

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00174891.</p> <p>Complaint #IN00174891: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153 and W154.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: 6/9, 6/10 and 6/16/15.</p> <p>Facility Number: 003184 Provider Number: 15G697 AIM Number: 200368720</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review the facility failed to meet the Condition of Participation: Governing Body for 3 of 4 sampled clients (B, C and D) and for 2 additional clients (E and F). The governing body failed to ensure clients B and C were not neglected and/or abused. The facility's governing body</p>	W 0102	In order to correct this deficiency, body checks have been implemented for clients B, C, D, E and F. These checks are done in the morning when the clients enter the day program and in the afternoon when they return from day program. The staff will then record any findings in the medical communication log and	07/16/2015

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

TITLE

(X6) DATE

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

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	<p>failed to ensure the facility developed a written policy and/or procedure which governed how the facility would utilize surveillance cameras, within the group home, to ensure clients were protected from abuse and/or neglect, and to ensure the facility monitored incident reports for patterns and/or trends. The facility's governing body failed to ensure facility staff reported allegations of abuse/neglect immediately to the administrator for clients B and C and conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D, E and F.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients B, C, D, E and F. The governing body failed to ensure clients B and C were not neglected and/or abused by facility staff. The governing body failed to ensure all injuries of unknown source, allegations of abuse and/or neglect were thoroughly investigated and/or documented for clients B, C, D, E and F. The governing body failed to ensure day program staff reported all allegations of abuse and/or neglect in a timely manner to ensure the protection of clients. Please see W122.</p>		<p>communicate any findings to the county QIDP and the day program manager. They will note what they found or note that they found nothing. An in-service training for house staff was held on 6/26/15. The staff was instructed that any possible allegations of ANE are to be reported to the QIDP or available supervisor immediately. All QIDPs will be re-trained on DSI's policy and procedures regarding ANE reporting on 7/15/15. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. Also, in order to better track adverse trends within the department, it has been decided that all DSI departments will utilize a real time tracking program that will be available to all program managers. The tracking report will inform any interested party the presence of any trends. Program managers will review the tracking report on a daily basis. DSI regional managers will ensure that the tracking system is accurate by conducting weekly spot audits. Any trend or pattern seen within the tracking report will be investigated immediately. The agency is also in the process of updating our video surveillance system as well as video surveillance review implementation. The</p>				

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	<p>2. The governing body failed to ensure the facility implemented its written policy and procedures to prevent abuse and/or neglect of clients in regard to staff to client abuse. The governing body failed to develop a specific system which monitored for patterns/trends in regard to injuries of unknown source to ensure clients were not being abused across all settings (group home and the facility's owned day program). The governing body failed to ensure facility staff reported allegations of abuse immediately to the administrator, and to ensure the facility conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D and F. The governing body failed to ensure its staff immediately reported all allegations of abuse and/or neglect to the administrator for clients B and C. The governing body failed to ensure the facility conducted thorough investigations in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D, E and F. Please see W104.</p> <p>This federal tag relates to complaint #IN00174891.</p> <p>9-3-1(a)</p>		<p>improvement will allow approved managers to more easily view the cameras from multiple electronic platforms, including company smart phones. The regional program manager for group homes will create and implement a mandatory observation schedule for QIDPs in the counties that have group homes with video surveillance. The QIDPs will be required to observe portions of each shift per week. The QIDPs will then be required to document what they observed in a shared folder accessible only to relative program managers. The regional program manager will review the documented observations and determine if staff training or other action is appropriate. In order to more effectively back up any ANE findings or any adverse trends, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions/ corrective measures that address the root cause of the investigation. The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The</p>	

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W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D) and for 2 additional clients (E and F), the governing body failed to exercise general policy and operating direction over the facility to ensure clients B, C, D and F were not neglected and/or abused. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed a written	W 0104	QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room/workshop in order to better monitor and document staff/client interactions. The house lead, county QIDP or the regional program manager will be present in the home and the day program on a daily basis in order to ensure proper staff/client interaction and to train and direct staff as needed. In order to correct this deficiency, body checks have been implemented for clients B, C, D, E and F. These checks are done in the morning when the clients enter the day program and in the afternoon when they return from day program. The staff will then record any findings in the medical communication log and communicate any findings to the county QIDP and the day program manager. They will note what they found or note that they	07/16/2015	

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	<p>policy and/or procedure which governed how the facility would utilize surveillance cameras, within the group home, to ensure clients were protected from abuse and/or neglect, and to ensure the facility monitored incident reports for patterns and/or trends. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure facility staff reported allegations of abuse/neglect immediately to the administrator for clients B and C and conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D, E and F.</p> <p>Findings include:</p> <p>1. During the 6/9/15 observation period between 4:30 PM and 5:45 PM, at the group home, surveillance cameras were located in the common areas of the group home (living room, dining room, hallways etc.).</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 6/9/15 at 2:50 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p>		<p>found nothing. An in-service training for house staff was held on 6/26/15. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. The staff were instructed that any possible allegations of ANE are to be reported to the QIDP or available supervisor immediately. All QIDPs will be re-trained on DSI's policy and procedures regarding ANE reporting on 7/15/15. Also, in order to better track adverse trends within the department, it has been decided that all DSI departments will utilize a real time tracking program that will be available to all program managers. The tracking report will inform any interested party the presence of any trends. Program managers will review the tracking report on a daily basis. DSI regional managers will ensure that the tracking system is accurate by conducting weekly spot audits. Any trend or pattern seen within the tracking report will be investigated immediately. The agency is also in the process of updating our video surveillance system as well as video surveillance review implementation. The improvement will allow approved managers to more easily view the cameras from multiple electronic platforms, including company</p>				

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	<p>-3/19/15 "Last evening when staff, [staff #3], was assisting [client B] with a shower he noted that [client B] had a 2" (inch) in diameter bruise on his upper right leg on his hip. Staff reports that the bruise was not there yesterday. [Client B] was asked what happened and he replied to staff, 'I fell on the sidewalk.' Staff reports that the previous day he had not been on a walk from the house. Additionally, [client B] often states he's fallen whether he has or not. He also has falls as a behavior...."</p> <p>The facility's 3/24/15 Incident Investigation indicated all facility staff and 1 day program staff were interviewed. The facility's 3/24/15 investigation indicated in the section entitled "Conclusion/Outcome/Systemic Changes: It is unknown how [client B] received his bruise."</p> <p>-3/25/15 "A HAB (habilitation) staff was in the workshop picking up a client for an outing, when he observed client [client F] turning his shirt around because it was backwards. Staff noticed he had a bruise on his left hip. Client [client F] was asked to come to a private office so the Day Program Manager and the Industry Manager could see the bruise. Day Program Manager asked [client F] if she could measure the injury and document it</p>		<p>smart phones. The regional program manager for group homes will create and implement a mandatory observation schedule for QIDPs in the counties that have group homes with video surveillance. The QIDPs will be required to observe portions of each shift per week. The QIDPs will then be required to document what they observed in a shared folder accessible only to relative program managers. The regional program manager will review the documented observations and determine if staff training or other action is appropriate. In order to more effectively back up any ANE findings or any adverse trends, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions that address the root cause of the investigation. The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order</p>	

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	<p>by taking a picture. There is no documentation, reports, or knowledge of an incident that would have caused this injury to [client F] by day program staff, workshop supervisors, or managers. The bruise is located on his left hip. The yellow portion of the bruise is 13 cm (centimeters) in width from left to right. The purple bruise look (sic) like a scrape but there is no tearing of the skin. There are 4 purple marks. The top purple mark is 5cm in length and the bottom two marks are 8.5 cm in length from left to right. The yellow portion is oval in shape, widening in the middle (top to bottom)...."</p> <p>The facility's 3/30/15 Incident Investigation indicated client E was interviewed in regard to client F's injury. Client E's 3/25/15 witness statement indicated "...[Client E] said [client F] got hurt over the weekend when he fell at R.R. (unidentified) This may or may not be true as [client E] is not always a good historian...." The facility's investigation indicated facility staff did not know how client F received the injury as no falls and/or behavior were indicated. The facility's 3/30/15 investigation indicated one staff thought client F may have injured himself on the door knobs as they were "...37," abt (about) the height of bruise. This may be how [client F] hurt</p>		<p>to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room/ Workshop in order to better monitor and document staff/client interactions. The house lead, county QIDP or the regional program manager will be present in the home and the day program on a daily basis in order to ensure proper staff/client interaction and to train and direct staff as needed.</p>	

