

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/23/2011
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN46410
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W0000	<p>This visit was for the investigation of complaint #IN00099678.</p> <p>COMPLAINT #IN00099678: SUBSTANTIATED, Federal and State deficiency related to the allegations are cited at W102, W104, W122, W149, W153, W154, and W157.</p> <p>Dates of Survey: November 21, 22, and 23, 2011.</p> <p>Surveyor: Susan Eakright, Medical Surveyor III</p> <p>Facility number: 001113 Provider number: 15G599 AIM number: 100245610</p> <p>The following deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 12-13-11 by C. Neary, Program Coordinator.</p>	W0000		
W0102	<p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview the Condition of Participation: Governing Body and Management was not met based on: The governing body failed to establish</p>	W0102	The governing body will exercise general policy, budget and operating direction over the facility. The facility trains all employees on policies of client protection, reporting of incidents and oversight to provide	12/25/2011

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>oversight of the facility to ensure Client Protections Condition of participation for 1 of 1 sample client (client A) who lived at the group home and was left unsupervised on the facility van, failed to ensure implementation of the agency's policy and procedure for abuse, neglect, and mistreatment prevention, failed to ensure the facility immediately reported incidents of abuse, neglect, and mistreatment, and failed to ensure thorough investigations were completed. The governing body failed to ensure implementation of effective corrective action to protect clients from allegations of abuse, neglect, and/or mistreatment systemically and failed to provide systemic oversight of the group home to ensure clients' rights and staff retraining was completed.</p> <p>Findings include:</p> <p>Please see W104. The governing body failed to ensure implementation of their abuse, neglect, and mistreatment policy and procedure to prevent client A's non compliance identified behavior, failed to ensure facility staff immediately reported allegations of neglect, failed to ensure documented corrective action to protect client A from his identified behavior, and failed to a ensure thorough investigation was completed. The governing body</p>		<p>protection to all clients in the facility care.The governing body will ensure implementation of said policies to provide protection to clients. Refer to W 104, W122Person responsible: Area DirectorCompletion date; 12/25/2011</p>		

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W0104	<p>failed to provide facility oversight to monitor staff interactions for behavior management and abuse, neglect, mistreatment policy implementation for 1 of 1 client (client A) who lived at the group home and was left unsupervised on the facility van.</p> <p>Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections, for 1 of 1 sample client (client A) who lived in the group home and was left unsupervised on the facility van. The facility neglected to implement their abuse, neglect, and mistreatment policy and procedure, to immediately report an incident of abuse, neglect, and mistreatment to the administrator, to complete thorough investigations, and to take immediate effective corrective action to protect client A from his identified behaviors.</p> <p>This federal tag relates to complaint #IN00099678.</p> <p>9-3-1(a)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 1 client (client A) who lived at the group home and was left unsupervised on the</p>	W0104	<p>The governing body will exercise general policy, budget, and operating direction over the facility. The facility will ensure the staff</p>	12/25/2011	

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	<p>facility van, the governing body failed to ensure implementation of their abuse, neglect, and mistreatment policy and procedure to prevent client A's non compliance identified behavior, failed to ensure facility staff immediately reported allegations of neglect, failed to ensure documented corrective action to protect client A from his identified behavior, and failed to ensure thorough investigation was completed. The governing body failed to provide facility oversight to monitor staff interactions for behavior management and abuse, neglect, mistreatment policy implementation.</p> <p>Findings include:</p> <p>On 11/21/11 at 12:30pm, the BDDS (Bureau of Developmental Disability Services) Reports from 9/1/11 through 11/21/11 were reviewed for the facility.</p> <p>-An 11/7/11 BDDS report for an incident on 11/7/11 at 12pm, indicated the facility "staff stated that [client A] had been in major behaviors all morning. [Client A] had refused to get out of the van during transporting for day service. (Unidentified multiple) Staff left [client A] unattended on the van" and the unidentified multiple staff were suspended.</p> <p>On 11/21/11 at 12:30pm, the facility's 11/7/11 "Quality Assurance Review" indicated client A refused to "get off van and was left unattended on van. The staff members are suspended pending the outcome of an investigation. Staff will be re-trained on [client A's] Behavior Development Plan</p>		<p>follow the facility policy and procedure to ensure protection of the client, correct immediate reporting of alleged neneglect and follow through on corrective action to client targeted behaviors. The facility trains staff prior to working with the client on policy and procedures to ensure their knowledge of said procedures.The Program director will ensure the staff are retrained on the behavioral plan of client A to ensure intervention of targeted behavior in the proper manner. In addition, the training will include client supervision levels, and procedures for reporting an incident, client rights and endangered adults. The Area director will retrain the program director and home manager on procedures of oversight of the home to monitor staff interaction for behavior management and abuse, neglect and treatment of client policies and policy of investigation procedures in the event of client incident.The Home manager will monitor the staff and client daily records on a daily basis to ensure the administration of policy is adhered to consistently. The Program Director will observe in the home on a weekly basis for a month to ensure staff are protecting the clients and adhering to the policy as written.Person Responsible: Area DirectorCompletion date:12/25/2011</p>				

