

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G220		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/30/2013	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408			
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W000000	<p>This visit was for the investigation of complaint #IN00137851.</p> <p>Complaint #IN00137851: Substantiated. Federal/state deficiencies related to the allegations are cited at W102, W104, W122 and W149.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: October 23, 24, 25, 28, 29, and 30, 2013.</p> <p>Facility Number: 000744 Provider Number: 15G220 AIM Number: 100234860</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/5/13 by Ruth Shackelford, 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.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 6 of 6 clients living in the group home (A, B, C, D, E and F) and one additional client (G). The governing body failed to protect the rights of the clients to be free of abuse and neglect. The governing body failed to implement its policies and procedures to prevent abuse and neglect of the clients. The governing body failed to ensure incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to ensure thorough investigations were conducted. The governing body failed to ensure staff #12 was suspended during an investigation. The governing body failed to ensure investigations were completed within five working days. The governing body failed to ensure appropriate corrective actions were taken following incidents. The governing body failed to ensure the facility received approval from BDDS prior to moving clients A and G. The governing body failed to ensure the group home was repaired, maintained and cleaned on a regular basis. The governing body failed to ensure the group home</p>	W000102	<p>W102 Plan of Correction: The Supervised Group Living (SGL) Director who failed to implement policies and procedures to prevent abuse and neglect of clients, who failed to report incidents in a timely manner, who failed to suspend staff during an investigation, who moved clients without approval from BDDS, and who failed to insure the group home was properly repaired, maintained and cleaned was suspended on 10/9/2013 and terminated on 10/10/2013. A former SGL director was hired as interim director on 10/11/2013 to immediately address and remediate compliance failures. A permanent SGL Director was hired start date effective 11/18/2013. Date of Completion: 11/18/2013 Plan of Prevention: The SGL Director will be trained on ICF/DD state and federal regulations and on state reporting procedures, will be mentored by former SGL Director for the next six months or longer if needed. Quality Assurance Monitoring: The agency's QA process will be revised to include: a review of all ISDH surveys; a review and report of all SGL abuse/neglect/exploitation investigations by third party QA team member; regular written</p>	11/18/2013			

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	<p>stairs leading to the basement were made non-slip after maintenance staff removed the carpeting.</p> <p>Findings include:</p> <p>1) Please refer to W122. For 6 of 6 clients living in the group home (A, B, C, D, E and F) and one additional client (G), the governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to ensure the rights of all clients to be free of abuse and neglect by failing to implement its policies and procedures prohibiting client abuse and neglect by failing to ensure: 1) its policies and procedures to prevent client abuse and neglect, an injury of unknown origin, elopement and client to client abuse were investigated within 5 working days, and incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, 2) incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, 3) incidents of an injury of unknown origin, elopement and client to client abuse were thoroughly investigated, 4) staff #12 was removed from client contact following an incident on 8/17/13, 5) the results of all investigations were reported to the administrator or designated representative</p>		<p>checklist reports from maintenance/cleaning crews when they are in and out of group homes. Further - the agency has initiated a new electronic internal incident reporting system which is under the operation of an administrative department which is not under the authority of programs.</p>		

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	<p>or other officials in accordance with State law complete investigations within 5 working days, 6) appropriate corrective actions were implemented.</p> <p>2) Please refer to W104. For 6 of 6 clients living in the group home (A, B, C, D, E and F) and one additional client (G), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) the group home was repaired, maintained and cleaned on a regular basis, 2) the group home stairs leading to the basement were made non-slip after the group home maintenance staff removed the carpeting from the stairs, and 3) the state process for temporarily transferring one client to another facility-operated group home was followed.</p> <p>This federal tag relates to complaint #IN00137851.</p> <p>9-3-1(a)</p>						

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F) and one additional client (G), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) the group home was repaired, maintained and cleaned on a regular basis, 2) the group home stairs leading to the basement were made non-slip after the group home maintenance staff removed the carpeting from the stairs, and 3) the state process for temporarily transferring one client to another facility-operated group home was followed.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/23/13 at 1:38 PM and indicated the following:</p> <p>1) On 10/7/13 at 2:00 PM, the Bureau of Developmental Disabilities Services (BDDS) Service Coordinator (SC) conducted a Home Inspection for a possible transition of clients A and G. The transition was not approved due to</p>	W000104	<p>W104 Plan of Correction: Item #1) The facility operations and maintenance was under the supervision of the Human Resources Director until 5/1/2013 at which time all agency facilities were placed under the supervision of the CFO. The long term maintenance supervisor was terminated in August 2013. The items listed on the BDDS report dated 10/7/2013 have all been remediated except for areas designated to be completed by professional contractors. The remodel of the kitchen and back porch are taking place as of this report 11/20/2013. The bathroom remodel will follow the completion of the other two areas. The items listed on the survey report from observations dated 10/23/2013, i.e. missing back porch ceiling tiles, soft kitchen floor, scuffed and patched walls, board in the upstairs bathroom, will be addressed and remediated by the professional contractor. The downstairs shower drain has been repaired. The downstairs dryer has been replaced. Item #2) the basement stairs have been rebuilt. Item # 3) Clients A and G received authorization from BDDS to switch placements on 11/20/2013. The BDDS Field Supervisor conducted a transition</p>	11/30/2013	

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	the following conditions: three medication cups at the end of the sidewalk and driveway, floor in the home was coming up in several places, walls in the screened in porch were falling apart, ceiling tiles were missing exposing pink insulation, ivy growing from the outside into the inside of the porch, feces on bathroom walls, floors and toilet, ceiling tiles in basement falling down and missing, water spots on ceiling tiles, mold on basement ceiling, water standing on basement floor, basement bathroom sink was falling off the wall, toilet full with feces, water damage around shower and toilet, drywall rotting at the bottom of the floors, holes in walls, toilet in upstairs bathroom falling apart, floor in front of dishwasher was coming apart, microwave was covered in food and had a foul odor, kitchen cabinets were broken, refrigerator light was out and the plastic crisper at the bottom was broken with sharp edges, broken glass outside of dining room window, wood trim in dining room was laying on the floor with the ends of the nails sticking up, wood board over a hole in the floor in the bathroom upstairs, shade covers missing over light bulbs, furnace vents were covered in dust/lint, bathroom in office was being used as a storage and "very dirty," couch on porch and living room had been urinated on multiple times per report from staff,		meeting on 11/20/2013 which included an extensive site visit of the facility. The BDDS official was satisfied that the items listed on the BDDS report dated 10/7/2013 had been remediated except for items included in the remodel, observed the current remodel of the kitchen and back porch, and received an update of the planned remodel of the bathroom, mold remediation plan and painting of the entire house upon completion of construction. See attached reports labeled W104. Date of Completion: 11/21/2013 except for items being addressed by the contractors. The remodel is estimated to be completed by the end of 2013. Plan of Prevention: The CFO has reorganized the operations and maintenance departments. Hite DSP staff have been retrained on the ICF/DD standards for the physical environment and how to report maintenance concerns, on client ISPs and BSPs; clients have received training on group home cleanliness standards and house rules. See attachment W104. Quality Assurance Monitoring: The agency's QA process will be revised to include: a review of all ISDH surveys; a periodic review of written checklist reports from maintenance/cleaning crews when they are in and out of group homes.	

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	<p>weeds growing out of gutters, trash and miscellaneous items are being stored under the outside back stairs, cigarette butts in the backyard (staff confirmed that the clients did not smoke), stone steps leading from garage to the front door are uneven and loose, staff reported none of the doors lock correctly, brown matter on the ceiling of the living room, client C's bedroom had blue liquid in two medication cups along with a bottle of Windex with the same blue liquid in it, client C, per staff's reports, ate all his meals in his bedroom, strong odor of bodily fluid (not urine), client C's floor was "extremely" sticky due to bodily fluid (not urine), and dirty dishes including a bowl of cereal in the bedroom. Client F's bedroom had dirty dishes in his room and the floor was coming up near his bed. Client B's bedroom smelled of urine and his dresser drawers were not functional. Client D's bedroom had a trash can of empty aluminum cans stacking in the corner that was overflowing. Client E's bedroom had a "very strong" body odor smell, no sheets on the bed, and brown matter on the floor. Client A's bedroom had no cover on an electrical outlet and the walls were falling apart.</p> <p>The BDDS follow-up report, dated 10/22/13 at 11:23 AM, indicated Stone Belt reported the following: "On 10/7/13</p>				

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	and 10/8/13 the BDDS SC did a site visit for possible transition of clients. The transition was not approved due to conditions stated in the initial incident report dated 10/7/13 and a verbal report via phone made to CEO (Chief Executive Officer) [name of CEO] by [name of BDDS staff] on 10/9/13. A written report was also received by CEO [name] on 10/9/13. The CEO suspended [name of Supported Group Living (SGL) Director] on 10/9/13 when it became apparent that he was minimizing the seriousness of the living conditions. The CEO, CFO (Chief Financial Officer) and facilities director, went to [name of group home] on 10/9/13 to do a site inspection, and assessment of health safety conditions and to begin an immediate plan of remediation. [Name of Director] was terminated on 10/10/13 and [name of interim Director] was appointed interim SGL Director. All health and safety and hygiene items were corrected on 10/10/13. On 10/10/13 CFO submitted a facility remediation plan to BDDS staff that outlined house remodel plans. A mold inspection and plan was completed by [name of company] on 10/11/13. [Name of cleaning company] did a top to bottom deep cleaning of the home on 10/14/13 and 10/15/13. An investigation of alleged neglect was completed and neglect was substantiated. APS (Adult Protective Services) was						

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	<p>notified by Stone Belt on 10/14/13. In addition to repairs, maintenance and long term plans for reconstruction, the facility completed one-on-one retraining of staff on IHP (Individualized Habilitation Plans) goals for client training in personal care, hygiene, and daily living skills in the home. All house staff were retrained during an in-home meeting on 10/13/13. This meeting included the Coordinator, House Manager and all DSPs (Direct Support Professionals). All staff were trained on being pro-active in the environment to ensure the health and safety of all clients in the home. The Coordinator has been trained and will continue to be trained on Stone Belt oversight procedures to ensure health, safety and cleanliness. The agency Quality Assurance Team and Safety team will examine this incident and revise their procedures to ensure the prevention of such situations. Status of the repairs to the home: the minor repairs to bathrooms, laundry room, and flooring have been completed. The more extensive work in the kitchen, porch and upstairs bathroom will be completed by [name of contractor]. Estimates for work are expected by 10/21/13 with work to begin as soon as possible after contracts have been signed. The anticipated timeline for completion as reported by the contractors is 3 to 4 weeks from the start</p>						

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	<p>of work. Mold reassessment on the garage area was to be completed following the porch renovation. The CFO sent BDDS staff a detailed, updated report on 10/18/13. Prevention plan: review of ISDH surveys and physical inspection of group homes using the agency's Environmental Assessment tool would be added to the agency's quality assurance process. Quality Assurance team meeting is scheduled for 10/22/13 to develop a plan and process for the SGL program."</p> <p>An electronic mail message (email) from the CFO to the BDDS staff, dated 10/18/13 at 1:05 PM, indicated, in part, "We are aggressively working to restore the homes to our expected level of quality and safety. [Name of group home]: Attached is the air quality inspection report from [name of company]. The report, as we expected, confirmed the mold issues on the porch and the garage/workshop areas. His recommendations for correction are in line with the previously described projects with the porch and once all the exterior work is completed we will have [name of company] preform (sic) a follow up inspection and testing. [Name of cleaning company] were brought into [name of group home] on Monday and Tuesday of this week and preformed (sic) a top to bottom deep clean of the home. This was</p>						

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	<p>in addition to clients and staff thoroughly cleaning each client bedroom last week. The professional cleaning included floors, walls, ceilings, inside and outside of cabinets, and bathrooms. In addition area rugs, all bedding in the house, towels, and several pieces of furniture have been replaced. Several new mattresses (fluid proof where needed) and being ordered as well. We have begun making the repairs to the downstairs bathroom/laundry room and now have two dehumidifiers running in the basement at all times. We are still waiting on the quotes from our contract on the other items, but will be having them completed just as soon as they get the crew scheduled. We have responded to the reportable incident regarding our investigation, staff retraining and programmatic support for the residents. We are putting our established client support and quality assurance processes back into place."</p> <p>The facility's investigation, dated 10/14/13, indicated the allegation of neglect was substantiated (the findings support the event as described). The investigation indicated, in part, "Based on a written reports (sic), site inspections, interviews with staff - the allegation of neglect is substantiated according to the agency's definition: Neglect: any action or behavioral interventions that risks the</p>			

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	<p>physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan. There are several factors that contributed to the physical condition of [name of group home] on 10/7/13. The first involves the agency's maintenance department. The former maintenance supervisor had a habit of telling DPS staff that we could not afford to repair things or replace things and they'd have to make do with what they had. This apparently was accepted throughout the SGL system. The second involves the SGL Director. In spite of many emails and photographs of repair and replacement needs from the [name of group home] Coordinator, the SGL Director repeatedly failed to do a direct examination of conditions or inadequate repair jobs, failed to use his financial authority and means to purchase needed equipment, and in general failed to insure that the home was properly</p>						

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	<p>maintained. The factors that led to the presence of feces, urine smells, other noxious odors and unacceptable state of uncleanliness and hygiene: staff not knowing and/or following the clients' IHPs, Behavior Support Plans which address individual needs for support and intervention, and not following or completing job checklists which give detailed directions about cleaning and sanitizing. Another major factor is DSP's confusion and misinformation about the proper exercise of client rights regarding refusals in programming, personal care, chores, active teaching, house rules, cleanliness and hygiene. Although the agency has a Quality Assurance Team and a Safety Committee - the group home ISDH survey reports and plans of correction are not reviewed by this team. It was discovered that for the past two years, the SGL Director had not been sharing the actual survey reports or the plans of correction with group home staff or interdisciplinary staff in spite of many requests. At this time, the agency does not have a process whereby someone outside of the SGL department systematically and formally does site visits and reviews and documents quality standards." The Corrective Actions included in the investigation included: "1. Contractor has been employed and had completed assessment and plan.</p>			

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	<p>Responsible Party: [name of CFO] will oversee completion of plan to remodel kitchen (sic) bathrooms, remove porch and replace with deck. Contractor has been requested to complete construction in the next 90 days. 2. Staff training in IHPs, client rights and behavior support to individuals with hygiene challenges. Client training in personal care, hygiene and taking care of their home. Person responsible: [interim Director] and various [name of group home] interdisciplinary team members for various topics: [name] Coordinator, [name] Social Worker, [name] Behaviorist. Completion dates: 10/13, 10/17, house meeting scheduled for 10/18/2013. 3. Mold assessment by [name of company]. Mold cleaned up in garage area. Porch area to be torn down and deck built. Responsible party: [CFO]. Work will follow completion of construction which had been requested to be done within (sic) next 90 days. 4. Professional cleaning: [name of company] - completed cleaning on 10/14 and 10/15/2013. Agency is considering proposal and plan for major cleaning that is beyond client and DSP responsibilities. Person responsible: [CFO]. 5. Replacement of bedding, furniture, household goods. Inventory completed 10/14/2013 and new items have been purchased and/or will be ordered.</p>			

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	<p>Responsible: [interim Director]. Completed in next 30 days. 6. Quality Assurance and Safety Committee revisions - Person Responsible: [name of CEO]. Completed in next 60 days. 7. Add back 20 hours to [name of group home] day aid position and open up full time day aid position at [name of another group home]. Responsible person: [interim Director] open position 10/11/2013. 8. Restructure SGL Coordinator positions so that a coordinator has two houses to support not three. Open [name of city] Coordinator position by 10/11/2013."</p> <p>A review of the former Director's employee file was conducted on 10/24/13 at 10:59 AM. The Employee Warning Notice, dated 10/10/13, indicated, "Over the past year multiple concerns have arisen in regards to your management and supervision of the agency's Supervised Group Living program. Your supervisor discussed these concerns with you on multiple occasions in one-on-one meetings and presented you with a formal development plan. To date, little improvement was evidenced in your job performance. On October 8th, you and your supervisor had a phone conversation with [name], Field Service Director, Bureau of Developmental Disabilities Service. During this conversation,</p>			

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	<p>[name] discussed numerous concerns about the condition of two Supervised Group Living sites that BDDS visited on October 7th. As follow-up to this conversation, your supervisor visited both sites and had follow-up inspections completed. The condition of these sites has substantiated your continued unacceptable management and supervision of the program. Your employment with Stone Belt is immediately terminated."</p> <p>An observation was conducted at the group home on 10/23/13 from 6:19 PM to 7:25 PM. During the observation, there were 14 ceiling tiles missing from the enclosed back porch. There was a puddle of water on the dining room floor from the upright freezer. The floor in front of the kitchen sink was soft and sunk down when stepped on. The group home stairs' carpet had been removed and non-slip strips were applied to the steps. Client A's former room (now client G's room) walls were scuffed and discolored with areas of missing paint and unpainted patches on the wall throughout the room. There was a five inches by seven inches area of black, green, and brown substance on the basement floor in the workshop area. Client D's bedroom blinds were covered in dust. The dryer in the basement had two areas on the inside of</p>						

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	<p>the dryer missing the protective coating. The areas with the missing coating were rusted. The laundry room area had unpainted patched walls. The floor drain in the laundry area was rusted and collapsed into itself. The drain was not functional due to being plugged up with rust. The downstairs shower was missing a drain cover. The upstairs bathroom floor next to the bathtub had patched with a piece of discolored (black, green and brown) plywood that was wet. The plywood was soft in places.</p> <p>On 10/23/13 at 6:58 PM, direct care staff #9 indicated he was at the home early to complete additional cleaning tasks. Staff #9 indicated there was a period of time when he had trouble getting his cleaning tasks completed due to client A staying up all night. Staff #9 indicated client A would prevent him from completing his cleaning by moving furniture to block staff #9 from cleaning. Client A would stand in his way to prevent him from cleaning. Client A would stay up all night and then sleep all day.</p> <p>On 10/24/13 at 11:54 AM, the group home Coordinator indicated he was present when the BDDS SC conducted the environmental assessment of the group home. The Coordinator indicated the floor in front of the kitchen sink was</p>			