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	<p>side...."</p> <p>-5/5/15 "Team Lead of the Personal Enhancement Program noticed bruising on [client D's] right arm just above his elbow. It is three linear marks between 1/2 inch and 3/4 inch. (sic) no more than a centimeter apart, going horizontal above his elbow. Staff immediately documented the bruising with pictures and notified manager. Manager contacted the residential program manager who had no knowledge of any injuries. An internal investigation and Day Programming staff had no knowledge of any incident that could have caused the bruising. When the program manager observed the bruising, it was noted the markings were too close for finger (sic) to be the cause but it looked more like he hit his elbow across an object, although nothing could be specifically determined as the cause." The facility's 5/8/15 Incident Investigation indicated the Residential Program Manager (RPM) "...stated that [client D] likes to lay on the floor at home near the register vents. If he had SIB and hit his arms on that it could be the cause but there were no reports from residential staff of knowledge of the occurrence." The facility's investigation indicated</p> <p>"...Conclusion/Outcome/Systemic</p>			

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	<p>Changes: Unknown bruise could have been from another client could (sic) have pinched him while in the day program or at home, but no evidence of that happening. Staff will monitor client for health and safety purposes."</p> <p>-5/5/15 "Team Lead was assisting [client C] with getting his drink when he reached his arm out and she noticed a bruise under his t shirt. The bruise was on the right arm on the inside of his bicep. The bruise was 2 centimeters by 1.5 centimeters...When the program manager observed the bruising, it was noted the bruise had two small blood dots where in the bruise as if he was poked by something." The facility's reportable incident report indicated the DPM conducted the investigation and the day program staff did not know how client C received the injury.</p> <p>-5/7/15 "[Client B] went to the bathroom and the staff that was assisting him saw two bruises on his right thigh. The top bruise is about 2 inches by 1.5 inches and a smaller one about 1/2 inch of space between and it is about 1/2 by 1/2 inch. Staff documented the bruise and notified residential QA but there were no reports that would explain the injury...."</p> <p>-5/21/15 "This morning when [client F]</p>			

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	<p>was receiving his morning breathing treatment staff noted a bruise on his upper left arm. The bruise was 2 cm. The client was asked but could not say how he got the bruise. The overnight staff did not know about the bruise. Today the Q talked with [client F]. He said he got the bruise on the vehicle. This Q will continue to see if it can be determined how he received this injury. The injury today appears to be around 1/2 inches high and 2 inches wide and a blotchy blue...."</p> <p>-6/4/15 "On 6/4/15, [client D] was seen to have a bruise 2 1/2 centimeter in width on inside of right elbow. Staff reviewed communication log and determined that the injury had to have happened during day program, there was no record of bruising during the PM body checks on 6/3/15 and no mention of bruising or adverse client interaction on the morning of 6/4/15. Staff asked [client D] what happened and client indicated, through verbalization and pointing that his roommate pinched him, causing the bruise...Staff will continue to monitor interactions between the two clients mentioned in order to avoid future altercations...."</p> <p>The facility's 12/22/11 Standard Operating Procedures (SOP) were</p>			

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	<p>reviewed on 6/9/15 at 1:48 PM. The facility's SOPs indicated the facility failed to indicate how and when the facility's surveillance cameras/system were to be utilized in regard to conducting investigations, and/or to be reviewed to prevent abuse/neglect of clients.</p> <p>Interview with staff #5 on 6/9/15 at 5:37 PM indicated client C would sometimes have injuries on his arms. Staff #5 stated "He (client C) has SIB marks on his arms from biting." Staff #5 stated "I will ask where stuff (clients' injuries of unknown source) comes from."</p> <p>Interview with staff #4 on 6/9/15 at 5:40 PM indicated clients would sometimes come home from work with marks and/or bruises on them. Staff #4 stated some injuries would sometimes be "logged in book." When asked if staff #4 witnessed and/or knew of abuse/neglect with clients, staff #4 stated "Not on my watch."</p> <p>Interview with staff #3 on 6/9/15 at 5:43 PM indicated he was not aware of any abuse/neglect of clients who lived at the group home. Staff #3 indicated client F would sometimes complain about the workshop/day program. Staff #3 stated "Could be just his (client F's) mood."</p>			

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	<p>When asked why the cameras were in the group home, staff #3 stated he thought they were there due to "past incidents of abuse."</p> <p>Interview with the RPM and the Qualified Intellectual Disabilities Professional (QIDP) on 6/10/15 at 11:45 AM indicated staff #1 had been terminated in regard to the 5/29/15 allegations. The RPM and the QIDP indicated they conducted the investigations in regard to client B, C, D and F's injuries of unknown source when discovered at the group home. The RPM indicated the facility staff was terminated over the 4/1/15 incident. When asked why the facility had camera surveillance in the group home, the RPM stated "Due to past problems." The RPM indicated the QIDP and/or RPM had access to the camera data. The RPM stated "We randomly review tapes and go live to see what is going on at the group home." The RPM and QIDP stated the current camera/surveillance system was not "user friendly." The RPM and the QIDP indicated the facility was in the process of trying to update their system which would allow the QIDP and RPM to review the tapes. The QIDP and the RPM indicated the facility had utilized the tapes from the camera to substantiate abuse in the past. The RPM indicated the</p>			

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	<p>facility did not have a policy and procedure which indicated how the cameras were to be utilized in regard to investigations and/or when to randomly review to ensure clients were not being neglected and/or abused.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent abuse and/or neglect of clients in regard to staff to client abuse. The governing body failed to exercise general policy and operating direction over the facility to develop a specific system which monitored for patterns/trends in regard to injuries of unknown source to ensure clients were not being abused across all settings (group home and the facility's owned day program). The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff reported allegations of abuse immediately to the administrator, and to ensure the facility conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D and F. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction</p>			

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W 0122 Bldg. 00	<p>over the facility to ensure its staff immediately reported all allegations of abuse and/or neglect to the administrator for clients B and C. Please see W153.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D, E and F. Please see W154.</p> <p>This federal tag relates to complaint #IN00174891.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review the facility failed to meet the Condition of Participation: Client Protections for 3 of 4 sampled clients (B, C and D) and for 2 additional clients (E and F). The facility failed to ensure clients B and C were not neglected and/or abused by facility staff. The facility failed to ensure all injuries of unknown source, allegations of abuse and/or neglect were thoroughly investigated</p>	W 0122	In order to correct this deficiency and ensure that the clients are provided the rights accorded them without having to claim them, the following actions have been enacted: An in-service training for house staff was conducted on 6/26/15. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. The staff were	07/16/2015

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	<p>and/or documented for clients B, C, D, E and F. The facility failed to ensure day program staff reported all allegations of abuse and/or neglect in a timely manner to ensure the protection of clients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to implement its written policy and procedures to prevent abuse and/or neglect of clients in regard to staff to client abuse. The facility failed to develop a specific system which monitored for patterns/trends in regard to injuries of unknown source to ensure clients were not being abused across all settings (group home and the facility's owned day program). The facility failed to ensure facility staff reported allegations of abuse immediately to the administrator, and to ensure the facility conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D and F. Please see W149. 2. The facility failed to ensure its staff immediately reported all allegations of abuse and/or neglect to the administrator for clients B and C. Please see W153. 3. The facility failed to conduct a thorough investigation in regard to the allegations of abuse, neglect and/or 		<p>instructed that any possible allegations of ANE are to be reported to the QIDP or available supervisor immediately. All QIDPs will be re-trained on DSI's policy and procedures regarding ANE reporting on 7/15/2015. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. Also, in order to better track adverse trends within the department, it has been decided that all DSI departments will utilize a real time tracking program that will be available to all program managers. The tracking report will inform any interested party the presence of any trends. Program managers will review the tracking report on a daily basis. DSI regional managers will ensure that the tracking system is accurate by conducting weekly spot audits. If any trends are discovered, the program manager will immediately conduct a full and thorough investigation, suspending any party suspected of ANE. The program manager will then allot the staff member a disciplinary action, up to and not excluding termination, according to the severity of findings. The agency is also in the process of updating our video surveillance system as well as video surveillance review implementation. The</p>		