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	<p>(BDP) and the residence required 24 hour supervision." No staff retraining and no investigation were available for review.</p> <p>On 11/21/11 at 1:45pm, an interview with the Site Director (SD) and the QDDP (Qualified Developmental Disability Professional) was completed. The SD and the QDDP both indicated they could not provide the time of the incident, the length of time client A was left alone on the van, or additional information not provided in the 11/7/11 BDDS report. Both indicated they were notified by the evening shift personnel of the incident.</p> <p>On 11/21/11 from 4pm until 5:20pm, interviews were completed at the group home with client A, the QDDP, DCS (Direct Care Staff) #6, and DCS #7. At 4:15pm, client A indicated he did not recall the 11/7/11 incident. At 4:15pm, DCS #6 and DCS #7 both stated client A had known behaviors of "non compliance, needs 24 hour supervision, and [client A] never (was) left alone at home or in the community." Both DCS #6 and DCS #7 stated "staff have to be there" with client A. At 5:15pm, the QDDP stated client A "was not independent to cross the street, did not recognize danger, and needs supervision." At 4pm, the QDDP indicated client A's 11/11 DSR (Daily Support Record) record and 11/11 Behavior Tracking data sheet were not available for review.</p> <p>On 11/22/11 at 9:15am, the QDDP was interviewed and provided an 11/16/11</p>				

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	<p>investigation for client A's 11/7/11 incident. The QDDP and the "Investigative Report" both indicated client A "was in major behaviors refusing to get off the van. [Client A] was left on van unsupervised." A list of staff who were interviewed was listed and the documents reviewed listed "MAR (Medication Administration Record), Behavior Development Plan (BDP), Daily Support Record (DSR) (for) 11/7/11, and Behavior Tracking data sheet (on) 11/7/11." No witness statements, no DSR record, and no Behavior Tracking data sheet were available for review. At 9:15am, the QDDP indicated these documents would be provided on 11/23/11.</p> <p>On 11/22/11 at 9:15am, the QDDP stated the documented 11/16/11 investigation outlined "discussions" the QDDP had with the staff in regards to client A's 11/7/11 incident. The QDDP stated she "paraphrased what the staff told her" and no witness statements, no dates, and no time of events were documented.</p> <p>-Undated DCS (Direct Care Staff) #3 "finding" indicated DCS #3 was at the group home. DCS #3 and DCS #1 got out of the van with unidentified clients and went inside. DCS #3 indicated she began to start preparing lunch, DCS #1 "completed paperwork," and DCS #3 stated "didn't know where the house phone was to call anyone to notify that the group home staff left [client A] in the van."</p> <p>-Undated DCS #5's "discussion" indicated client A "was sitting on the van by his self (sic) when (DCS #5) arrived" to the group home "about 12:10 or 12:15pm." DCS #5's</p>				

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	<p>"discussion" indicated DCS #5 "got on the van with [client A] and asked [client A] to get off the van, (and) [client A] got off the van with no problem." DCS #5 indicated client A "had urine on self (sic)."</p> <p>-Undated DCS #4's "discussion" indicated DCS #4 called the office to report to the QDDP the following: "as [DCS #4] was walking (into) the house door [DCS #1 and DCS #2] was walking out of the house saying we are gone, and [client A] is still on the van." DCS #4 stated she "was not really sure how long [client A] was left on the van."</p> <p>-Undated DCS #2's "discussion" indicated client A refused to get out of the van at day service community location and the day service coordinator told DCS #2 to "take [client A] to the house." DCS #2 stated DCS #3 and her clients were standing at the door of the group home "when the van pulled up." DCS #1 "got out of the van and opened the (group home) door for the staff and [DCS #1] stayed in the house and finished her paperwork." DCS #2 stated "[client A] was never alone," DCS #2 was "aware [client A] 24 hour supervision (sic)."</p> <p>-Undated DCS #1's "discussion" indicated she "went to take [client A]" to the community day service and "no (one) was there then went back (to the group home)." DCS #1 stated "don't know how long [client A] was out there by his self."</p> <p>On 11/22/11 at 9:15am, the 11/16/11 "Investigation" for client A's 11/7/11 incident indicated "Conclusion: Based on the information revealed in the investigation,</p>			

