars, flipped off drivers from the driveway and crossed the highway at one point. When client B reentered the home around 10:00 PM, client B threatened to throw items at the staff. When client B was asked to take his medications, he started screaming, slamming his bedroom door and kicked the shared wall between his room and client E's room. This continued until 11:30 PM. The overnight staff informed the psychiatric pager staff who had arrived that she could leave. Client B started throwing objects (pillow, laundry basket lid, bottle of Listerine and a bucket) at staff. Client B went into his room and started kicking the wall to client E's room and shouting. At 11:40 PM, client B kicked client E's bedroom door and staff got in between to block. Client B went into his room and</p>						

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	<p>threatened to throw items at staff. Client B hit himself in the head with the items. Staff contacted the former QIDP. The QIDP informed staff to lock any items used by client B to hit himself with in the office. The items included small metal tin, several tin cans, larger plastic bins, the laundry basket lid, a small frying pan and a metal mug. Each time staff confiscated an item, client B kicked, scratched, slapped and attempted to bite the staff. Staff blocked client B with a couch cushion. Client B struck the fire detector in the living room and broke it. Staff did not have the alarm box key to disarm the alarm. Client B continued slamming doors, slapping and kicking until around 2:00 AM when he threw the laundry bin at the exposed florescent light tubes in the living room and one fell. Client B swung the tube at the staff but staff blocked it using a brief hold on the ground and preventing him from reaching the tube or laundry bin. Client B attempted to hit additional tubes with a tennis ball and the laundry basket. The psychiatric pager staff returned at 2:20 AM. Client B was calm during her visit but when she left at 3:25 AM, client B began kicking the other clients' bedroom doors, screamed, and slammed his own door until around 4:00 AM. Client B was apologetic. Client C woke up at 4:00 AM and client B apologized to him.</p>			

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	<p>Client B was calm until 5:40 AM when client C went back to bed. Client B started kicking the wall in his room and yelling but he was quiet around 6:00 AM. Client B refused to take his bedtime medications.</p> <p>27) On 8/2/14 at 5:45 PM, client B hit client C with a towel in the head and face. Staff blocked client B's attempts to hit client C. Client B grabbed client C's shirt collar and pulled hard and would not let go. Staff attempted to release client B's grip. Client B jumped through the pass through window and grabbed client C's shirt collar with both hands from the back. Staff attempted to release client B's grip. Client C's face started to turn red. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/3/14, indicated, "...[client B] was using [client C's] own shirt to choke him. [Client B] was also attempting to bite any staff's arms and hands as they tried to remove [client B's] hands." Staff used a bear hug hold on client B. Client B's grip was released. Client B kicked and spit at client C while pushing against the staff holding him. Client B headbutted the staff's collarbone repeatedly while scratching the staff's arms and hands with his fingernails. When staff attempted to switch due to the first staff's fatigue, client B broke free. Client B threw grill</p>			

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	<p>parts and lighter fluid at the house and attempted to kick the window in (the window was already broken). The BDDS report indicated, "Even after attempts to talk to [client B] about why he was angry, plan next day's events, help with cleaning, or go on walks with him, [client B] continued displaying unsafe behavior for the next 5 hours, including throwing rocks at cars, standing in the middle of [name of streets], and attacking staff. Multiple refusals to talk, and refusals to stop attacking [client C]. [Client B] signed multiple times that he wanted to hit [client C] more and that he wanted to hit staff more, throw rocks and other objects, stand in the road, and break more property... Staff monitored [client C] (housemate) the rest of the night for any adverse effects from the abrasion." The Client to Client Aggression Inquiry, reviewed by the administrator on 8/16/14, indicated, "I recommend that [client B] be placed in a different residential setting that is more appropriate for him. He is becoming a danger to himself and others in the house."</p> <p>28) On 8/1/14 at 7:00 PM, client B got into client A's bedroom. It took until 9:15 PM to get client B to exit client A's bedroom. Client A locked his bedroom door. Client B attempted to stop staff #2 from leaving the group home. Staff #2</p>						

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	<p>was able to leave the group home. Client B, at 9:40 PM, broke his fire detector in his bedroom. Client B blocked staff from accessing the fire panel. Client E attempted to attack client B while he obstructed the fire panel. Client E struck staff on the left side of the head with his right hand. At 10:00 PM, client B kicked client C's bedroom door and tried to wake up clients C and D who were asleep in their rooms. Client B started slamming his door repeatedly. Client E went to the kitchen to get a drink and client B knocked the drink out of client E's hands. Client B threw milk, juice and water at client E. Client E threw parts of the vacuum at client B. Client B threw utensils, chairs, and a sauce pan at client E. Client B hit client E in the head with a bottle brush and then a small sauce pan. Client E went into a fetal position and started crying. Both clients threw the metal napkin holder at each other until it broke. Client B threw backpacks and chair until he hit one of the plastic light covers in the living room. The cover fell and broke. Client B spit on staff. Client B kicked, slapped and attempted to bite staff. Client B threw chairs, cups of water, tennis balls, laundry basket lid, and utensils at staff. This lasted from 10:00 PM to 2:50 AM. The Stone Belt ARC, Inc. Incident Report indicated, "There were several points where I</p>			

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	<p>contacted the emergency pager, [former QIDP], and [former manager] and in some cases it was because I didn't feel like I could keep the clients safe due to the types of things [client B] was throwing, or that [client E] might have needed medical attention from being hit in the head with a sauce pan." The report indicated, "[Client B] ran out of steam at around 2:50 AM, changed mood drastically and was apologetic and helpful. He helped me do dishes, mop, and do laundry." The investigation, reviewed by the administrator on 8/10/14, indicated, in part, "I recommend that [client B] be placed in a different residential setting that is more appropriate for him. He is becoming a danger to himself and others in the house."</p> <p>29) On 8/1/14 between 12:45 AM and 1:50 AM, client B woke up and started hitting his wall which prevented another client from sleeping. Staff redirected client B but then heard client B throwing a softball. The fire system alarm near the kitchen started going off and client B came running out of his room. Client B either hit the smoke alarm in his room with the ball or unscrewed the cap causing the alarm to go off. Staff was able to get the alarm off but client B was agitated. Client B signed to staff he</p>			

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	<p>wanted to hit his smoke detector again. Staff stood in client B's room for most of an hour trying to redirect client B. Client B threw his shoes at staff and the smoke detector. Client B kicked his window and hit his window with softballs from his room. At 1:30 AM, staff told client B if he did not stop he would put him in a hold. Client B pulled a picture off the wall and grabbed the pin that was holding it up. Client B attempted to poke staff with the pin so staff took it from him and performed a baskethold for 3 minutes. After being released, client B attempted to hit staff with several objects. Client B eventually calmed down.</p> <p>30) On 7/28/14 at 5:30 PM, client B returned to the group home from the grocery store. Client B started bringing in groceries. Client E wanted to assist. Client B tried to close the front door when client E went outside. Clients B and E ran to the van. Client E grabbed some bags and client B hit him on the shoulder. Staff got in between the clients. Client E grabbed another bag and client B reached over the staff and hit client E on the right shoulder. There was no documentation the incident was reported to BDDS. The investigative report was signed as reviewed by the administrator on 8/8/14. The investigative report indicated, in part, "I</p>				