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	<p>soft, most likely from a leaking dishwasher. The Coordinator indicated it took the previous maintenance staff two years to replace the previous dishwasher. The Coordinator indicated the floor in front of the bathtub in the upstairs bathroom had a soft floor. He indicated the previous maintenance staff put a board on the floor which was not the best solution. He indicated the board was supposed to be covered however the repair was never completed. He indicated it was a temporary fix that was never finished. The Coordinator indicated the back porch had issues with loose walls. He indicated it was reported to BDDS the clients used the room however the clients did not use the porch regularly. The Coordinator indicated there was some water in the basement work room from two days of substantial rain. The Coordinator indicated there were issues with the gutters not moving water away from the home and the gutters needed to be cleaned out. The Coordinator indicated the basement bathroom sink being pulled away from the wall was the result of client A using the sink to pull himself up out of his wheelchair. The Coordinator stated it, "Took a long time to get a washer." The Coordinator indicated he was not aware of rust in the dryer. The Coordinator indicated the stairs were discussed. He indicated the</p>			

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	<p>carpet was removed from the stairs but then nothing was done to the stairs. The Coordinator indicated the former Director was working on getting the stairs repaired but the maintenance staff never followed through. The Coordinator indicated the former Director did not consistently visit the group home. The Coordinator indicated the CEO was the Director's supervisor. The Coordinator was not aware of a time the CEO had visited the group home in the past year.</p> <p>On 10/29/13 at 10:58 AM the CEO stated, "We had a system breakdown." The CEO stated the issues were "egregious" and "significant." The CEO indicated the former Director minimized the seriousness of the environmental issues at the group home. The CEO indicated the seriousness of the issues was reported to her by the BDDS Field Services staff. The CEO indicated she suspended and then terminated the former Director's employment with the facility.</p> <p>On 10/23/13 at 2:03 PM, the interim Director indicated neglect was substantiated at the group home due to the environmental issues. The interim Director indicated the former Director was terminated. On 10/29/13 at 1:01 PM, the interim Director indicated the former Director did not implement the facility's</p>				

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	<p>policies and procedures. The interim Director indicated the former Director minimized things at the group home. The interim Director indicated there was a general lack of structure and expectations at the group home.</p> <p>On 10/28/13 at 12:24 PM, the Maintenance Staff stated the condition of the group home "wasn't good." The MS indicated facility staff have gone through and cleaned a lot of stuff. The MS indicated the carpets were cleaned, the walls were washed, the gutters were cleaned out, cleaned up brush and replaced numerous appliances. The MS indicated the kitchen was scheduled to be completely gutted and replaced, including the floor, starting in a few days. The MS indicated he had replaced the dishwasher, washing machine, freezer, refrigerator and a new dryer was ordered. The MS indicated the entire house was going to be repainted once the construction was completed. The MS indicated he replaced the downstairs sink. The MS indicated there was a lack of cleaning at the house. The MS indicated the facility had hauled off a lot of trash and debris from inside the home. The MS indicated the past administration allowed the issues to occur. The MS stated, "issues had been accumulating over the years and got out of control." The MS stated he "inherited</p>			

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	<p>a lot of the issues." The MS indicated the staff had been retrained on their cleaning duties. The MS indicated the floor drain in the laundry area needed to be addressed. The MS indicated he was not sure if the drain went anywhere and he was not sure if it functioned or not.</p> <p>2) On 9/21/13 at 9:15 PM, client B was standing at the top of the stairs. Client B told clients A, D and staff #10 goodnight. He turned around and tripped on the lip of the steps and went straight down seven steps to his face. Staff #10 called 911 and attempted to stop the bleeding from his face. Client B was transported to the emergency room. No bones were broken. He was released and instructed to see his primary care physician.</p> <p>An email (electronic mail), dated 1/28/13, from the Program Coordinator (PC) to the maintenance staff indicated, "Do you know when the floor will be installed and the carpet laid at [name of group home]?" On 1/29/13, the maintenance staff indicated, "Um what floor are you talking about being installed? To the best of my knowledge the flooring is in good shape. We are not putting carpet back, We're go (sic) to use the carefree plank till we get to the steps then on the steps we are going to recover them with wood and stain. I have to order the planking so it will be</p>						

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	<p>one day next week."</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated the carpet was removed from the stairs in response to the last annual survey. The PC indicated he did not know the date the carpet was removed. The PC indicated at the time of client B's fall, there were no non-slip strips on the stairs. The PC indicated non-slip strips were installed on the stairs after client B fell. The PC indicated there was no conclusion on the stairs. He indicated no action was taken until client B fell.</p> <p>On 5/5/13 at 11:30 AM, client D was walking up the stairs carrying a box of sodas. He lost his footing and fell down a few steps. He had a small abrasion on his shin.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated the carpet was removed from the stairs in response to the last annual survey. The PC indicated he did not know the date the carpet was removed. The PC indicated at the time of client B's fall, there were no non-slip strips on the stairs. The PC indicated non-slip strips were installed on the stairs after client B fell. The PC indicated there was no conclusion on the stairs. He indicated no action was taken until client</p>				

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	<p>B fell.</p> <p>3) On 10/24/13 at 9:55 AM, the BDDS SC indicated the group home did not have permission to move clients A and G (they switched placements at the other's group home). The BDDS SC indicated BDDS did not approve the move. The BDDS SC indicated the Director moved clients A and G without approval or permission from BDDS.</p> <p>The facility was unable to provide documentation indicating BDDS approved of the moves for clients A and G.</p> <p>On 10/24/13 at 11:54 AM, the group home Coordinator indicated clients A and G switched placements at their group homes on 10/7/13. The Coordinator indicated the switch was not permanent and the clients were having extended visits to the other's group home. The Coordinator indicated the Director was told by BDDS that BDDS was not approving the transition. The Coordinator indicated he sent an email to the BDDS SC on 10/7/13 indicating how the facility was going to address the environmental concerns. The Coordinator indicated the BDDS SC indicated if she had a list of the issues and how the facility was going to address them, the facility could move</p>						

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	<p>forward with the transition. The Coordinator indicated the BDDS SC did not indicate the issues needed to be addressed prior to the transition. The Coordinator stated the facility went through the transition process as "we were supposed to" through BDDS. The Coordinator indicated he was not sure if the facility received the final approval for the temporary transfer. The Coordinator indicated the BDDS SC informed him during the walk-through if the facility provided a list of the environmental issues they would address, she would give approval for the transition.</p> <p>On 10/29/13 at 10:58 AM, the Chief Executive Officer (CEO) indicated the facility did not have approval from BDDS to transfer clients A and G. The CEO indicated the facility was working on obtaining BDDS approval for the moves. The CEO indicated the facility should have obtained approval from BDDS prior to moving clients A and G. The CEO indicated the clients moved on 10/7/13.</p> <p>On 10/23/13 at 2:03 PM, the interim Director indicated BDDS did not approve of the transfer of clients A and G.</p> <p>This federal tag relates to complaint #IN00137851.</p>						

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F) and one additional client (G), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all clients to be free of abuse and neglect by failing to implement its policies and procedures prohibiting client abuse and neglect by failing to ensure: 1) its policies and procedures to prevent client abuse and neglect, an injury of unknown origin, elopement and client to client abuse were investigated within 5 working days, and incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, 2) incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, 3) incidents of an injury of unknown origin, elopement and client to client abuse were thoroughly investigated, 4) staff #12 was removed from client contact following an incident on 8/17/13, 5) the results of all investigations were reported to the administrator or designated representative or other officials in accordance with State law complete investigations within 5 working days, 6) appropriate corrective</p>	W000122	<p>W122 Plan of Correction: The Supervised Group Living (SGL) Director who failed to implement policies and procedures to prevent abuse and neglect of clients, to investigate a client elopement, to investigate injuries of unknown origin, who failed to report incidents in a timely manner, and who failed to suspend staff under investigation for allegations of abuse/neglect was terminated on 10/10/2013. A former SGL director was hired as interim director on 10/11/2013 to immediately address and remediate compliance failures. A permanent SGL Director was hired start date effective 11/18/2013. The new SGL Director is a Licensed Clinical Social Worker who is knowledgeable of the state and agency client protection laws and policies. For corrections to incidents cited under W149, W153, W154, W155, W156, W157, see those ID Prefix Tags. Date of Completion: 11/18/2013 Plan of Prevention: The SGL Director will be trained on ICF/DD state and federal regulations and on state reporting procedures, will be mentored by former SGL Director for the next six months or longer if needed. Quality Assurance Monitoring: The agency's QA process will be</p>	11/18/2013			

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	<p>actions were implemented.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 12 of 54 incident/investigative reports reviewed affecting clients A, B, C, D, E, F and G, the facility neglected to implement its policies and procedures to prevent client abuse and neglect, investigate an injury of unknown origin, elopement and client to client abuse, complete investigations within 5 working days, prevent further abuse while an investigation was in progress and report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>2) Please refer to W153. For 4 of 54 incident/investigative reports reviewed affecting clients A and C, the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>3) Please refer to W154. For 4 of 54 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to thoroughly investigate an injury of unknown origin, elopements and client to client abuse.</p> <p>4) Please refer to W155. For 3 of 54</p>		<p>revised to include: a review of all ISDH surveys; a review and report of all SGL abuse/neglect/exploitation investigations by third party QA team member including failure to suspend staff immediately upon notification of allegations of A/N/E. The QA team will recommend and monitor corrective actions. Further - the agency has initiated a new electronic internal incident reporting system which is under the operation of an administrative department not under the authority of programs.</p>				

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	<p>incident/investigative reports reviewed affecting clients A, C and F, the facility failed to prevent potential abuse while the investigation was in progress.</p> <p>5) Please refer to W156. For 3 of 5 investigations reviewed affecting clients B, C and F, the facility failed to report results of all investigations to the administrator or designated representative or other officials in accordance with State law complete investigations within 5 working days.</p> <p>6) Please refer to W157. For 4 of 54 incident/investigative reports reviewed affecting clients A and C, the facility failed to implement appropriate corrective actions.</p> <p>This federal tag relates to complaint #IN00137851.</p> <p>9-3-2(a)</p>						

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W000149	<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 12 of 54 incident/investigative reports reviewed affecting clients A, B, C, D, E, F and G, the facility neglected to implement its policies and procedures to prevent client abuse and neglect, investigate an injury of unknown origin, elopement and client to client abuse, complete investigations within 5 working days, prevent further abuse while an investigation was in progress and report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/23/13 at 1:38 PM and indicated the following:</p> <p>1) On 10/7/13 at 2:00 PM, the Bureau of Developmental Disabilities Services (BDDS) Service Coordinator (SC) conducted a Home Inspection for a possible transition of clients A and G. The transition was not approved due to the following conditions: three medication cups at the end of the</p>	W000149	W149 Plan of Correction: Internal IRs: The agency has implemented a new internal incident reporting system designed to address various failures in implementing the agency's procedures on reporting and investigating allegations of A/N/E. The process includes the following steps: the written incident report is submitted within 24 hours (or immediately if it contains an allegation of A/N/E) to a designated administrative staff. The staff enters the incident into the electronic system, attaches required follow up/investigative forms, completes a BDDS report if indicated, notifies a supervisor if indicated and sends an electronic copy of the report to the facility support team. Each member of the support team reads, reviews, documents actions taken and signs the report. The report requires the review and signature of the director before the report is electronically filed. Staff training: the facility social worker retrained facility staff on incident reporting and client rights. The facility behaviorist retrained facility staff on incident reporting and on the Behavior Support Plans of clients with targeted behaviors of defiance and refusals which	11/22/2013	

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	sidewalk and driveway, floor in the home was coming up in several places, walls in the screened in porch were falling apart, ceiling tiles were missing exposing pink insulation, ivy growing from the outside into the inside of the porch, feces on bathroom walls, floors and toilet, ceiling tiles in basement falling down and missing, water spots on ceiling tiles, mold on basement ceiling, water standing on basement floor, basement bathroom sink was falling off the wall, toilet full with feces, water damage around shower and toilet, drywall rotting at the bottom of the floors, holes in walls, toilet in upstairs bathroom falling apart, floor in front of dishwasher was coming apart, microwave was covered in food and had a foul odor, kitchen cabinets were broken, refrigerator light was out and the plastic crisper at the bottom was broken with sharp edges, broken glass outside of dining room window, wood trim in dining room was laying on the floor with the ends of the nails sticking up, wood board over a hole in the floor in the bathroom upstairs, shade covers missing over light bulbs, furnace vents were covered in dust/lint, bathroom in office was being used as a storage and "very dirty," couch on porch and living room had been urinated on multiple times per report from staff, weeds growing out of gutters, trash and miscellaneous items are being stored		contain strategies for staff to prevent and/or intervene in situations which historically lead to aggressive behaviors. See attachments labeled W 149. Date of Completion: 11/22/2013 Plan of Prevention: The implementation of an electronic system to deliver reports quickly to multiple members of the support team. The department will arrange for staff training in incident reporting and investigations from an outside expert. Quality Assurance Monitoring: The group home internal audit will be revised to reflect all of the required elements of an incident report. The QA team process will be revised to include a review of all ISDH surveys; a review and report of all SGL abuse/neglect/exploitation investigations by third party QA team member and the QA team will recommend and monitor corrective actions.				

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	<p>under the outside back stairs, cigarette butts in the backyard (staff confirmed that the clients did not smoke), stone steps leading from garage to the front door are uneven and loose, staff reported none of the doors lock correctly, brown matter on the ceiling of the living room, client C's bedroom had blue liquid in two medication cups along with a bottle of Windex with the same blue liquid in it, client C, per staff's reports, ate all his meals in his bedroom, "strong" odor of bodily fluid (not urine), client C's floor was "extremely sticky" due to bodily fluid (not urine), and dirty dishes including a bowl of cereal in the bedroom. Client F's bedroom had dirty dishes in his room and the floor was coming up near his bed. Client B's bedroom smelled of urine and his dresser drawers were not functional. Client D's bedroom had a trash can of empty aluminum cans stacking in the corner that was overflowing. Client E's bedroom had a "very strong" body odor smell, no sheets on the bed, and brown matter on the floor. Client A's bedroom had no cover on an electrical outlet and the walls were falling apart. This affected clients A, B, C, D, E, F and G.</p> <p>The BDDS follow-up report, dated 10/22/13 at 11:23 AM, indicated Stone Belt reported the following: "On 10/7/13 and 10/8/13 the BDDS SC did a site visit</p>						

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	<p>for possible transition of clients. The transition was not approved due to conditions stated in the initial incident report dated 10/7/13 and a verbal report via phone made to CEO (Chief Executive Officer) [name of CEO] by [name of BDDS staff] on 10/9/13. A written report was also received by CEO [name] on 10/9/13. The CEO suspended [name of Supported Group Living (SGL) Director] on 10/9/13 when it became apparent that he was minimizing the seriousness of the living conditions. The CEO, CFO (Chief Financial Officer) and facilities director, went to [name of group home] on 10/9/13 to do a site inspection, and assessment of health safety conditions and to begin an immediate plan of remediation. [Name of Director] was terminated on 10/10/13 and [name of interim Director] was appointed interim SGL Director. All health and safety and hygiene items were corrected on 10/10/13. On 10/10/13 CFO submitted a facility remediation plan to BDDS staff that outlined house remodel plans. A mold inspection and plan was completed by [name of company] on 10/11/13. [Name of cleaning company] did a top to bottom deep cleaning of the home on 10/14/13 and 10/15/13. An investigation of alleged neglect was completed and neglect was substantiated. APS (Adult Protective Services) was notified by Stone Belt on 10/14/13. In</p>				

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	<p>addition to repairs, maintenance and long term plans for reconstruction, we have also completed one-on-one retraining of staff on IHP (Individualized Habilitation Plans) goals for client training in personal care, hygiene, and daily living skills in the home. All house staff will also be retrained during an in-home meeting on 10/13/13. This meeting included the Coordinator, House Manager and all DSP's (Direct Support Professionals). All staff will be training on being pro-active in the environment to ensure the health and safety of all clients in the home. The Coordinator has been trained and will continue to be trained on Stone Belt oversight procedures to ensure health, safety and cleanliness. The agency Quality Assurance Team and Safety team will examine this incident and revise their procedures to ensure the prevention of such situations. Status of the repairs to the home: the minor repairs to bathrooms, laundry room, and flooring have been completed. The more extensive work in the kitchen, porch and upstairs bathroom will be completed by [name of contractor]. Estimates for work are expected by 10/21/13 with work to begin as soon as possible after contracts have been signed. The anticipated timeline for completion as reported by the contractors is 3 to 4 weeks from the start of work. Mold reassessment on the</p>			

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	<p>garage area is to be completed following the porch renovation. CFO sent BDDS staff a detailed, updated report on 10/18/13. Prevention plan: review of ISDH surveys and physical inspection of group homes using the agency's Environmental Assessment tool is to be added to the agency's quality assurance process. Quality Assurance team meeting is scheduled for 10/22/13 to develop a plan and process for the SGL program."</p> <p>An electronic mail message (email) from the CFO to the BDDS staff, dated 10/18/13 at 1:05 PM, indicated, in part, "We are aggressively working to restore the homes to our expected level of quality and safety. [Name of group home]: Attached is the air quality inspection report from [name of company]. The report, as we expected, confirmed the mold issues on the porch and the garage/workshop areas. His recommendations for correction are in line with the previously described projects with the porch and once all the exterior work is completed we will have [name of company] preform (sic) a follow up inspection and testing. [Name of cleaning company] were brought into [name of group home] on Monday and Tuesday of this week and preformed (sic) a top to bottom deep clean of the home. This was in addition to clients and staff thoroughly</p>						