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	<p>injuries of unknown source for clients B, C, D, E and F. Please see W154.</p> <p>This federal tag relates to complaint #IN00174891.</p> <p>9-3-2(a)</p>		<p>improvement will allow approved managers to more easily view the cameras from multiple electronic platforms, including company smart phones. The regional program manager for group homes will create and implement a mandatory observation schedule for QIDPs in the counties that have group homes with video surveillance. The QIDPs will be required to observe portions of each shift per week. The QIDPs will then be required to document what they observed in a shared folder accessible only to relative program managers. If, during video observations, the QIDP discovers any instances of possible ANE, the QIDP will immediately initiate a full and through investigation, suspending any staff suspected of ANE until the investigation is completed. The program manager will then allot the staff member disciplinary action, up to and not excluding termination, according to the severity of findings. In order to back up any ANE findings or any adverse trend, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions/ corrective</p>	

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D) and for 2 additional clients (E and F), the facility neglected to implement its written policy and procedures to prevent abuse and/or neglect of clients in regard to staff to			W 0149	actions that address the root cause of the investigation. The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room/ Workshop in order to better monitor and document staff/client interactions. The house lead, county QIDP or the regional program manager will be present in the home and the day program on a daily basis in order to ensure proper staff/client interaction and to train and direct staff as needed. In order to correct this deficiency, policy has been implemented whose structure will help prevent, identify, investigate and report abuse, neglect and mistreatment of clients. Staff will also be screened and trained through the following policies: body checks		07/16/2015

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	<p>client abuse. The facility neglected to develop a specific system which monitored for patterns/trends in regard to injuries of unknown source to ensure clients were not being abused across all settings (group home and the facility's owned day program). The facility neglected to develop a written policy and/or procedure which governed how the facility would utilize surveillance cameras, within the group home, to ensure clients were protected from abuse and/or neglect.</p> <p>The facility neglected to implement its written policy and procedures to ensure staff immediately reported allegations of abuse and/or neglect to the administrator, and to provide evidence of a thorough investigation in regard to allegations of abuse, neglect and/or clients' injuries of unknown source.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 6/9/15 at 2:50 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following allegations of neglect and/or abuse from the facility's owned day program and/or group home:</p>		<p>have been implemented for clients B, C, D, E and F. These checks are done in the morning before the clients enter the day program and in the afternoon when they return from day program. The staff will then record any findings in the medical communication log and communicate any findings to the county QIDP and the day program manager. They will note what they found or note that they found nothing. The county QIDP will review multiple times a week the documented checks in order to ensure staff are performing effective checks. An in-service training for house staff was held on 6/26/15. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. The staff were instructed that any possible allegation of ANE is to be reported to the QIDP or available supervisor immediately. Any staff who fail to comply with this directive in the future will receive a disciplinary action or terminated. All QIDPs will be re-trained on DSI's policy and procedures regarding ANE reporting on 7/15/2015. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. Also, in order to better</p>		

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	<p>-4/1/15 "Day Program Manager Assistant (DPMA) went to the Personal Enhancement Program (PEP) to get a magazine. When she walked in she observed [client C] entering the kitchen area and trying to steal drinks out of the cabinet. Staff followed [client C] into the kitchen and proceeded to hit [client C] at the base of his head with the palm of her hand 3 times. [Client C] had a red mark from the contact but it vanished within minutes after the incident. Staff was suspended pending investigation. The team lead was at a presentation for bed bug awareness, the new hire who was shadowing was in the employee bathroom, and the second staff was assisting a client in the bathroom at the time of the incident." The 4/1/15 reportable incident report and/or investigations indicated the facility neglected to document an investigation in regard to the above allegation of staff to client abuse as no investigation was attached and/or provided.</p> <p>-5/29/15 at 9:35 AM, "Staff (staff #2) reported to Day Program Manager (DPM) on Monday 6/1/15 that she saw the second staff (staff #1) in the PEP room throw [client C] against the wall repeatedly be (sic) his neck with both hands and then held him against the wall with one hand around his neck. She</p>		<p>track adverse trends within the department, it has been decided that all DSI departments will utilize areal time tracking program that will be available to all program managers. The tracking report will inform any interested party the presence of any trends. Program managers will review the tracking report on a daily basis. DSI regional managers will ensure that the tracking system is accurate by conducting weekly spot audits. If a program manager is unable to perform weekly checks due to illness or time off, the regional manager or QA (if applicable) will perform the required checks and documentation. If any trends are discovered, the program manager will immediately conduct a full and thorough investigation, suspending any party suspected of ANE. The program manager will then allot the staff member a disciplinary action, up to and not excluding termination, according to the severity of findings. The agency is also in the process of updating our video surveillance system as well as video surveillance review implementation. The improvement will allow approved managers to more easily view the cameras from multiple electronic platforms, including company smart phones. The regional program manager for group homes will create and implement a mandatory observation</p>	

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	<p>(staff #2) reported the noise of the incident caused two people outside the room to step in to make sure things were ok but the staff had released him prior to their entry. Staff were suspended pending the investigation. Alleged abusive staff (staff #1) reported the incident occurring as follows; [Client C] tried to steal another clients (sic) drink and she redirected him. She reported that [client C] slapped the counter twice after being redirected. She reported [client C] then walked up to the wall and smacked the wall, then went after another client and staff intervened by stepping between them then he went over to the door and squeezed his own neck, punched himself in the neck, and slammed the back of his head off the wall and his his head off the counter. She reported he threw the books off the shelf and after picking them up he went and laid on the couch.</p> <p>Day Program Manager interviewed the Group Home Manager and Assistant Manager about the possibility of [client C] having a history of SIB (self-injurious behavior) of squeezing his neck or punching his neck and it was stated that there is no history of that behavior. His behavior patterns are physical aggression of punching or pinching others, SIB of punching his lower jaw and temple, biting his arms, and banging his forehead on the counter, doorways or walls.</p>		<p>schedule for QIDPs in the counties that have group homes with video surveillance. The QIDPs will be required to observe portions of each shift per week. If the QIDPs are unable to perform video observations, the regional manager or QA (if applicable) will perform the observations and required documentation. The QIDPs will then be required to document what they observed in a shared folder accessible only to relative program managers. If, during video observations, the QIDP discovers any instances of possible ANE, the QIDP will immediately initiate a full and through investigation, suspending any staff suspected of ANE until the investigation is completed. The program manager will then allot the staff member disciplinary action, up to and not excluding termination, according to the severity of findings. In order to back up any ANE findings or any adverse trend, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions/corrective actions that address the root cause of the investigation. The Quality Assurance Social Service</p>		

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	<p>Day Program Manager Assistant went down to look at [client C] to determine if injuries were present but no markings were left. She then asked [client C] to grab his throat or choke himself to see if he was capable of doing that gesture but he just placed one hand on his chest and made a gagging face.</p> <p>Day Program Manager called the alleged abuser into the office to interview her and her comments were the same as she reported on the report. When asked if the reports were accurate she responded that [Client C] 'was off the chain.' Day Program Manager then responded that [client C] does not have a history of choking himself or squeezing/punching his neck and she continued to respond that '[Client C] was off the chain.'</p> <p>Day Program Manager called the reporting staff into the office and interviewed her. The staff modeled the incident by re-enacting it with the day program manager. She placed the day program manager where [client C] was standing and she stood where the alleged abuser was standing. She stated [client C] came up to the staff and tried to pinch her and that's when she placed her hands around my neck and mimicked a thrust backward several times then removed one hand and mimicked a hold on the neck. She removed her hand and stepped back before the Quality Manager came in</p>		<p>Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room/ Workshop in order to better monitor and document staff/client interactions. The house lead, county QIDP or the regional program manager will be present in the home and the day program on a daily basis in order to ensure proper staff/client interaction and to train and direct staff as needed.</p>	

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	<p>through the one door and the training nurse came in through the other to check what the commotion was.</p> <p>Day Program Manager spoke with Quality Manager. She asked why he entered the room and what he saw when he went in. He stated he heard banging against the wall several times and when he walked in [client C] was hanging a picture on the wall.</p> <p>Day Program Manager interviewed the training nurse and he reported that he heard banging against the wall 5 or 6 times and when he entered the staff (staff #1) was moving back from the client and she redirected him to the sensory area of the room which point there was no further commotion. Investigation was completed on 6/2/2015. The reporting staff was counseled and retrained on reporting practices on 6/2/2015. The staff that was alleged abusive will be terminated on 6/3/15 with a disciplinary action based on DSI (Development Services Incorporated) policy. Staff will maintain health and safety." The facility's 5/29/15 reportable incident report indicated the incident occurred on 5/29/15 but facility staff did not report the allegation of staff to client physical abuse until 6/1/15. The 5/29/15 reportable incident report indicated the facility neglected to interview verbal clients in the PEP room.</p>			

