

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN 47201
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W0000	<p>This visit was for a the investigation of complaint #IN00106975.</p> <p>Complaint #IN00106975 - Substantiated , Federal and State deficiencies related to the allegation(s) cited at W149, W153, and W154.</p> <p>Survey Dates: May 3, 4, 5, and 9, 2012.</p> <p>Facility Number: 000630 Provider Number: 15G090 AIM Number: 100233920</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 5/10/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting clients B, C, E and F, the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 5/3/12 at 1:47 PM. On 4/7/12 "while lunch or dinner was being prepared," client F went into the kitchen where staff #5 was working. Staff #11 went into the kitchen and escorted client F out of the area and to his room. It was reported by staff #11 while in client F's room, client F had a behavior and threw himself to the floor causing a bloody nose. The incident report indicated, "This is not a typical behavior and no behavior report was done by [staff #11] reporting this behavior." The report indicated, "The Q (Qualified Mental Retardation Professional - QMRP) was told of the incident yesterday (4/11/12) after the team meeting and is currently interviewing staff to ascertain what happened and whether or not a report was needed and</p>	W0149	<p>Agency policies and procedures clearly prohibit abuse, neglect, or mistreatment of clients as well as responsibility for timely reporting of any suspicion of or witnessing such actions. All staff are required to complete training on these policies and procedures initially upon hiring and annually thereafter. QIDP's and house staff will be retrained on these policies and procedures to prevent reoccurrence of noncompliance in this area. QIDP's are responsible for ensuring that staff maintain compliance with annual training and adherence to agency policy. QIDP and SGL Manager will continue to review and investigate all allegations. Failure to follow agency procedures on reporting timely will be addressed with retraining and possible disciplinary action per agency policy.</p> <p>Responsible for QA: QIDP, SGL Manager June 1, 2012</p>	06/01/2012			

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	<p>whether there are more serious concerns."</p> <p>The investigation, dated 4/16/12, indicated the following, "It was unable to be determined how [client F] received a bloody nose. However, in the course of the investigation several other concerning situations were noted that made it apparent that's staff's (#11) employment should be terminated."</p> <p>-An interview in the facility's investigation with staff #4 indicated on 4/11/12, staff #4 asked the QMRP after the team meeting if she received a report from staff #11 over the weekend about client F's behavior causing a bloody nose. Staff #4 reported he was told by staff #11 that client F had a behavior throwing himself to the floor causing a bloody nose. Staff #4 indicated he was doubtful of the story since client F did not throw himself to the floor during a behavior at any time staff #4 had observed client F's behaviors. Staff #11 did not inform staff #4 when the incident occurred.</p> <p>-An interview in the facility's investigation with staff #12 indicated she had received a text from staff #4 (no date or time noted) indicating what staff #4 was told by staff #11. Staff #4 reported no report had been completed but client F had a bloody nose. Staff #12 indicated she had found bloody Kleenex on the floor of client F's bedroom on Monday</p>						

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	<p>(4/9/12) morning. Staff #12 indicated staff #1 and #13 reported to her they heard staff #11 say he would like to, "Smack the s--- out of [client F] because of the way he eats slowly and takes small sips, like a sissy." This was reported on Tuesday (4/10/12) evening and supposedly said by staff #11 at dinner time. Staff #1 and #13 told staff #12 they felt client F was afraid of staff #11. Staff #12 indicated she had observed no signs of this from staff #11. The facility did not provide documentation the allegation was investigated.</p> <p>-An interview with staff #7 included in the facility's investigation indicated, "... she feels [staff #11] is impatient with the guys and that he had yelled at another client to put his fork down."</p> <p>-An interview in the facility's investigation with staff #5 indicated, "[Staff #11] grabbed [client F] by the arm and escorted him to his room. When [client F] was in his room [staff #5] could hear him make a noise he normally makes when he is agitated. When [staff #11] came out [staff #5] was told that [client F] had thrown himself on the floor causing his nose to bleed... [Client #5] stated that he'd later showered [client F] and when he did he noted no blood or mark on [client F's] nose. Q asked if he'd witnessed any unusual or inappropriate actions by [staff #11] and he stated nothing first hand. He</p>						