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	<p>cleaning each client bedroom last week. The professional cleaning included floors, walls, ceilings, inside and outside of cabinets, and bathrooms. In addition area rugs, all bedding in the house, towels, and several pieces of furniture have been replaced. Several new mattresses (fluid proof where needed) and being ordered as well. We have begun making the repairs to the downstairs bathroom/laundry room and now have two dehumidifiers running in the basement at all times. We are still waiting on the quotes from our contract on the other items, but will be having them completed just as soon as they get the crew scheduled. We have responded to the reportable incident regarding our investigation, staff retraining and programmatic support for the residents. We are putting our established client support and quality assurance processes back into place."</p> <p>The facility's investigation, dated 10/14/13, indicated the allegation of neglect was substantiated (the findings support the event as described). The investigation indicated, in part, "Based on a written reports (sic), site inspections, interviews with staff - the allegation of neglect is substantiated according to the agency's definition: Neglect: any action or behavioral interventions that risks the physical or emotional safety and well</p>						

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	<p>being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan. There are several factors that contributed to the physical condition of [name of group home] on 10/7/13. The first involves the agency's maintenance department. The former maintenance supervisor had a habit of telling DPS staff that we could not afford to repair things or replace things and they'd have to make do with what they had. This apparently was accepted throughout the SGL system. The second involves the SGL Director. In spite of many emails and photographs of repair and replacement needs from the [name of group home] Coordinator, the SGL Director repeatedly failed to do a direct examination of conditions or inadequate repair jobs, failed to use his financial authority and means to purchase needed equipment, and in general failed to insure that the home was properly maintained. The factors that led to the</p>						

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	<p>presence of feces, urine smells, other noxious odors and unacceptable state of uncleanliness and hygiene: staff not knowing and/or following the clients' IHPs, Behavior Support Plans which address individual needs for support and intervention, and not following or completing job checklists which give detailed directions about cleaning and sanitizing. Another major factor is DSP's confusion and misinformation about the proper exercise of client rights regarding refusals in programming, personal care, chores, active teaching, house rules, cleanliness and hygiene. Although the agency has a Quality Assurance Team and a Safety Committee - the group home ISDH survey reports and plans of correction are not reviewed by this team. It was discovered that for the past two years, the SGL Director had not been sharing the actual survey reports or the plans of correction with group home staff or interdisciplinary staff in spite of many requests. At this time, the agency does not have a process whereby someone outside of the SGL department systematically and formally does site visits and reviews and documents quality standards." The Corrective Actions included in the investigation included: "1. Contractor has been employed and had completed assessment and plan. Responsible Party: [name of CFO] will</p>			

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	<p>oversee completion of plan to remodel kitchen (sic) bathrooms, remove porch and replace with deck. Contractor has been requested to complete construction in the next 90 days. 2. Staff training in IHPs, client rights and behavior support to individuals with hygiene challenges. Client training in personal care, hygiene and taking care of their home. Person responsible: [interim Director] and various [name of group home] interdisciplinary team members for various topics: [name] Coordinator, [name] Social Worker, [name] Behaviorist. Completion dates: 10/13, 10/17, house meeting scheduled for 10/18/2013. 3. Mold assessment by [name of company]. Mold cleaned up in garage area. Porch area to be torn down and deck built. Responsible party: [CFO]. Work will follow completion of construction which had been requested to be done within (sic) next 90 days. 4. Professional cleaning: [name of company] - completed cleaning on 10/14 and 10/15/2013. Agency is considering proposal and plan for major cleaning that is beyond client and DSP responsibilities. Person responsible: [CFO]. 5. Replacement of bedding, furniture, household goods. Inventory completed 10/14/2013 and new items have been purchased and/or will be ordered. Responsible: [interim Director].</p>			

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	<p>Completed in next 30 days. 6. Quality Assurance and Safety Committee revisions - Person Responsible: [name of CEO]. Completed in next 60 days. 7. Add back 20 hours to [name of group home] day aid position and open up full time day aid position at [name of another group home]. Responsible person: [interim Director] open position 10/11/2013. 8. Restructure SGL Coordinator positions so that a coordinator has two houses to support not three. Open [name of city] Coordinator position by 10/11/2013."</p> <p>A review of the former Director's employee file was conducted on 10/24/13 at 1:22 PM. The Employee Warning Notice, dated 10/10/13, indicated, "Over the past year multiple concerns have arisen in regards to your management and supervision of the agency's Supervised Group Living program. Your supervisor discussed these concerns with you on multiple occasions in one-on-one meetings and presented you with a formal development plan. To date, little improvement was evidenced in your job performance. On October 8th, you and your supervisor had a phone conversation with [name], Field Service Director, Bureau of Developmental Disabilities Service. During this conversation, [name] discussed numerous concerns</p>			

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	<p>about the condition of two Supervised Group Living sites that BDDS visited on October 7th. As follow-up to this conversation, your supervisor visited both sites and had follow-up inspections completed. The condition of these sites has substantiated your continued unacceptable management and supervision of the program. Your employment with Stone Belt is immediately terminated."</p> <p>A review of the former Director's development plan, dated 7/19/13, was conducted on 10/24/13 at 10:59 AM. The plan indicated, in part, "A number of situations have arisen in recent weeks that have caused concern regarding how you have handled them and specifically how this had impacted client safety and quality of life. Additionally there have been ongoing concerns brought to me throughout your tenure as Director of Supervised Group Living that need to be addressed on a systemic level. Most recently there have been substantiated allegations of abuse and/or neglect that I believe you have not responded to with the appropriate level of seriousness and concern for the ongoing client safety. Specifically, I believe you failed to follow, and didn't cause your staff to follow Stone Belt's reporting, investigation and disciplinary procedures.</p>						

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	In [name of group home], there were ongoing abuse and neglect issues what were unreported. After a client's report, an investigation was done that resulted in the immediate dismissal of two of the employees. While there were omissions and cover-ups by those staff and possibly others, I was alarmed that some of these more obvious situations were not observed and responded to by management in a timely fashion. Knowing the family dynamics of the house manager, I had specifically asked that the coordinator be cued into signs and symptoms of unhealthy cultures. We had reasons to be suspicious of inappropriate actions by the house manager that proved to be founded. Additionally when the neglect on the part of the manager and the abuse of the subordinate were substantiated, HR (Human Resources) took appropriate actions to dismiss the employees, but the findings of the investigation were not reported as required within 24 hours of knowledge of the incidents. I'm concerned that those reports may not have been generated had I not asked about them. Also, I believe the nature of the initial incident that included a client having knives in his room without staff knowledge was downplayed. Your coordinator should have known and followed this procedure without questions and it was your job to make sure this was						

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	<p>the case... Your response to these incidents and others has created a discordance within the system. As we've discussed, social workers, behaviorists and others have expressed that concerns they bring to you are not addressed. While I know that other employees are not always privy to disciplinary responses and other follow-up, there is an ongoing and persistent pattern of their concerns and complaints that at least in part validates their feelings. Furthermore, I believe this has caused communication and cooperation problems between the residential and clinical staff. It is likely your guardedness toward your department has exacerbated this rift. While this may be unintentional on you part, it has created an undesirable effect. Your demeanor will greatly influence your staff's response. Looking back over the past couple of years, there appears to be a pattern of tolerance for inappropriate staff behaviors, some of which have led to a great deal of upheaval within the system and possibly harm to clients both direct and indirect. This includes situations with [name of three staff] among others. Earlier recognition of and intervention in these cases would have caused significantly less turmoil to the system and risk to clients. While I'm not sure of the causal factors that lead (sic) to these problematic issues, I do believe that you</p>				

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	are capable of changing your response patterns, I have laid out the following development plan steps that must be enacted immediately: 1) You must consistently and completely follow Stone Belt's incident reporting and investigation procedures. Downplaying or minimizing of the issues cannot and will not be tolerated. Your direct reports must know and strictly follow them as well. Your direct reports must be thoroughly trained on all Stone Belt incident reporting and investigation procedures and be informed that they must follow them at all times. It should be made clear that they should not require you to direct them to do this. 2) You must create a cooperative and respectful attitude between group home staff and clinical staff. The clinicians should be perceived as a resource to the home and all should work for the betterment and the protection of the clients. When clinical staff brings (sic) concerns to you, you need to better communicate and respond to them that you are listening. With their professional training, they serve as a resource to you and others in identifying unhealthy and inappropriate staff behaviors. These are things that you are not trained to identify and may not be inclined to recognize in others. 3) You must do a consistent job of holding staff accountable, taking necessary disciplinary action and			

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	<p>communicating the seriousness of client rights violations and abuse and neglect infractions. I urge you to carefully evaluate the needed action to keep clients safe, even if that means more severe action with a staff person than your comfort level allows. Appropriate documentation must be provided to Human Resources for inclusion in employee files any time disciplinary action is carried out...".</p> <p>An observation was conducted at the group home on 10/23/13 from 6:19 PM to 7:25 PM. During the observation, there were 14 ceiling tiles missing from the enclosed back porch. There was a puddle of water on the dining room floor from the upright freezer. The floor in front of the kitchen sink was soft and sunk down when stepped on. The basement stairs' carpet had been removed and non-slip strips were applied to the steps. Client A's former room (now client G's room) walls were scuffed and discolored with areas of missing paint and unpainted patches on the wall throughout the room. There was a 5 inches by seven inches area of black, green, and brown substance on the basement floor in the workshop area. Client D's bedroom blinds were covered in dust. The dryer in the basement had two areas on the inside of the dryer missing the protective coating. The areas</p>						

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	<p>with the missing coating were rusted. The laundry room area had unpainted patched walls. The floor drain in the laundry area was rusted and collapsed into itself. The drain was not functioning due to being plugged up with rust. The downstairs shower was missing a drain cover. The upstairs bathroom floor next to the bathtub had patched with a piece of discolored (black, green and brown) plywood that was wet. The plywood was soft in places.</p> <p>On 10/23/13 at 6:58 PM, direct care staff #9 indicated he was at the home early to complete additional cleaning tasks. Staff #9 indicated there was a period of time when he had trouble getting his cleaning tasks completed due to client A staying up all night. Staff #9 indicated client A would prevent him from completing his cleaning by moving furniture to block staff #9 from cleaning. Client A would stand in his way to prevent him from cleaning. Client A would stay up all night and then sleep all day.</p> <p>On 10/24/13 at 11:54 AM, the group home Coordinator indicated he was present when the BDDS SC conducted the environmental assessment of the group home. The Coordinator indicated the floor in front of the kitchen sink was soft, most likely from a leaking</p>						

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	dishwasher. The Coordinator indicated it took the previous maintenance staff two years to replace the previous dishwasher. The Coordinator indicated the floor in front of the bathtub in the upstairs bathroom had a soft floor. He indicated the previous maintenance staff put a board on the floor which was not the best solution. He indicated the board was supposed to be covered however the repair was never completed. He indicated it was a temporary fix that was never finished. The Coordinator indicated the back porch had issues with loose walls. He indicated it was reported to BDDS the clients used the room however the clients did not use the porch regularly. The Coordinator indicated there was some water in the basement work room from two days of substantial rain. The Coordinator indicated there were issues with the gutters not moving water away from the home and the gutters needed to be cleaned out. The Coordinator indicated the basement bathroom sink being pulled away from the wall was the result of client A using the sink to pull himself up out of his wheelchair. The Coordinator stated it, "Took a long time to get a washer." The Coordinator indicated he was not aware of rust in the dryer. The Coordinator indicated the stairs were discussed. He indicated the carpet was removed from the stairs but			

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	<p>then nothing was done to the stairs. The Coordinator indicated the Director was working on getting the stairs repaired but the maintenance staff never followed through. The Coordinator indicated the Director did not consistently visit the group home. The Coordinator indicated the CEO was the Director's supervisor. The Coordinator was not aware of a time the CEO had visited the group home in the past year.</p> <p>On 10/23/13 at 2:03 PM, the interim Director indicated neglect was substantiated at the group home due to the environmental issues. The interim Director indicated the Director was terminated. On 10/29/13 at 1:01 PM, the interim Director indicated the former Director did not implement the facility's policies and procedures. The interim Director indicated the former Director minimized things at the group home. The interim Director indicated there was a general lack of structure and expectations at the group home.</p> <p>On 10/29/13 at 10:58 AM the CEO stated, "We had a system breakdown." The CEO stated the issues were "egregious" and "significant." The CEO indicated the former Director minimized the seriousness of the environmental issues at the group home. The CEO indicated the</p>						

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	<p>seriousness of the issues was reported to her by the BDDS Field Services staff. The CEO indicated she suspended and then terminated the former Director's employment with the facility.</p> <p>2) On 9/27/13 at 8:50 PM, client C was in the medication area preparing to take his medications. Client B entered the room and tried to talk to client C. Staff #3 heard client C say "Stop talking to me" in a tone that was like talking through his teeth. Staff #3 turned around and observed client C was holding onto client B's face with both hands. Client C stated, "Stop talking to me" and pushed client B to the floor. Client B hit his back on the filing cabinet.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated an inquiry (investigation) was conducted but it was in the interim Director's mailbox for her to review. The PC indicated the inquiry took longer than 5 working days to contact the weekend overnight staff. The PC indicated the inquiry was not completed within 5 working days which was the timeframe for completing investigations.</p> <p>On 10/29/13 at 10:58 AM the CEO indicated client to client aggression was considered abuse. The CEO indicated the</p>				

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	<p>staff should prevent client to client abuse.</p> <p>3) On 9/22/13 at 11:00 PM, client A was in his room moving things around when staff heard a loud crash from client A's room. The Incident Report, dated 9/22/13, indicated, in part, "I did not see this happen but I could hear it from the top of the steps and [client A] told me what just happen (sic)." The report indicated, "Pain and swelling in his right foot and big toe." The report indicated "none" in the witnesses of incident section. On 9/23/13 at 9:00 AM, client A was taken to a local walk-in doctor's office. The Outside Services Report, dated 9/23/13, indicated, "R (right) 1st toe fracture in multiple areas of distal phalanx." There was no investigation of the incident as an injury of unknown origin. The incident was not reported to BDDS. The Incident Report section "Supervisor must document action taken section" indicated, in part, "[Client A] had a fractured toe. He had been seen by a physician and will be seen by a surgeon soon." There was no additional corrective action implemented.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated an investigation was not conducted. The PC indicated the staff heard the loud noise and went to see what happened. The staff</p>				

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	<p>indicated client A told him what happened therefore the incident and subsequent injury was not unknown. The PC indicated client A was seen by a physician and a surgeon. The PC indicated there was no additional corrective action taken to prevent a future occurrence.</p> <p>On 10/29/13 at 12:55 PM, the interim Director indicated interviews should have been obtained from the staff and client.</p> <p>On 10/29/13 at 10:58 AM the CEO indicated an inquiry should have been completed.</p> <p>4) On 9/19/13 at 1:30 PM (reported to BDDS on 9/23/13), client C was upset due to a phone call and he tried to contact staff to talk to at the facility-operated day program. Client C, when unable to locate staff to speak with, vacated the day program premises and began walking toward a local bookstore. He turned around and came back. Client C informed the classroom teacher and a Day Program Coordinator he had left. There was no investigation of the incident. There was no documentation the facility took corrective action to address elopement from the day program. This was the second incident of elopement from the day program (first incident was</p>			

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	<p>on 5/31/13). The BDDS follow-up report, dated 9/30/13, indicated, in part, "[Client C's] plan does not address elopement at this time... There will be no changes to [client C's] plan at this time." There was no documentation staff were retrained to closely supervise client C. There was no documentation addressing that staff were unaware client C left the premises until he returned and reported he eloped.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated he spoke to and provided training to client C on what he could do when he was upset. The PC indicated client C did not speak to staff prior to leaving the building. The PC indicated he told client C he needed to talk to staff when he was upset and tell them he was leaving. The PC indicated client C had a cellphone and there was no history of elopement (prior incident on 5/31/13 from the day program). The PC indicated elopement was not added to client C's Behavior Support Plan. The PC indicated an investigation should have been conducted.</p> <p>On 10/29/13 at 10:58 AM the CEO indicated an investigation should have been conducted.</p> <p>5) On 8/18/13 at 10:00 PM, client A hit client C's hands causing client C to spill</p>				

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	<p>his snack. The BDDS report, dated 8/19/13, indicated, in part, "Reaching past staff, [client C] pushed [client A] back, causing him to stumble several steps back and fall through a glass window. At this time staff jumped down through the window to make sure [client A] was ok, at which point it was discovered that [client A] had cut his elbow on some of the broken glass... [Client A] was admitted to [name of hospital] at 11:00 PM. While there he received three stitches on his left elbow, and two stitches on his right thumb." The Social Work Notes, undated and not signed by the Director, did not indicate when the facility completed the investigation. The investigation included interviews with staff conducted on 8/29/13. The Incident Report, dated 8/18/13, indicated in the action taken section, "The support team met on 8/20/13 to discuss a plan for staff training and client development." A review of the Support Team Review Form, dated 8/20/13, was conducted on 10/29/13 at 1:38 PM. The form indicated, in part, "Discussed the incident reports from the past weekend (17 & (and) 18 August). Reviewed BSPs and strategies, as well as the dynamics between staff and [client A]. Coordinator will meet with both staff members. The Team shared concerns about a particular staff and his involvement in these incidents. The</p>			

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	<p>Social Worker will write an IR (incident report) for a client rights violation if after discussin - g with the Director, the Director and Social Worker deem it necessary. Staff will be trained on [client A's] calming techniques (learned in therapy). Client Rights training for the [name of group home] gentlemen will be scheduled." There was no corrective action to address the supervision and protection of client A. There was no documentation the staff and the clients received training provided in the training documentation.</p> <p>The Social Work Notes indicated, in part, "SW (Social Worker) met with [client C] to process the incident between him and [client A]. [Client C] reported that [client A] had hit him in the face, early that day. He reported that he had gotten a snack from the kitchen and was walking back to his room. [Client C] reported that [client A] had gotten all the way around his 1:1 staff. He reported that [client A] knocked his snack out of his hand and punched him in the face twice. [Client C] reported that staff got in between them again. He reported that he got all the way around the staff, grabbed [client A] with both hands by the collar of his shirt, swung him around 180 degrees and tossed him out the window. [Client C] reported that he (sic) [client</p>						