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	<p>staff was negligent in leaving [client A] unattended on the van. [Client A] was never signed over to the [staff at the group home on 11/7/11]."</p> <p>On 11/23/11 at 8:20am, an interview with the QDDP was completed. The QDDP indicated client A's 11/7/11 incident had no witness statements, no DSR record, and no 11/2011 Behavior Tracking data sheet available for review. The QDDP indicated the investigative results had not been reported to the administrator. The QDDP indicated no staff retraining had been completed for client A's BDP and client A's supervision needs, The QDDP indicated the two staff involved were suspended after the incident. The QDDP stated the two staff (DCS #1 and DCS #2) "had went out back to smoke during the day" and finished paper work while client A was left on the van unsupervised. The QDDP indicated the 11/7/11 incident was not immediately investigated. The QDDP provided a "Monthly Progress Report" which indicated the agency completed one oversight visit in each month proceeding the 11/7/11 incident and no monitoring oversight had been completed since the 11/7/11 incident.</p> <p>Client A's record was reviewed on 11/22/11 at 10:30am. Client A's 10/20/11 ISP (Individual Support Plan) and 12/30/10 BDP both indicated an identified behavior of non compliance. Client A's 11/16/11 "Risk Management Assessment and Plan" indicated client A "does not have the knowledge to make (decisions about transportation), [client</p>			

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	<p>A] is to be supervised 24 hours a day, staff should remain with [client A] at all times monitoring his environment for safety, [client A] has had instance in the past in which he did not report abuse or neglect, staff should continually monitor [client A] for any signs of abuse or neglect, and report suspicions immediately to a supervisor, does not manage his own funds properly, (and) staff supervision needs 24 hour awake supervision."</p> <p>On 11/21/11 at 1:25pm, a record review of the facility's 7/2006 "Quality and Risk Management" indicated the company prohibited neglect of clients and indicated, "Neglect, means the failure by any staff members to supply or to ensure the supply of necessary food, clothing, shelter, health care, or supervision for an individual being served." The policy/procedure indicated the company "Practices prohibited include the following" which included leaving the clients unsupervised and "...6. C. Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employees. 1. Investigations will be conducted for the following incidents: allegations of suspected abuse, neglect, or exploitation...2. Investigation findings will be submitted to the Director of Program Services for review and development of further recommendations as needed within 5 days of the incident."</p> <p>This federal tag relates to complaint</p>				

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W0122	<p>#IN00099678.</p> <p>9-3-1(a)</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>Based on interview and record review for 1 of 1 sample client (client A) who had been left unsupervised, the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement their abuse, neglect, and mistreatment policy and procedure, to immediately report an incident of staff abuse/neglect/mistreatment to the administrator; to complete a thorough investigation, and to take immediate effective corrective action to protect client A from his identified behaviors.</p> <p>Findings include:</p> <p>Please refer to W149. The facility neglected to implement their policy and procedure for abuse, neglect, and mistreatment to protect client A from neglect, neglected to provide supervision, neglected to immediately report client A's 11/7/11 incident to the administrator, neglected to complete a thorough investigation, and neglected to take effective corrective action for 1 of 1 client (client A) who lived at the group home</p>	W0122	<p>Please refer to W149, W153, W154 and W157 Person Responsible: Area Director Completion date: 12/25/2011</p>	12/25/2011	

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W0149	<p>and was left unsupervised on the facility van.</p> <p>Please refer to W153. The facility staff failed to immediately report 1 of 12 BDDS (Bureau of Developmental Disability) reports, for client A's 11/7/11 incident to the administrator for 1 of 1 client (client A) who lived at the group home and was left unsupervised on the facility van.</p> <p>Please refer to W154. The facility failed to thoroughly investigate client A's allegation of abuse, neglect, and mistreatment for 1 of 1 client (client A) who lived at the group home and was left unsupervised on the facility van.</p> <p>Please refer to W157. The facility failed to take sufficient corrective action for a documented incident of neglect to protect client A from his identified behaviors.</p> <p>This federal tag relates to complaint #IN00099678.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, for 1</p>	W0149	The Program director will ensure the staff are retrained on the behavioral plan of Client A to	12/25/2011	