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	<p>did state that he'd been told by other staff that they'd seen [client F] flinch when [staff #11] passed by him and [staff #5] also understood that there had been a situation on Tuesday (no date) where [staff #11] forced [client F] to stay in a chair and would not allow him to sit on the couch." The facility did not provide documentation the allegation of staff #11 forcing client F to stay in a chair was investigated.</p> <p>-An interview in the facility's investigation with the QMRP regarding her viewing the video tapes of the common areas of the group home was reviewed. The QMRP indicated, "It was observed by this Q on the camera that during dinner time [staff #11] left four clients [clients B, C, E and F] alone for a considerable period of time (3 and a half minutes) knowing that among those clients there were clients with choking problems and were to have 100% supervision. [Staff #11] watched TV seated in the living room during the time. It was also noted that [staff #11] left two clients unattended on the vehicle and then came back in to get the other two clients prior to an outing. Due to lack of judgement and staff being within their probationary period the staff's employment was terminated."</p> <p>-An interview with staff #11 included in the facility's investigation indicated client</p>						

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	<p>F started food seeking on 4/7/12 around 11:30 AM or 11:45 AM and had gone into the kitchen three times. Staff #11 indicated staff #5 was cooking at the stove so staff #11 thought he'd stop a behavior before it happened and escorted [client F] to his room. While in client F's room, client F either tripped or fell. Staff #11 indicated client F tripped due to a shoe being on the wrong foot. Staff #11 indicated client F fell right onto his face and had a small amount of blood coming from his nose. On this date, staff #11 indicated client F had been right in staff #5's face so staff #11 made the decision to remove him.</p> <p>A review of the security videos of the common areas of the group home was conducted on 5/3/12 at 3:08 PM. On 4/7/12 at 12:22 PM, client F entered the dining room after carrying in groceries from outside. Staff #11 approached client F after getting up out of a recliner while watching TV, pointed toward the living room and then restrained client F's arms and escorted to his bedroom. There was no apparent reason for the restraint and escort. At 12:55 PM, staff #11 and client F were in the living room. Staff #11 was leaned back in a recliner watching TV when client F got up and entered the dining room. Client F was standing by his chair in the dining room when staff</p>						

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	<p>#11 entered, pointed toward the living room, and then grabbed client F's right arm and pulled him away from the table. Staff #11 then restrained client F by holding his arms and pushed him to client F's bedroom. There was no apparent reason for the restraint/escort to his bedroom. At 1:02 PM, client F exited his bedroom and stood in the doorway to the living room for several seconds before staff #11 quickly got out of the recliner (watching TV) and approached client F. Client F returned to his room and staff #11 returned to the recliner to watch more TV.</p> <p>A review of the facility's Work Reported document (showing the hours staff worked at the home) was conducted on 5/4/12 at 1:28 PM. Staff #11 worked at the group home on 4/7/12 from 7:00 AM to 11:00 PM, 4/8/12 from 7:00 AM to 11:00 PM, 4/9/12 from 4:00 PM to 8:00 PM and 4/10/12 from 4:00 PM to 8:00 PM. The facility was unable to provide documentation when staff #11 was suspended from working at the group home.</p> <p>A review of client F's Behavior Management Program, dated 8/26/11, was conducted on 5/3/12 at 3:37 PM. The plan indicated he had targeted behaviors of excessive eating, sneaking food, eating</p>			

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	<p>inedible food and incontinence. For excessive eating, staff were to offer a light snack if between meals. If he has had enough, tell him so and redirect to other activities out of the kitchen. For sneaking food, the plan indicated ask him to return the food, ask him to show you what he wants and give a light snack. Do not attempt to physically take the food. Monitor and redirect to other activities or take out for an activity. The plan for physical aggression and property destruction indicated a 2 man transport position may be used. There was no escorts, holds or restraints in client F's plan for food-related behavior.</p> <p>A review of the facility's policy and procedure for Identifying and Reporting Violations of Client Rights, dated 4/12/06, was reviewed on 5/3/12 at 1:45 PM. The policy indicated rights violations included abuse, neglect, exploitation and mistreatment. Abuse was defined as, "the intentional or willful infliction of physical injury, the unnecessary use of physical or chemical restraints or isolation, punishment that results in physical harm or pain." Neglect was defined as, "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."</p>			