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	<p>recommend that either [client E] or [client B] be moved to another residential setting. This is not an example of an extreme incident, but these situations are too frequent and the abuse that results (as the state calls it peer to peer abuse), is scarring emotionally and psychologically. I do not believe that it is safe to continue supporting both of these clients in this environment."</p> <p>31) On 7/27/14 at 5:00 AM, client C grabbed client E's shirt on his way out of the bathroom. Client E started to choke client C with both hands from the front. Staff pried client E's hands off of client C's neck and put him in a temporary hold for a few seconds. Client C went to bed. Client E wanted an Ensure from the office. Client C exited his room and tried to leave the house through the back door. Client E took four Ensures from the office and was sitting in the living room drinking them. Staff removed one of the Ensures. Client E struck the staff in the back twice with his fist. Staff turned around and client E struck him on the right side of his jaw. Client E dumped an Ensure on the staff. Client C was not injured.</p> <p>32) On 7/25/14 at 9:00 PM, client B attempted to prevent staff from leaving at the end of their shift by standing in front</p>			

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	<p>of the staff's car door and getting behind the car and preventing it from backing out. Staff blocked client B causing him to get more frustrated. At 9:30 PM, client B entered the house and sat on client E's lap while on the couch and would not move. Client E attempted to choke client B with his right arm. Staff blocked the choking attempt. Client B went outside and got into the group home van and started honking the horn at 9:45 PM. Staff called the home manager who instructed the staff to attempt to remove client B from the van since the honking of the horn was disruptive to the neighbors and client B's peers who were trying to sleep. Staff attempted three bear hugs unsuccessfully. Staff used a baskethold to remove him from the van and locked the van's doors. Client B entered the house. At 10:30 PM, client B slammed the kitchen door 4 times and the clock fell off the wall and broke, shattering the glass of the clock. Client B ran from the glass shards and staff blocked him. Staff cleaned up the glass. At 10:40 PM, client B threatened to throw a frying pan at staff. Client B hit the kitchen window. At 10:50 PM, client E walked up to the kitchen to see what was going on and client B threw the frying pan at client E. Staff blocked the frying pan. Staff called the pager. Client B calmed down during the call and put</p>			

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	<p>the pan away. After the call, client B got the pan out again. Staff climbed over the kitchen bar and restrained client B in a bear hug to prevent him from harming himself by breaking the window with the frying pan. Staff prompted client B out of the kitchen. The pager was called again. Client B went to his room from 11:00 PM to 11:20 PM. Client B went outside and stood in the middle of the street outside the house. A car pulled into the neighborhood when client B was still in the road. Staff put client B in a bear hug to remove him from the road. Client B went back inside the house and calmed down.</p> <p>33) On 7/24/14 at 7:00 PM, client B refused to leave client E's bedroom. Client B left client E's room with one of client E's shoes. Client E was standing in front of client B's room demanding his shoe back. Client E was redirected to his room. Client B gave client E his shoe back. Client B attempted to aggress on client C as he exited the medication area. His attempts were blocked. Client C dropped to the floor and client B put his foot on client C. Client B hit the staff in the back and client B was restrained in a standing baskethold. Once released, client B hit the staff again. Client B was restrained again. Once released, client B attempted to aggress on client C. Client</p>			

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	<p>C went into the bathroom with staff to take a shower. Client B kicked and slammed doors. Client B slammed the office door several times repeatedly. Client B started crying and saying he was sorry. The BDDS report, dated 7/25/14, indicated none of the clients were injured. The investigation, dated 7/30/14, indicated, in part, "I recommend that [client B] be moved from [name of group home]. He continues to target [client C] and this (sic) creating an unsafe environment for [client C]. I believe that this targeting will continue."</p> <p>34) On 7/22/14 at 12:00 PM, client B refused his morning medications.</p> <p>35) On 7/10/14 from 10-10:30 PM, client B threw items at staff. Client E observed client B enter the kitchen for some grapes. Client E yelled, "The kitchen is closed." Client B responded, "Nuh uh." This lasted for 10 minutes. Client E was prompted to ignore client B. Client E was yelling "no." Client C woke up. The staff left the kitchen area to attend to client C, who appeared unstable (gait). Clients B and E were in the kitchen yelling at each other. Staff was assisting client C to the table, client E ran to client B and choked and shook him. Staff removed client E's hands from client B and escorted client E to the front</p>			

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	<p>room. Client E attempted to hit staff. Clients B and E calmed down. The investigation, dated 7/17/14 did not have a signature indicating the report was reviewed by the administrator. The investigation indicated, in part, "I do not believe that [name of group home] is an appropriate setting for both [client B and client E]. It is becoming increasingly more and more difficult to support both clients in this setting. These incidents are most dangerous overnight when there is only one staff."</p> <p>36) On 7/7/14 at 10:15 AM, client B was in his room when a repair company arrived to repair client C's broken door to his bathroom. Client B became upset when they finished. Client B attempted to follow the repairmen outside and then attempted to break the new door. Client B grabbed the back of client C's shirt but let go when prompted. Client B spit on staff and threw a shoe at staff. Client B hit staff and pulled the staff's shirt. Client B was placed in a baskethold to escort him to his room. Client B dropped to the floor in the hallway. Client B ran outside and sat in the driveway.</p> <p>37) On 7/5/14 at 10:30 PM, client B attempted to lie down on top of client E. Client B attempted to nudge and shove client E. Client E attempted to hit and</p>			

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	<p>kick client B. Client E started ignoring client B. Client B went outside to throw cups of water at passing cars. Client B threw a cup of water at a car with the window open. The car stopped and client B ran inside the house and watched as the car waited for about 5 minutes. At 10:50 PM, client E got up to use the restroom and client B took his spot on the couch. When client E returned, he got aggravated and attempted to hit, kick and throw his shoes at client B. Client E sat on the couch with client B. Client B started pulling client E's hair and staff sat in between the clients. Client B attempted to reach around the staff. While blocking client B, client B grabbed the staff's right hand and shook it and staff felt a sharp pain on his ring finger. The investigation, dated 7/8/14, indicated, in part, "Considering [client E's] current psychiatric state and [client B's] predisposition to bother and intentionally disturb [client E], I do not think that it is appropriate for these two individuals to live together. It is exceptionally challenging to support two such individuals in this setting...".</p> <p>38) On 6/30/14 (no time indicated), the investigative report (there was no facility incident report or BDDS reports to review), dated 7/1/14, indicated, in part, "[Client B] was quite upset and was</p>			

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	<p>standing outside of [client E's] door banging on it and yelling. [Client E] was in his room and was awake. The other guys were not awake. I made sure that [client C] was not hurt when [client B] hit him on the back of the head. [Client C] fell, but not as a result of [client B] hitting him. [Client C] was okay. I stayed with [client C] for as long as he was up. We went to the dining room table and had a snack. [Client B] followed but I stayed with [client C] and [client B] did not do anything else." The recommendations section indicated, "[Name of a former staff] completed training with me about the importance of ensuring that bedroom doors are locked when arriving at work. [Former staff] understood how important that is. I do not believe that any other training is necessary at this time."</p> <p>39) On 6/29/14-6/30/14 (no time indicated), the investigative report (there was no facility incident report or BDDS reports to review), dated 7/1/14, indicated, in part, "[Client C] had gotten up. [Client B] was yelling loudly after he stopped banging on [client E's] door. [Client E] was awake but in his room. I got [client C] to sit down at the table and I was sitting next to him... It happened so fast. I was sitting on the other side of the table from [client B] who was yelling.</p>			