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	<p>A] got what he deserved. He reported that the police came and took his information. He reported that the police officers told him that it was self defense. [Client C] was not opening (sic) to listening (sic) SW explain definition of self defense. He was no longer interested in discussing the issue."</p> <p>On 10/30/13 at 9:45 AM, the Social Worker (SW) indicated staff #12 was terminated. The SW indicated staff #12 was not doing his job appropriately. The SW indicated when she spoke to client C, she was concerned about his version of the incident. The SW indicated client A's version of the incident matched the incident report and staff interviews. The SW stated she thought client C was trying to be "bravado" during her interview with him. The SW indicated client C's story changed regarding the incident of client A going out the window.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client A went out the window by the kitchen in the living room near the dining room. The PC indicated client A was pushed even though staff was in between the clients. The PC indicated client A fell through the glass pane. The PC indicated client C typically only targeted client A after</p>						

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	<p>client A was doing something to provoke client C. The PC indicated there have been no incidents in which client C was physically aggressive toward client A without client A first provoking client C. On 10/24/13 at 12:35 PM, the Program Coordinator (PC) indicated the team met to discuss the incident. The PC indicated staff #12 was terminated. The PC indicated the staff were regularly trained on client A's 1:1 protocol. The PC indicated staff were informally trained to understand client A targets client C. The PC indicated it was useful for staff to stay outside of client C's bedroom door to encourage him to stay in his room when client A was targeting him. The PC indicated the staff were informally trained to encourage client C to use words and not aggression.</p> <p>On 10/29/13 at 10:58 AM the CEO indicated client to client aggression was considered abuse. The CEO indicated the staff should prevent client to client abuse.</p> <p>6) On 8/18/13 at 5:30 PM, client A entered the front door causing the door to hit client C. Client C reacted by pushing client A to the floor. Client C hit client A once in the face.</p> <p>The Social Work Notes, undated and not</p>						

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	<p>signed by the Director, did not indicate when the facility completed the investigation. The investigation included interviews with staff conducted on 8/29/13. The notes Conclusion indicated, in part, "[Client A's] plan calls for 1:1 (one on one) staffing. [Client A] had followed [staff #12] outside. [Staff #12] reportedly was trying to enter the house through the garage and wanting [client A] to follow him. This did not happen. [Client A] entered the front door quickly, hitting [client C] with the door. [Client C] then tackled and hit [client A]. [Staff #4] was reportedly in the kitchen and unaware that [client A] was not with his 1:1. During this altercation with [client C], [client A] did not have adequate supervision, as written in his plan. This is (sic) meets criteria for neglect."</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client to client aggression was abuse.</p> <p>On 10/29/13 at 10:58 AM the CEO indicated client to client aggression was considered abuse. The CEO indicated the staff should prevent client to client abuse.</p> <p>On 10/30/13 at 9:45 AM, the Social Worker (SW) indicated she reviewed the incidents on 8/18/13 informally. The SW</p>			
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	<p>indicated she was not instructed or directed to investigate the incidents. The SW indicated the support team met and decided it needed further review. The SW indicated she spoke to the former Director who indicated documentation on the support team note would be fine. The SW indicated the former Director knew the action he was going to take with staff #12. The SW indicated the former Director was going to terminate staff #12. The SW indicated she sent her notes to the CEO and her supervisor. The SW indicated the CEO requested additional information but it was not a formal investigation. The SW indicated she thought staff #12 was suspended.</p> <p>7) On 8/17/13 at 8:30 AM (the incident was not reported to BDDS), client F received his medications from former staff #12. Staff #12 prompted client F to take a shower after the medication pass. Client F indicated he was going to go back to bed. Staff #12 indicated, per the Incident Report, dated 8/17/13, "I then explained to him that it was not a healthy choice and that his bed sheets are dirty and needed to be washed. [Client F] kept saying to me that he really needed to lay down during this time when I was trying to explain the better option. By the time he understood what I was telling him he started to get upset. When I asked him if</p>						

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	I could help take off his sheets with him he agreed. After that, he wanted to lay on his bed without a sheet. I explained to him that his bed was still dirty along with his clothes, and he needed to take a shower so he would have clean clothes and be clean. Then he sprung up from his bed and started hitting me with pillows. I was able to get the pillows away from him. After that, he started swing (sic) his fists at me along with kicking me. He then connected one of his kicks on my testicles. After that, when I had the wind knocked out of me he was backing me into a corner where it was almost impossible for me to block or possibly put him into a hold so I had to push him out of my way on his back so I could leave the room. [Staff #4] walking in (sic) during the end of it and took over trying to calm [client F] down after I left. She left the room shortly after me. I also apologized for pushing him but explained there wasn't much else I could do to avoid myself being injured. He understood and was able to stay calm after. I checked where I pushed him 30 minutes later and there appeared to be no marks or bruises." The Supervisor must document action taken section indicated, "The situation has been attended to and [client F] and [staff #12] are both fine." The investigation, dated 8/29/13, indicated, in part, "The IR (incident				

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	report) was submitted as a Behavioral Incident of Client Aggression. The Support Team met to review and determined the incident was a possible client rights violation. This review is being completed to determine (sic) [client F's] rights were violated." The Finding section of the investigation indicated a client rights violation was substantiated (the findings support the event as described). [Staff #12] was the only person interviewed during this review. The SGL Director reported that enough information had been gathered to make a personnel decision. Through [staff #12's] description of the incident, it appears that he engaged [client F] in a power struggle. [Staff #12] reported deciding that [client F] could not take his radio in the bathroom during his shower because it was (sic) safety risk. [Client F] reportedly became upset. [Staff #12] reported following [client F] into his bedroom which appeared to increase [client F's] agitation. [Staff #12] reported prompting [client F] to change his bed sheets since he had been incontinent. He also prompted him to not lie down on the bed and to go take a shower. [Staff #12] reportedly was explaining to [client F] that is (sic) was unhealthy to be in soiled clothes and have a soiled bed. [Staff #12] reported that [client F] began hitting him with a pillow. He reported that he			

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	<p>caught the end of the pillow and [client F] let go. He reported that [client F] began kicking at him as he backed up into the corner of the room. [Staff #12] reported that [client F] kicked him in the testicles and he doubled over. [Staff #12] reported realizing he needed to leave the area. He reported that he raised his arm to push [client F] out of the way, without looking up. He demonstrated that he intended to use his forearm to block and push [client F]. He reported that his hand was closed in a fist. He reported that as he looked up, [client F] was walking away and the pinky side of his fist made contact on [client F's] back. [Staff #12] had several opportunities to disengage from [client F], walk away, and/or ask for another staff to assist [client F]... Given the limited information gathered, this incident was a client rights violation." The investigation indicated, "While enough information was gathered to make a personnel decision, this SW (Social Worker) followed the investigation procedure and finished interviewing the other people involved... None of the physical interventions described in the interviews are CPI (Crisis Prevention Institute) interventions. It appears that an unauthorized intervention was used by [staff #12] to get away from [client F] and leave the room... [Client F] reported</p>			

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	<p>that [staff #12] was mad during the incident. [Staff #4] reported that [staff #12] appeared angry. [Client F] reported that he was upset by the incident. [Staff #4] reported comforting [client F] after the incident. It appears that [client F] experience (sic) emotional trauma... This incident appears to meet the criteria of emotional/verbal abuse." The investigation indicated, "Stone Belt's Incident Investigation/Review Protocol states, in part, 'Within 24 hours of written incident report or other notification, the director will assess and determine what type of investigation/review is to be done.' The incident happened on 8/17/13 and the investigation was requested and begun on 8/22/13. This policy was not followed. During the interview process, [staff #4] was clear that she believed the incident to be abusive. According to [former Director] interview, [staff #4] reported that [staff #12] pushed [client F] and did not indicate the incident to be an allegation of abuse..."</p> <p>A review of staff #12's employee file was conducted on 10/29/13 at 2:39 PM. Staff #12 was terminated on 8/23/13. The Employee Warning discharge documentation indicated, in part, "On Saturday, August 17th, an incident occurred at [name of group home] between client (F) and [staff #12]."</p>			

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	<p>Following a review of the incident it was determined that there was a Client Rights violation. As per Stone Belt Rights policy, the client can choose and refuse treatment, intervention and services. When the client refused to follow direction from [staff #12], [staff #12] should have stepped away from the situation. This led to physical contact between both parties. Second serious incident in the past 4 months, with the other occurring on 5/4/2013. Staff terminated on 8/23/13." There was no documentation staff #12 was suspended during the investigation. Staff #12 worked at the group home on 8/17/13 from 6:00 AM to 9:38 PM, 8/18/13 from 6:37 AM to 11:59 PM, 8/19/13 from 12:01 AM to 2:34 AM, and 8/19/13 from 7:38 AM to 11:42 AM. On 5/4/13, staff #12 received his first written warning. The issue noted indicated, "Allegation of abuse was substantiated by investigation regarding the interaction between client at [name of a different group home] and [staff #12]. This included verbal and physical abuse as the staff was trying to get client to shower after soiling himself. Staff reported allegation himself. He is getting assistance through Employee Assistance Program. Has been removed as manager at [name of different group home] and will be reassigned. Staff was suspended during investigation. Due to</p>			

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	<p>the incident, staff cannot visit house when particular client is home. Any further issues of this nature can lead to further disciplinary action, up to and including termination." On 8/5/13, staff #12 received a written warning for visiting the group home without authorization. The warning indicated, "[Staff #12] does not have permission to visit [name of group home] nor have contact with two specific clients [clients' initials]. Future visits will result in further disciplinary action up to and including termination."</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated staff #12 was terminated. The PC indicated a BDDS report should have been completed and he thought there was one in the system. The PC indicated there were questions about the incident and what actually occurred and what staff #12 reported. The PC indicated staff #12 reported something different to staff, the pager staff and to the former Director. The PC indicated staff #12's story changed and his verbal report was not clear that he pushed client F. The PC indicated pushing was not a part of the CPI training staff received to implement the clients' behavior plans.</p> <p>An interview with the Human Resources</p>			

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	<p>Director (HRD) was conducted on 10/30/13 at 11:59 AM. The HRD indicated she reviewed staff #12's employee record and indicated there was no documentation staff #12 was suspended at anytime in August 2013 prior to being terminated. The HRD indicated staff #12 should have been suspended during the investigation.</p> <p>8) On 8/13/13 at 11:45 AM at the facility-operated day program, client F was arguing with another client when he said, "I am going to backhand him." Staff was nearby to make sure this did not happen and blocked the attempt. Client F then walked outside and attempted to hit a female peer twice but staff were able to block the attempts. He then used his other hand and was able to hit the female peer on the upper right arm. The peer had red marks on her arm that went away after an hour.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client to client aggression was abuse.</p> <p>On 10/29/13 at 10:58 AM the CEO indicated client to client aggression was considered abuse. The CEO indicated the staff should prevent client to client abuse.</p>						

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	<p>9) On 8/8/13 at 9:30 AM, client F and client E were arguing. Client E ran from the kitchen to the living room and poked client F above his eye with two fingers. Client F was not injured.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client to client aggression was abuse.</p> <p>On 10/29/13 at 10:58 AM the CEO indicated client to client aggression was considered abuse. The CEO indicated the staff should prevent client to client abuse.</p> <p>10) On 7/29/13 at 8:30 AM at the facility-operated day program, client F and a male peer were joking around about "wanting to fight." Client F got upset and kicked at the peer but made minimal contact to his right shin. The peer did not have an injury.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client to client aggression was abuse.</p> <p>On 10/29/13 at 10:58 AM the CEO indicated client to client aggression was considered abuse. The CEO indicated the staff should prevent client to client abuse.</p>				

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	<p>11) On "date of incident unknown" client A reported to his behavior consultant (BC), [name of BC], that he used a knife to unscrew hinges from his door and that staff, [name of staff #13], used a physical restraint on him. He reported this to the BC on 6/13/13. This was included in the investigation, dated 6/20/13. The restraint was not reported. It was unclear how [client A] was restrained. The incident was being investigated as an allegation of a client's rights violation. The Findings section indicated the incident was substantiated (the findings support the event as described). The report indicated, in part, "[Client A] refused to be interviewed for this investigation. There were several different attempts with different mental health providers. [Client A] refused each time. [Client A] was able to begin to provide some information on 6/20/13 to [name], Social Work Manager. [Client A] indicated that he had more information to share. A follow up appointment was scheduled for 6/21/13.</p> <p>Through the interview process, several different events were discovered. Some of the events required Incident Reports, per Stone Belt policy. Incident Reports were not filed and the information was not shared with the support team.</p>						

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	<p>[Client A] had four sharp kitchen knives in his bedroom. He had used the knives to dismantle his door frame, his door knob and large sections of drywall in his room which left partially exposed electrical hardware. [Client A] described being restrained while he was using the knife to dismantle his doorknob. The property destruction and the physical intervention require Incident Reports, per Stone Belt Policy. Neither were reported.</p> <p>It was reported that [staff #13] was providing sugary snacks and beverages to [client A] during the overnight hours. It was reported that [staff #13] provided M&M's to [client F] at 1:00 AM. [Client F] is diabetic and his morning reading was very high. The house nurse determined that this was not life threatened (sic) but could have caused the doctor to change [client F's] medication based on the inaccurate information. Giving clients gifts of snacks and pops does not comply with Stone Belt's 'Gift Giving Procedure.' The house manager, [staff #14] reported being aware of [staff #13] giving snacks and drinks to clients. She reported observing [staff #13] giving clients [company name] cakes one morning, as well as giving [client A] a [name of soda] one morning. This was not reported or</p>			
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	<p>addressed in a supervisory manner.</p> <p>The tool box, kept in the [name of group home] office, had its lock ripped off. [Staff #14] reported knowing the lock was removed. She reported that she did not inquire with anyone about the broken lock. She reported that the lock did not work properly and she assumed that was why someone broke the lock off. This property destruction was not reported.</p> <p>On 5/31/13, [client A] suffered a head wound. [Staff #13] reported on the Incident Report that [client A] was sitting on a loveseat, goofy (sic) around, that he fell backwards and hit his head on a weight that was sitting on the couch cushion. He reported the event happened at 1:00 AM. [Staff #13] did not call the pager until 2:00 AM. He reported to the pager that [client A] had a scratch on his head, he kept him awake for 45 minutes and that he had applied first aid. Morning staff, [staff #8], reported that she cleaned and re-banded the wound in the morning. She reported concern about the wound and contacted [staff #14], her supervisor. [Staff #14] reportedly told [staff #8] that she had seen the wound and did not think it was that bad. [Staff #8] reported to this interviewer that she did not see the wound until after [client A] had been</p>						

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	<p>examined at the hospital. Stone Belt Nurse Manager was notified of the head wound. She instructed that [client A] be taken for assessment. The hospital reported that it was too late to give stitches, indicating that he should have had been seen early (sic). [Staff #14] reported that she was not present at the time of the incident. [Client A] disclosed on 6/20/13, that [staff #14] was present at the time he hit his head. He reported that [staff #14] and [staff #13] were in the backyard smoking while he was on a couch on the back porch. [Staff #14] reported that she does not do pop in visits during overnight hours. [Staff #14] was not scheduled to be working at 1:00 AM that morning. [Staff #13's] report to the pager did not match the Incident Report. He did not communicate with the team or day program that [client A] had an injury to his head. He did not accurately report that [staff #14] was a witness. [Client A] did not receive medical attention in a timely manner due to lack of communication and inaccurate reporting to the pager.</p> <p>[Client A] reported that he had tried to hit [staff #13] with a belt. [Staff #14] reported that she was present during this incident. She reported that [client A] was holding the buckle and [staff #13] caught and yanked the belt from [client</p>			

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	<p>A's] hand. [Staff #13] reportedly said I'll give it back if you don't hit again, to which [client A] agreed. [Staff #14] reported telling [client A], if you hit again I'll take it away for the night and you can get it back in the morning. Yanking the belt from his hand is an inappropriate intervention. Staff would move out of the way or use a block for their own protection. The belt was put in a drawer in the office. Client's personal items are not to be restricted without HRC (Human Rights Committee) approval. The restriction is not in [client A's] BSP (Behavior Support Plan) and did not have HRC approval. There was no Incident Report or communication regarding this incident.</p> <p>It was reported by [staff #8] that [client A] has had a drastic change in his hygiene in the last month which was not reported to the support team. [Staff #14] reported that she noticed the change about two weeks ago. She did not report the change. This type of change in [client A's] behavior should have been reported to the support team. There appears to be a lack of communication by staff.</p> <p>[Staff #14] reported she did not know about a secret [client A] has been asked to keep. She then asked the interviewer</p>						

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	<p>if [client A] said who asked him to keep the secret. The interviewer stated that was not something that could be shared. Witness, [name of witness], reported [staff #14] smiled slightly at the interviewer response.</p> <p>The above summary displays a number of incidents where Stone Belt policy was not followed, Incident Reports were not written for physical restraints and property destruction, Incident Reports did not match the reports given to the pager causing a delay in [client A] receiving appropriate medical treatment in a timely manner. [Client A] was able to carry several sharp kitchen knives to his room, use them as tools to remove parts of his door and drywall as well as, store them in his bedroom with no staff intervention and no communication to the support team. These events display a pattern of neglect involving [staff #13] and [staff #14].</p> <p>[Name of LCSW], LCSW (Licensed Clinical Social Worker) met with [client A] at 10th street building at Stone Belt on 6/20/13 in Room 17-A with [name of BC], witnessing the interview. [BC] is [client A's] behaviorist. [Client A] had been observed by [LCSW] to be anxious, and interrupting the front desk receptionist while at Stone Belt.</p>						