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	<p>of 1 client (client A) who lived at the group home and was left unsupervised on the facility van, the facility neglected to implement their policy and procedure for abuse/neglect/mistreatment to protect client A from neglect, neglected to provide supervision, neglected to immediately report client A's 11/7/11 incident to the administrator, neglected to complete a thorough investigation, and neglected to take effective corrective action to protect client A from his identified behaviors.</p> <p>Findings include:</p> <p>On 11/21/11 at 12:30pm, the BDDS (Bureau of Developmental Disability Services) Reports from 9/1/11 through 11/21/11 were reviewed for the facility.</p> <p>-An 11/7/11 BDDS report for an incident on 11/7/11 at 12pm, indicated the facility "staff stated that [client A] had been in major behaviors all morning. [Client A] had refused to get out of the van during transporting for day service. (Unidentified multiple) Staff left [client A] unattended on the van" and the unidentified multiple staff were suspended.</p> <p>On 11/21/11 at 12:30pm, the facility's 11/7/11 "Quality Assurance Review" indicated client A refused to "get off van and was left unattended on van. The staff members are suspended pending the outcome of an investigation. Staff will be re-trained on [client A's] Behavior Development Plan (BDP) and the residence required 24 hour supervision." No staff retraining and no</p>		<p>ensure intervention of targeted behavior in the proper manner. In addition the training will include client supervision levels, policy and procedures for reporting and incident, client rights and endangered adults. The Area Director will retrain the Home manager and Program Director on procedures of oversight of the home to monitor staff interactions for behavior management and abuse, neglect and treatment of client policies and policy of investigation provcedures in event of client incident. The Home Manager will monitor the staff, client daily records and behavioral data on a daily basis to ensure the administration policy is adhered to consistently. The Program Director will observe in the home on a weekly basis for a month to ensure staff are protecting the clients and adhering to the policies as written. Person Responsible: Area Director Completion date: 12/25/2011</p>		

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	<p>investigation were available for review.</p> <p>On 11/21/11 at 1:45pm, an interview with the Site Director (SD) and the QDDP (Qualified Developmental Disability Professional) was completed. The SD and the QDDP both indicated they could not provide the time of the incident, the length of time client A was left alone on the van, or additional information not provided in the 11/7/11 BDDS report. Both indicated they were notified by the evening shift personnel of the incident.</p> <p>On 11/21/11 from 4pm until 5:20pm, interviews were completed at the group home with client A, the QDDP, DCS (Direct Care Staff) #6, and DCS #7. At 4:15pm, client A indicated he did not recall the 11/7/11 incident. At 4:15pm, DCS #6 and DCS #7 both stated client A had known behaviors of "non compliance, needs 24 hour supervision, and [client A] never (was) left alone at home or in the community." Both DCS #6 and DCS #7 stated "staff have to be there" with client A. At 5:15pm, the QDDP stated client A "was not independent to cross the street, did not recognize danger, and needs supervision." At 4pm, the QDDP indicated client A's 11/11 DSR (Daily Support Record) record and 11/11 Behavior Tracking data sheet were not available for review.</p> <p>On 11/22/11 at 9:15am, the QDDP was interviewed and provided an 11/16/11 investigation for client A's 11/7/11 incident. The QDDP and the "Investigative Report"</p>				

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	<p>both indicated client A "was in major behaviors refusing to get off the van. [Client A] was left on van unsupervised." A list of staff who were interviewed was listed and the documents reviewed listed "MAR (Medication Administration Record), Behavior Development Plan (BDP), Daily Support Record (DSR) (for) 11/7/11, and Behavior Tracking data sheet (on) 11/7/11." No witness statements, no DSR record, and no Behavior Tracking data sheet were available for review. At 9:15am, the QDDP indicated these documents would be provided on 11/23/11.</p> <p>On 11/22/11 at 9:15am, the QDDP stated the documented 11/16/11 investigation outlined "discussions" the QDDP had with the staff in regards to client A's 11/7/11 incident. The QDDP stated she "paraphrased what the staff told her" and no witness statements, no dates, and no time of events were documented.</p> <p>-Undated DCS (Direct Care Staff) #3 "finding" indicated DCS #3 was at the group home. DCS #3 and DCS #1 got out of the van with unidentified clients and went inside. DCS #3 indicated she began to start preparing lunch, DCS #1 "completed paperwork," and DCS #3 stated "didn't know where the house phone was to call anyone to notify that the group home staff left [client A] in the van."</p> <p>-Undated DCS #5's "discussion" indicated client A "was sitting on the van by his self (sic) when (DCS #5) arrived" to the group home "about 12:10 or 12:15pm." DCS #5's "discussion" indicated DCS #5 "got on the van with [client A] and asked [client A] to get</p>				