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	<p>[Client E] came pretty quickly out of his room and slapped [client B] and then went... [Client E] ran to his room right as I was telling him that he couldn't hit [client B]. They ended up in two different rooms and there was no further contact for the evening." Client B was not injured.</p> <p>40) On 6/27/14 at 6:35 PM, client B was eating dinner and got up to get the empty bottles client E threw into the trash can. Client B threw the bottles into the backyard. Client E jumped up to get the bottles. Client E came inside, wet (due to rain) and cursed at client B. Client E threw the bottles away again. Client B took the bottles out of the trash can and threw them outside. Client E grabbed client B's shirt by the collar with both hands. Client B bit down on client E's left forearm, resulting in a puncture. Client E backed away. Later in the evening, client D was agitated with client B's behavior (loud noises and encroaching on personal space). Client D moved past staff to sit between clients B and E who were on the couch. Client D grabbed client B's hat and crushed his drink can. Client B pushed and grabbed client D. Client D grabbed the phone and remote from client E and attempted to block client E from seeing the television. Client E attempted to grab and hit client</p>			

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	D. Client E threw the remote at client D and client D threw the broken pieces of the remote at client E. Client D continued to display aggressive behavior toward clients B and E for 20 minutes. The BDDS report, dated 6/28/14, indicated, "No serious injuries were incurred by the clients." The BDDS report did not indicate who was injured and what the injuries consisted of. The investigation, dated 7/1/14, indicated, "I recommend that [client B] and his guardian pursue a CIH (Community Integration and Habilitation) waiver. This incident is another example of how [client B's] anxiety and aptness for intentionally upsetting his housemates has resulted in an incident. While I recognize that this tendency is not new to [client B], my concern, and hence my initial statement, arises from the increase in this behavior especially directed towards [client E], who also exhibits high anxiety and an inability to regulate responses on his own. [Client E] had made improvements in this area and ought not regress. I believe that two clients with such extreme anxiety in one house is too much. We will use new strategies developed by [Social Worker] to assist in calming [client B] in an attempt to reduce anxiety and redirect him during these situations."						

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	<p>41) On 6/22/14 at 5:00 PM, client B entered the home yelling. Client B told the staff they could no longer work with client C. Staff explained he was working with client C. Client B threatened to bite, hit, kick and spit at client C. Client C and staff walked away. Client B followed them and continued to threaten client C. Client B hit client C but it was partially blocked. Client D walked into the room at the time client B hit client C. Client D attempted to hit client B. Client D followed client B around the house while client B yelled he was going to hurt client C. The Stone Belt ARC, Inc. Incident Report, dated 6/22/14, indicated, "[Staff] was at this point preparing to get [clients C and D] out of the violent and stressful environment, grabbing [client C's] backpack off of the coat rack in the living room." Clients C and D were trying to leave and client B blocked their exit. Client D leaned and charged from the living room to the kitchen area and shoved client B down pushing him into the door. Client B fell to the floor. No one was injured.</p> <p>42) On 6/5/14 at 4:45 PM, client A received a phone call on the group home phone. Client B became agitated and wanted the telephone. Client B threatened to hit client A. Client A left to go on a walk. Client B threw items at the</p>			

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	<p>staff who left with client A. Client A went on his walk and client B followed. Client B attempted to hit the staff. Client A pushed client B. Client C had arrived in the van. Client C's staff decided to leave with client C after seeing client B agitated. Client B held onto the van's mirror in an attempt to keep the van from leaving. Staff redirected client B. Client B went into the group home and started throwing objects at the staff. Client B went into his room and threw objects at staff. The Social Worker attempted to take client D into the staff office but client B rushed in and would not leave. The Social Worker and client D left the area. Client C returned to the home and laid on the floor. Client B laid on top of client C. Client B, with prompting, got off of client C. The incident report, dated 6/5/14, indicated at 9:00 PM at the time the incident report was written, client B was in his room pounding on client E's wall.</p> <p>On 6/5/14 (no time indicated), the Client to Client Inquiry, dated 6/11/14, indicated client B was preventing client C from taking a shower. Eventually client C got into the bathroom. Client B banged on the door. Client D came down the hall and grabbed client B and put him in a headlock. Client D released the hold when prompted. Client B was not</p>						

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	<p>injured. The investigation indicated, in part, "I recommend that [client B] be moved from [name of group home] as soon as possible. I fear for his long term safety. It is becoming increasingly more difficult for us to protect [client B] with [client D] feeling emboldened and recognizing that his interventions are calming [client B]. [Client D] is stronger than most staff, quick and not easily restrained. I fear that [client B's] continued presence in the house will result in a serious injury or abuse. I recommend that the Director seek an emergency waiver for [client B]."</p> <p>43) On 5/13/14 from 9:50 PM to 11:00 PM, client B blocked the office door so the staff could not get in. Client C went to the office door and gave staff a hug. Client B grabbed client C's shirt collar and client B refused to let go. Staff prompted client B but refused to let go. Staff removed client B's grip, finger by finger, from client C's shirt. Client B went into client C's room. Client C attempted to crawl into bed where client B was sitting. Client B grabbed client C's shirt collar again and held it. Client B released his grip and went to bed. Client C was not injured. The investigation, dated 5/16/14, indicated, "I strongly recommend that [client B] be moved to another residential location. It is not safe</p>						

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	<p>for him to be in a house with this set of clients. [Client B] has been involved in 11 client to client incidents since the beginning of April."</p> <p>44) On 5/12 to 5/13/14 from 10:30 PM to 12:00 AM, client B went to client C's room and woke him up by being loud in the hallway and knocking on client C's door. Client C exited his room and client B went in and sat on client C's dresser. As staff attempted to get client B to leave client C's room, client B laid on client C's bed. Client C walked up several times to go back to bed. The Stone Belt ARC, Inc. Incident Report, dated 5/15/14, indicated, in part, "After this happened for awhile I let [client C] attempt to crawl into his bed. [Client B] grabbed hold of [client C's] shirt by the collar so I asked him to let go of [client C] but I eventually had to pull [client B's] hand off of [client C's] shirt. [Client B] then sat up in bed while [client C] was half on the bed...". Staff asked client B if he needed an escort to his own room and client B said, "Nuh uh." Staff told client B he was going to have to call the pager. Client B eventually got up and left client C's room. Staff locked client C's door and escorted client B to the hallway. Client B went to his room but stayed awake all night. The investigation, dated 5/16/14, indicated, "I strongly recommend that [client B] be</p>			

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	<p>moved to another residential location. It is not safe for him to be in a house with this set of clients. [Client B] has been involved in 11 client to client incidents since the beginning of April."</p> <p>45) On 5/9/14 at 7:00 PM, clients B, D and E were getting ready to return from dinner in the van. Clients B and E got into a disagreement about what radio station to listen to. Client E cursed at client B and hit him on the left arm. Client D hit client E on his right arm. Client E hit client D on his left arm. Everyone calmed. When they returned home, client E pushed client D in the back. The investigation, dated 5/13/14, indicated, "I strongly recommend that [client B] receive alternate residential placement. [Clients B and E] can not live together safely. There has (sic) been 8 incidents of peer to peer abuse between these two clients in the past 5 weeks. [Client B] is a more appropriate candidate for waiver placement than [client E], which is why I recommend that he be moved instead of [client E]."</p> <p>46) On 4/22/14 at 2:00 AM, client B turned client E's bedroom light on and off. For two hours, client B attempted to "pester" client E by turning his light off and on and hitting and kicking his door and wall. Client B put his feet into client</p>			

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	E's room. Client B threw a magazine, paper towels and sodas into client E's bedroom. Staff stayed in between the clients. Client B woke up client C. Staff called the pager and was told there was no one to come and help. Client C walked to the entryway and attempted to leave the house. When staff got to the hallway, client E was bent over client B. Client B was on the floor and client E was punching him in the face. Staff prompted client E to stop. Client B returned to turning the lights off and on and hitting client E's door and wall. Client B threatened to run away. Client B walked outside and stood outside for an hour. The report indicated there were no injuries. The investigation, dated 4/28/14, indicated, "I recommend that [client B] be moved out of [name of group home]. While we will continue to support [clients B and E] at the same residence for as long as they are both here, it is now clear that this is not a healthy environment for these two clients. If we want to see true, continued and further development with [client B], he needs intensive supports in an environment where he does not have targets for his frustration. While that might sound unreasonable, it is not reasonable or safe to subject other highly anxious, volatile clients to behaviors that are unsolicited. I will continue to make						