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	<p>[LCSW] talked to [name of day program Coordinator] that morning concerning [client A's] behavior, and [name of day program Coordinator] stated that [client A] had been highly agitated that morning and trying to get staff attention. [LCSW] was aware of the ongoing investigation related to [client A] at [name of group home], and also that [client A] had been refusing to talk to his social worker [name] LCSW, and his Behaviorist [name], while at the same time indicating that he had information he was anxious about disclosing. [LCSW] contacted [BC] to request that she offer [client A] some support as he appeared to be highly agitated at Day Program. [BC] came to Day Program to talk to [client A] and then contacted [LCSW] stating that [client A] had stated he wanted to talk to [LCSW] about some of the incidents which he had been avoiding talking to [Social Worker] and [BC]. [LCSW] agreed to meet with [client A] to let him share his concerns about these incidents. [Client A] communicates by individualized sign, vocalizations, some words and pantomiming actions.</p> <p>[Client A] indicated that he went to [name of staff], staff person at Stone Belt who handles Incident Reports. He had been asking [name of staff] and [BC], 'why staff had lied on the IR' it was not</p>			

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	<p>immediately clear which IR he was referring to. I asked [client A] to tell me about some of the incidents which had happened recently, which he had not talked to [SW] about. [Client A] related the first incident as being one where he was 'picking at' staff [#13] with his fingers and [staff #13] told [client A] to 'give his space.' [Client A] showed how he had put his foot up on [staff #13's] leg and [client A] stated that [staff #13] put him in a hold following this. [Client A] then related an incident in which he had hit [staff #13] with his belt and [staff #13] took the belt away from [client A], and put the belt in his pocket. [Client A] then talked about concerns about his having incontinence of urine both at Day Program and on his community job. He kept asking 'why' and [LCSW] told [client A] there could be a few reasons 'why' a person would have urinary accidents: 1) Being anxious and 'forgetting to go to the bathroom and having an accident.' 2) Having a urinary tract infection, where there is pain and a person doesn't know that they have to go. 3) Someone has touched them on their privates or done something to their private that is worrying them or making them uncomfortable. [Client A] was asking about the mosquito bite that had been found on his penis earlier in the week, and asking about 'why' and 'why</p>			

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	<p>the Doctor had given him medicine for it.' I explained that the Doctor thought it was a bug bite, and that he had [client A] get some medicine so it wouldn't be uncomfortable. I asked [client A] if anyone had touched his penis and he said 'no.' I asked [client A] if he was worried about something, and he indicated he was. I asked [client A] if he was having pain in his penis and he said 'no.' [BC] stated that [client A] had told her earlier that he had urinated in a plastic tote in his room, and this was not like [client A]. [Client A] pantomimed this. When I asked him why he had urinated in the tote, or if anyone had him urinate in a container, he said 'no' and 'shrugged his shoulder's (sic) to say he did not know or remember.' [Client A] then pantomimed elaborately about his taking a knife to the door on his bedroom, cutting around the door, cutting around the door knob, door frame, and cutting into the ceiling tiles in his room. He indicated he thought what he had done 'was bad.' I asked him why he had taken the knife to his door, and along the wall, door knob and door frame. He indicated that he could not find the key to open his door, and he wanted to get into his room. He indicated that the key is kept in the office, but that it was lost so he couldn't get into his room. I asked him if he had damaged his door when he was trying to</p>			
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	<p>get it open. He pantomimed opening and shutting the door many times which caused damage to the door. He pantomimed about trying to get into the office to find the key. [Client A] indicated that his staff [staff #13] was there in the office, and that the house manager [staff #14] was also at the house in the office when he was trying to get into the office. [Client A] stated he kept opening and shutting the door. I asked [client A] if he felt better after talking about these incidents. He nodded and looked happy about talking about these issues. I asked if he would come to talk with me again the next day at my office to tell me about anything else that is worrying him, so that he can be calmer. He agreed to come back to meet with me and [BC] the next day, for counseling to allow him to vent his concerns about issues he was suppressing. He seemed to be most concerned about IR's not being written about the events he was describing, staff 'lying (sic) on IR's,' and events around urinary incontinence, using a knife to break into or out of his room, and struggling to get or find a key to his room in the office. These were events that had not been documented in IR's, or Forum's (communication between staff) and his team was not aware of what or how these events had transpired."</p>			
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	<p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client A gave him two knives from client A's bedroom. Client A indicated to the PC he had been restrained by staff. There was an investigation which determined client A had been restrained by staff and it was not reported to administrative staff. The PC indicated the former House Manager (#14) was complicit on not reporting the restraint and another incident in which client A hit his head. The PC indicated it was determined the HM was present but did not report to the pager staff (on-call). The PC indicated staff #13 reported the incident to the pager but not accurately. The PC indicated client A received first aid but needed additional medical treatment. The PC indicated client A needed sutures but the doctor wrote it was too late for sutures. The PC indicated the HM and staff #13 were terminated.</p> <p>On 10/29/13 at 1:01 PM, the interim Director indicated the former Director did not implement the facility's policies, procedures and systems. The interim Director indicated the former Director minimized things at the group home. The interim Director indicated there was a general lack of structure and expectations at the group home. The interim Director stated, "This is not the</p>						

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	<p>way we do things."</p> <p>12) On 5/31/13 at 1:05 AM, client A, per the BDDS report dated 5/31/13, was sitting on the arm of his sofa and fell backward hitting his head on a weight that was sitting on the sofa cushion. The report indicated, "Because he hit his head, [staff #13] had [client A] stay awake for 45 minutes and then he called the emergency pager on-call to report the fall. At that point he reported [client A] was behaving normally... the on-call recommended that staff check on [client A] hourly throughout the night and call back if they observed anything concerning.</p> <p>The investigation, dated 6/20/13, indicated on 5/31/13, [client A] suffered a head wound. The investigation indicated, "[Staff #13] reported on the Incident Report that [client A] was sitting on a loveseat, goofy (sic) around, that he fell backwards and hit his head on a weight that was sitting on the couch cushion. He reported the event happened at 1:00 AM. [Staff #13] did not call the pager until 2:00 AM. He reported to the pager that [client A] had a scratch on his head, he kept him awake for 45 minutes and that he had applied first aid. Morning staff, [staff #8], reported that she cleaned and re-banded the wound</p>						

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	<p>in the morning. She reported concern about the wound and contacted [staff #14], her supervisor. [Staff #14] reportedly told [staff #8] that she had seen the wound and did not think it was that bad. [Staff #8] reported to this interviewer that she did not see the wound until after [client A] had been examined at the hospital. Stone Belt Nurse Manager was notified of the head wound. She instructed that [client A] be taken for assessment. The hospital reported that it was too late to give stitches, indicating that he should have had been seen early (sic). [Staff #14] reported that she was not present at the time of the incident. [Client A] disclosed on 6/20/13, that [staff #14] was present at the time he hit his head. He reported that [staff #14] and [staff #13] were in the backyard smoking while he was on a couch on the back porch. [Staff #14] reported that she does not do pop in visits during overnight hours. [Staff #14] was not scheduled to be working at 1:00 AM that morning. [Staff #13's] report to the pager did not match the Incident Report. He did not communicate with the team or day program that [client A] had an injury to his head. He did not accurately report that [staff #14] was a witness. [Client A] did not receive medical attention in a timely manner due to lack of communication and inaccurate reporting</p>			

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	to the pager." A review of client A's record was conducted on 10/29/13 at 10:47 AM. Client A was seen at the emergency room on 5/31/13 due to a cut on the back of his				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review and interview for 4 of 54 incident/investigative reports reviewed affecting clients A and C, the facility failed to report incidents 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 10/23/13 at 1:38 PM and indicated the following:</p> <p>1) On 9/22/13 at 11:00 PM, client A was in his room moving things around when staff heard a loud crash from client A's room. The Incident Report, dated 9/22/13, indicated, in part, "I did not see this happen but I could hear it from the top of the steps and [client A] told me what just happen (sic)." The report indicated, "Pain and swelling in his right foot and big toe." The report indicated "none" in the witnesses of incident</p>	W000153	W153 Plan of Correction: Facility staff have been retrained on all aspects of incident reporting including what constitutes and incident, timelines and reporting to the state agency within 24 hours of a reportable condition. See W104 The facility has also reorganized the group home management system to include more coordinator (Q) positions in order to increase client support, staff training and supervision, facility monitoring and compliance with incident reporting and investigations. There is a new Coordinator assigned to Hite house who received training in group home regulations, incident reporting, follow up investigations and required timeframes. See attached documents labeled W 153. Date of Completion: 11/21/2013 Plan of Prevention: The facility has developed a new electronic incident reporting system to ensure that all allegations of mistreatment, abuse, neglect, and injuries of unknown source are reported immediately to the administrator or designated staff in accordance with state law. The department will arrange for staff training in	11/21/2013			

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	<p>section. On 9/23/13 at 9:00 AM, client A was taken to a local walk-in doctor's office. The Outside Services Report, dated 9/23/13, indicated, "R (right) 1st toe fracture in multiple areas of distal phalanx." The incident was not reported to BDDS.</p> <p>On 10/29/13 at 10:58 AM, the Chief Executive Officer (CEO) indicated BDDS reports should be submitted within 24 hours.</p> <p>2) On 9/19/13 at 1:30 PM (reported to BDDS on 9/23/13), client C was upset due to a phone call and he tried to contact staff to talk to at the facility-operated day program. Client C, when unable to locate staff to speak with, vacated the day program premises and began walking toward a local bookstore. He turned around and came back. Client C informed the classroom teacher and a Day Program Coordinator he had left.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated he spoke to and provided training to client C on what he could do when he was upset. The PC indicated client C did not speak to staff prior to leaving the building. The PC indicated he told client C he needed to talk to staff when he was upset and tell them he was leaving. The PC indicated</p>		<p>incident reporting and investigations from an outside expert. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA member including failure to comply with the state law regarding A/N/E reports and the QA team will recommend and monitor corrective actions.</p>				

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	<p>client C had a cellphone and there was no history of elopement.</p> <p>On 10/29/13 at 10:58 AM, the Chief Executive Officer (CEO) indicated BDDS reports should be submitted within 24 hours.</p> <p>3) On 8/17/13 at 8:30 AM (the incident was not reported to BDDS), client F received his medications from former staff #12. Staff #12 prompted client F to take a shower after the medication pass. Client F indicated he was going to go back to bed. Staff #12 indicated, per the Incident Report, dated 8/17/13, "I then explained to him that it was not a healthy choice and that his bed sheets are dirty and needed to be washed. [Client F] kept saying to me that he really needed to lay down during this time when I was trying to explain the better option. By the time he understood what I was telling him he started to get upset. When I asked him if I could help take off his sheets with him he agreed. After that, he wanted to lay on his bed without a sheet. I explained to him that his bed was still dirty along with his clothes, and he needed to take a shower so he would have clean clothes and be clean. Then he sprung up from his bed and started hitting me with pillows. I was able to get the pillows away from him. After that, he started swing (sic) his</p>			

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	<p>fists at me along with kicking me. He then connected one of his kicks on my testicles. After that, when I had the wind knocked out of me he was backing me into a corner where it was almost impossible for me to block or possibly put him into a hold so I had to push him out of my way on his back so I could leave the room. [Staff #4] walking in (sic) during the end of it and took over trying to calm [client F] down after I left. She left the room shortly after me. I also apologized for pushing him but explained there wasn't much else I could do to avoid myself being injured. He understood and was able to stay calm after. I checked where I pushed him 30 minutes later and there appeared to be no marks or bruises." The Supervisor must document action taken section indicated, "The situation has been attended to and [client F] and [staff #12] are both fine." The investigation, dated 8/29/13, indicated, in part, "The IR (incident report) was submitted as a Behavioral Incident of Client Aggression. The Support Team met to review and determined the incident was a possible client rights violation. This review is being completed to determine (sic) [client F's] rights were violated." The Finding section of the investigation indicated a client rights violation was substantiated (the findings support the event as described). [Staff #12] was the only</p>			

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	<p>person interviewed during this review. The SGL Director reported that enough information had been gathered to make a personnel decision. Through [staff #12's] description of the incident, it appears that he engaged [client F] in a power struggle. [Staff #12] reported deciding that [client F] could not take his radio in the bathroom during his shower because it was (sic) safety risk. [Client F] reportedly became upset. [Staff #12] reported following [client F] into his bedroom which appeared to increase [client F's] agitation. [Staff #12] reported prompting [client F] to change his bed sheets since he had been incontinent. He also prompted him to not lie down on the bed and to go take a shower. [Staff #12] reportedly was explaining to [client F] that is (sic) was unhealthy to be in soiled clothes and have a soiled bed. [Staff #12] reported that [client F] began hitting him with a pillow. He reported that he caught the end of the pillow and [client F] let go. He reported that [client F] began kicking at him as he backed up into the corner of the room. [Staff #12] reported that [client F] kicked him in the testicles and he doubled over. [Staff #12] reported realizing he needed to leave the area. He reported that he raised his arm to push [client F] out of the way, without looking up. He demonstrated that he intended to use his forearm to block and push [client</p>			

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	F]. He reported that his hand was closed in a fist. He reported that as he looked up, [client F] was walking away and the pinky side of his fist made contact on [client F's] back. [Staff #12] had several opportunities to disengage from [client F], walk away, and/or ask for another staff to assist [client F]... Given the limited information gathered, this incident was a client rights violation." The investigation indicated, "While enough information was gathered to make a personnel decision, this SW (Social Worker) followed the investigation procedure and finished interviewing the other people involved... None of the physical interventions described in the interviews are CPI (Crisis Prevention Institute) interventions. It appears that an unauthorized intervention was used by [staff #12] to get away from [client F] and leave the room... [Client F] reported that [staff #12] was mad during the incident. [Staff #4] reported that [staff #12] appeared angry. [Client F] reported that he was upset by the incident. [Staff #4] reported comforting [client F] after the incident. It appears that [client F] experience (sic) emotional trauma... This incident appears to meet the criteria of emotional/verbal abuse." The investigation indicated, "Stone Belt's Incident Investigation/Review Protocol states, in part, 'Within 24 hours of written				

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	<p>incident report or other notification, the director will assess and determine what type of investigation/review is to be done.' The incident happened on 8/17/13 and the investigation was requested and begun on 8/22/13. This policy was not followed. During the interview process, [staff #4] was clear that she believed the incident to be abusive. According to [former Director] interview, [staff #4] reported that [staff #12] pushed [client F] and did not indicate the incident to be an allegation of abuse...".</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated staff #12 was terminated. The PC indicated a BDDS report should have been completed and he thought there was one in the system. The PC indicated there were questions about the incident and what actually occurred and what staff #12 reported. The PC indicated staff #12 reported something different to staff, the pager staff and to the former Director. The PC indicated staff #12's story changed and his verbal report was not clear that he pushed client F. The PC indicated pushing was not a part of the CPI training staff received to implement the clients' behavior plans.</p> <p>On 10/29/13 at 10:58 AM, the Chief Executive Officer (CEO) indicated BDDS reports should be submitted within 24</p>						

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	<p>hours.</p> <p>4) On "date of incident unknown" client A reported to his behavior consultant (BC), [name of BC], that he used a knife to unscrew hinges from his door and that staff, [name of staff #13], used a physical restraint on him. He reported this to the BC on 6/13/13. This was included in the investigation, dated 6/20/13. The restraint was not reported. It was unclear how [client A] was restrained. The incident was investigated as an allegation of a client's rights violation. The Findings section indicated the incident was substantiated (the findings support the event as described). The report indicated, in part, "[Client A] refused to be interviewed for this investigation. There were several different attempts with different mental health providers. [Client A] refused each time. [Client A] was able to begin to provide some information on 6/20/13 to [name], Social Work Manager. [Client A] indicated that he had more information to share. A follow up appointment was scheduled for 6/21/13.</p> <p>Through the interview process, several different events were discovered. Some of the events required Incident Reports, per Stone Belt policy. Incident Reports were not filed and the information was not shared with the support team.</p>						

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	<p>[Client A] had four sharp kitchen knives in his bedroom. He had used the knives to dismantle his door frame, his door knob and large sections of drywall in his room which left partially exposed electrical hardware. [Client A] described being restrained while he was using the knife to dismantle his doorknob. The property destruction and the physical intervention require Incident Reports, per Stone Belt Policy. Neither were reported.</p> <p>It was reported that [staff #13] was providing sugary snacks and beverages to [client A] during the overnight hours. It was reported that [staff #13] provided M&M's to [client F] at 1:00 AM. [Client F] is diabetic and his morning reading was very high. The house nurse determined that this was not life threatened (sic) but could have caused the doctor to change [client F's] medication based on the inaccurate information. Giving clients gifts of snacks and pops does not comply with Stone Belt's 'Gift Giving Procedure.' The house manager, [staff #14] reported being aware of [staff #13] giving snacks and drinks to clients. She reported observing [staff #13] giving clients [company name] cakes one morning, as well as giving [client A] a [name of soda] one morning. This was not reported or addressed in a supervisory</p>			

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	<p>manner.</p> <p>The tool box, kept in the [name of group home] office, had its lock ripped off. [Staff #14] reported knowing the lock was removed. She reported that she did not inquire with anyone about the broken lock. She reported that the lock did not work properly and she assumed that was why someone broke the lock off. This property destruction was not reported.</p> <p>On 5/31/13, [client A] suffered a head wound. [Staff #13] reported on the Incident Report that [client A] was sitting on a loveseat, goofy (sic) around, that he fell backwards and hit his head on a weight that was sitting on the couch cushion. He reported the event happened at 1:00 AM. [Staff #13] did not call the pager until 2:00 AM. He reported to the pager that [client A] had a scratch on his head, he kept him awake for 45 minutes and that he had applied first aid. Morning staff, [staff #8], reported that she cleaned and re-bandaged the wound in the morning. She reported concern about the wound and contacted [staff #14], her supervisor. [Staff #14] reportedly told [staff #8] that she had seen the wound and did not think it was that bad. [Staff #8] reported to this interviewer that she did not see the wound until after [client A] had been examined at the hospital. Stone</p>			