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	<p>An interview with staff #5 was conducted on 5/3/12 at 4:22 PM. Staff #5 indicated on 4/7/12, client F entered the kitchen with staff #11 following him. Staff #11 took client F to his room. Staff #5 indicated he could hear that client F was agitated and then heard a sound. Staff #11 then went through the kitchen toward the office; staff #5 indicated he assumed staff #11 went to get first aid supplies. Staff #5 indicated on his way through, staff #11 indicated client F had a "fit" and threw himself on the floor causing a bloody nose. Staff #5 indicated he had not witnessed staff #11 being abusive. Staff #5 indicated client F throwing himself to the floor was not a typical behavior. Indicated he heard through the grapevine staff #11 was verbally abusive but did not report this to administrative staff since he did not witness the abuse.</p> <p>An interview with staff #4 was conducted on 5/4/12 at 12:34 PM. Staff #4 indicated on 4/7/12 when he arrived for his overnight shift, staff #11 told him about client F having a behavior in which he threw himself to the floor. He indicated staff #11 "claimed" client F threw himself to the floor 2-3 times causing a bloody nose. Staff #4 indicated he had worked with client F for 5 years and had never witnessed or heard of client F throwing</p>						

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	<p>himself to the floor. He indicated he was suspicious of the story. Staff #4 indicated when staff #11 left at the end of his shift, staff #4 and staff #7 looked at each other and indicated they did not believe the story. Staff #4 indicated he instructed staff #11 to complete an incident report which he did not do. Staff #4 indicated he reported his concerns on 4/11/12 after a staff meeting. Staff #4 indicated he told the QMRP and the nurse he did not feel comfortable with staff #11 working in the home. Staff #4 indicated he was informed by the QMRP she was aware of concerns and was investigating them. Staff #4 indicated he did not observe injuries to client F. Staff #4 indicated staff #12 found a wad of bloody tissues in client F's room at some point.</p> <p>An interview with staff #7 was conducted on 5/4/12 at 12:49 PM. Staff #7 indicated she worked the overnight shift from 4/7/12 to 4/8/12. She indicated when she arrived to work, staff #11 told her client F had a behavior. Staff #11 told her he could not remember what happened but staff #11 took client F to his room and he went berserk. Staff #11 told staff #7 client F threw himself face first to the floor 2-3 times. Staff #7 indicated she questioned his story as she had worked with client F for over 2 years and had never witnessed him throw himself to the</p>			

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	<p>floor. Staff #7 indicated staff #11 repeated client F had thrown himself to the floor and bloodied his nose. Staff #7 indicated client F's nose was swollen the next morning. She indicated she could not remember if she reported her concerns to anyone until the QMRP contacted her for a statement for the investigation.</p> <p>An interview with the QMRP was conducted on 5/3/12 at 3:54 PM. The QMRP indicated the facility should prevent and prohibits abuse and neglect of the clients. The QMRP indicated the staff should immediately report concerns of abuse and neglect. The QMRP indicated she watched the video from 4/7/12 of the common areas of the group home and observed staff #11 in the living room watching TV while clients B, C, E and F were in the dining room eating. She indicated the first period was 3 minutes and then he checked on them. The second period was 1.5 minutes staff #11 left the clients unattended. The QMRP indicated she stopped watching the video due to knowing staff #11 was negligent; the QMRP did not watch the video of staff #11 escorting client F to his room. The QMRP indicated investigations were not conducted of the allegations noted during the investigation of client F's bloody nose.</p> <p>This federal tag relates to Complaint</p>						

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting clients B, C, E and F, the facility failed to ensure staff immediately reported concerns regarding abuse and neglect to administrative staff, in accordance with State law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 5/3/12 at 1:47 PM. On 4/7/12 "while lunch or dinner was being prepared," client F went into the kitchen where staff #5 was working. Staff #11 went into the kitchen and escorted client F out of the area and to his room. It was reported by staff #11 while in client F's room, client F had a behavior and threw himself to the floor causing a bloody nose. The incident report indicated, "This is not a typical behavior and no behavior report was done by [staff #11] reporting this behavior." The report indicated, "The Q (Qualified Mental Retardation Professional - QMRP) was told of the</p>	W0153	<p>Agency policies and procedures clearly prohibit abuse, neglect, or mistreatment of clients as well as responsibility for timely reporting of any suspicion of or witnessing such actions. All staff are required to complete training on these policies and procedures initially upon hiring and annually thereafter. QIDP's and house staff will be retrained on these policies and procedures to prevent reoccurrence of noncompliance in this area. QIDP's are responsible for ensuring that staff maintain compliance with annual training and adherence to agency policy. QIDP and SGL Manager will continue to review and investigate all allegations. Failure to follow agency procedures on reporting timely will be addressed with retraining and possible disciplinary action per agency policy.</p> <p>Responsible for QA: QIDP, SGL Manager June 1, 2012</p>	06/01/2012