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	<p>this singular recommendation if client to client aggression between these two clients continues."</p> <p>47) On 4/10/14, the Client to Client Aggression Inquiry, dated 4/16/14, indicated, "[Client C] was wandering around. [Client B] went into [client E's] room and would not leave. [Client D] was in his own room. [Client C] went outside about 20 minutes into the incident. [Client E] immediately got angry when [client B] would not leave his room. [Client B] tried to throw a shoe at [client E]. I was in between the two clients the entire time... In the midst of them trying to hit each other, I reminded the guys [clients B and E] about the house meeting that they had with [Social Worker] where they discussed civility and not hurting each other. I then asked [client E] if he would come into the office with me to calm down. I needed to go in there anyway to clean up the scrape on his knee from [client B] throwing a shoe at him. The shoe (hit) [client E's] knee. After [client B] went into the office came out and started to upset [client E] again, [client D] seemed to have had enough. When [client D] got involved, despite my redirections, I decided that I had to call the police or someone was going to get hurt. (It should be noted that [staff] called the Central</p>			

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	<p>Pager first and [name of group home] Coordinator was carrying the Central Pager. He picked up another client and staff that were elsewhere before coming to [name of group home]. When [client E] left his room and went with me to the office, [client B] calmed down and left [client E's] bedroom. Unfortunately, when [client E] left the office and returned to his bedroom, [client B] went back into the bedroom and [client E] got upset all over again. Eventually, I got [client B] to go with me to the office to talk, which also de-escalated the situation. He was fine for that time, but once he left the office, he resumed his behavior. He knew that it was going to get a rise out of [client E] and that [client E] would not stop yelling and would eventually try to hurt [client B]. Once I called the police, everyone calmed down. They all wanted to talk and I asked them to give me a moment before we started talking again. They all needed a break to relax and compose themselves."</p> <p>48) On 4/6/14 at 7:00 PM, client B returned to the group home. Client B slammed client E's open bedroom door against the wall. Client E yelled at client B. Client B screamed at client E. Client B threw his wallet and watch at client E. Staff approached and client B slammed client E's door shut. Client E locked his</p>						

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	<p>door. Client B kicked client E's door. Client B attempted to use a quarter to unlock client E's door. Staff blocked the attempt. Client D exited his room screaming, pulling his hair and hit the walls. Client D slammed the fire door closed. Client B continued to kick client E's door while screaming. Client B hit staff in the face repeatedly. Client D opened the fire door, screaming and attempted to charge at client B. Client B went into the dining room and threw a ketchup bottle and cups at client C. Client B lunged over the table trying to hit client C. Staff called 911. Client B continued to scream and threaten to hurt client C. Staff informed client B the police were called. He continued to scream and pace through the house but no longer threatened his roommates. The police arrived and spoke to client B about the consequences of hurting others. Client B remained calm. The investigation, dated 4/11/14, indicated, in part, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of Supervised Group Living..."</p> <p>49) On 4/6/14 at 11:30 AM, client B returned to the group home. Client E was asleep in his bed. Client B slapped client E's open door with his hand. Client E woke up and asked client B to stop.</p>						

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	<p>Client B screamed "No" and continued to slap the door. Client E asked client B to stop for 15 minutes. Client B started throwing clothes at client E. Client B grabbed one of client E's shirts and ran to his room. Client E followed him. Client B locked his door. Client B screamed through the door and client E pounded on client B's door. Client D returned to his room and client B left his room to scream at client E from client E's doorway. Client D lunged at client B and grabbed the medallion he had received the day before and ripped it off of client B's neck. Client B and E exchanged slaps and pushes around the staff in between them. Client E "became violently aggressive attempting to punch [client B] and a rear bear hug was used to stop the attack." Client B attempted to hit client C but the staff blocked his attempts. The Stone Belt ARC, Inc. Incident Report, dated 4/6/14, indicated, "[Client D] repeatedly left his room to express his excruciating emotional and physical stress from hearing and witnessing the events... [Client D] expressed multiple times he wanted to fight with [client B], but staff was able to talk to him about appropriate outlets for his anger." The investigation, dated 4/11/14, indicated, in part, "I recommend that [name of group home] receive more staffing support. I am going to discuss this with the Director of</p>			

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	<p>Supervised Group Living...".</p> <p>50) On 3/24/14 at 7:50 PM, client B ran out of the living room and into client E's room. He laid on the floor and would not leave. Client E went to his room and sat on his bed. Client E hit client B in the face with an open hand twice yelling for him to get out of his room. Client E continued to yell at client B. Client E reached over and slapped client B in the face. Client E hand was removed and prevented from further aggression. Client E went to take his medications. Client E returned and started yelling at client B. Client B was lying on the floor. Client E pushed the staff out of the way and jumped on client B. Client E pushed client B's head into a pile of clothes on the floor. Staff attempted to pull client E off of client B. Client E stopped and got up. Clients B and E were not injured.</p> <p>51) On 3/4/14 at 9:45 AM at the facility-operated day program, client B asked client E to have a turn playing a video game. Client E refused. Client B asked a second time. Client E shoved client B. Client B was not injured.</p> <p>52) On 3/3/14 at 8:05 PM, client E was lying in his bed. Client E wanted the hallway light off so he could sleep. Client B covered the light switch so the</p>			

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	<p>lights would stay on. Client E started calling client B names. Client E picked up a fork and threw it at client B but missed. Client E attempted to throw his soda on client B but missed. Client E spilled his drink all over himself. Client E yelled at client B for making him spill his soda. Client E attempted to hit client B but staff stayed in between the clients. Client B punched client E's right side. Client E had small scratches on his right hand requiring first aid.</p> <p>53) On 3/1/14 at 1:00 PM, client B scratched client E's face on his left eye after client E threw a water bottle at client B. The water bottle missed. Client B picked up the water bottle and threw it at client E's soda. Client E's soda spilled on the floor. Client E went to get his eye checked and once finished, he and client B called each other names through the doorway.</p> <p>54) On 2/19/14 at 7:30 PM, client A was carrying laundry to his room. Client B attempted to assist him. Client A asked client B to stop. Client B pushed his way into client A's bedroom and threw himself onto the floor. The Stone Belt ARC, Inc. Incident Report, dated 2/19/14, indicated, "[Client A] flew into a rage and began kicking and stomping at [client B's] face. [Client B] did not put up a</p>			

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	<p>fight. Staff moved [client A] away from [client B], where he sat briefly on his bed while being asked to stop. [Client A] got up very shortly afterward and began attacking [client B] again. [Client A] was asked to stop and when he refused, he was put in a bear-hug from behind, and staff moved him to the hallway, where he was asked to go to the formal room to cool down." Client B was not injured.</p> <p>55) On 2/17/14 at 6:16 PM, client E asked client B to use the phone. Client B said, "no." Client E asked again. Client B said, "no." Client E asked a third time and client B threw a magazine at client E. Client E went to his room. Client B banged on his door. Client D exited his room 3 or 4 times, each time he put his hands on his ears. Client D pushed client B and client B fell. Client D got on top of client B. Staff prompted client D to get off of client B. None of the clients were injured.</p> <p>56) On 2/6/14 at 8:30 PM, client B knocked a container of mixed fruit out of client A's hand. Client A punched client B in the face. Client B's face was red.</p> <p>57) On 12/22/13 at 2:00 PM, client B called out to client C in a friendly manner. As client C approached client B, client B kicked client C in the abdomen.</p>						