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	<p>-5/29/15 at 12:00 PM, "The second staff (staff #2) in the PEP room reported that staff (staff #1) prompted [client B] to eat his lunch one time before throwing the food in the trash. [Client B] often requires assistance and supervision while eating...." The 5/29/15 reportable incident report indicated the incident occurred on 5/29/15 but staff #2 did not report the allegation of staff to client neglect until 6/1/15. The facility's reportable incident report indicated "...Both staff are suspended pending investigation. Investigation was completed on 6/2/2015. The reporting staff was counseled and retrained on reporting practices on 6/2/2015. The staff that was alleged neglectful will be terminated on 6/3/15 with a disciplinary action based on DSI policy. Staff will maintain health and safety." The 5/29/15 reportable incident report indicated the facility neglected to document an investigation in regard to the above allegation of staff to client abuse as no investigation was attached.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations indicated the following injuries of unknown source:</p> <p>-3/19/15 "Last evening when staff, [staff</p>						

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	<p>#3], was assisting [client B] with a shower he noted that [client B] had a 2" (inch) in diameter bruise on his upper right leg on his hip. Staff reports that the bruise was not there yesterday. [Client B] was asked what happened and he replied to staff, 'I fell on the sidewalk.' Staff reports that the previous day he had not been on a walk from the house. Additionally, [client B] often states he's fallen whether he has or not. He also has falls as a behavior. This Q (Qualified Intellectual Disabilities Professional) talked with PEP room staff who reported a calm day yesterday. She stated that they had watched a movie the previous afternoon. The only thing that she could think of that could've caused the injury was the way that [client B] often throws himself into chairs. Had he been at the window and run to the chair for the movie he would've thrown himself on his right side into the arm of the chair. Staff reports the arms of the chair are hard and he could've bruised himself on this. This would have been at the hip area. This Q will continue to investigate to see if the cause of the injury can be discovered...."</p> <p>The facility's 3/24/15 Incident Investigation indicated all facility staff and 1 day program staff were interviewed. The facility's 3/24/15 investigation indicated in the section</p>						

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	<p>entitled "Conclusion/Outcome/Systemic Changes: It is unknown how [client B] received his bruise." The facility's investigation of client B's injury of unknown source indicated the facility neglected to include any recommendations with the investigation.</p> <p>-3/25/15 "A HAB (habilitation) staff was in the workshop picking up a client for an outing, when he observed client [client F] turning his shirt around because it was backwards. Staff noticed he had a bruise on his left hip. Client [client F] was asked to come to a private office so the Day Program Manager and the Industry Manager could see the bruise. Day Program Manager asked [client F] if she could measure the injury and document it by taking a picture. There is no documentation, reports, or knowledge of an incident that would have caused this injury to [client F] by day program staff, workshop supervisors, or managers. The bruise is located on his left hip. The yellow portion of the bruise is 13 cm (centimeters) in width from left to right. The purple bruise look (sic) like a scrape but there is no tearing of the skin. There are 4 purple marks. The top purple mark is 5cm in length and the bottom two marks are 8.5 cm in length from left to right. The yellow portion is oval in shape, widening in the middle (top to</p>			

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	<p>bottom). Day Program Manager attempted to contact Q and QA (Qualified Intellectual Disabilities Professional Assistant) to see if residential staff reported any incidents but were unavailable at the time. Day Program Manager passed the information on to Regional Group Home Manager who said they would begin investigating immediately."</p> <p>The facility's 3/30/15 Incident Investigation indicated client E was interviewed in regard to client F's injury. Client E's 3/25/15 witness statement indicated "...[Client E] said [client F] got hurt over the weekend when he fell at R.R. (unidentified) This may or may not be true as [client E] is not always a good historian...." The facility's investigation indicated facility staff did not know how client F received the injury as no falls and/or behavior were indicated. The facility's 3/30/15 investigation indicated one staff thought client F may have injured himself on the door knobs as they were "...37," abt (about) the height of bruise. This may be how [client F] hurt side...." The 3/30/15 investigation indicated the facility neglected to include any conclusion and/or recommendations in regard to the investigation of client E's injury.</p>				

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	<p>-5/5/15 "Team Lead of the Personal Enhancement Program noticed bruising on [client D's] right arm just above his elbow. It is three linear marks between 1/2 inch and 3/4 inch. (sic) no more than a centimeter apart, going horizontal above his elbow. Staff immediately documented the bruising with pictures and notified manager. Manager contacted the residential program manager who had no knowledge of any injuries. An internal investigation and Day Programming staff had no knowledge of any incident that could have caused the bruising. When the program manager observed the bruising, it was noted the markings were too close for finger (sic) to be the cause but it looked more like he hit his elbow across an object, although nothing could be specifically determined as the cause."</p> <p>The facility's 5/8/15 Incident Investigation indicated the Residential Program Manager (RPM) "...stated that [client D] likes to lay on the floor at home near the register vents. If he had SIB and hit his arms on that it could be the cause but there were no reports from residential staff of knowledge of the occurrence." The facility's 5/8/15 investigation indicated 3 day program staff and the RPM were interviewed. The facility's investigation indicated "...Conclusion/Outcome/Systemic</p>			

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	<p>Changes: Unknown bruise could have been from another client could (sic) have pinched him while in the day program or at home, but no evidence of that happening. Staff will monitor client for health and safety purposes." The facility's 5/8/15 investigation indicated the facility neglected to interview/document interviews of group home staff and/or clients in regard to client D's injury of unknown source.</p> <p>-5/5/15 "Team Lead was assisting [client C] with getting his drink when he reached his arm out and she noticed a bruise under his t shirt. The bruise was on the right arm on the inside of his bicep. The bruise was 2 centimeters by 1.5 centimeters...When the program manager observed the bruising, it was noted the bruise had two small blood dots where in the bruise as if he was poked by something." The facility's reportable incident report indicated the DPM conducted the investigation and the day program staff did not know how client C received the injury. The facility's investigation also indicated the RPM was the only group home staff who was interviewed. The facility's 5/5/15 reportable incident report indicated the facility neglected to document and/or conduct a thorough investigation in regard to the client's injury of unknown</p>			

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	<p>source.</p> <p>-5/7/15 "[Client B] went to the bathroom and the staff that was assisting him saw two bruises on his right thigh. The top bruise is about 2 inches by 1.5 inches and a smaller one about 1/2 inch of space between and it is about 1/2 by 1/2 inch. Staff documented the bruise and notified residential QA but there were no reports that would explain the injury. Staff in the Day Program room did not have any knowledge of a specific incident that caused the bruise but did state that [client B] rushes when he walks and often times bumps into tables, countertop in the bathroom and railings in the hallway at his home and the height of the bruise matches the height of those few items." The 5/7/15 investigation indicated the facility neglected to document a thorough investigation as no group home staff and/or day program staff interviews were included.</p> <p>-5/21/15 "This morning when [client F] was receiving his morning breathing treatment staff noted a bruise on his upper left arm. The bruise was 2 cm. The client was asked but could not say how he got the bruise. The overnight staff did not know about the bruise. Today the Q talked with [client F]. He said he got the bruise on the vehicle.</p>			

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	<p>This Q will continue to see if it can be determined how he received this injury. The injury today appears to be around 1/2 inches high and 2 inches wide and a blotchy blue...." The 5/21/15 reportable incident report indicated the facility neglected to conduct a thorough investigation in regard to client F's injury of unknown source as no additional documentation was attached.</p> <p>-6/4/15 "On 6/4/15, [client D] was seen to have a bruise 2 1/2 centimeter in width on inside of right elbow. Staff reviewed communication log and determined that the injury had to have happened during day program, there was no record of bruising during the PM body checks on 6/3/15 and no mention of bruising or adverse client interaction on the morning of 6/4/15. Staff asked [client D] what happened and client indicated, through verbalization and pointing that his roommate pinched him, causing the bruise...Staff will continue to monitor interactions between the two clients mentioned in order to avoid future altercations...."</p> <p>The facility's above mentioned investigations in regard to client B, C, D and F's incidents of unknown source indicated the facility neglected to address and/or look at the number of injuries of</p>			