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	<p>incident yesterday (4/11/12) after the team meeting and is currently interviewing staff to ascertain what happened and whether or not a report was needed and whether there are more serious concerns."</p> <p>The investigation, dated 4/16/12, indicated the following, "It was unable to be determined how [client F] received a bloody nose. However, in the course of the investigation several other concerning situations were noted that made it apparent that's staff's (#11) employment should be terminated."</p> <p>-An interview in the facility's investigation with staff #4 indicated on 4/11/12, staff #4 asked the QMRP after the team meeting if she received a report from staff #11 over the weekend about client F's behavior causing a bloody nose. Staff #4 reported he was told by staff #11 that client F had a behavior throwing himself to the floor causing a bloody nose. Staff #4 indicated he was doubtful of the story since client F did not throw himself to the floor during a behavior at any time staff #4 had observed client F's behaviors. Staff #11 did not inform staff #4 when the incident occurred.</p> <p>-An interview in the facility's investigation with staff #12 indicated she had received a text from staff #4 (no date or time noted) indicating what staff #4 was told by staff #11. Staff #4 reported</p>				

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	<p>no report had been completed but client F had a bloody nose. Staff #12 indicated she had found bloody Kleenex on the floor of client F's bedroom on Monday (4/9/12) morning. Staff #12 indicated staff #1 and #13 reported to her they heard staff #11 say he would like to, "Smack the s--- out of [client F] because of the way he eats slowly and takes small sips, like a sissy." This was reported on Tuesday (4/10/12) evening and supposedly said by staff #11 at dinner time. Staff #1 and #13 told staff #12 they felt client F was afraid of staff #11. Staff #12 indicated she had observed no signs of this from staff #11. The facility did not provide documentation the allegation was investigated.</p> <p>-An interview with staff #7 included in the facility's investigation indicated, "... she feels [staff #11] is impatient with the guys and that he had yelled at another client to put his fork down."</p> <p>-An interview in the facility's investigation with staff #5 indicated, "[Staff #11] grabbed [client F] by the arm and escorted him to his room. When [client F] was in his room [staff #5] could hear him make a noise he normally makes when he is agitated. When [staff #11] came out [staff #5] was told that [client F] had thrown himself on the floor causing his nose to bleed... [Client #5] stated that he'd later showered [client F] and when he</p>						

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	<p>did he noted no blood or mark on [client F's] nose. Q asked if he'd witnessed any unusual or inappropriate actions by [staff #11] and he stated nothing first hand. He did state that he'd been told by other staff that they'd seen [client F] flinch when [staff #11] passed by him and [staff #5] also understood that there had been a situation on Tuesday (no date) where [staff #11] forced [client F] to stay in a chair and would not allow him to sit on the couch." The facility did not provide documentation the allegation of staff #11 forcing client F to stay in a chair was investigated.</p> <p>-An interview in the facility's investigation with the QMRP regarding her viewing the video tapes of the common areas of the group home was reviewed. The QMRP indicated, "It was observed by this Q on the camera that during dinner time [staff #11] left four clients [clients B, C, E and F] alone for a considerable period of time (3 and a half minutes) knowing that among those clients there were clients with choking problems and were to have 100% supervision. [Staff #11] watched TV seated in the living room during the time. It was also noted that [staff #11] left two clients unattended on the vehicle and then came back in to get the other two clients prior to an outing. Due to lack of judgement and staff being within their</p>						