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	<p>off the van, (and) [client A] got off the van with no problem." DCS #5 indicated client A "had urine on self (sic)."</p> <p>-Undated DCS #4's "discussion" indicated DCS #4 called the office to report to the QDDP the following: "as [DCS #4] was walking (into) the house door [DCS #1 and DCS #2] was walking out of the house saying we are gone, and [client A] is still on the van." DCS #4 stated she "was not really sure how long [client A] was left on the van."</p> <p>-Undated DCS #2's "discussion" indicated client A refused to get out of the van at day service community location and the day service coordinator told DCS #2 to "take [client A] to the house." DCS #2 stated DCS #3 and her clients were standing at the door of the group home "when the van pulled up." DCS #1 "got out of the van and opened the (group home) door for the staff and [DCS #1] stayed in the house and finished her paperwork." DCS #2 stated "[client A] was never alone," DCS #2 was "aware [client A] 24 hour supervision (sic)."</p> <p>-Undated DCS #1's "discussion" indicated she "went to take [client A]" to the community day service and "no (one) was there then went back (to the group home)." DCS #1 stated "don't know how long [client A] was out there by his self."</p> <p>On 11/22/11 at 9:15am, the 11/16/11 "Investigation" for client A's 11/7/11 incident indicated "Conclusion: Based on the information revealed in the investigation, staff was negligent in leaving [client A] unattended on the van. [Client A] was never</p>				

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	<p>signed over to the [staff at the group home on 11/7/11]."</p> <p>On 11/23/11 at 8:20am, an interview with the QDDP was completed. The QDDP indicated client A's 11/7/11 incident had no witness statements, no DSR record, and no Behavior Tracking data sheet available for review. The QDDP indicated the investigative results had not been reported to the administrator. The QDDP indicated no staff retraining had been completed for client A's BDP, client A's supervision needs, and for the prevention of abuse/neglect/mistreatment. The QDDP indicated the two staff involved were suspended after the incident. The QDDP indicated the 11/7/11 incident was not immediately investigated.</p> <p>Client A's record was reviewed on 11/22/11 at 10:30am. Client A's 10/20/11 ISP (Individual Support Plan) and 12/30/10 BDP both indicated an identified behavior of non compliance. Client A's 11/16/11 "Risk Management Assessment and Plan" indicated client A "does not have the knowledge to make (decisions about transportation), [client A] is to be supervised 24 hours a day, staff should remain with [client A] at all times monitoring his environment for safety, [client A] has had instance in the past in which he did not report abuse or neglect, staff should continually monitor [client A] for any signs of abuse or neglect, and report suspicions immediately to a supervisor, does not manage his own funds properly, (and) staff supervision needs 24 hour awake</p>				

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	<p>supervision."</p> <p>On 11/21/11 at 1:25pm, a record review of the facility's 7/2006 "Quality and Risk Management" indicated the company prohibited neglect of clients and indicated, "Neglect, means the failure by any staff members to supply or to ensure the supply of necessary food, clothing, shelter, health care, or supervision for an individual being served." The policy indicated allegations of neglect should be reported immediately to the administrator. The policy/procedure indicated the company "Practices prohibited include the following" which included leaving the clients unsupervised and "...6. C. Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employees. 1. Investigations will be conducted for the following incidents: allegations of suspected abuse, neglect, or exploitation...2. Investigation findings will be submitted to the Director of Program Services for review and development of further recommendations as needed within 5 days of the incident."</p> <p>This federal tag relates to complaint #IN00099678.</p> <p>9-3-2(a)</p>				