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	<p>Client B threw items and spit at client C. Client C was not injured. The investigation, dated 12/30/13, indicated, "[Client B] needs to be seen by a professional sign language therapist for assessment so that they can prevent/assist us with how best to use sign language to communicate with [client B]. This will go a long way towards helping him to reduce frustration that leads to aggression."</p> <p>A review on 10/7/14 at 12:39 PM of client B's Behavioral Support Plan (BSP), dated 8/6/14, indicated he had the following maladaptive behaviors targeted in his plan: disruptive behaviors, physical aggression, stealing, inappropriate refusals, self-injurious behaviors, and elopement. Client B's BSP indicated in the General Proactive Strategies section, in part, "3. It is important that staff keep [client B] busy. [Client B] has a lot of energy and tends to display maladaptive behaviors when he is not engaged. [Client B] should be encouraged to play games, help staff with tasks ([client B] generally likes to help), watch TV, etc. If staff can keep [client B's] mind active (by teaching him about the things he shows an interest in like sports, or explaining how things work) and can keep his hands busy with different tasks, he is much less likely to display disruptive behaviors... 6.</p>			

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	<p>Actively communicate with [client B] whenever possible. [Client B] enjoys being around and talking with a wide variety of people; he has a lot of ideas and interests and is excited to share them. Use sign language as much as possible and encourage [client B] to take time to sign and communicate with others. Encourage [client B] to communicate using full sentences, as this has been shown to help [client B] reduce his anxiety and communicate more clearly...</p> <p>12. If [client B] is showing signs of increased agitation or is displaying non-redirectable, disruptive behavior, staff should attempt to engage [client B] and supervise him more closely until he has calmed. When [client B] is excessively disruptive and is fighting for control, ignoring his disruptive behaviors may serve to increase the behavior and could possibly lead to physical aggression...</p> <p>13. Staff should be aware of where [client B's] roommates are in relation to [client B] when he is agitated or excessively anxious. Keeping [client B] engaged in an area of the house that is away from other clients will lessen the possibility that he will have the opportunity to aggress on his housemates...</p> <p>16. [Client B] sometimes displays anxiety around bedtime. During the overnight shift, it has historically been helpful for staff (especially new staff) to</p>			

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	<p>reassure [client B] that he is safe by conducting a brief inspection of the exterior doors and show him that the doors are locked and secure. After this inspection, staff may accompany [client B] to his room to show him that his room is secure. The important part is to be very low-key, reassuring, and not impatient. Reassure [client B] that he will be safe while he sleeps. If [client B] chooses to remain awake, staff may offer [client B] the opportunity to help with the chores."</p> <p>Client B's Support Team Review Form, dated 11/6/13, indicated, in part, "[QIDP] and the team believes that [client B] needs 24/7 staffing. His behavior overnight necessitates extra staffing in the 10P-6A hours. The [name of former group home] team believes that [name of group home] is a better fit for [client B]. The team will want to hear what the [name of group home] team thinks."</p> <p>Client B's Support Team Review Form, dated 11/8/13, indicated, in part, "The team [names of group homes] has received approval for [client B] to move to [name of group home] permanently. The [name of client B's former group home] team will schedule more training for [name of group home] staff. The team will consult with the [name of</p>						

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	<p>agency] staff will talk about transitioning [client B]."</p> <p>Client B's Support Team Review Form, dated 12/5/13, indicated, in part, "[Client B] recently invaded another client's room when the client was sleeping. The client was upset by the incident. The team has decided to include a two person transport to [client B's] plan to address the above incident. The team will continue to support [client B] in his programming. The team has decided to train on [client B's] Behavior Support Plan."</p> <p>Client B's Support Team Review Form, dated 12/11/13, indicated, in part, "Locks are going to be put on clients' doors to address the issue with [client B] going into clients' rooms...".</p> <p>Client B's Support Team Review Form, dated 1/8/14, indicated, in part, "The team has decided to not implement the token economy. The team decided to not include the two person transport into [client B's] plan. [Client B's] cable has been fixed and [client B] is now enjoying television in his room. The team believes that a speech and hearing evaluation to assess sign language needs and the best proactive approach to addressing [client B's] needs."</p>			

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	<p>Client B's Support Team Review Form, dated 1/10/14, indicated, in part, "[Client B] was held (baskethold) during an incident of agitation. The team has reviewed this incident. The team does not believe that adding holds to [client B's] plan is a good idea."</p> <p>Client B's Support Team Review Form, dated 2/18/14, indicated, in part, "The team reviewed the recent (2/17/14) elopement issue. [Client B] eloped from the house during the overnight shift. [Behavior Specialist] remarked that retraining might be useful. [Behavior Specialist] remarked that having [name of another Behavior Specialist] might be useful. She remarked that calling the psych (psychiatric) pager might be a reinforcer for his behavior. The team will train staff about how to react in the moment. [QIDP] will talk to [Director] about staffing changes that might help to support staff. [Social Worker] proposed a brainstorming session with staff at an upcoming meeting to get them to consider other options."</p> <p>Client B's Support Team Review Form, dated 2/25/14, indicated, in part, "[Behavior Specialist] is going to add elopement to [client B's] Behavioral Support Plan. [Behavior Specialist] will consult with [name of psychiatrist] about</p>			

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	<p>options... The team is considering adding a token economy to [client B's] BSP to desensitize him to wanting to be in the office."</p> <p>Client B's Support Team Review Form, dated 3/5/14, indicated, in part, "[Client B] has been a part of several incidents with another client. The team is going to talk and train [client B] about avoiding conflict and saving for a new TV. Having a new TV will help anxiety surrounding public spaces...".</p> <p>Client B's Support Team Review Form, dated 4/8/14, indicated, in part, "[Client B] has been involved in multiple issues of aggression with other clients. [Client B] needs continued regular support and the team will assert that is necessary...".</p> <p>Client B's Support Team Review Form, dated 4/10/14, indicated, in part, "[Client B] has been involved in multiple incidents of aggression with other clients. The team will ensure that the guardian is aware of all emergent issues... The team will continue to support [client B]. [Director] and [QIDP] will discuss options for increased support at the house. [Social Worker] will continue to conduct client house meetings to discuss important issues relating to house relations."</p>						

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	<p>Client B's Support Team Review Form, dated 4/25/14, indicated, in part, "The team will develop an elopement risk plan strategy to be included in his Behavioral Support Plan. The behaviorist will develop proactive strategies to reduce the likelihood of elopement. The staff will be retrained once the BSP has been updated."</p> <p>Client B's Support Team Review Form, dated 5/7/14, indicated, in part, "[Client B] has been involved in many incidents of client to client aggression in the past two months: [QIDP] will talk to [Director] about options for a waiver for [client B]. An elopement protocol has been added to the Behavioral Support Plan. The team will train staff on this addition."</p> <p>Client B's Support Team Review Form, dated 5/16/14, indicated, in part, "[Client B] was improperly restrained. The staff was pulled from his shift by the Director who reviewed the Behavioral Support Plan and CPI training. The staff will return to work immediately. The staff will be sure to look [client B] in the eye when speaking to him to reduce his anxiety. The team will ensure that behavior tracking is complete, and thorough. [QIDP] will revamp [client</p>			