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	<p>probationary period the staff's employment was terminated." -An interview with staff #11 included in the facility's investigation indicated client F started food seeking on 4/7/12 around 11:30 AM or 11:45 AM and had gone into the kitchen three times. Staff #11 indicated staff #5 was cooking at the stove so staff #11 thought he'd stop a behavior before it happened and escorted [client F] to his room. While in client F's room, client F either tripped or fell. Staff #11 indicated client F tripped due to a shoe being on the wrong foot. Staff #11 indicated client F fell right onto his face and had a small amount of blood coming from his nose. On this date, staff #11 indicated client F had been right in staff #5's face so staff #11 made the decision to remove him.</p> <p>A review of the security videos of the common areas of the group home was conducted on 5/3/12 at 3:08 PM. On 4/7/12 at 12:22 PM, client F entered the dining room after carrying in groceries from outside. Staff #11 approached client F after getting up out of a recliner while watching TV, pointed toward the living room and then restrained client F's arms and escorted to his bedroom. There was no apparent reason for the restraint and escort. At 12:55 PM, staff #11 and client F were in the living room. Staff #11 was</p>						

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	<p>leaned back in a recliner watching TV when client F got up and entered the dining room. Client F was standing by his chair in the dining room when staff #11 entered, pointed toward the living room, and then grabbed client F's right arm and pulled him away from the table. Staff #11 then restrained client F by holding his arms and pushed him to client F's bedroom. There was no apparent reason for the restraint/escort to his bedroom. At 1:02 PM, client F exited his bedroom and stood in the doorway to the living room for several seconds before staff #11 quickly got out of the recliner (watching TV) and approached client F. Client F returned to his room and staff #11 returned to the recliner to watch more TV.</p> <p>A review of the facility's Work Reported document (showing the hours staff worked at the home) was conducted on 5/4/12 at 1:28 PM. Staff #11 worked at the group home on 4/7/12 from 7:00 AM to 11:00 PM, 4/8/12 from 7:00 AM to 11:00 PM, 4/9/12 from 4:00 PM to 8:00 PM and 4/10/12 from 4:00 PM to 8:00 PM. The facility was unable to provide documentation when staff #11 was suspended from working at the group home.</p> <p>A review of client F's Behavior</p>						

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	<p>Management Program, dated 8/26/11, was conducted on 5/3/12 at 3:37 PM. The plan indicated he had targeted behaviors of excessive eating, sneaking food, eating inedible food and incontinence. For excessive eating, staff were to offer a light snack if between meals. If he has had enough, tell him so and redirect to other activities out of the kitchen. For sneaking food, the plan indicated ask him to return the food, ask him to show you what he wants and give a light snack. Do not attempt to physically take the food. Monitor and redirect to other activities or take out for an activity. The plan for physical aggression and property destruction indicated a 2 man transport position may be used. There was no escorts, holds or restraints in client F's plan for food-related behavior.</p> <p>An interview with staff #5 was conducted on 5/3/12 at 4:22 PM. Staff #5 indicated on 4/7/12, client F entered the kitchen with staff #11 following him. Staff #11 took client F to his room. Staff #5 indicated he could hear that client F was agitated and then heard a sound. Staff #11 then went through the kitchen toward the office; staff #5 indicated he assumed staff #11 went to get first aid supplies. Staff #5 indicated on his way through, staff #11 indicated client F had a "fit" and threw himself on the floor causing a</p>			

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	<p>bloody nose. Staff #5 indicated he had not witnessed staff #11 being abusive. Staff #5 indicated client F throwing himself to the floor was not a typical behavior. Indicated he heard through the grapevine staff #11 was verbally abusive but did not report this to administrative staff since he did not witness the abuse.</p> <p>An interview with staff #4 was conducted on 5/4/12 at 12:34 PM. Staff #4 indicated on 4/7/12 when he arrived for his overnight shift, staff #11 told him about client F having a behavior in which he threw himself to the floor. He indicated staff #11 "claimed" client F threw himself to the floor 2-3 times causing a bloody nose. Staff #4 indicated he had worked with client F for 5 years and had never witnessed or heard of client F throwing himself to the floor. He indicated he was suspicious of the story. Staff #4 indicated when staff #11 left at the end of his shift, staff #4 and staff #7 looked at each other and indicated they did not believe the story. Staff #4 indicated he instructed staff #11 to complete an incident report which he did not do. Staff #4 indicated he reported his concerns on 4/11/12 after a staff meeting. Staff #4 indicated he told the QMRP and the nurse he did not feel comfortable with staff #11 working in the home. Staff #4 indicated he was informed by the QMRP she was aware of</p>				