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	<p>Belt Nurse Manager was notified of the head wound. She instructed that [client A] be taken for assessment. The hospital reported that it was too late to give stitches, indicating that he should have had been seen early (sic). [Staff #14] reported that she was not present at the time of the incident. [Client A] disclosed on 6/20/13, that [staff #14] was present at the time he hit his head. He reported that [staff #14] and [staff #13] were in the backyard smoking while he was on a couch on the back porch. [Staff #14] reported that she does not do pop in visits during overnight hours. [Staff #14] was not scheduled to be working at 1:00 AM that morning. [Staff #13's] report to the pager did not match the Incident Report. He did not communicate with the team or day program that [client A] had an injury to his head. He did not accurately report that [staff #14] was a witness. [Client A] did not receive medical attention in a timely manner due to lack of communication and inaccurate reporting to the pager.</p> <p>[Client A] reported that he had tried to hit [staff #13] with a belt. [Staff #14] reported that she was present during this incident. She reported that [client A] was holding the buckle and [staff #13] caught and yanked the belt from [client A's] hand. [Staff #13] reportedly said I'll give</p>			

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	<p>it back if you don't hit again, to which [client A] agreed. [Staff #14] reported telling [client A], if you hit again I'll take it away for the night and you can get it back in the morning. Yanking the belt from his hand is an inappropriate intervention. Staff would move out of the way or use a block for their own protection. The belt was put in a drawer in the office. Client's personal items are not to be restricted without HRC (Human Rights Committee) approval. The restriction is not in [client A's] BSP (Behavior Support Plan) and did not have HRC approval. There was no Incident Report or communication regarding this incident.</p> <p>It was reported by [staff #8] that [client A] has had a drastic change in his hygiene in the last month which was not reported to the support team. [Staff #14] reported that she noticed the change about two weeks ago. She did not report the change. This type of change in [client A's] behavior should have been reported to the support team. There appears to be a lack of communication by staff.</p> <p>[Staff #14] reported she did not know about a secret [client A] has been asked to keep. She then asked the interviewer if [client A] said who asked him to keep the secret. The interviewer stated that was</p>			

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	<p>not something that could be shared. Witness, [name of witness], reported [staff #14] smiled slightly at the interviewer response.</p> <p>The above summary displays a number of incidents where Stone Belt policy was not followed, Incident Reports were not written for physical restraints and property destruction, Incident Reports did not match the reports given to the pager causing a delay in [client A] receiving appropriate medical treatment in a timely manner. [Client A] was able to carry several sharp kitchen knives to his room, use them as tools to remove parts of his door and drywall as well as, store them in his bedroom with no staff intervention and no communication to the support team. These events display a pattern of neglect involving [staff #13] and [staff #14].</p> <p>[Name of LCSW], LCSW (Licensed Clinical Social Worker) met with [client A] at 10th Street building at Stone Belt on 6/20/13 in Room 17-A with [name of BC], witnessing the interview. [BC] is [client A's] behaviorist. [Client A] had been observed by [LCSW] to be anxious, and interrupting the front desk receptionist while at Stone Belt. [LCSW] talked to [name of day program Coordinator] that morning concerning</p>						

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	<p>[client A's] behavior, and [name of day program Coordinator] stated that [client A] had been highly agitated that morning and trying to get staff attention. [LCSW] was aware of the ongoing investigation related to [client A] at [name of group home], and also that [client A] had been refusing to talk to his social worker [name] LCSW, and his Behaviorist [name], while at the same time indicating that he had information he was anxious about disclosing. [LCSW] contacted [BC] to request that she offer [client A] some support as he appeared to be highly agitated at Day Program. [BC] came to Day Program to talk to [client A] and then contacted [LCSW] stating that [client A] had stated he wanted to talk to [LCSW] about some of the incidents which he had been avoiding talking to [Social Worker] and [BC]. [LCSW] agreed to meet with [client A] to let him share his concerns about these incidents. [Client A] communicates by individualized sign, vocalizations, some words and pantomiming actions.</p> <p>[Client A] indicated that he went to [name of staff], staff person at Stone Belt who handles Incident Reports. He had been asking [name of staff] and [BC], 'why staff had lied on the IR' it was not immediately clear which IR he was referring to. I asked [client A] to tell me</p>			

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	<p>about some of the incidents which had happened recently, which he had not talked to [SW] about. [Client A] related the first incident as being one where he was 'picking at' staff [#13] with his fingers and [staff #13] told [client A] to 'give his space.' [Client A] showed how he had put his foot up on [staff #13's] leg and [client A] stated that [staff #13] put him in a hold following this. [Client A] then related an incident in which he had hit [staff #13] with his belt and [staff #13] took the belt away from [client A], and put the belt in his pocket. [Client A] then talked about concerns about his having incontinence of urine both at Day Program and on his community job. He kept asking 'why' and [LCSW] told [client A] there could be a few reasons 'why' a person would have urinary accidents: 1) Being anxious and 'forgetting to go to the bathroom and having an accident.' 2) Having a urinary tract infection, where there is pain and a person doesn't know that they have to go. 3) Someone has touched them on their privates or done something to their private that is worrying them or making them uncomfortable. [Client A] was asking about the mosquito bite that had been found on his penis earlier in the week, and asking about 'why' and 'why the Doctor had given him medicine for it.' I explained that the Doctor thought it was a</p>			

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	<p>bug bite, and that he had [client A] get some medicine so it wouldn't be uncomfortable. I asked [client A] if anyone had touched his penis and he said 'no.' I asked [client A] if he was worried about something, and he indicated he was. I asked [client A] if he was having pain in his penis and he said 'no.' [BC] stated that [client A] had told her earlier that he had urinated in a plastic tote in his room, and this was not like [client A]. [Client A] pantomimed this. When I asked him why he had urinated in the tote, or if anyone had him urinate in a container, he said 'no' and 'shrugged his shoulder's (sic) to say he did not know or remember.' [Client A] then pantomimed elaborately about his taking a knife to the door on his bedroom, cutting around the door, cutting around the door knob, door frame, and cutting into the ceiling tiles in his room. He indicated he thought what he had done 'was bad.' I asked him why he had taken the knife to his door, and along the wall, door knob and door frame. He indicated that he could not find the key to open his door, and he wanted to get into his room. He indicated that the key is kept in the office, but that it was lost so he couldn't get into his room. I asked him if he had damaged his door when he was trying to get it open. He pantomimed opening and shutting the door many times which caused damage to the door. He</p>			

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	<p>pantomimed about trying to get into the office to find the key. [Client A] indicated that his staff [staff #13] was there in the office, and that the house manager [staff #14] was also at the house in the office when he was trying to get into the office. [Client A] stated he kept opening and shutting the door. I asked [client A] if he felt better after talking about these incidents. He nodded and looked happy about talking about these issues. I asked if he would come to talk with me again the next day at my office to tell me about anything else that is worrying him, so that he can be calmer. He agreed to come back to meet with me and [BC] the next day, for counseling to allow him to vent his concerns about issues he was suppressing. He seemed to be most concerned about IR's not being written about the events he was describing, staff 'lying (sic) on IR's,' and events around urinary incontinence, using a knife to break into or out of his room, and struggling to get or find a key to his room in the office. These were events that had not been documented in IR's, or Forum's (communication between staff) and his team was not aware of what or how these events had transpired."</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client A gave him two knives from client A's bedroom.</p>						

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	<p>Client A indicated to the PC he had been restrained by staff. There was an investigation which determined client A had been restrained by staff and it was not reported to administrative staff. The PC indicated the former House Manager (#14) was complicit on not reporting the restraint and another incident in which client A hit his head. The PC indicated it was determined the HM was present but did not report to the pager staff (on-call). The PC indicated staff #13 reported the incident to the pager but not accurately. The PC indicated client A received first aid but needed additional medical treatment. The PC indicated client A needed sutures but the doctor wrote it was too late for sutures. The PC indicated the HM and staff #13 were terminated.</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 observation, record review and interview for 4 of 54 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to thoroughly investigate an injury of unknown origin, elopement and client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/23/13 at 1:38 PM and indicated the following:</p> <p>1) On 9/22/13 at 11:00 PM, client A was in his room moving things around when staff heard a loud crash from client A's room. The Incident Report, dated 9/22/13, indicated, in part, "I did not see this happen but I could hear it from the top of the steps and [client A] told me what just happen (sic)." The report indicated, "Pain and swelling in his right foot and big toe." The report indicated "none" in the witnesses of incident section. On 9/23/13 at 9:00 AM, client A was taken to a local walk-in doctor's office. The Outside Services Report, dated 9/23/13, indicated, "R (right) 1st toe</p>	W000154	<p>W154 Plan of Correction: Facility coordinator was trained on all aspects of incident reporting, including the need to follow up on injuries of unknown origin, client elopement, and client to client aggression. See attachment labeled W153. Date of Completion: 11/21/2013 Plan of Prevention: The facility has developed a new electronic incident reporting system to ensure that all allegations of mistreatment, abuse, neglect, and injuries of unknown source, elopement are reported immediately to the administrator or designated staff in accordance with state law. The department will arrange for staff training in incident reporting and investigations from an outside expert. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA member including failure to do follow up investigations on allegations of A/N/E, injuries of unknown origin, and client elopement and the QA team will recommend and monitor corrective actions.</p>	11/21/2013	

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	<p>fracture in multiple areas of distal phalanx." There was no investigation of the incident as an injury of unknown origin.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated an investigation was not conducted. The PC indicated the staff heard the loud noise and went to see what happened. The staff indicated client A told him what happened therefore the incident and subsequent injury was not unknown.</p> <p>2) On 9/19/13 at 1:30 PM (reported to BDDS on 9/23/13), client C was upset due to a phone call and he tried to contact staff to talk to at the facility-operated day program. Client C, when unable to locate staff to speak with, vacated the day program premises and began walking toward a local bookstore. He turned around and came back. Client C informed the classroom teacher and a Day Program Coordinator he had left. There was no investigation of the incident.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated he spoke to and provided training to client C on what he could do when he was upset. The PC indicated client C did not speak to staff prior to leaving the building. The PC indicated he told client C he needed to</p>						

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	<p>talk to staff when he was upset and tell them he was leaving. The PC indicated client C had a cellphone and there was no history of elopement. The PC indicated he was not aware of an investigation being conducted. The PC indicated an investigation should have been conducted.</p> <p>3) On 8/18/13 at 10:00 PM, client A hit client C's hands causing client C to spill his snack. The BDDS report, dated 8/19/13, indicated, in part, "Reaching past staff, [client C] pushed [client A] back, causing him to stumble several steps back and fall through a glass window. At this time staff jumped down through the window to make sure [client A] was ok, at which point it was discovered that [client A] had cut his elbow on some of the broken glass... [Client A] was admitted to [name of hospital] at 11:00 PM. While there he received three stitches on his left elbow, and two stitches on his right thumb." The Social Work Notes, undated and not signed by the Director, did not indicate when the facility completed the investigation. The investigation included interviews with staff conducted on 8/29/13.</p> <p>The Social Work Notes indicated, in part, "SW (Social Worker) met with [client C] to process the incident between him and [client A]. [Client C] reported that [client</p>				

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	<p>A] had hit him in the face, early that day. He reported that he had gotten a snack from the kitchen and was walking back to his room. [Client C] reported that [client A] had gotten all the way around his 1:1 staff. He reported that [client A] knocked his snack out of his hand and punched him in the face twice. [Client C] reported that staff got in between them again. He reported that he got all the way around the staff, grabbed [client A] with both hands by the collar of his shirt, swung him around 180 degrees and tossed him out the window. [Client C] reported that he (sic) [client A] got what he deserved. He reported that the police came and took his information. He reported that the police officers told him that it was self defense. [Client C] was not opening (sic) to listening (sic) SW explain definition of self defense. He was no longer interested in discussing the issue." The investigation did not include a conclusion for this incident.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client A went out the window by the kitchen in the living room near the dining room. The PC indicated client A was pushed even though staff was in between the clients. The PC indicated client A fell through the glass pane. The PC indicated client C typically only targeted client A after client</p>						

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	<p>A was doing something to provoke client C. The PC indicated there have been no incidents in which client C was physically aggressive toward client A without client A first provoking client C.</p> <p>4) On "date of incident unknown" client A reported to his behavior consultant (BC), [name of BC], that he used a knife to unscrew hinges from his door and that staff, [name of staff #13], used a physical restraint on him. He reported this to the BC on 6/13/13. This was included in the investigation, dated 6/20/13. The investigation indicated, "The restraint was not reported. It was unclear how [client A] was restrained. The incident was being investigated as an allegation of a client's rights violation." The Findings section indicated the incident was substantiated (the findings support the event as described). The report indicated, in part, "[Client A] refused to be interviewed for this investigation. There were several different attempts with different mental health providers. [Client A] refused each time. [Client A] was able to begin to provide some information on 6/20/13 to [name], Social Work Manager. [Client A] indicated that he had more information to share. A follow up appointment was scheduled for 6/21/13.</p> <p>Through the interview process, several</p>						

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	<p>different events were discovered. Some of the events required Incident Reports, per Stone Belt policy. Incident Reports were not filed and the information was not shared with the support team.</p> <p>[Client A] had four sharp kitchen knives in his bedroom. He had used the knives to dismantle his door frame, his door knob and large sections of drywall in his room which left partially exposed electrical hardware. [Client A] described being restrained while he was using the knife to dismantle his doorknob. The property destruction and the physical intervention require Incident Reports, per Stone Belt Policy. Neither were reported.</p> <p>It was reported that [staff #13] was providing sugary snacks and beverages to [client A] during the overnight hours. It was reported that [staff #13] provided M&M's to [client F] at 1:00 AM. [Client F] is diabetic and his morning reading was very high. The house nurse determined that this was not life threatened (sic) but could have caused the doctor to change [client F's] medication based on the inaccurate information. Giving clients gifts of snacks and pops does not comply with Stone Belt's 'Gift Giving Procedure.' The house manager, [staff #14] reported being aware of [staff #13] giving snacks and drinks to clients.</p>				

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	<p>She reported observing [staff #13] giving clients [company name] cakes one morning, as well as giving [client A] a [name of soda] one morning. This was not reported or addressed in a supervisory manner.</p> <p>The tool box, kept in the [name of group home] office, had its lock ripped off. [Staff #14] reported knowing the lock was removed. She reported that she did not inquire with anyone about the broken lock. She reported that the lock did not work properly and she assumed that was why someone broke the lock off. This property destruction was not reported.</p> <p>On 5/31/13, [client A] suffered a head wound. [Staff #13] reported on the Incident Report that [client A] was sitting on a loveseat, goofy (sic) around, that he fell backwards and hit his head on a weight that was sitting on the couch cushion. He reported the event happened at 1:00 AM. [Staff #13] did not call the pager until 2:00 AM. He reported to the pager that [client A] had a scratch on his head, he kept him awake for 45 minutes and that he had applied first aid. Morning staff, [staff #8], reported that she cleaned and re-banded the wound in the morning. She reported concern about the wound and contacted [staff #14], her supervisor. [Staff #14] reportedly told</p>				

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	<p>[staff #8] that she had seen the wound and did not think it was that bad. [Staff #8] reported to this interviewer that she did not see the wound until after [client A] had been examined at the hospital. Stone Belt Nurse Manager was notified of the head wound. She instructed that [client A] be taken for assessment. The hospital reported that it was too late to give stitches, indicating that he should have had been seen early (sic). [Staff #14] reported that she was not present at the time of the incident. [Client A] disclosed on 6/20/13, that [staff #14] was present at the time he hit his head. He reported that [staff #14] and [staff #13] were in the backyard smoking while he was on a couch on the back porch. [Staff #14] reported that she does not do pop in visits during overnight hours. [Staff #14] was not scheduled to be working at 1:00 AM that morning. [Staff #13's] report to the pager did not match the Incident Report. He did not communicate with the team or day program that [client A] had an injury to his head. He did not accurately report that [staff #14] was a witness. [Client A] did not receive medical attention in a timely manner due to lack of communication and inaccurate reporting to the pager.</p> <p>[Client A] reported that he had tried to hit [staff #13] with a belt. [Staff #14]</p>						

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	<p>reported that she was present during this incident. She reported that [client A] was holding the buckle and [staff #13] caught and yanked the belt from [client A's] hand. [Staff #13] reportedly said I'll give it back if you don't hit again, to which [client A] agreed. [Staff #14] reported telling [client A], if you hit again I'll take it away for the night and you can get it back in the morning. Yanking the belt from his hand is an inappropriate intervention. Staff would move out of the way or use a block for their own protection. The belt was put in a drawer in the office. Client's personal items are not to be restricted without HRC (Human Rights Committee) approval. The restriction is not in [client A's] BSP (Behavior Support Plan) and did not have HRC approval. There was no Incident Report or communication regarding this incident.</p> <p>It was reported by [staff #8] that [client A] has had a drastic change in his hygiene in the last month which was not reported to the support team. [Staff #14] reported that she noticed the change about two weeks ago. She did not report the change. This type of change in [client A's] behavior should have been reported to the support team. There appears to be a lack of communication by staff.</p>						

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	<p>[Staff #14] reported she did not know about a secret [client A] has been asked to keep. She then asked the interviewer if [client A] said who asked him to keep the secret. The interviewer stated that was not something that could be shared. Witness, [name of witness], reported [staff #14] smiled slightly at the interviewer response.</p> <p>The above summary displays a number of incidents where Stone Belt policy was not followed, Incident Reports were not written for physical restraints and property destruction, Incident Reports did not match the reports given to the pager causing a delay in [client A] receiving appropriate medical treatment in a timely manner. [Client A] was able to carry several sharp kitchen knives to his room, use them as tools to remove parts of his door and drywall as well as, store them in his bedroom with no staff intervention and no communication to the support team. These events display a pattern of neglect involving [staff #13] and [staff #14].</p> <p>[Name of LCSW], LCSW (Licensed Clinical Social Worker) met with [client A] at 10th street building at Stone Belt on 6/20/13 in Room 17-A with [name of BC], witnessing the interview. [BC] is [client A's] behaviorist. [Client A] had</p>						