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	<p>B's] active treatment schedule within one week. [QIDP] will review the activity schedule and update it. Sleptime schedules will be updated. [QIDP] has expressed his concern to [Director] that the other clients in the house are not safe with [client B] there. The team agrees with this personal suggestion...".</p> <p>Client B's Support Team Review Form, dated 5/22/14, indicated, in part, "[Client B] has been involved in several incidents with other clients. The team does not believe that [client B] is safe in his current environment. A new residential placement is necessary... The team would like to pursue a CIH (Community Integration and Habilitation) waiver for [client B]."</p> <p>Client B's Support Team Review Form, dated 5/29/14, indicated, in part, "[Client B] was in an incident that required staff to use a baskethold. This was an unauthorized restraint as there are no restraints in [client B's] plan. The team believes that the restraint was used appropriately. The team believes that adding restraints to [client B's] plan is necessary: basketholds, bear bugs, 1 and 2 person transports. [Behavior Specialist] will talk to [client B's] guardian. The team reasserts our position that [client B] would be better served in</p>			

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	<p>another residential environment. [Social Worker] will talk to the staff who performed the hold."</p> <p>Client B's Support Team Review Form, dated 6/9/14, indicated, in part, "[Client B] has been involved in fewer incidents of aggression this past month. The team is tracking the active treatment implementation regularly. [Former Qualified Intellectual Disabilities Professional - QIDP] will finish [client B's] Active Treatment Schedule at the end of this week. The staff will 'mask' their consumption of caffeinated beverages by putting beverages in a cup... The team is discussing the transition from a stable staff (current) to another staff...".</p> <p>Client B's Support Team Review Form, dated 8/13/14, indicated, in part, "Latuda (psychotropic medication) has been added to [client B's] regimen. Propranolol (psychotropic medication) will end tomorrow. Trazadone (sic-psychotropic medication) has been discontinued. [Client B] has been involved in a number of incidents of client to client aggression. An exclusionary time out will be added to [client B's] Behavioral Support Plan... The staff will receive training on two person transports. The staff will be trained on CPI (Crisis Prevention</p>			

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W000436	<p>Institute) to deal with two person transports. The staff will be trained on the Behavioral Support Plan. [Behavior Specialist] and [QIDP] will purchase blocking pads for [name of group home]. The staff will receive training on blocking pads...".</p> <p>A 4/25/14 Nursing Consultation indicated, in part, "Nurse attended [name of group home] support team meeting today regarding [client B's] recent behaviors/IRs (incident reports). Nurse recommended considering moving [client B] from [name of group home] as he does not get along well with his roommates. Suggested 1:1 (one on one) staffing for [client B] at all times. Also, recommended if [client B] leaves [name of group home] property and only one staff is present,</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 3 of 3 clients in the sample with adaptive equipment (B, D and E), the facility failed to ensure: 1) client E's glasses were in good repair and staff taught client E to use and make informed</p>	W000436	<p>1) Plan of correction: Support team reviewed client E's has an appointment made with his eye doctor in the next few weeks. Plan of prevention: Day aid has been trained to follow through with all recommendations and</p>	11/28/2014

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	<p>choices about wearing his glasses, 2) client D was taught to use and make informed choices about wearing his glasses, 3) client D's communication device was in working order and 4) client B had a plan to teach him to use a temporary, trial communication device (client B was being assessed for the need of the device).</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM and 10/7/14 from 6:03 AM to 8:19 AM. During the observations, client E did not wear glasses and staff did not prompt client E to wear his glasses.</p> <p>On 10/8/14 at 12:48 PM, a review of client E's record was conducted. Client E's 8/22/14 Stone Belt Medication Information Sheet indicated, "Glasses to be worn full time, per [name of optometrist] 2/27/14." Client E's Stone Belt Outside Services Report (Vision), dated 2/27/14, indicated, "Glasses prescribed for full-time wear" due to astigmatism (refractive error of the eye causing blurred vision). Client E's 10/24/13 Nurse Quarterly Physical indicated, in part, "[Client E] stated he is prescribed glasses but does not wear them." Client E's 5/19/14 Nurse</p>		<p>physician orders along with ensuring adaptive equipment is in good repair (attachment h). Quality monitoring: House manager has been trained to monitor outside service reports and that orders have been followed (attachment i). 2) Plan of correction: Support team reviewed client D's has an appointment made with his eye doctor in the next few weeks. A goal has been introduced to train client d in wearing his glasses. Plan of prevention: Day aid has been trained to follow through with all recommendations and physician orders along with ensuring adaptive equipment is in good repair (attachment h). Quality monitoring: House manager has been trained to monitor outside service reports and that orders have been followed (attachment i). 3) Plan of correction: IPP has been introduced to teach client d to use communication devise (attachment j) 3)Planof prevention: QDIP is no longer employed with Stone Belt and is not eligible for rehire. 3)Quality monitoring: House manager has been trained to monitor outside service reports and that orders have been followed / IDTs held, training plans introduced when needed (attachment i) Plan of correction:IPP has been introduced to teach client b to use temporary communication devise(attachment j) Plan of</p>		

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	<p>Quarterly Physical indicated, in part, "[Client E] is prescribed glasses but does not wear them, he broke a pair of glasses after having them for one day." Client E's 8/20/14 Nurse Quarterly Physical indicated, in part, "[Client E] is prescribed glasses but does not wear them (broke initial pair and has refused to get another pair per staff report - mother/guardian is aware and does not want to push the issue of glasses unless [client E] has dramatic change in eye sight)." Client E's Individual Support Plan, dated 4/21/14, did not include a plan to teach client E to wear his glasses. On 10/8/14 at 3:08 PM, the Group Home Director (GHD) indicated client E should have his glasses available in the house to wear. The GHD indicated client E needed a plan to address his refusals to wear his glasses.</p> <p>2) Observations were conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM and 10/7/14 from 6:03 AM to 8:19 AM. During the observations, client D did not wear glasses. Client D was not offered glasses and was not prompted to his glasses.</p> <p>A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's 10/30/13, 2/26/14, 5/19/14 and 8/20/14 Nurse Quarterly Physicals indicated, in part, "[Client D] is prescribed glasses but chooses not to</p>		<p>prevention:QDIP is no longer employed with Stone Belt and is not eligible for rehire. Quality monitoring:House manager has been trained to monitor outside service reports and that orders have been followed / IDTs held, training plans introduced when needed(attachment i)</p>	

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	<p>wear." Client D's 7/26/13 Individual Support Plan did not include a training objective for client D to wear his glasses. On 10/8/14 at 3:08 PM, the Group Home Director (GHD) indicated client D needed a plan to address his refusals to wear his glasses.</p> <p>3) Observations were conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM and 10/7/14 from 6:03 AM to 8:19 AM. During the observations, client D's communication device was hanging in the office area of the group home. Client D's communication device did not turn on and was not able to be used by client D. During the observations, client D was not offered and did not use his communication device.</p> <p>On 10/6/14 at 3:19 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she had worked at the group home for one week and she had not observed client D to use the communication device.</p> <p>On 10/6/14 at 3:38 PM, staff #4 (substitute) indicated she had not observed client D to use his communication device. Staff #4 indicated she had never attempted to get client D to use his communication device. Staff #4 indicated she had not</p>			

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	<p>observed other staff prompt client D to use his communication device.</p> <p>A review of client D's record was conducted on 10/8/14 at 11:22 AM. Client D's record did not contain documentation of the assessment/evaluation indicating the need for the communication device. Client D's Individual Support Plan (ISP), dated 7/26/13, included a training objective to increase the use of his communication device. The ISP indicated, in part, "Staff Instructions: [Client D] currently has several methods through which to communicate, including but not limited to, an abbreviated sign language, a communication box and picture schedules/choice books. Encourage [client D] to communicate his wants and needs utilizing any of the above mentioned tools... Staff should also encourage [client D] to use his picture schedule or communication box when making choices or communicating preferences." Client D's Nurse Quarterly Physicals, dated 10/30/13, 2/26/14, 5/19/14 and 8/20/14 indicated, in part, "Has a communication device but he does not choose to use it very often."</p> <p>On 10/8/14 at 1:55 PM, the Behavior Specialist indicated client D communicated enough to get his point</p>				