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W0153	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, 1 of 12 BDDS (Bureau of Developmental Disability) reports and for 1 of 1 client (client A) who lived at the group home and was left unsupervised on the facility van, the facility staff failed to immediately report client A's 11/7/11 incident to the administrator.</p> <p>Findings include:</p> <p>On 11/21/11 at 12:30pm, the BDDS (Bureau of Developmental Disability Services) Reports from 9/1/11 through 11/21/11 were reviewed for the facility.</p> <p>-An 11/7/11 BDDS report for an incident on 11/7/11 at 12pm, indicated the facility "staff stated that [client A] had been in major behaviors all morning. [Client A] had refused to get out of the van during transporting for day service. (Unidentified) Staff left [client A] unattended on the van" and the unidentified staff were suspended.</p> <p>On 11/21/11 at 12:30pm, the facility's 11/7/11 "Quality Assurance Review" indicated client A refused to "get off van and was left unattended on van. The staff members are suspended pending the outcome of an investigation. Staff will be re-trained on [client A's] Behavior Development Plan</p>	W0153	<p>The facility currently as a witten policy and procedure on mistreatment, neglect or abuse of a client and the reporting there of. All new employees are trained on the policy and the procedure for reporting injury of the clients to the proper authorities within and outside the agency. The Program Director will retrain the staff on the policy and procedures of reporting immediately client incidents with allegations of mistreatment, neglect or abuse. The Area Director will retrain the Home Manager and the Program Director to adhere to the reporting guidelines of reporting an incident within twenty-four hrs for all clients in the event of injury or bruising of unknown orgin to ensure investigation of such incident is investigated and reported within 24 hours as mandated. The Home manager will monitor the daily support records and behavior support data daily to ensure client incidents are reported to the Program Director. Program Director will monitor the staff and documentation logs weekly to ensure that incidents are reported to the Program Director. Program Director will monitor the staff and documentation logs weekly to</p>	12/25/2011	

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	<p>(BDP) and the residence required 24 hour supervision."</p> <p>On 11/21/11 at 1:45pm, an interview with the Site Director (SD) and the QDDP (Qualified Developmental Disability Professional) was completed. The SD and the QDDP both indicated they could not provide the time of the incident, the length of time client A was left alone on the van, or additional information not provided in the 11/7/11 BDDS report. Both indicated they were notified by the evening shift personnel of the incident.</p> <p>On 11/21/11 from 4pm until 5:20pm, interviews were completed at the group home with client A, the QDDP, DCS (Direct Care Staff) #6, and DCS #7. At 4:15pm, client A indicated he did not recall the 11/7/11 incident. At 4:15pm, DCS #6 and DCS #7 both stated client A had known behaviors of "non compliance, needs 24 hour supervision, and [client A] never (was) left alone at home or in the community." Both DCS #6 and DCS #7 stated "staff have to be there" with client A. At 5:15pm, the QDDP stated client A "was not independent to cross the street, did not recognize danger, and needs supervision."</p> <p>On 11/22/11 at 9:15am, the 11/16/11 "Investigation" for client A's 11/7/11 incident indicated "Conclusion: Based on the information revealed in the investigation, staff was negligent in leaving [client A] unattended on the van. [Client A] was never</p>		<p>ensure that incidents that occur are to ensure that incidents that occur are reported in a timely manner in the future. Person responsible: Area Director Completion date: 12/25/2011</p>		

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W0154	<p>signed over to the [staff at the group home on 11/7/11]."</p> <p>On 11/23/11 at 8:20am, an interview with the QDDP was completed. The QDDP indicated the incident was not been reported immediately to the administrator and should have been.</p> <p>This federal tag relates to complaint #IN00099678.</p> <p>9-3-2(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, for 1 of 1 client (client A) who lived at the group home and was left unsupervised on the facility van, the facility failed to complete a thorough investigation.</p> <p>Findings include:</p> <p>On 11/21/11 at 12:30pm, the BDDS (Bureau of Developmental Disability Services) Reports from 9/1/11 through 11/21/11 were reviewed for the facility.</p> <p>-An 11/7/11 BDDS report for an incident on 11/7/11 at 12pm, indicated the facility "staff stated that [client A] had been in major behaviors all morning. [Client A] had refused to get out of the van during transporting for day service. (Unidentified) Staff left [client A] unattended on the van" and the unidentified staff were suspended.</p>	W0154	<p>The facility currently trains all supervisors upon hire on the policy and format of investigation of client incidents, reporting procedures and follow up to client incidents requiring investigation. The Area Director will retrain the Program director and Home manager to adhere to guidelines of immediate investigation and suspension of staff with alleged suspect of client mistreatment, neglect or abuse. The training will include investigation of such incident is investigated thoroughly and reported within 24 hours as mandated. In the future, the Program Director will immediately begin an investigation upon receiving information on suspected alleged client mistreatment, neglect, or abuse. The Program director will follow</p>	12/25/2011	