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	<p>concerns and was investigating them. Staff #4 indicated he did not observe injuries to client F. Staff #4 indicated staff #12 found a wad of bloody tissues in client F's room at some point.</p> <p>An interview with staff #7 was conducted on 5/4/12 at 12:49 PM. Staff #7 indicated she worked the overnight shift from 4/7/12 to 4/8/12. She indicated when she arrived to work, staff #11 told her client F had a behavior. Staff #11 told her he could not remember what happened but staff #11 took client F to his room and he went berserk. Staff #11 told staff #7 client F threw himself face first to the floor 2-3 times. Staff #7 indicated she questioned his story as she had worked with client F for over 2 years and had never witnessed him throw himself to the floor. Staff #7 indicated staff #11 repeated client F had thrown himself to the floor and bloodied his nose. Staff #7 indicated client F's nose was swollen the next morning. She indicated she could not remember if she reported her concerns to anyone until the QMRP contacted her for a statement for the investigation.</p> <p>An interview with the QMRP was conducted on 5/3/12 at 3:54 PM. The QMRP indicated the facility should prevent and prohibits abuse and neglect of the clients. The QMRP indicated the staff</p>				

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	<p>should immediately report concerns of abuse and neglect. The QMRP indicated she watched the video from 4/7/12 of the common areas of the group home and observed staff #11 in the living room watching TV while clients B, C, E and F were in the dining room eating. She indicated the first period was 3 minutes and then he checked on them. The second period was 1.5 minutes staff #11 left the clients unattended. The QMRP indicated she stopped watching the video due to knowing staff #11 was negligent; the QMRP did not watch the video of staff #11 escorting client F to his room. The QMRP indicated separate investigations were not conducted of the allegations noted during the investigation of client F's bloody nose.</p> <p>This federal tag relates to Complaint #IN00106975.</p> <p>9-3-2(a)</p>						

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting clients B, C, E and F, the facility failed to ensure thorough investigations of abuse and neglect were conducted.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 5/3/12 at 1:47 PM. On 4/7/12 "while lunch or dinner was being prepared," client F went into the kitchen where staff #5 was working. Staff #11 went into the kitchen and escorted client F out of the area and to his room. It was reported by staff #11 while in client F's room, client F had a behavior and threw himself to the floor causing a bloody nose. The incident report indicated, "This is not a typical behavior and no behavior report was done by [staff #11] reporting this behavior." The report indicated, "The Q (Qualified Mental Retardation Professional - QMRP) was told of the incident yesterday (4/11/12) after the team meeting and is currently interviewing staff to ascertain what happened and whether or not a report was needed and</p>	W0154	<p>QIDP's will be retrained on thorough investigations to include initiating new investigations when separate allegations are indicated during the course of any investigation. An investigation will be conducted to look into statements made by staff during the investigation referenced in this survey report. SGL Manager, Family Services Director, and Quality Assurance Director review all investigations for compliance to agency policy.</p> <p>Responsible for QA: QIDP, SGL Manager June 8, 2012</p>	06/08/2012			

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	<p>whether there are more serious concerns."</p> <p>The investigation, dated 4/16/12, indicated the following, "It was unable to be determined how [client F] received a bloody nose. However, in the course of the investigation several other concerning situations were noted that made it apparent that's staff's (#11) employment should be terminated."</p> <p>-An interview in the facility's investigation with staff #4 indicated on 4/11/12, staff #4 asked the QMRP after the team meeting if she received a report from staff #11 over the weekend about client F's behavior causing a bloody nose. Staff #4 reported he was told by staff #11 that client F had a behavior throwing himself to the floor causing a bloody nose. Staff #4 indicated he was doubtful of the story since client F did not throw himself to the floor during a behavior at any time staff #4 had observed client F's behaviors. Staff #11 did not inform staff #4 when the incident occurred.</p> <p>-An interview in the facility's investigation with staff #12 indicated she had received a text from staff #4 (no date or time noted) indicating what staff #4 was told by staff #11. Staff #4 reported no report had been completed but client F had a bloody nose. Staff #12 indicated she had found bloody Kleenex on the floor of client F's bedroom on Monday</p>			