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	<p>across. The BS indicated he was not aware of a plan for client D to use a communication device. The BS indicated client D needed another evaluation regarding the use of the device.</p> <p>On 10/8/14 at 3:04 PM, the Group Home Director indicated client D needed a plan to use his communication device.</p> <p>4) Observations were conducted at the group home on 10/6/14 from 2:53 PM to 6:05 PM and 10/7/14 from 6:03 AM to 8:19 AM. During the observations, client B was not offered and did not use his communication device. During the observations, client B's communication device was hanging in the office area of the group home. On 10/7/14 at 8:08 AM, client B was getting ready to leave the group home for the day. Client B had the communication device hanging around his neck from a neck strap.</p> <p>On 10/7/14 at 8:08 AM, client B's day program staff #1 stated client B "reluctantly" used the communication device. Staff #1 stated, "Never on his own accord." Staff #1 indicated the speech therapist will decide at client B's next appointment if client B could keep the device since it was loaned to client B to see if he would use it. Staff #1 indicated client B had the device for</p>			

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	<p>awhile. Staff #1 indicated the trial period had been extended a few time in order to get client B to use the device more often.</p> <p>A review of client B's record was conducted on 10/7/14 at 12:39 PM. Client B's 8/7/13 Individual Support Plan did not address the use of the communication device. There was no documentation in client B's record indicating there was a plan to get client B to use his device.</p> <p>Client B's Support Team Review Form, dated 3/5/14, indicated, in part, "The Social Work team is going to be working with [client B] two days a week on a new loaner program iPad to see if the app (application) on the loaner will be good for [client B]. [Social Worker] is going to work with [Life Long Learning Coordinator] about the prospect of [Coordinator's] employees working with [client B] during LL (Life Long Learning) hours."</p> <p>Client B's Support Team Review Form, dated 6/9/14, indicated, in part, "IT (Information Technology) is working on HIPAA (Health Insurance Portability and Accountability Act) concerns. [Social Worker] is following up on the assistive communication device. The [name of university] professional responsible is</p>						

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	<p>waiting on prior authorization."</p> <p>Client B's Support Team Review Form, dated 8/13/14, indicated, in part, "[Social Worker] will follow [name of staff] as it relates to the AAC (Augmentative and Alternative Communication) device, program and scheduling appointments."</p> <p>On 10/6/14 at 3:19 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she had worked at the group home for one week and had not observed client B to use his communication device.</p> <p>On 10/6/14 at 3:38 PM, staff #4 (substitute) indicated she had not observed client B to use his communication device. Staff #4 indicated she had attempted to get client B to use the device however he refused to do so.</p> <p>On 10/14/14 at 2:39 PM, the Social Worker (SW) indicated client B currently had a loaned communication device for a trial period. The SW indicated there was a tracking sheet and staff were supposed to be encouraging client B to use the device regularly to get him to communication effectively. The SW indicated the day program staff who took client B to his appointments with the</p>			

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W000440	<p>Speech Therapist were supposed to train the group home staff on how to use the device with client B. The SW indicated he was unclear if the day program staff trained the group home staff to use the device with client B.</p> <p>This federal tag relates to complaint #IN00156855.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>On 10/6/14 at 11:42 AM, a review of the facility's evacuation drills was conducted. During the day shift (6:00 AM to 2:00 PM), there were no evacuation drills conducted from 3/2/14 to 10/6/14. During the evening shift (2:00 PM to 10:00 PM), there were no evacuation drills conducted from 3/20/14 to 10/6/14. During the night shift, there were no evacuation drills conducted from 3/16/14</p>	W000440	<p>Plan of correction: November drills were completed correctly and on time</p> <p>Plan of prevention: New drill schedule has been created to assist all homes in completing appropriately</p> <p>Quality monitoring: House manager has been trained to monitor drills and to conduct them efficiently(attachment i) (attachment ee)</p>	11/28/2014

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W000488	<p>to 10/6/14.</p> <p>On 10/6/14 at 2:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated there should be one evacuation drill per shift per quarter.</p> <p>On 10/6/14 at 11:58 AM, the Group Home Director (GHD) indicated there should be one evacuation drill per shift per quarter. The GHD indicated the previous QIDP did not see drills as important. The GHD stated the previous manager and QIDP "had a culture of helplessness."</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to ensure the clients were involved with serving themselves breakfast.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/7/14 from 6:03 AM to 8:19 AM. At 7:50 AM, staff #3 served</p>	W000488	<p>Plan of correction: Deckard team have been trained on active treatment and ensuring that meals are served family style (attachment b)(attachment e). Plan of prevention: QDIP and HM are no longer employed with Stone Belt and is not eligible for rehire. Quality monitoring: House manager and day aid has been trained on ensuring that staff serve meals family style (attachment i).</p>	11/14/2014

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	<p>oatmeal onto client B, C, D and E's plates. At the time, client C was in bed. Clients B, D and E were present and available to serve themselves. The clients were not prompted or offered to serve themselves. At 7:51 AM, staff #3 served eggs to clients A and E. At 7:53 AM, staff #3 carried around a plate and served bacon onto client A, B, C, D and E's plates. At this time, clients A, B and E were eating. Clients C and D were in their rooms. At 7:57 AM, client C entered the dining room and staff #3 poured his juice into his cup. At 8:02 AM, client D entered the dining room. Client D's plate had eggs, bacon, and oatmeal on it prior to client D entering the dining room. Staff #3 poured client D's juice. At 8:08 AM, staff #3 served client D a plate with a second biscuit and more oatmeal. At 8:16 AM, staff #3 served client D more oatmeal.</p> <p>On 10/8/14 at 3:08 PM, the Group Home Director indicated the clients should serve themselves during each meal. The GHD indicated the clients should be involved with their meal preparation including serving themselves and pouring their own drinks.</p> <p>9-3-8(a)</p>			

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met:</p> <p>1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (Qualified</p>	W009999	<p>1) Plan of correction: QDIP's employment was terminated on 10/24/2014. She is not eligible for employment with Stone Belt (attachment w). Plan of prevention: Human resources will ensure that all noted issues are PDD screenings are completed. Quality monitoring: Human resource director will monitor that employee screening is completed. 2) Plan of correction: QDIP's employment was terminated on 10/24/2014. She is not eligible for employment with Stone Belt (attachment w).. Plan of prevention: Human resources will ensure that all noted issues are investigated. Quality monitoring: Human resource director will monitor that employee screening is completed. 3) Plan of correction: QDIP's employment was terminated on 10/24/2014. She is not eligible for employment with Stone Belt (attachment w).. Plan of prevention: Human resources will ensure that Core a and B test scores are documented in employee files. Quality monitoring: Human resource director will monitor employee files. 1-10) Plan of correction: The majority of the 10 of 112 incidents regarding clients A, B,C,D, E they were not reported within 24hours occurred between the months of March-August</p>	11/14/2014	

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	<p>Intellectual Disabilities Professional - QIDP), the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 10/7/14 at 11:46 AM. The facility's Qualified Intellectual Disabilities Professional (QIDP) employee file indicated her most recent Mantoux test was conducted on 9/13/13. There was no documentation the QIDP had a Mantoux completed since 9/13/13.</p> <p>On 10/7/14 at 12:12 PM, the Human Resources Director indicated the facility should have documentation of an annual Mantoux test for each employee.</p> <p>On 10/14/14 at 11:28 AM, the Organizational Effectiveness Coordinator (OEC) indicated the QIDP should have an annual Mantoux test.</p> <p>2) 460 IAC 9-3-2 Resident Protections</p> <p>c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: 1) evidence of abuse or fraud in any setting; 2) repeated and substantial violation of</p>		(attachment n). Plan of prevention: The staff including; emergency pager, social workers, and behavioral consultant have been trained in reporting incidents within 24 hours in accordance to state law (attachment b). Plan of monitoring: Director will continue to train staff each month at weekly meeting and monthly at Shiloh.	