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	<p>been observed by [LCSW] to be anxious, and interrupting the front desk receptionist while at Stone Belt. [LCSW] talked to [name of day program Coordinator] that morning concerning [client A's] behavior, and [name of day program Coordinator] stated that [client A] had been highly agitated that morning and trying to get staff attention. [LCSW] was aware of the ongoing investigation related to [client A] at [name of group home], and also that [client A] had been refusing to talk to his social worker [name] LCSW, and his Behaviorist [name], while at the same time indicating that he had information he was anxious about disclosing. [LCSW] contacted [BC] to request that she offer [client A] some support as he appeared to be highly agitated at Day Program. [BC] came to Day Program to talk to [client A] and then contacted [LCSW] stating that [client A] had stated he wanted to talk to [LCSW] about some of the incidents which he had been avoiding talking to [Social Worker] and [BC]. [LCSW] agreed to meet with [client A] to let him share his concerns about these incidents. [Client A] communicates by individualized sign, vocalizations, some words and pantomiming actions.</p> <p>[Client A] indicated that he went to [name of staff], staff person at Stone Belt who</p>			

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	handles Incident Reports. He had been asking [name of staff] and [BC], 'why staff had lied on the IR' it was not immediately clear which IR he was referring to. I asked [client A] to tell me about some of the incidents which had happened recently, which he had not talked to [SW] about. [Client A] related the first incident as being one where he was 'picking at' staff [#13] with his fingers and [staff #13] told [client A] to 'give his space.' [Client A] showed how he had put his foot up on [staff #13's] leg and [client A] stated that [staff #13] put him in a hold following this. [Client A] then related an incident in which he had hit [staff #13] with his belt and [staff #13] took the belt away from [client A], and put the belt in his pocket. [Client A] then talked about concerns about his having incontinence of urine both at Day Program and on his community job. He kept asking 'why' and [LCSW] told [client A] there could be a few reasons 'why' a person would have urinary accidents: 1) Being anxious and 'forgetting to go to the bathroom and having an accident.' 2) Having a urinary tract infection, where there is pain and a person doesn't know that they have to go. 3) Someone has touched them on their privates or done something to their private that is worrying them or making them uncomfortable. [Client A] was			

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	<p>asking about the mosquito bite that had been found on his penis earlier in the week, and asking about 'why' and 'why the Doctor had given him medicine for it.' I explained that the Doctor thought it was a bug bite, and that he had [client A] get some medicine so it wouldn't be uncomfortable. I asked [client A] if anyone had touched his penis and he said 'no.' I asked [client A] if he was worried about something, and he indicated he was. I asked [client A] if he was having pain in his penis and he said 'no.' [BC] stated that [client A] had told her earlier that he had urinated in a plastic tote in his room, and this was not like [client A]. [Client A] pantomimed this. When I asked him why he had urinated in the tote, or if anyone had him urinate in a container, he said 'no' and 'shrugged his shoulder's (sic) to say he did not know or remember.' [Client A] then pantomimed elaborately about his taking a knife to the door on his bedroom, cutting around the door, cutting around the door knob, door frame, and cutting into the ceiling tiles in his room. He indicated he thought what he had done 'was bad.' I asked him why he had taken the knife to his door, and along the wall, door knob and door frame. He indicated that he could not find the key to open his door, and he wanted to get into his room. He indicated that the key is kept in the office, but that it was lost so he couldn't</p>						

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	<p>get into his room. I asked him if he had damaged his door when he was trying to get it open. He pantomimed opening and shutting the door many times which caused damage to the door. He pantomimed about trying to get into the office to find the key. [Client A] indicated that his staff [staff #13] was there in the office, and that the house manager [staff #14] was also at the house in the office when he was trying to get into the office. [Client A] stated he kept opening and shutting the door. I asked [client A] if he felt better after talking about these incidents. He nodded and looked happy about talking about these issues. I asked if he would come to talk with me again the next day at my office to tell me about anything else that is worrying him, so that he can be calmer. He agreed to come back to meet with me and [BC] the next day, for counseling to allow him to vent his concerns about issues he was suppressing. He seemed to be most concerned about IR's not being written about the events he was describing, staff 'lying (sic) on IR's,' and events around urinary incontinence, using a knife to break into or out of his room, and struggling to get or find a key to his room in the office. These were events that had not been documented in IR's, or Forum's (communication between staff) and his team was not aware of what or how these</p>			

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	<p>events had transpired."</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client A gave him two knives from client A's bedroom. Client A indicated to the PC he had been restrained by staff. There was an investigation which determined client A had been restrained by staff and it was not reported to administrative staff. The PC indicated the former House Manager (#14) was complicit on not reporting the restraint and another incident in which client A hit his head. The PC indicated it was determined the HM was present but did not report to the pager staff (on-call). The PC indicated staff #13 reported the incident to the pager but not accurately. The PC indicated client A received first aid but needed additional medical treatment. The PC indicated client A needed sutures but the doctor wrote it was too late for sutures. The PC indicated the HM and staff #13 were terminated.</p> <p>9-3-2(a)</p>						

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W000155	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 3 of 54 incident/investigative reports reviewed affecting clients A, C and F, the facility failed to prevent potential abuse while the investigation was in progress.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/23/13 at 1:38 PM and indicated the following:</p> <p>1) On 8/17/13 at 8:30 AM (the incident was not reported to BDDS), client F received his medications from former staff #12. Staff #12 prompted client F to take a shower after the medication pass. Client F indicated he was going to go back to bed. Staff #12 indicated, per the Incident Report, dated 8/17/13, "I then explained to him that it was not a healthy choice and that his bed sheets are dirty and needed to be washed. [Client F] kept saying to me that he really needed to lay down during this time when I was trying to explain the better option. By the time he understood what I was telling him he started to get upset. When I asked him if I could help take off his sheets with him he agreed. After that, he wanted to lay on</p>	W000155	<p>W155 Plan of Correction: The SGL Director who did not follow state regulations and agency policies to immediately suspend staff #12 (who had previously been involved in a substantiated allegation of client abuse in May 2013) upon a second known allegation of client abuse, has been terminated. A new SGL Director was hired start date effective 11/18/2013. The new SGL Director is a Licensed Clinical Social Worker who is knowledgeable of the state and agency client protection laws and policies. In addition, a new facility coordinator has been hired and trained on all aspects of incident reporting, including the need to take measures to protect clients including immediate staff suspension. See attachment labeled W153. Date of Completion: 11/21/2013 Plan of Prevention: All facility staff and administrative staff have been trained on incident reporting procedures, including the directive to report suspected A/N/E immediately to a supervisor, to the pager, to the agency's/state's hotline. As an added measure the agency has an anonymous reporting system. All agency staff have been trained on the directive to ensure client safety immediately, and</p>	11/21/2013			

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	<p>his bed without a sheet. I explained to him that his bed was still dirty along with his clothes, and he needed to take a shower so he would have clean clothes and be clean. Then he sprung up from his bed and started hitting me with pillows. I was able to get the pillows away from him. After that, he started swing (sic) his fists at me along with kicking me. He then connected one of his kicks on my testicles. After that, when I had the wind knocked out of me he was backing me into a corner where it was almost impossible for me to block or possibly put him into a hold so I had to push him out of my way on his back so I could leave the room. [Staff #4] walking in (sic) during the end of it and took over trying to calm [client F] down after I left. She left the room shortly after me. I also apologized for pushing him but explained there wasn't much else I could do to avoid myself being injured. He understood and was able to stay calm after. I checked where I pushed him 30 minutes later and there appeared to be no marks or bruises." The Supervisor must document action taken section indicated, "The situation has been attended to and [client F] and [staff #12] are both fine." The investigation, dated 8/29/13, indicated, in part, "The IR (incident report) was submitted as a Behavioral Incident of Client Aggression. The Support Team met to review and</p>		<p>supervisors have been trained to suspend staff pending the outcome of an investigation. The department will arrange for staff training in incident reporting and investigations from an outside expert. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all investigations of A/N/E by a third party QA member to the team. The agency's investigation procedure allows the investigator to sort any/all incident reports in the IR tracking system by staff to determine if there are prior allegations of A/N/E. The investigation procedure also allows the investigator to review pertinent warnings or disciplinary measures in the personnel file. The QA members reviewing A/N/E reports also have access to these systems and reports during their review of completed investigations. It is the responsibility of the third party QA member to raise any/all questions about procedures and decisions, including personnel decisions. The QA team will recommend and monitor corrective actions.</p>				

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	determined the incident was a possible client rights violation. This review is being completed to determine (sic) [client F's] rights were violated." The Finding section of the investigation indicated a client rights violation was substantiated (the findings support the event as described). [Staff #12] was the only person interviewed during this review. The SGL Director reported that enough information had been gathered to make a personnel decision. Through [staff #12's] description of the incident, it appears that he engaged [client F] in a power struggle. [Staff #12] reported deciding that [client F] could not take his radio in the bathroom during his shower because it was (sic) safety risk. [Client F] reportedly became upset. [Staff #12] reported following [client F] into his bedroom which appeared to increase [client F's] agitation. [Staff #12] reported prompting [client F] to change his bed sheets since he had been incontinent. He also prompted him to not lie down on the bed and to go take a shower. [Staff #12] reportedly was explaining to [client F] that is (sic) was unhealthy to be in soiled clothes and have a soiled bed. [Staff #12] reported that [client F] began hitting him with a pillow. He reported that he caught the end of the pillow and [client F] let go. He reported that [client F] began kicking at him as he backed up into the corner of						

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	<p>the room. [Staff #12] reported that [client F] kicked him in the testicles and he doubled over. [Staff #12] reported realizing he needed to leave the area. He reported that he raised his arm to push [client F] out of the way, without looking up. He demonstrated that he intended to use his forearm to block and push [client F]. He reported that his hand was closed in a fist. He reported that as he looked up, [client F] was walking away and the pinky side of his fist made contact on [client F's] back. [Staff #12] had several opportunities to disengage from [client F], walk away, and/or ask for another staff to assist [client F]... Given the limited information gathered, this incident was a client rights violation." The investigation indicated, "While enough information was gathered to make a personnel decision, this SW (Social Worker) followed the investigation procedure and finished interviewing the other people involved... None of the physical interventions described in the interviews are CPI (Crisis Prevention Institute) interventions. It appears that an unauthorized intervention was used by [staff #12] to get away from [client F] and leave the room... [Client F] reported that [staff #12] was mad during the incident. [Staff #4] reported that [staff #12] appeared angry. [Client F] reported that he was upset by the incident. [Staff #4]</p>						

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	<p>reported comforting [client F] after the incident. It appears that [client F] experience (sic) emotional trauma... This incident appears to meet the criteria of emotional/verbal abuse." The investigation indicated, "Stone Belt's Incident Investigation/Review Protocol states, in part, 'Within 24 hours of written incident report or other notification, the director will assess and determine what type of investigation/review is to be done.' The incident happened on 8/17/13 and the investigation was requested and begun on 8/22/13. This policy was not followed. During the interview process, [staff #4] was clear that she believed the incident to be abusive. According to [former Director] interview, [staff #4] reported that [staff #12] pushed [client F] and did not indicate the incident to be an allegation of abuse..."</p> <p>A review of staff #12's employee file was conducted on 10/29/13 at 2:39 PM. Staff #12 was terminated on 8/23/13. The Employee Warning discharge documentation indicated, in part, "On Saturday, August 17th, an incident occurred at [name of group home] between client and [staff #12]. Following a review of the incident it was determined that there was a Client Rights violation. As per Stone Belt Rights policy, the client can choose and refuse treatment,</p>			

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	<p>intervention and services. When the client refused to follow direction from [staff #12], [staff #12] should have stepped away from the situation. This led to physical contact between both parties. Second serious incident in the past 4 months, with the other occurring on 5/4/2013. Staff terminated on 8/23/13." There was no documentation staff #12 was suspended during the investigation. Staff #12 worked at the group home on 8/17/13 from 6:00 AM to 9:38 PM, 8/18/13 from 6:37 AM to 11:59 PM, 8/19/13 from 12:01 AM to 2:34 AM, and 8/19/13 from 7:38 AM to 11:42 AM. On 5/4/13, staff #12 received his first written warning. The issue noted indicated, "Allegation of abuse was substantiated by investigation regarding the interaction between client at [name of a different group home] and [staff #12]. This included verbal and physical abuse as the staff was trying to get client to shower after soiling himself. Staff reported allegation himself. He is getting assistance through Employee Assistance Program. Has been removed as manager at [name of different group home] and will be reassigned. Staff was suspended during investigation. Due to the incident, staff cannot visit house when particular client is home. Any further issues of this nature can lead to further disciplinary action, up to and including termination."</p>			

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	<p>On 8/5/13, staff #12 received a written warning for visiting the group home without authorization. The warning indicated, "[Staff #12] does not have permission to visit [name of group home] nor have contact with two specific clients [clients' initials]. Future visits will result in further disciplinary action up to and including termination."</p> <p>An interview with the Human Resources Director (HRD) was conducted on 10/30/13 at 11:59 AM. The HRD indicated she reviewed staff #12's employee record and indicated there was no documentation staff #12 was suspended at anytime in August 2013 prior to being terminated. The HRD indicated staff #12 should have been suspended during the investigation.</p> <p>2) On 8/18/13 at 5:30 PM, client A entered the front door causing the door to hit client C. Client C reacted by pushing client A to the floor. Client C hit client A once in the face.</p> <p>The Social Work Notes, undated and not signed by the Director or the Social Worker, did not indicate when the facility completed the review. The review included interviews with staff conducted on 8/29/13. The notes Conclusion indicated, in part, "[Client A's] plan calls</p>						

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	<p>for 1:1 (one on one) staffing. [Client A] had followed [staff #12] outside. [Staff #12] reportedly was trying to enter the house through the garage and wanting [client A] to follow him. This did not happen. [Client A] entered the front door quickly, hitting [client C] with the door. [Client C] then tackled and hit [client A]. [Staff #4] was reportedly in the kitchen and unaware that [client A] was not with his 1:1. During this altercation with [client C], [client A] did not have adequate supervision, as written in his plan. This is (sic) meets criteria for neglect."</p> <p>An interview with the Human Resources Director (HRD) was conducted on 10/30/13 at 11:59 AM. The HRD indicated she reviewed staff #12's employee record and indicated there was no documentation staff #12 was suspended at anytime in August 2013 prior to being terminated. The HRD indicated staff #12 should have been suspended.</p> <p>On 10/30/13 at 9:45 AM, the Social Worker (SW) indicated she reviewed the incidents on 8/18/13 informally. The SW indicated she was not instructed or directed to investigate the incidents. The SW indicated the support team met and decided it needed further review. The</p>						

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	<p>SW indicated she spoke to the former Director who indicated documentation on the support team note would be fine. The SW indicated the former Director knew the action he was going to take with staff #12. The SW indicated the former Director was going to terminate staff #12. The SW indicated she sent her notes to the CEO and her supervisor. The SW indicated the CEO requested additional information but it was not a formal investigation. The SW indicated she thought staff #12 was suspended.</p> <p>3) On 8/18/13 at 10:00 PM, client A hit client C's hands causing client C to spill his snack. The BDDS report, dated 8/19/13, indicated, in part, "Reaching past staff, [client C] pushed [client A] back, causing him to stumble several steps back and fall through a glass window. At this time staff jumped down through the window to make sure [client A] was ok, at which point it was discovered that [client A] had cut his elbow on some of the broken glass... [Client A] was admitted to [name of hospital] at 11:00 PM. While there he received three stitches on his left elbow, and two stitches on his right thumb." The Social Work Notes, undated and not signed by the Director, did not indicate when the facility completed the investigation. The investigation included interviews with</p>						

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	<p>staff conducted on 8/29/13. The Incident Report, dated 8/18/13, indicated in the action taken section, "The support team met on 8/20/13 to discuss a plan for staff training and client development." A review of the Support Team Review Form, dated 8/20/13, was conducted on 10/29/13 at 1:38 PM. The form indicated, in part, "Discussed the incident reports from the past weekend (17 & (and) 18 August). Reviewed BSPs and strategies, as well as the dynamics between staff and [client A]. Coordinator will meet with both staff members. The Team shared concerns about a particular staff and his involvement in these incidents. The Social Worker will write an IR (incident report) for a client rights violation if after discussing with the Director, the Director and Social Worker deem it necessary. Staff will be trained on [client A's] calming techniques (learned in therapy). Client Rights training for the [name of group home] gentlemen will be scheduled." There was no corrective action to address the supervision and protection of client A. There was no documentation the staff and the clients received training provided in the training documentation.</p> <p>The Social Work Notes indicated, in part, "SW (Social Worker) met with [client C] to process the incident between him and</p>						

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	<p>[client A]. [Client C] reported that [client A] had hit him in the face, early that day. He reported that he had gotten a snack from the kitchen and was walking back to his room. [Client C] reported that [client A] had gotten all the way around his 1:1 staff. He reported that [client A] knocked his snack out of his hand and punched him in the face twice. [Client C] reported that staff got in between them again. He reported that he got all the way around the staff, grabbed [client A] with both hands by the collar of his shirt, swung him around 180 degrees and tossed him out the window. [Client C] reported that he (sic) [client A] got what he deserved. He reported that the police came and took his information. He reported that the police officers told him that it was self defense. [Client C] was not opening (sic) to listening (sic) SW explain definition of self defense. He was no longer interested in discussing the issue."</p> <p>On 10/30/13 at 9:45 AM, the Social Worker (SW) indicated staff #12 was terminated. The SW indicated staff #12 was not doing his job appropriately. The SW indicated when she spoke to client C, she was concerned about his version of the incident. The SW indicated client A's version of the incident matched the incident report and staff interviews. The SW stated she thought client C was trying</p>						