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	<p>(4/9/12) morning. Staff #12 indicated staff #1 and #13 reported to her they heard staff #11 say he would like to, "Smack the s--- out of [client F] because of the way he eats slowly and takes small sips, like a sissy." This was reported on Tuesday (4/10/12) evening and supposedly said by staff #11 at dinner time. Staff #1 and #13 told staff #12 they felt client F was afraid of staff #11. Staff #12 indicated she had observed no signs of this from staff #11. The facility did not provide documentation the allegation was investigated.</p> <p>-An interview with staff #7 included in the facility's investigation indicated, "... she feels [staff #11] is impatient with the guys and that he had yelled at another client to put his fork down."</p> <p>-An interview in the facility's investigation with staff #5 indicated, "[Staff #11] grabbed [client F] by the arm and escorted him to his room. When [client F] was in his room [staff #5] could hear him make a noise he normally makes when he is agitated. When [staff #11] came out [staff #5] was told that [client F] had thrown himself on the floor causing his nose to bleed... [Client #5] stated that he'd later showered [client F] and when he did he noted no blood or mark on [client F's] nose. Q asked if he'd witnessed any unusual or inappropriate actions by [staff #11] and he stated nothing first hand. He</p>						

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	<p>did state that he'd been told by other staff that they'd seen [client F] flinch when [staff #11] passed by him and [staff #5] also understood that there had been a situation on Tuesday (no date) where [staff #11] forced [client F] to stay in a chair and would not allow him to sit on the couch." The facility did not provide documentation the allegation of staff #11 forcing client F to stay in a chair was investigated.</p> <p>-An interview in the facility's investigation with the QMRP regarding her viewing the video tapes of the common areas of the group home was reviewed. The QMRP indicated, "It was observed by this Q on the camera that during dinner time [staff #11] left four clients [clients B, C, E and F] alone for a considerable period of time (3 and a half minutes) knowing that among those clients there were clients with choking problems and were to have 100% supervision. [Staff #11] watched TV seated in the living room during the time. It was also noted that [staff #11] left two clients unattended on the vehicle and then came back in to get the other two clients prior to an outing. Due to lack of judgement and staff being within their probationary period the staff's employment was terminated." There was not a separate investigation conducted regarding staff #11 being negligent during</p>			

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	<p>dinner.</p> <p>-An interview with staff #11 included in the facility's investigation indicated client F started food seeking on 4/7/12 around 11:30 AM or 11:45 AM and had gone into the kitchen three times. Staff #11 indicated staff #5 was cooking at the stove so staff #11 thought he'd stop a behavior before it happened and escorted [client F] to his room. While in client F's room, client F either tripped or fell. Staff #11 indicated client F tripped due to a shoe being on the wrong foot. Staff #11 indicated client F fell right onto his face and had a small amount of blood coming from his nose. On this date, staff #11 indicated client F had been right in staff #5's face so staff #11 made the decision to remove him.</p> <p>A review of the security videos of the common areas of the group home was conducted on 5/3/12 at 3:08 PM. On 4/7/12 at 12:22 PM, client F entered the dining room after carrying in groceries from outside. Staff #11 approached client F after getting up out of a recliner while watching TV, pointed toward the living room and then restrained client F's arms and escorted to his bedroom. There was no apparent reason for the restraint and escort. At 12:55 PM, staff #11 and client F were in the living room. Staff #11 was leaned back in a recliner watching TV</p>				

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	<p>when client F got up and entered the dining room. Client F was standing by his chair in the dining room when staff #11 entered, pointed toward the living room, and then grabbed client F's right arm and pulled him away from the table. Staff #11 then restrained client F by holding his arms and pushed him to client F's bedroom. There was no apparent reason for the restraint/escort to his bedroom. At 1:02 PM, client F exited his bedroom and stood in the doorway to the living room for several seconds before staff #11 quickly got out of the recliner (watching TV) and approached client F. Client F returned to his room and staff #11 returned to the recliner to watch more TV.</p> <p>A review of the facility's Work Reported document (showing the hours staff worked at the home) was conducted on 5/4/12 at 1:28 PM. Staff #11 worked at the group home on 4/7/12 from 7:00 AM to 11:00 PM, 4/8/12 from 7:00 AM to 11:00 PM, 4/9/12 from 4:00 PM to 8:00 PM and 4/10/12 from 4:00 PM to 8:00 PM. The facility was unable to provide documentation when staff #11 was suspended from working at the group home.</p> <p>A review of client F's Behavior Management Program, dated 8/26/11, was</p>						