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	<p>unknown source, at the day program and/or group home, to ensure clients were not potentially being abused and/or neglected. The facility neglected to develop a system which specifically monitored for patterns and/or trends to prevent abuse and/or neglect of clients.</p> <p>During the 6/9/15 observation period at the day program between 11:02 AM and 12:45 PM indicated client C would walk around the day program room, attempted to get into the kitchen to steal drinks and/or eloped from the day program room on multiple occasions during the observation period. Client C would get upset and slap the side of his face when redirected, but did not attempt to bang his head and/or choke himself. During the 6/9/15 observation period, clients B and D stayed in the day program room sitting at a table. Clients B and D would stand and/or change chairs, but did not attempt to get out of staff's sight as they stayed in the room where staff were located.</p> <p>During the 6/9/15 observation period between 4:30 PM and 5:45 PM, at the group home, client D was able to ambulate independently, but stayed in the same room with facility staff. Client D sat in the living room on the couch and/or chair. Client F also sat in the living room with other clients and/or staff. Client F</p>			

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	<p>was able to ambulate independently with a steady gait. Client C attempted to leave the group home once and went to the driveway where cars were parked. Client B ambulated independently slightly bent forward. Client B did not bump into items when ambulating. Client B did require staff redirection to not bother client C in regard to wanting to repeatedly give client C a high five sign/gesture. Staff #3 followed the client out and redirected the client to return to the house. During the above 6/9/15 observation period, surveillance cameras were located in the common areas of the group home (living room, dining room, hallways etc.).</p> <p>Staff #1's personnel record was reviewed on 6/10/15 at 10:00 AM. Staff #1's personnel record indicated the staff worked in the facility's day program. Staff #1's personnel record also indicated staff #1's 6/3/15 Counseling Memorandum indicated staff #1 was terminated on 6/8/15 for neglect and abuse of clients at the day program.</p> <p>The facility's policy and procedures were reviewed on 6/9/15 at 11:00 AM. The facility's 4/12/06 policy entitled Identifying and Reporting Suspected Abuse and Neglect indicated the following "...Definitions:</p>			

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	<p>1. Physical Abuse: Knowingly or intentionally touching another person in a rude, insolent or angry manner; punishment with resulting physical harm or pain; unnecessary physical or chemical restraints.</p> <p>2. Verbal/Emotional Abuse: Includes oral, written, and/or gestured language that includes disparaging or derogatory remarks. Also includes demeaning tones or harsh language. Includes unreasonable confinements, intimidation or humiliation...</p> <p>4. Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care, food, medical care, shelter, or supervision..." The facility's 4/12/06 policy indicated the facility defined "...Injuries of Unknown Origin: Any significant injury of unknown origin should be investigated as potential abuse or neglect. Description of significant injury include large bruising; burns, unusual marks on the skin; any area that is visibly swollen or red; finger like bruising (as if grabbed); any unusual complaints of pain by the client with no known medical reason...." The facility's policy and procedures indicated facility staff were to "...immediately report this suspicion within one hour of discovery to their supervisor/QMRP or the emergency</p>			

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	<p>response system...." The facility's 4/12/06 policy indicated "...The Department Manager and/or Program Director will conduct a full internal investigation in cooperation with responsible authorities such as: Indiana State Police, Child or Adult Protective Services, Bureau of Quality Improvement Services, Indiana State Board of health, etc...."</p> <p>The facility's 12/22/11 Standard Operating Procedures (SOP) were reviewed on 6/9/15 at 1:48 PM. The facility's SOPs indicated the facility neglected to develop a system which monitored and specifically tracked injuries of unknown source in regard to patterns and trends. The facility's 12/22/11 SOPs also indicated the facility neglected to indicate how and when the facility's surveillance cameras/system was to be utilized in regard to conducting investigations, and/or to be reviewed to prevent abuse/neglect of clients.</p> <p>Interview with DPM on 6/9/15 at 12:45 PM and on 6/10/15 at 9:15 AM indicated the day program had terminated staff in the past several months for abuse and/or neglect of clients. The DPM indicated she (DPM) was having to work in the PEP room as there was only 1 regular staff left to work in the PEP room where</p>						

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	clients A, B, C and D attended during the day. The DPM stated staff #1 "did not have a history of abuse but had personal issues." The DPM stated the "Team Lead" was not in the room when the 5/29/15 incidents occurred. The DPM stated "It is hard to keep staff in that room." When asked if she had been aware of any injuries of unknown source regarding the clients in the PEP room, the DPM stated "[Client B] has a pattern of bruises from bumping into table. No other injuries which would indicate any additional abuse at this time." The DPM indicated staff #2 did not report the allegation of abuse and/or neglect with clients B and C until 6/1/15. The DPM indicated she counseled staff #2 in regard to the late reporting and reminded the staff allegations of abuse and/or neglect should be reported immediately. The DPM indicated staff #2 should have reported the allegations within a half hour of the incident occurring. The DPM indicated if staff #2 had reported the first allegation of abuse to the DPM on 5/29/15 at 9:35 AM, the other incidents which occurred on 5/29/15 could have been prevented. The DPM indicated when she spoke with staff #1, staff #1 was undergoing some personal issues at home which appeared to affect staff #1's ability to do her job. The DPM indicated she conducted the investigation in regard			

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	<p>to client B and C's allegations of abuse/neglect on 5/29/15. The DPM indicated she had not written/typed up the 5/29/15 investigation as she had been working in the PEP room. The DPM indicated she spoke with the day program staff who worked in the PEP room. The DPM stated she did not interview any clients as the clients would not be able to give "an accurate account of what happened." The DPM indicated staff #1 was terminated for abuse and neglect in regard to the 5/29/15 allegations.</p> <p>Interview with staff #5 on 6/9/15 at 5:37 PM indicated client C would sometimes have injuries on his arms. Staff #5 stated "He (client C) has SIB marks on his arms from biting." Staff #5 stated "I will ask where stuff (clients' injuries of unknown source) comes from."</p> <p>Interview with staff #4 on 6/9/15 at 5:40 PM indicated clients would sometimes come home from work with marks and/or bruises on them. Staff #4 stated some injuries would sometimes be "logged in book." When asked if staff #4 witnessed and/or knew of abuse/neglect with clients, staff #4 stated "Not on my watch."</p> <p>Interview with staff #3 on 6/9/15 at 5:43 PM indicated he was not aware of any</p>			

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	<p>abuse/neglect of clients who lived at the group home. Staff #3 indicated client F would sometime complain about the workshop/day program. Staff #3 stated "Could be just his (client F's) mood." When asked why the cameras were in the group home, staff #3 stated he thought they were there due to "past incidents of abuse."</p> <p>Interview with the RPM and the Qualified Intellectual Disabilities Professional (QIDP) on 6/10/15 at 11:45 AM indicated the DPM had conducted the investigation in regard to the 5/29/15 allegations of abuse/neglect involving clients B and C. The RPM and the QIDP indicated staff #1 had been terminated in regard to the 5/29/15 allegations. The RPM and the QIDP indicated they conducted the investigations in regard to client B, C, D and F's injuries of unknown source when discovered at the group home. The RPM and/or the QIDP indicated the facility did not document its investigation of client D's 6/4/15 injury of unknown source. The RPM indicated the reportable incident reports, in regard to injuries of unknown source, should have been investigated. The RPM and the QIDP indicated they and/or the DPM may not have included documentation to ensure all injuries of unknown source were</p>			

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	<p>thoroughly investigated. The RPM indicated the 4/1/15 allegation of abuse regarding client C was investigated by the DPM. The RPM stated the investigation was "done but not documented." The RPM indicated the facility staff was terminated over the 4/1/15 incident. When asked if the facility had looked at and/or reviewed the number of incidents involving injuries of unknown source as a whole for the the group home to rule out abuse, the RPM and the QIDP stated "No." The RPM indicated the facility had a system in place which looked for patterns and trends. The RPM and the QIDP indicated they were not aware of any patterns and/or trends in regard to injuries of unknown source. The RPM stated his supervisor (administrative staff #1) tracked "Trends of Incident Reports Analysis." The RPM stated administrative staff #1 only tracked the number of injuries of unknown source by "county and quarters." The RPM stated there had been 5 incidents of unknown source for "[Name] County" for the months of January 2015 to March 2015. The RPM indicated in the quarter of (October 2015 to December 2014) there were 3 incidents of injuries of unknown source in the county. The RPM indicated from July 2014 to September 2014, there were also 3 incidents of unknown origin in the county. The RPM and the QIDP</p>			