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	<p>applicable laws and rules in the operation of any type of residential, health or developmental program in the care of dependant persons; or 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.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (QIDP), the facility failed to ensure the QIDP's file contained documentation the facility followed-up on a criminal records check, dated 9/11/14, completed by the county sheriff's department in which the QIDP lived.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 10/7/14 at 11:46 AM. The facility's QIDP's employee file did not contain documentation the facility followed-up on a criminal records check, dated 9/11/14, completed by the county sheriff's department in which the QIDP lived. The county police check indicated, in part, "Has a record with this</p>			

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	<p>department." There was no documentation on the form or in the QIDP's employee file indicating what her record consisted of.</p> <p>On 10/7/14 at 12:12 PM, the Human Resources Director (HRD) indicated the QIDP would need to go back to the police department who completed the form to ensure the form was completed correctly (thought the police department may have checked the wrong box). The HRD indicated the QIDP would need to get documentation of her record, if there was one, and provide it to the facility for review. The HRD indicated she was not sure if someone in Human Resources was following up on obtaining the information or not. The HRD indicated her criminal history should have been followed up on.</p> <p>On 10/14/14 at 11:28 AM, the Organizational Effectiveness Coordinator (OEC) indicated the facility should have followed up on obtaining the QIDP's criminal record.</p> <p>3) 460 IAC 9-3-6 Health Care Services</p> <p>b) All personnel who administer medication to residents or observe resident self-administering medication shall have received and successfully</p>						

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	<p>completed training using materials approved by the council.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, record review and interview for 1 of 3 employee files reviewed (QIDP), the facility failed to provide documentation indicating the QIDP's test scores for the completion of Core A and B medication administration training.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/7/14 from 6:03 AM to 8:19 AM. At 6:42 AM, client B received his medications from the Qualified Intellectual Disabilities Professional (QIDP). At 7:05 AM, client D received his medications from the QIDP.</p> <p>A review of the facility's employee files was conducted on 10/7/14 at 11:46 AM. The facility's Qualified Intellectual Disabilities Professional (QIDP) employee file contained a Certificate of Completion, dated November 2009, for the QIDP completing Living in the Community Medication Administration Core A/Core B. The certificate did not include the QIDP's test scores for Core A</p>			

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	<p>and B.</p> <p>On 10/7/14 at 12:12 PM, the Human Resource Director (HRD) indicated the QIDP's certificate was from her previous employer. The HRD indicated the facility should have requested the QIDP to obtain her test scores for Core A and B. The HRD indicated the facility should have requested the test scores when the QIDP provided the certificate. The HRD stated, "the certificate does not count."</p> <p>On 10/14/14 at 11:28 AM, the Organizational Effectiveness Coordinator (OEC) indicated the facility should have ensured the receipt of the QIDP's test scores for Core A and B. The OEC indicated the certificate was not sufficient.</p> <p>4) 460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 15. A fall resulting in injury, regardless of the severity of the injury. 16. A medication error or medical treatment error as follows: c. Missed medication - not given. 19. Use of any physical or manual restraint regardless of: a.</p>						

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	<p>planning; b. human rights committee approval; and c. informed consent.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 9 of 112 incident/investigative reports reviewed affecting clients B and E, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS), within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/6/14 at 12:31 PM and indicated the following:</p> <p>1) On 9/27/14 at 9:00 PM, client B "shoved his way in to the med room between med passes." Client B sat in the middle of the room in a chair. Client B screamed and motioned he was going to break a window for 5 minutes. When client B stood up to go toward the window, staff used a two person transport to assist him to his room. The incident was reported to BDDS on 9/29/14.</p> <p>2) On 9/12/14 at 12:00 PM, client B refused his morning medications. The</p>			

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	<p>incident was reported to BDDS on 9/15/14.</p> <p>3) On 9/11/14 at 5:00 PM, client B went to take his evening medications. Client B then refused to take them. Once the overnight staff arrived, client B began acting in an aggressive manner to the staff, refusing to let them clock in, hitting them, and destroying the staff's glasses. Client B slammed his door repeatedly and began throwing items at staff. Client B left the house at 11:30 PM with staff following. Staff never left client B's vicinity. After two and a half hours of walking around the neighborhood, client B and staff returned to the group home. Client B refused to take his medications. The incident was reported to BDDS on 9/13/14.</p> <p>4) On 8/26/14 at 12:00 PM, client B refused to take his morning medications. There was no documentation the incident was reported to BDDS.</p> <p>5) On 8/16/14 at 2:10 AM, client D was prompted to use the restroom due to incontinence. Client D's bed was soaked with urine. Client D took a shower and staff heard a loud noise from the bathroom and heard client D yell for help. Client D was getting up off the bathtub floor. Client D scraped his right</p>						

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	<p>cheek during the fall. Staff used hydrogen peroxide to clean the injury. There was no documentation the fall with injury was reported to BDDS. A second incident report, dated 8/16/14, indicated, "Come to find out hours later that the fact the client had fallen in the shower apparently he hit so hard it caused a pipe to burst in the wall causing water to leak into the dining room & living room areas." There was no documentation the incident was reported to BDDS.</p> <p>6) On 8/15/14 at 8:20 PM, client B had been aggressive. At 7:40 PM, he threw an apple off of the apple tree and hit the group home van. At 8:20 PM, client B hit staff in the back. Client B threw a pen and hit the same staff in the back of the head. Client B was told throwing items was inappropriate and he attempted to aggress on three staff. Client B was put in a baskethold but he spit and kicked at the staff who was attempting to leave. Client B was in the baskethold for 10 minutes. While in a baskethold, client B hit the staff in the chest and attempted to spit on staff. When released, client B grabbed staff's shirt so the staff could not enter the office and tore the staff's shirt. Client B was placed in a bear hug for 30 seconds. Client B yelled and slammed doors once released for 15 minutes. The incident was reported to BDDS on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408			
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	<p>8/18/14.</p> <p>7) On 8/8/14 at 12:00 AM, client B went to bed early and would not wake up to take his medications. There was no documentation the incident was reported to BDDS.</p> <p>8) On 8/3/14 at 12:00 PM, the incident report indicated, "[Client B] stayed up until very early in the morning displaying unsafe behavior, and fell asleep about 5:30 AM." Client B did not take his morning medications. There was no documentation the incident was reported to BDDS.</p> <p>9) On 8/2/14 at 12:00 AM, client E refused his medications. The incident was reported to BDDS on 8/4/14.</p> <p>On 10/6/14 at 2:14 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated BDDS reports should be submitted within 24 hours of the incident. The QIDP indicated falls with injury, medication refusals and restraints should be reported to BDDS within 24 hours.</p> <p>9-3-3(e) 9-3-2(c) 9-3-6(b) 9-3-1(b)</p>						

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

PRINTED: 12/31/2014
FORM APPROVED
OMB NO. 0938-0391

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