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	<p>conducted on 5/3/12 at 3:37 PM. The plan indicated he had targeted behaviors of excessive eating, sneaking food, eating inedible food and incontinence. For excessive eating, staff were to offer a light snack if between meals. If he has had enough, tell him so and redirect to other activities out of the kitchen. For sneaking food, the plan indicated ask him to return the food, ask him to show you what he wants and give a light snack. Do not attempt to physically take the food. Monitor and redirect to other activities or take out for an activity. The plan for physical aggression and property destruction indicated a 2 man transport position may be used. There was no escorts, holds or restraints in client F's plan for food-related behavior.</p> <p>An interview with staff #5 was conducted on 5/3/12 at 4:22 PM. Staff #5 indicated on 4/7/12, client F entered the kitchen with staff #11 following him. Staff #11 took client F to his room. Staff #5 indicated he could hear that client F was agitated and then heard a sound. Staff #11 then went through the kitchen toward the office; staff #5 indicated he assumed staff #11 went to get first aid supplies. Staff #5 indicated on his way through, staff #11 indicated client F had a "fit" and threw himself on the floor causing a bloody nose. Staff #5 indicated he had</p>			

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN 47201			
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	<p>not witnessed staff #11 being abusive. Staff #5 indicated client F throwing himself to the floor was not a typical behavior. Indicated he heard through the grapevine staff #11 was verbally abusive but did not report this to administrative staff since he did not witness the abuse.</p> <p>An interview with staff #4 was conducted on 5/4/12 at 12:34 PM. Staff #4 indicated on 4/7/12 when he arrived for his overnight shift, staff #11 told him about client F having a behavior in which he threw himself to the floor. He indicated staff #11 "claimed" client F threw himself to the floor 2-3 times causing a bloody nose. Staff #4 indicated he had worked with client F for 5 years and had never witnessed or heard of client F throwing himself to the floor. He indicated he was suspicious of the story. Staff #4 indicated when staff #11 left at the end of his shift, staff #4 and staff #7 looked at each other and indicated they did not believe the story. Staff #4 indicated he instructed staff #11 to complete an incident report which he did not do. Staff #4 indicated he reported his concerns on 4/11/12 after a staff meeting. Staff #4 indicated he told the QMRP and the nurse he did not feel comfortable with staff #11 working in the home. Staff #4 indicated he was informed by the QMRP she was aware of concerns and was investigating them.</p>						

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	<p>Staff #4 indicated he did not observe injuries to client F. Staff #4 indicated staff #12 found a wad of bloody tissues in client F's room at some point.</p> <p>An interview with staff #7 was conducted on 5/4/12 at 12:49 PM. Staff #7 indicated she worked the overnight shift from 4/7/12 to 4/8/12. She indicated when she arrived to work, staff #11 told her client F had a behavior. Staff #11 told her he could not remember what happened but staff #11 took client F to his room and he went berserk. Staff #11 told staff #7 client F threw himself face first to the floor 2-3 times. Staff #7 indicated she questioned his story as she had worked with client F for over 2 years and had never witnessed him throw himself to the floor. Staff #7 indicated staff #11 repeated client F had thrown himself to the floor and bloodied his nose. Staff #7 indicated client F's nose was swollen the next morning. She indicated she could not remember if she reported her concerns to anyone until the QMRP contacted her for a statement for the investigation.</p> <p>An interview with the QMRP was conducted on 5/3/12 at 3:54 PM. The QMRP indicated the facility should prevent and prohibits abuse and neglect of the clients. The QMRP indicated the staff should immediately report concerns of</p>			

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	<p>abuse and neglect. The QMRP indicated she watched the video from 4/7/12 of the common areas of the group home and observed staff #11 in the living room watching TV while clients B, C, E and F were in the dining room eating. She indicated the first period was 3 minutes and then he checked on them. The second period was 1.5 minutes staff #11 left the clients unattended. The QMRP indicated she stopped watching the video due to knowing staff #11 was negligent; the QMRP did not watch the video of staff #11 escorting client F to his room. The QMRP indicated investigations were not conducted of the allegations noted during the investigation of client F's bloody nose.</p> <p>This federal tag relates to Complaint #IN00106975.</p> <p>9-3-2(a)</p>				