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	<p>indicated [name] county's data would include two group homes within that county of which River Road was one of the group homes. The RPM and the QIDP indicated the facility's current tracking of patterns and trends was not specific in regard to group home, clients, shifts and/or staff who worked with clients at the River Road group home. The RPM indicated since 3/2015, there had been an increase in the number of incidents/clients with injuries of unknown source. When asked why the facility had camera surveillance in the group home, the RPM stated "Due to past problems." The RPM indicated the QIDP and/or RPM had access to the camera data. The RPM stated "We randomly review tapes and go live to see what is going on at the group home." The RPM and QIDP stated the current camera/surveillance system was not "user friendly." The RPM and the QIDP indicated the facility was in the process of trying to update their system which would allow the QIDP and RPM to review the tapes more often. The QIDP and the RPM indicated the facility had utilized the tapes from the camera to substantiate abuse in the past. The RPM indicated the facility did not have a policy and procedure which indicated how the cameras were to be utilized in regard to investigations and/or when to</p>			

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W 0153 Bldg. 00	<p>review to ensure clients were not being neglected and/or abused.</p> <p>2. The facility failed to ensure its staff immediately reported all allegations of abuse and/or neglect to the administrator for clients B and C. Please see 153.</p> <p>3. The facility failed to conduct thorough investigations in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D, E and F. Please see 154.</p> <p>This federal tag relates to complaint #IN00174891.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 2 of 15 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure its staff immediately reported all allegations of abuse and/or neglect to the administrator for clients B and C.</p>	W 0153	In order to correct this deficiency, the following policies have been implemented in order to facilitate greater awareness of how to document and discover injuries of unknown origin as well as how staff should respond when discovery of an injury of unknown origin is discovered: body checks	07/16/2015

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	<p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 6/9/15 at 2:50 PM. The facility's 5/29/15 reportable incident report indicated at 9:35 AM, "Staff (staff #2) reported to Day Program Manager (DPM) on Monday 6/1/15 that she saw the second staff (staff #1) in the PEP room throw [client C] against the wall repeatedly by (sic) his neck with both hands and then held him against the wall with one hand around his neck. She (staff #2) reported the noise of the incident caused two people outside the room to step in to make sure things were ok but the staff had released him prior to their entry..."</p> <p>The facility's 5/29/15 reportable incident report indicated the incident occurred on 5/29/15 but facility staff did not report the allegation of staff to client physical abuse until 6/1/15.</p> <p>The facility's 5/29/15 reportable incident at 12:00 PM, indicated "The second staff (staff #2) in the PEP room reported that staff (staff #1) prompted [client B] to eat his lunch one time before throwing the food in the trash. [Client B] often requires assistance and supervision while eating..." The 5/29/15 reportable</p>		<p>have been implemented for clients B and C (as well as all other group home clients). These checks are done in the morning before the clients enter the day program and in the afternoon before they return from day program. This practice will help shorten the lag time on reporting on injuries of unknown source. This practice will help isolate instances of injuries of unknown origin. The staff will then record any findings in the medical communication log and communicate any findings to the county QIDP and the day program manager. They will note what they found or note that they found nothing. An in-service training for day program and house staff was held on 6/26/15. Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. The staff are were instructed that any possible allegation of ANE were to be reported to the QIDP or available supervisor immediately. The manager reported to will then be expected to decide the appropriate course to take according to DSi's standard operating procedure. Staff are to observe the chain of command when reporting an injury, ensuring that the incident is reported in a timely manner. The QIDP will continue to make monthly</p>				

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W 0154 Bldg. 00	<p>incident report indicated the incident occurred on 5/29/15 but staff #2 did not report the allegation of staff to client neglect until 6/1/15. The facility's reportable incident report indicated "...Both staff are suspended pending investigation. Investigation was completed on 6/2/2015. The reporting staff was counseled and retrained on reporting practices on 6/2/2015."</p> <p>Interview with DPM on 6/9/15 at 12:45 PM and on 6/10/15 at 9:15 AM indicated staff #2 did not report the allegation of abuse and/or neglect with clients B and C until 6/1/15. The DPM indicated she counseled staff #2 in regard to the late reporting and reminded the staff allegations of abuse and/or neglect should be reported immediately. The DPM indicated if staff #2 had reported the first allegation of abuse to the DPM on 5/29/15 at 9:35 AM, the other incidents which occurred on 5/29/15 could have been prevented.</p> <p>This federal tag relates to complaint #IN00174891.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>		<p>observations of staff/client interactions. The QIDP and day program manager will ensure through weekly visits to the pep room that staff/client interactions are appropriate and that staff are properly reporting unknown injuries. The county QIDP and regional program manager will ensure that weekly, unannounced visits to the county group homes are conducted and documented. The day program manager, QIDP and RPM will make weekly visits to the PEP room/ Workshop in order to better monitor and document staff/client interactions.</p>				

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	<p>alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 11 of 15 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, C, D, E and F.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 6/9/15 at 2:50 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-3/19/15 "Last evening when staff, [staff #3], was assisting [client B] with a shower he noted that [client B] had a 2" (inch) in diameter bruise on his upper right leg on his hip. Staff reports that the bruise was not there yesterday. [Client B] was asked what happened and he replied to staff, 'I fell on the sidewalk.' Staff reports that the previous day he had not been on a walk from the house. Additionally, [client B] often states he's fallen whether he has or not. He also has falls as a behavior. This Q (Qualified</p>	W 0154	<p>In order to back up any ANE findings or any adverse trend, the agency will develop an agency investigation team. This team will include quality assurance managers from each department. The goal of this new arrangement is to have investigations conducted by managers from differing departments. This team will be instructed upon proper investigative techniques and systemic resolutions that address the root cause of the investigation. They will be instructed upon the proper collection of interviews, statements, physical evidence and any pertinent maps, pictures or diagrams. This team will also be asked to attend INARF's incident investigation and recommendations training on 8/11/2015. The RPM will review all completed investigations in order to determine if the corrective actions are adequate and in line with state regulations. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and request investigations if they meet the criteria. The day program manager, QIDP and RPM will make weekly visits to the PEP room/Workshop in order to better monitor and document staff/client interactions.</p>	07/16/2015

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	<p>Intellectual Disabilities Professional) talked with PEP room staff who reported a calm day yesterday. She stated that they had watched a movie the previous afternoon. The only thing that she could think of that could've caused the injury was the way that [client B] often throws himself into chairs. Had he been at the window and run to the chair for the movie he would've thrown himself on his right side into the arm of the chair. Staff reports the arms of the chair are hard and he could've bruised himself on this. This would have been at the hip area. This Q will continue to investigate to see if the cause of the injury can be discovered...."</p> <p>The facility's 3/24/15 Incident Investigation indicated all facility staff and 1 day program staff were interviewed. The facility's 3/24/15 investigation indicated in the section entitled "Conclusion/Outcome/Systemic Changes: It is unknown how [client B] received his bruise." The facility's investigation of client B's injury of unknown source indicated the facility failed to include any recommendations with the investigation.</p> <p>-3/25/15 "A HAB (habilitation) staff was in the workshop picking up a client for an outing, when he observed client [client F] turning his shirt around because it was</p>						

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	<p>backwards. Staff noticed he had a bruise on his left hip. Client [client F] was asked to come to a private office so the Day Program Manager and the Industry Manager could see the bruise. Day Program Manager asked [client F] if she could measure the injury and document it by taking a picture. There is no documentation, reports, or knowledge of an incident that would have caused this injury to [client F] by day program staff, workshop supervisors, or managers. The bruise is located on his left hip. The yellow portion of the bruise is 13 cm (centimeters) in width from left to right. The purple bruise look (sic) like a scrape but there is no tearing of the skin. There are 4 purple marks. The top purple mark is 5cm in length and the bottom two marks are 8.5 cm in length from left to right. The yellow portion is oval in shape, widening in the middle (top to bottom). Day Program Manager attempted to contact Q and QA (Qualified Intellectual Disabilities Professional Assistant) to see if residential staff reported any incidents but were unavailable at the time. Day Program Manager passed the information on to Regional Group Home Manager who said they would begin investigating immediately."</p> <p>The facility's 3/30/15 Incident</p>			