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	<p>On 11/21/11 at 12:30pm, the facility's 11/7/11 "Quality Assurance Review" indicated client A refused to "get off van and was left unattended on van. The staff members are suspended pending the outcome of an investigation. Staff will be re-trained on [client A's] Behavior Development Plan (BDP) and the residence required 24 hour supervision." No investigation was available for review.</p> <p>On 11/21/11 at 1:45pm, an interview with the Site Director (SD) and the QDDP (Qualified Developmental Disability Professional) was completed. The SD and the QDDP both indicated they could not provide the time of the incident, the length of time client A was left alone on the van, or additional information not provided in the 11/7/11 BDDS report.</p> <p>On 11/21/11 from 4pm until 5:20pm, interviews were completed at the group home with client A, the QDDP, DCS (Direct Care Staff) #6, and DCS #7. At 4:15pm, client A indicated he did not recall the 11/7/11 incident. At 4:15pm, DCS #6 and DCS #7 both stated client A had known behaviors of "non compliance, needs 24 hour supervision, and [client A] never (was) left alone at home or in the community." Both DCS #6 and DCS #7 stated "staff have to be there" with client A. At 5:15pm, the QDDP stated client A "was not independent to cross the street, did not recognize danger, and needs supervision." At 4pm, the QDDP indicated</p>		<p>the guidlines of completionn of the investigation within the designated time frames outlines in the policy. The Area Director will follow up with Program Director to ensure the investigation is meeting criteria of the company policy. Person responsible: Area Director Completion Date: 12/25/2011</p>		

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	<p>client A's 11/11 DSR record and 11/11 Behavior Tracking data sheet were not available for review.</p> <p>On 11/22/11 at 9:15am, the QDDP was interviewed and provided an 11/16/11 investigation for client A's 11/7/11 incident. The QDDP and the "Investigative Report" both indicated client A "was in major behaviors refusing to get off the van. [Client A] was left on van unsupervised." A list of staff who were interviewed was listed and the documents reviewed listed "MAR (Medication Administration Record), Behavior Development Plan (BDP), Daily Support Record (DSR) (for) 11/7/11, and Behavior Tracking data sheet (on) 11/7/11." No witness statements, no DSR record, and no Behavior Tracking data sheet were available for review. At 9:15am, the QDDP indicated these documents would be provided on 11/23/11.</p> <p>On 11/22/11 at 9:15am, the QDDP stated the documented 11/16/11 investigation outlined "discussions" the QDDP had with the staff in regards to client A's 11/7/11 incident. The QDDP stated she "paraphrased what the staff told her."</p> <p>-Undated DCS (Direct Care Staff) #3 "finding" indicated DCS #3 was at the group home. DCS #3 and DCS #1 got out of the van with unidentified clients and went inside. DCS #3 indicated she began to start preparing lunch, DCS #1 "completed paperwork," and DCS #3 stated "didn't know where the house phone was to call anyone to notify that the</p>						

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	<p>group home staff left [client A] in the van." -Undated DCS #5's "discussion" indicated client A "was sitting on the van by his self (sic) when (DCS #5) arrived" to the group home "about 12:10 or 12:15pm." DCS #5's "discussion" indicated DCS #5 "got on the van with [client A] and asked [client A] to get off the van, (and) [client A] got off the van with no problem." DCS #5 indicated client A "had urine on self (sic)."</p> <p>-Undated DCS #4's "discussion" indicated DCS #4 called the office to report to the QDDP the following: "as [DCS #4] was walking (into) the house door [DCS #1 and DCS #2] was walking out of the house saying we are gone, and [client A] is still on the van." DCS #4 stated she "was not really sure how long [client A] was left on the van."</p> <p>-Undated DCS #2's "discussion" indicated client A refused to get out of the van at the day service community location and the day service coordinator told DCS #2 to "take [client A] to the house." DCS #2 stated DCS #3 and her clients were standing at the door of the group home "when the van pulled up." DCS #1 "got out of the van and opened the (group home) door for the staff and [DCS #1] stayed in the house and finished her paperwork." DCS #2 stated "[client A] was never alone," DCS #2 was "aware [client A] 24 hour supervision (sic)."</p> <p>-Undated DCS #1's "discussion" indicated she "went to take [client A]" to the community day service and "no (one) was there then went back (to the group home)." DCS #1 stated "don't know how long [client A] was out there by his self."</p>				

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	<p>On 11/22/11 at 9:15am, the 11/16/11 "Investigation" for client A's 11/7/11 incident indicated "Conclusion: Based on the information revealed in the investigation, staff was negligent in leaving [client A] unattended on the van. [Client A] was never signed over to the [staff at the group home on 11/7/11]."</p> <p>On 11/23/11 at 8:20am, an interview with the QDDP was completed. The QDDP indicated client A's 11/7/11 incident had no witness statements, no DSR record, and no Behavior Tracking data sheet available for review.</p> <p>Client A's record was reviewed on 11/22/11 at 10:30am. Client A's 10/20/11 ISP (Individual Support Plan) and 12/30/10 BDP both indicated an identified behavior of non compliance. Client A's 11/16/11 "Risk Management Assessment and Plan" indicated client A "does not have the knowledge to make (decisions about transportation), [client A] is to be supervised 24 hours a day, staff should remain with [client A] at all times monitoring his environment for safety, [client A] has had instance in the past in which he did not report abuse or neglect, staff should continually monitor [client A] for any signs of abuse or neglect, and report suspicions immediately to a supervisor, does not manage his own funds properly, (and) staff supervision needs 24 hour awake supervision."</p> <p>On 11/21/11 at 1:25pm, a record review of</p>				