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	to be "bravado" during her interview with him. The SW indicated client C's story changed regarding the incident of client A going out the window. 9-3-2(a)			

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W000156	<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 observation, record review and interview for 3 of 5 investigations reviewed affecting clients B, C and F, the facility failed to report results of all investigations to the administrator or designated representative or other officials in accordance with State law complete investigations within 5 working days.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/23/13 at 1:38 PM and indicated the following:</p> <p>1) On 9/27/13 at 8:50 PM, client C was in the medication area preparing to take his medications. Client B entered the room and tried to talk to client C. Staff #3 heard client C say "Stop talking to me" in a tone that was like talking through his teeth. Staff #3 turned around and observed client C was holding onto client B's face with both hands. Client C stated, "Stop talking to me" and pushed client B to the floor. Client B hit his back on the</p>	W000156	<p>W156 Plan of Correction: Facility staff have been retrained on all aspects of incident reporting including what constitutes and incident, notifying supervisors and/or on-call personnel of allegations of A/N/E or other incidents of immediate jeopardy, and reporting to the state agency within 24 hours of a reportable condition. See W104 The facility has also hired a new SGL Director who is a Licensed Clinical Social Worker knowledgeable of the state and agency client protection laws and policies including to complete investigations within 5 days. There is a new Coordinator assigned to Hite house who received training in group home regulations, incident reporting, follow up investigations and required timeframes. See attached documents labeled W 153. Date of Completion: 11/21/2013 Plan of Prevention: The facility has developed a new electronic incident reporting system to ensure that all allegations of mistreatment, abuse, neglect, and injuries of unknown source are reported immediately to the administrator or designated staff in accordance</p>	11/21/2013

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	<p>filing cabinet. On 10/29/13 at 1:01 PM, the facility provided documentation the incident was investigated.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated an inquiry (investigation) was conducted but it was in the interim Director's mailbox for her to review. The PC indicated the inquiry took longer than 5 working days to contact the weekend overnight staff. The PC indicated the inquiry was not completed within 5 working days which was the timeframe for completing investigations.</p> <p>2) On 8/17/13 at 8:30 AM, client F received his medications from former staff #12. Staff #12 prompted client F to take a shower after the medication pass. Client F indicated he was going to go back to bed. Staff #12 indicated, per the Incident Report, dated 8/17/13, "I then explained to him that it was not a healthy choice and that his bed sheets are dirty and needed to be washed. [Client F] kept saying to me that he really needed to lay down during this time when I was trying to explain the better option. By the time he understood what I was telling him he started to get upset. When I asked him if I could help take off his sheets with him he agreed. After that, he wanted to lay on his bed without a sheet. I explained to</p>		<p>with state law. This enables the director to quickly assess the need for follow up investigations and monitor the timelines.</p> <p>Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA member including failure to comply with the state law regarding completing investigations within 5 days and the QA team will recommend and monitor corrective actions. The department will arrange for staff training in incident reporting and investigations from an outside expert.</p>		

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	<p>him that his bed was still dirty along with his clothes, and he needed to take a shower so he would have clean clothes and be clean. Then he sprung up from his bed and started hitting me with pillows. I was able to get the pillows away from him. After that, he started swing (sic) his fists at me along with kicking me. He then connected one of his kicks on my testicles. After that, when I had the wind knocked out of me he was backing me into a corner where it was almost impossible for me to block or possibly put him into a hold so I had to push him out of my way on his back so I could leave the room. [Staff #4] walking in (sic) during the end of it and took over trying to calm [client F] down after I left. She left the room shortly after me. I also apologized for pushing him but explained there wasn't much else I could do to avoid myself being injured. He understood and was able to stay calm after. I checked where I pushed him 30 minutes later and there appeared to be no marks or bruises." The Supervisor must document action taken section indicated, "The situation has been attended to and [client F] and [staff #12] are both fine." The investigation, dated 8/29/13, indicated, in part, "The IR (incident report) was submitted as a Behavioral Incident of Client Aggression. The Support Team met to review and determined the incident was a possible</p>						

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	<p>client rights violation. This review is being completed to determine (sic) [client F's] rights were violated." The Finding section of the investigation indicated a client rights violation was substantiated (the findings support the event as described). [Staff #12] was the only person interviewed during this review. The SGL Director reported that enough information had been gathered to make a personnel decision. Through [staff #12's] description of the incident, it appears that he engaged [client F] in a power struggle. [Staff #12] reported deciding that [client F] could not take his radio in the bathroom during his shower because it was (sic) safety risk. [Client F] reportedly became upset. [Staff #12] reported following [client F] into his bedroom which appeared to increase [client F's] agitation. [Staff #12] reported prompting [client F] to change his bed sheets since he had been incontinent. He also prompted him to not lie down on the bed and to go take a shower. [Staff #12] reportedly was explaining to [client F] that is (sic) was unhealthy to be in soiled clothes and have a soiled bed. [Staff #12] reported that [client F] began hitting him with a pillow. He reported that he caught the end of the pillow and [client F] let go. He reported that [client F] began kicking at him as he backed up into the corner of the room. [Staff #12] reported that [client</p>			

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	F] kicked him in the testicles and he doubled over. [Staff #12] reported realizing he needed to leave the area. He reported that he raised his arm to push [client F] out of the way, without looking up. He demonstrated that he intended to use his forearm to block and push [client F]. He reported that his hand was closed in a fist. He reported that as he looked up, [client F] was walking away and the pinky side of his fist made contact on [client F's] back. [Staff #12] had several opportunities to disengage from [client F], walk away, and/or ask for another staff to assist [client F]... Given the limited information gathered, this incident was a client rights violation." The investigation indicated, "While enough information was gathered to make a personnel decision, this SW (Social Worker) followed the investigation procedure and finished interviewing the other people involved... None of the physical interventions described in the interviews are CPI (Crisis Prevention Institute) interventions. It appears that an unauthorized intervention was used by [staff #12] to get away from [client F] and leave the room... [Client F] reported that [staff #12] was mad during the incident. [Staff #4] reported that [staff #12] appeared angry. [Client F] reported that he was upset by the incident. [Staff #4] reported comforting [client F] after the			
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	<p>incident. It appears that [client F] experience (sic) emotional trauma... This incident appears to meet the criteria of emotional/verbal abuse." The investigation indicated, "Stone Belt's Incident Investigation/Review Protocol states, in part, 'Within 24 hours of written incident report or other notification, the director will assess and determine what type of investigation/review is to be done.' The incident happened on 8/17/13 and the investigation was requested and begun on 8/22/13. This policy was not followed. During the interview process, [staff #4] was clear that she believed the incident to be abusive. According to [former Director] interview, [staff #4] reported that [staff #12] pushed [client F] and did not indicate the incident to be an allegation of abuse..."</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated staff #12 was terminated. The PC indicated a BDDS report should have been completed and he thought there was one in the system. The PC indicated there were questions about the incident and what actually occurred and what staff #12 reported. The PC indicated staff #12 reported something different to staff, the pager staff and to the former Director. The PC indicated staff #12's story changed and his verbal report was not clear that he pushed client F. The</p>			

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	<p>PC indicated pushing was not a part of the CPI training staff received to implement the clients' behavior plans.</p> <p>On 10/29/13 at 10:58 AM the Chief Executive Officer (CEO) indicated the facility should complete investigations within 5 business days of the date of the incident.</p> <p>3) On 8/18/13 at 10:00 PM, client A hit client C's hands causing client C to spill his snack. The BDDS report, dated 8/19/13, indicated, in part, "Reaching past staff, [client C] pushed [client A] back, causing him to stumble several steps back and fall through a glass window. At this time staff jumped down through the window to make sure [client A] was ok, at which point it was discovered that [client A] had cut his elbow on some of the broken glass... [Client A] was admitted to [name of hospital] at 11:00 PM. While there he received three stitches on his left elbow, and two stitches on his right thumb." The Social Work Notes, undated and not signed by the Director, did not indicate when the facility completed the investigation. The investigation included interviews with staff conducted on 8/29/13.</p> <p>The Social Work Notes indicated, in part, "SW (Social Worker) met with [client C]</p>				

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	<p>to process the incident between him and [client A]. [Client C] reported that [client A] had hit him in the face, early that day. He reported that he had gotten a snack from the kitchen and was walking back to his room. [Client C] reported that [client A] had gotten all the way around his 1:1 staff. He reported that [client A] knocked his snack out of his hand and punched him in the face twice. [Client C] reported that staff got in between them again. He reported that he got all the way around the staff, grabbed [client A] with both hands by the collar of his shirt, swung him around 180 degrees and tossed him out the window. [Client C] reported that he (sic) [client A] got what he deserved. He reported that the police came and took his information. He reported that the police officers told him that it was self defense. [Client C] was not opening (sic) to listening (sic) SW explain definition of self defense. He was no longer interested in discussing the issue." The investigation did not include a conclusion for this incident.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client A went out the window by the kitchen in the living room near the dining room. The PC indicated client A was pushed even though staff was in between the clients. The PC indicated client A fell through the</p>			

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	<p>glass pane. The PC indicated client C typically only targeted client A after client A was doing something to provoke client C. The PC indicated there have been no incidents in which client C was physically aggressive toward client A without client A first provoking client C.</p> <p>On 10/29/13 at 10:58 AM the CEO indicated client to client aggression was considered abuse. The CEO indicated the staff should prevent client to client abuse. The CEO indicated investigations should be completed within 5 working days.</p> <p>4) On 8/18/13 at 5:30 PM, client A entered the front door causing the door to hit client C. Client C reacted by pushing client A to the floor. Client C hit client A once in the face.</p> <p>The Social Work Notes, undated and not signed by the Director, did not indicate when the facility completed the investigation. The investigation included interviews with staff conducted on 8/29/13. The notes Conclusion indicated, in part, "[Client A's] plan calls for 1:1 (one on one) staffing. [Client A] had followed [staff #12] outside. [Staff #12] reportedly was trying to enter the house through the garage and wanting [client A] to follow him. This did not happen. [Client A] entered the front door quickly,</p>				

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	<p>hitting [client C] with the door. [Client C] then tackled and hit [client A]. [Staff #4] was reportedly in the kitchen and unaware that [client A] was not with his 1:1. During this altercation with [client C], [client A] did not have adequate supervision, as written in his plan. This is (sic) meets criteria for neglect."</p> <p>On 10/29/13 at 10:58 AM the CEO indicated client to client aggression was considered abuse. The CEO indicated the staff should prevent client to client abuse. The CEO indicated investigations should be completed within 5 working days.</p> <p>9-3-2(a)</p>				

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W000157	<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 4 of 54 incident/investigative reports reviewed affecting clients A and C, the facility failed to implement appropriate corrective actions.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/23/13 at 1:38 PM and indicated the following:</p> <p>1) On 9/22/13 at 11:00 PM, client A was in his room moving things around when staff heard a loud crash from client A's room. The Incident Report, dated 9/22/13, indicated, in part, "I did not see this happen but I could hear it from the top of the steps and [client A] told me what just happen (sic)." The report indicated, "Pain and swelling in his right foot and big toe." The report indicated "none" in the witnesses of incident section. On 9/23/13 at 9:00 AM, client A was taken to a local walk-in doctor's office. The Outside Services Report, dated 9/23/13, indicated, "R (right) 1st toe fracture in multiple areas of distal phalanx." The Incident Report section "Supervisor must document action taken</p>	W000157	<p>W157 Plan of Correction: The facility has hired a new SGL Director who is a Licensed Clinical Social Worker knowledgeable of the state and agency client protection laws and policies including the need to take corrective action to prevent future occurrences of known incidents. The facility has also hired a new coordinator who has been trained on incident reporting, follow up investigations and the need for corrective action. See attached documents labeled W 153. Date of Completion: 11/21/2013 Plan of Prevention: The facility has developed a new electronic incident reporting system to ensure that all incidents are reported immediately to the administrator or designated staff in accordance with state law. The template includes a section for members of the facility support team to document actions taken and follow up reports. The department will arrange for staff training in incident reporting and investigations from an outside expert. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA member including failure to take corrective action to prevent repeated incidents and the QA</p>	11/21/2013			

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	<p>section" indicated, in part, "[Client A] had a fractured toe. He had been seen by a physician and will be seen by a surgeon soon." There was no additional corrective action implemented.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated client A was seen by a physician and a surgeon. The PC indicated, on 10/30/13 at 10:33 AM, the item client A dropped on his foot was removed from the room however there was no documentation this corrective action was implemented. The PC indicated there was no additional corrective action taken to prevent a future occurrence.</p> <p>2) On 9/19/13 at 1:30 PM (reported to BDDS on 9/23/13), client C was upset due to a phone call and he tried to contact staff to talk to at the facility-operated day program. Client C, when unable to locate staff to speak with, vacated the day program premises and began walking toward a local bookstore. He turned around and came back. Client C informed the classroom teacher and a Day Program Coordinator he had left. There was no documentation the facility took corrective action to address elopement from the day program. This was the second incident of elopement from the day program (first incident was on</p>		<p>team will recommend and monitor corrective actions.</p>		

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	<p>5/31/13). The BDDS follow-up report, dated 9/30/13, indicated, in part, "[Client C's] plan does not address elopement at this time... There will be no changes to [client C's] plan at this time." There was no documentation staff were retrained to closely supervise client C. There was no documentation addressing that staff were unaware client C left the premises until he returned and reported he eloped. There was no documentation of corrective action.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated he spoke to and provided training to client C on what he could do when he was upset. The PC indicated client C did not speak to staff prior to leaving the building. The PC indicated he told client C he needed to talk to staff when he was upset and tell them he was leaving. The PC indicated client C had a cellphone and there was no history of elopement (prior incident on 5/31/13 from the day program). The PC indicated elopement was not added to client C's Behavior Support Plan.</p> <p>3) On 8/18/13 at 10:00 PM, client A hit client C's hands causing client C to spill his snack. The BDDS report, dated 8/19/13, indicated, in part, "Reaching past staff (#12), [client C] pushed [client A] back, causing him to stumble several</p>						

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	<p>steps back and fall through a glass window. At this time staff jumped down through the window to make sure [client A] was ok, at which point it was discovered that [client A] had cut his elbow on some of the broken glass... [Client A] was admitted to [name of hospital] at 11:00 PM. While there he received three stitches on his left elbow, and two stitches on his right thumb." The Social Work Notes, undated and not signed by the Director, did not indicate when the facility completed the investigation. The investigation included interviews with staff conducted on 8/29/13. The Incident Report, dated 8/18/13, indicated in the action taken section, "The support team met on 8/20/13 to discuss a plan for staff training and client development." A review of the Support Team Review Form, dated 8/20/13, was conducted on 10/29/13 at 1:38 PM. The form indicated, in part, "Discussed the incident reports from the past weekend (17 & (and) 18 August). Reviewed BSPs and strategies, as well as the dynamics between staff and [client A]. Coordinator will meet with both staff members. The Team shared concerns about a particular staff and his involvement in these incidents. The Social Worker will write an IR (incident report) for a client rights violation if after discussing with the Director, the Director</p>				

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	<p>and Social Worker deem it necessary. Staff will be trained on [client A's] calming techniques (learned in therapy). Client Rights training for the [name of group home] gentlemen will be scheduled." There was no corrective action to address the supervision and protection of client A. There was no documentation the staff and the clients received training. There was no documentation of the corrective action taken.</p> <p>The Social Work Notes indicated, in part, "SW (Social Worker) met with [client C] to process the incident between him and [client A]. [Client C] reported that [client A] had hit him in the face, early that day. He reported that he had gotten a snack from the kitchen and was walking back to his room. [Client C] reported that [client A] had gotten all the way around his 1:1 staff. He reported that [client A] knocked his snack out of his hand and punched him in the face twice. [Client C] reported that staff got in between them again. He reported that he got all the way around the staff, grabbed [client A] with both hands by the collar of his shirt, swung him around 180 degrees and tossed him out the window. [Client C] reported that he (sic) [client A] got what he deserved. He reported that the police came and took his information. He reported that the police</p>						

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	<p>officers told him that it was self defense. [Client C] was not opening (sic) to listening (sic) SW explain definition of self defense. He was no longer interested in discussing the issue." There was no documentation of corrective actions taken.</p> <p>On 10/24/13 at 12:35 PM, the Program Coordinator (PC) indicated the team met to discuss the incident. The PC indicated staff #12 was terminated. The PC indicated the staff were regularly trained on client A's 1:1 protocol. The PC indicated staff were informally trained to understand client A targets client C. The PC indicated it was useful for staff to stay outside of client C's bedroom door to encourage him to stay in his room when client A was targeting him. The PC indicated the staff were informally trained to encourage client C to use words and not aggression.</p> <p>4) On 8/18/13 at 5:30 PM, client A entered the front door causing the door to hit client C. Client C reacted by pushing client C to the floor. Client C hit client A once in the face.</p> <p>The Social Work Notes, undated and not signed by the Director, did not indicate when the facility completed the investigation. The investigation included</p>						

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	<p>interviews with staff conducted on 8/29/13. The notes Conclusion indicated, in part, "[Client A's] plan calls for 1:1 (one on one) staffing. [Client A] had followed [staff #12] outside. [Staff #12] reportedly was trying to enter the house through the garage and wanting [client A] to follow him. This did not happen. [Client A] entered the front door quickly, hitting [client C] with the door. [Client C] then tackled and hit [client A]. [Staff #4] was reportedly in the kitchen and unaware that [client A] was not with his 1:1. During this altercation with [client C], [client A] did not have adequate supervision, as written in his plan. This is (sic) meets criteria for neglect." There was no documentation of the corrective action taken.</p> <p>On 10/24/13 at 2:46 PM, the Program Coordinator (PC) indicated he did not have documentation corrective action was implemented to address the incident with the exception of staff #12 being terminated.</p> <p>9-3-2(a)</p>				

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