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	<p>Investigation indicated client E was interviewed in regard to client F's injury. Client E's 3/25/15 witness statement indicated "...[Client E] said [client F] got hurt over the weekend when he fell at R.R. (unidentified) This may or may not be true as [client E] is not always a good historian...." The facility's investigation indicated facility staff did not know how client F received the injury as no falls and/or behavior were indicated. The facility's 3/30/15 investigation indicated one staff thought client F may have injured himself on the door knobs as they were "...37," abt (about) the height of bruise. This may be how [client F] hurt side...." The 3/30/15 investigation indicated the facility failed to include any conclusion and/or recommendations in regard to the investigation of client F's injury.</p> <p>-4/1/15 "Day Program Manager Assistant (DPMA) went to the Personal Enhancement Program (PEP) to get a magazine. When she walked in she observed [client C] entering the kitchen area and trying to steal drinks out of the cabinet. Staff followed [client C] into the kitchen and proceeded to hit [client C] at the base of his head with the palm of her hand 3 times. [Client C] had a red mark from the contact but it vanished within minutes after the incident. Staff was</p>						

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	<p>suspended pending investigation. The team lead was at a presentation for bed bug awareness, the new hire who was shadowing was in the employee bathroom, and the second staff was assisting a client in the bathroom at the time of the incident." The 4/1/15 reportable incident report and/or investigations indicated the facility failed to document an investigation in regard to the above allegation of staff to client abuse as no investigation was attached and/or provided.</p> <p>-5/5/15 "Team Lead of the Personal Enhancement Program noticed bruising on [client D's] right arm just above his elbow. It is three linear marks between 1/2 inch and 3/4 inch. (sic) no more than a centimeter apart, going horizontal above his elbow. Staff immediately documented the bruising with pictures and notified manager. Manager contacted the residential program manager who had no knowledge of any injuries. An internal investigation and Day Programming staff had no knowledge of any incident that could have caused the bruising. When the program manager observed the bruising, it was noted the markings were too close for finger (sic) to be the cause but it looked more like he hit his elbow across an object, although nothing could be</p>			

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	<p>specifically determined as the cause." The facility's 5/8/15 Incident Investigation indicated the Residential Program Manager (RPM) "...stated that [client D] likes to lay on the floor at home near the register vents. If he had SIB and hit his arms on that it could be the cause but there were no reports from residential staff of knowledge of the occurrence." The facility's 5/8/15 investigation indicated 3 day program staff and the RPM were interviewed. The facility's investigation indicated "...Conclusion/Outcome/Systemic Changes: Unknown bruise could have been from another client could (sic) have pinched him while in the day program or at home, but no evidence of that happening. Staff will monitor client for health and safety purposes." The facility's 5/8/15 investigation indicated the facility failed to interview/document interviews of group home staff and/or clients in regard to client D's injury of unknown source.</p> <p>-5/5/15 "Team Lead was assisting [client C] with getting his drink when he reached his arm out and she noticed a bruise under his t shirt. The bruise was on the right arm on the inside of his bicep. The bruise was 2 centimeters by 1.5 centimeters...When the program manager observed the bruising, it was</p>			

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	<p>noted the bruise had two small blood dots where in the bruise as if he was poked by something." The facility's reportable incident report indicated the DPM conducted the investigation and the day program staff did not know how client C received the injury. The facility's investigation also indicated the RPM was the only group home staff who was interviewed. The facility's 5/5/15 reportable incident report indicated the facility failed to document and/or conduct a thorough investigation in regard to the client's injury of unknown source.</p> <p>-5/7/15 "[Client B] went to the bathroom and the staff that was assisting him saw two bruises on his right thigh. The top bruise is about 2 inches by 1.5 inches and a smaller one about 1/2 inch of space between and it is about 1/2 by 1/2 inch. Staff documented the bruise and notified residential QA but there were no reports that would explain the injury. Staff in the Day Program room did not have any knowledge of a specific incident that caused the bruise but did state that [client B] rushes when he walks and often times bumps into tables, countertop in the bathroom and railings in the hallway at his home and the height of the bruise matches the height of those few items." The 5/7/15 investigation indicated the facility failed to document a thorough</p>			

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	<p>investigation as no group home staff and/or day program staff interviews were included.</p> <p>-5/21/15 "This morning when [client F] was receiving his morning breathing treatment staff noted a bruise on his upper left arm. The bruise was 2 cm. The client was asked but could not say how he got the bruise. The overnight staff did not know about the bruise. Today the Q talked with [client F]. He said he got the bruise on the vehicle. This Q will continue to see if it can be determined how he received this injury. The injury today appears to be around 1/2 inches high and 2 inches wide and a blotchy blue...." The 5/21/15 reportable incident report indicated the facility failed to conduct a thorough investigation in regard to client F's injury of unknown source as no additional documentation was attached.</p> <p>-5/29/15 at 9:35 AM, "Staff (staff #2) reported to Day Program Manager (DPM) on Monday 6/1/15 that she saw the second staff (staff #1) in the PEP room throw [client C] against the wall repeatedly be (sic) his neck with both hands and then held him against the wall with one hand around his neck. She (staff #2) reported the noise of the incident caused two people outside the</p>			

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	<p>room to step in to make sure things were ok but the staff had released him prior to their entry. Staff were suspended pending the investigation. Alleged abusive staff (staff #1) reported the incident occurring as follows; [Client C] tried to steal another clients (sic) drink and she redirected him. She reported that [client C] slapped the counter twice after being redirected. She reported [client C] then walked up to the wall and smacked the wall, then went after another client and staff intervened by stepping between them then he went over to the door and squeezed his own neck, punched himself in the neck, and slammed the back of his head off the wall and his his head off the counter. She reported he threw the books off the shelf and after picking them up he went and laid on the couch.</p> <p>Day Program Manager interviewed the Group Home Manager and Assistant Manager about the possibility of [client C] having a history of SIB (self-injurious behavior) of squeezing his neck or punching his neck and it was stated that there is no history of that behavior. His behavior patterns are physical aggression of punching or pinching others, SIB of punching his lower jaw and temple, biting his arms, and banging his forehead on the counter, doorways or walls.</p> <p>Day Program Manager Assistant went down to look at [client C] to determine if</p>			

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	<p>injuries were present but no markings were left. She then asked [client C] to grab his throat or choke himself to see if he was capable of doing that gesture but he just placed one hand on his chest and made a gagging face.</p> <p>Day Program Manager called the alleged abuser into the office to interview her and her comments were the same as she reported on the report. When asked if the reports were accurate she responded that [Client C] 'was off the chain.' Day Program Manager then responded that [client C] does not have a history of choking himself or squeezing/punching his neck and she continued to respond that '[Client C] was off the chain.'</p> <p>Day Program Manager called the reporting staff into the office and interviewed her. The staff modeled the incident by re-enacting it with the day program manager. She placed the day program manager where [client C] was standing and she stood where the alleged abuser was standing. She stated [client C] came up to the staff and tried to pinch her and that's when she placed her hands around my neck and mimicked a thrust backward several times then removed one hand and mimicked a hold on the neck. She removed her hand and stepped back before the Quality Manager came in through the one door and the training nurse came in through the other to check</p>			

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	<p>what the commotion was.</p> <p>Day Program Manager spoke with Quality Manager. She asked why he entered the room and what he saw when he went in. He stated he heard banging against the wall several times and when he walked in [client C] was hanging a picture on the wall.</p> <p>Day Program Manager interviewed the training nurse and he reported that he heard banging against the wall 5 or 6 times and when he entered the staff (staff #1) was moving back from the client and she redirected him to the sensory area of the room which point there was no further commotion. Investigation was completed on 6/2/2015. The reporting staff was counseled and retrained on reporting practices on 6/2/2015. The staff that was alleged abusive will be terminated on 6/3/15 with a disciplinary action based on DSI (Development Services Incorporated) policy. Staff will maintain health and safety." The 5/29/15 reportable incident report indicated the facility failed to interview verbal clients in the PEP room.</p> <p>-5/29/15 at 12:00 PM, "The second staff (staff #2) in the PEP room reported that staff (staff #1) prompted [client B] to eat his lunch one time before throwing the food in the trash. [Client B] often requires assistance and supervision while</p>			