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W0157	<p>the facility's 7/2006 "Quality and Risk Management" indicated "...C. Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employees."</p> <p>This federal tag relates to complaint #IN00099678.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, for 1 of 1 client (client A) who lived at the group home and was left unsupervised on the facility van, the facility failed to provide supervision and to take effective corrective action for a documented incident of neglect to protect client A from his identified behaviors.</p> <p>Findings include:</p> <p>On 11/21/11 at 12:30pm, the BDDS (Bureau of Developmental Disability Services) Reports from 9/1/11 through 11/21/11 were reviewed for the facility.</p> <p>-An 11/7/11 BDDS report for an incident on 11/7/11 at 12pm, indicated the facility "staff stated that [client A] had been in major behaviors all morning. [Client A] had refused to get out of the van during transporting for day service. (Unidentified) Staff left [client A] unattended on the van" and the unidentified staff were suspended.</p>	W0157	<p>The facility will ensure that if an alleged violation of client treatment policy is verified, the appropriate corrective action will take place. The facility will address such verified violation with corrective action plan based on the needs of the individual and the agencies involved. The facility will ensure that an immediate follow up internally and with other agencies occurs after a client incident warranting a BDDS incident report. The corrective action follow up will include steps to prevent future occurrences of violation of client treatment. The facility has developed a corrective action plan to converge with the day program to review the protocol for client A to ensure the day program has the knowledge of the client behaviorial support plan and supervision level. In the future, the facility will contact the</p>	12/25/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/23/2011
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	<p>On 11/21/11 at 12:30pm, the facility's 11/7/11 "Quality Assurance Review" indicated client A refused to "get off van and was left unattended on van. The staff members are suspended pending the outcome of an investigation. Staff will be re-trained on [client A's] Behavior Development Plan (BDP) and the residence required 24 hour supervision." No staff retraining was available for review.</p> <p>On 11/21/11 from 4pm until 5:20pm, interviews were completed at the group home with client A, the QDDP, DCS (Direct Care Staff) #6, and DCS #7. At 4:15pm, client A indicated he did not recall the 11/7/11 incident. At 4:15pm, DCS #6 and DCS #7 both stated client A had known behaviors of "non compliance, needs 24 hour supervision, and [client A] never (was) left alone at home or in the community." Both DCS #6 and DCS #7 stated "staff have to be there" with client A and both indicated no retraining of client A's BDP or Abuse/Neglect prevention had been completed. At 5:15pm, the QDDP stated client A "was not independent to cross the street, did not recognize danger, and needs supervision."</p> <p>On 11/22/11 at 9:15am, the QDDP (Qualified Developmental Disability Professional) was interviewed and provided an 11/16/11 investigation for client A's 11/7/11 incident. The QDDP and the "Investigative Report" both indicated client A "was in major behaviors refusing to get off the van. [Client</p>		<p>day placement branch of the facility preceeding an incident to develop an immediate corrective action plan. The facility will document the training of, facilitation and contacts made with the day program as part of the corrective action. Person responsible: Program Director Completion Date: 12/25/2011</p>		

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	<p>A] was left on van unsupervised."</p> <p>On 11/22/11 at 9:15am, the 11/16/11 "Investigation" for client A's 11/7/11 incident indicated "Conclusion: Based on the information revealed in the investigation, staff was negligent in leaving [client A] unattended on the van. [Client A] was never signed over to the [staff at the group home on 11/7/11]."</p> <p>On 11/23/11 at 8:20am, an interview with the QDDP was completed. The QDDP indicated no staff retraining had been completed for client A's BDP, client A's supervision needs, and for the prevention of abuse/neglect/mistreatment. The QDDP indicated the two staff involved were suspended after the incident. The QDDP stated the two staff (DCS #1 and DCS #2) "had went out back to smoke during the day" while client A was left on the van unsupervised.</p> <p>This federal tag relates to complaint #IN00099678.</p> <p>9-3-2(a)</p>				