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	<p>eating...." The 5/29/15 reportable incident report indicated the incident occurred on 5/29/15 but staff #2 did not report the allegation of staff to client neglect until 6/1/15. The facility's reportable incident report indicated "...Both staff are suspended pending investigation. Investigation was completed on 6/2/2015. The reporting staff was counseled and retrained on reporting practices on 6/2/2015. The staff that was alleged neglectful will be terminated on 6/3/15 with a disciplinary action based on DSI policy. Staff will maintain health and safety." The 5/29/15 reportable incident report indicated the facility failed to document an investigation in regard to the above allegation of staff to client abuse as no investigation was attached.</p> <p>Interview with DPM on 6/9/15 at 12:45 PM and on 6/10/15 at 9:15 AM indicated the day program had terminated staff in the past several months for abuse and/or neglect of clients. The DPM indicated she conducted the investigation in regard to client B and C's allegations of abuse/neglect on 5/29/15. The DPM indicated she conducted the investigations for the day program when injuries of unknown source were discovered, and/or allegations of abuse/neglect were made. The DPM</p>			

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203			
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	<p>indicated she had not written/typed up the 5/29/15 investigation as she had been working in the PEP room. The DPM indicated she spoke with the day program staff who worked in the PEP room. The DPM stated she did not interview any clients as the clients would not be able to give "an accurate account of what happened."</p> <p>Interview with the RPM and the Qualified Intellectual Disabilities Professional (QIDP) on 6/10/15 at 11:45 AM indicated the DPM had conducted the investigation in regard to the 5/29/15 allegations of abuse/neglect involving clients B and C. The RPM and the QIDP indicated staff #1 had been terminated in regard to the 5/29/15 allegations. The RPM and the QIDP indicated they conducted the investigations in regard to client B, C, D and F's injuries of unknown source when discovered at the group home. The RPM and/or the QIDP indicated indicated the facility did not document its investigation of client D's 6/4/15 injury of unknown source. The RPM indicated the reportable incident reports, in regard to injuries of unknown source, should have been investigated. The RPM and the QIDP indicated they and/or the DPM may not have included documentation to ensure all injuries of unknown source were thoroughly</p>						

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	<p>investigated. The RPM indicated the 4/1/15 allegation of abuse regarding client C was investigated by the DPM. The RPM stated the investigation was "done but not documented." The RPM indicated the facility staff was terminated over the 4/1/15 incident. When asked if the facility had looked at and/or reviewed the number of incidents involving injuries of unknown source as a whole for the the group home to rule out abuse, The RPM and the QIDP stated "No."</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 6/9/15 at 2:50 PM. The facility's 3/27/15 reportable incident report indicated "Last evening at home a bruise, 2" long by 1/2" wide, was noticed by staff on [client E's] left foot on the top where the toes meet the foot. When asked [client E] said another client had stomped on his foot while he was in the bathroom at the workshop. When later asked by staff about whether or not he'd told staff at the workshop he replied that he tried...This Q will begin an investigation on Monday with the workshop staff to determine if and when the situation happened. The client is not always a good historian but he definitely has a bruise and we need to determine what happened if possible...."</p>			

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	<p>The facility's 3/30/15 Incident Investigation indicated 3 workshop staff were interviewed about in regard to client E's bruised foot. The facility's 3/30/15 investigation indicated client E had not reported his foot being injured at the workshop. The 3/30/15 investigation indicated the perpetrator indicated he was in the bathroom with client E but denied "stomping" on client E's foot. The facility's 3/30/15 investigation indicated "...Conclusion/Outcome/Systemic Changes: It is likely that client's injury was caused by a co-worker at W/S (workshop) although co-worker denies this." The facility's investigation failed to interview any additional clients who may have been in the bathroom/or in the area when the incident occurred, and/or failed to interview group home staff in regard to the client's injury.</p> <p>The facility's 4/7/15 reportable incident report indicated "Yesterday evening the Q received a phone call from staff at [client E's] home, [staff #5], who reported that [client E's] right foot toes were all purple and bruised. The bruised area was 3" x (by) 2". When staff asked [client E] what happened he reported that a client in the workshop had stomped on his foot while they were in the restroom earlier that day or the day before. He reported that it was the same client that</p>			

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	<p>had stomped on his left foot in March. Today [client E] went to [name of medical facility] due to his injury and an x-ray was done of his foot. Although [client E] is not complaining of pain the x-ray revealed a fracture distal right, 1st (first) metatarsal. The doctor writes that this is a stable fracture and should heal uneventfully and that the client may work if he is able to sit and elevate his right foot. He should have no prolonged walking or standing. He will be wearing a post op (operative) shoe for the metatarsal fracture. This situation is to be investigated. After [client E's] left foot was stomped on there was a plan in place at the workshop that this other client and [client E] were not to be in the restroom together and therefore passes to the restroom were not to be given at the same time for these two clients. Assuming that [client E] is being truthful it seems that the plan was not followed...." The facility's 4/7/15 reportable incident report indicated the facility did not conduct a thorough investigation in regard to client E's fractured toe/foot as no additional information in regard to an investigation was documented/completed.</p> <p>Interview with the QIDP on 6/10/15 at 11:45 AM indicated she conducted the investigations of client E's 3/27 and</p>			

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W 0267 Bldg. 00	<p>4/7/15 injuries. The QIDP indicated the workshop was to keep client E separate from his peer at the workshop so the clients were not in the bathroom at the same time. In regard to the 4/7/15 injury/fracture, the QIDP stated there was "no actual investigation. I took the [client E's] word for it."</p> <p>This federal tag relates to complaint #IN00174891.</p> <p>9-3-2(a)</p> <p>483.450(a)(1) CONDUCT TOWARD CLIENT The facility must develop and implement written policies and procedures for the management of conduct between staff and clients.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure a staff person did not use inappropriate language when working around clients at the day program.</p> <p>Findings include:</p> <p>During the 6/9/15 observation period between 11:02 AM and 12:45 PM, at the day program, staff #6 wheeled a client into the PEP (Personal Enhancement Program) room. Staff #7 stated to staff</p>	W 0267	In order to correct this deficiency, the staff in question was issued a counseling memorandum regarding the proper use of language when clients are present. An in-service was held on 6/26/15 to address the expectation of proper discourse between staff and clients and staff to staff. Staff are to maintain a professional demeanor while working and strive to set a good example as a mentor. Staff are expected to act (language, action, discipline, rules etc.) in a way that promotes the clients' quality of life. The QIDP will use monthly observations as well as weekly	07/16/2015

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	<p>#6 "We are revoking your vacation." Staff #6 replied/stated in a loud tone "B....., I'm still going." After staff #6 made his statement, staff #9 said "sh sh" and looked in the surveyor's direction. Staff #6 turned around to see who staff #9 was looking at. Staff #6 turned back around and left the PEP room. Clients A, B, C and D were present when staff #6 made the statement. The Day Program Manager (DPM), staff #7 and #9 were also present in the area/PEP room.</p> <p>Interview with staff #9 on 6/9/15 at 1:00 PM stated facility staff should not use "inappropriate language" in front of clients.</p> <p>Interview with administrative staff #3 on 6/9/15 at 1:09 PM indicated facility staff should not curse/use inappropriate language around clients. When asked if the facility had a policy and procedure in regard to staff to client interactions, administrative staff #3 indicated she would check to see. Administrative staff #3 indicated the staff to client interactions were a part of facility's staff training the facility provided when staff were hired.</p> <p>Interview with the Residential Program Manager (RPM) on 6/9/15 at 1:11 PM when told what happened in the PEP</p>		<p>unannounced visits to ensure that staff are using appropriate language. The day program manager, QIDP and RPM will make weekly visits to the PEP room in order to better monitor and document staff/client interactions. The day program manager, QIDP and RPM will make multiple weekly visits to the PEP room/ Workshop in order to ensure staff are interacting with the clients in a positive and uplifting manner.</p>		

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	<p>room, stated "Definitely inappropriate." The RPM indicated staff to client interactions and conduct were a part of the facility's Standard Operating Procedures manual.</p> <p>Interview with the DPM on 6/10/15 at 9:15 AM indicated she heard staff #6's statement on 6/9/15. The DPM indicated staff #6 should not have used that kind of language in front of clients. The DPM indicated she was not staff #6's supervisor as the staff person, who was assisting the client, was from a group home. The DPM indicated she reported the incident to staff #6's supervisor.</p> <p>The facility's 12/22/11 Standard Operating Procedures (SOP) were reviewed on 6/9/15 at 1:48 PM. The facility's SOP indicated in regard to clients' rights, facility staff were not to swear and/or use "name calling" when around clients.</p> <p>9-3-5(a)</p>			