

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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W0000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00107066.</p> <p>Complaint #IN00107066-Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W186 and W240.</p> <p>Dates of Survey: 4/23, 4/24, 4/25, 4/26, 4/27, 4/30 and 5/4/12</p> <p>Facility Number: 0011595 Provider Number: 15G749 Aim Number: 200905630</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Jo Anna Scott, Medical Surveyor III (4/25 to 4/27/12)</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/11/12 by Ruth Shackelford, 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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W0102	<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 for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the governing body failed to ensure the facility implemented its policy and procedures to prevent abuse and/or neglect of clients. The governing body failed to ensure the facility reported all allegations of abuse/neglect to state authorities, to conduct thorough investigations and to ensure the rights of clients were not violated. The governing body failed to ensure the facility had sufficient staff to monitor/supervise the clients in the specialized behavioral group home.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D). The governing body failed to implement its written policy and procedures to prevent neglect of clients in regard to client to client incidents and in regard to a sexual incident at the day program. The governing body failed to implement its</p>	W0102	<p>Corrective Action: (Specific) All staff will be retrained on preventing abuse, neglect, and exploitation by accurately reporting any allegation or incident to the Executive Director immediately and all state agencies. The Quality Assurance Team will retrained on preventing abuse, neglect and exploitation by accurately reporting any allegation or incident to the Executive Director immediately and all state agencies. The Quality Assurance Department will be retrained on investigation procedures to ensure a thorough investigation is completed and the rights of the clients are not violated. All cleaning supplies, including, laundry detergent will be unlocked for access to all clients. The Program Coordinator will be retrained that all clients have access to hand soap and paper towels in the bathroom. The Program Coordinator will be retrained that the staffing of the ESN (Extensive Support Needs) homes will include the updated reimbursement guideline which indicates that individuals living in residences under this category must be supervised at all time and the staffing pattern at full capacity should be a minimum of three (3) staff on the day shift,</p>	06/03/2012			

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	<p>policy and procedures to conduct thorough investigations and to report all allegations of abuse/neglect to state authorities. Please see W122.</p> <p>2. The governing body failed to ensure the facility implemented its written policy and procedures to prevent abuse and neglect of clients in regard to client aggression involving clients A, B, C and D. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to a sexual incident at the workshop.</p> <p>The governing body failed to ensure the facility clients had access to laundry detergent and cleaning supplies as they were locked in the group home for clients A, B, C and D. The governing body failed to ensure all clients had access to hand soap and paper towels in the bathroom for clients C and D.</p> <p>The governing body failed to ensure the facility accurately reported an allegation of neglect in regard to a van accident and to report allegations of neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC</p>		<p>three (3) on the evening shift, and two (2) on the night shift. How others will be identified: (Systemic) All homes that are classified ESN (Extensive Support Needs) residences will have a staffing pattern of three (3) on the day shift, three (3) on the evening shift, and two (2) on the night shift. All staff during orientation are trained on preventing abuse, neglect and exploitation by accurately reporting any allegation or incident to the Executive Director immediately and all state agencies. All staff are trained that all clients have access to cleaning supplies, hand soap, and paper towels in the bathroom. Measures to be put in place: All staffing patterns in the ESN (Extensive Support Needs) residences will be reviewed and approved by the Executive Director to ensure compliance of the updated reimbursement guideline for individuals living in the ESN homes is followed All staff will be retrained on preventing abuse, neglect, and exploitation by accurately reporting any allegation or incident to the Executive Director immediately and all state agencies. The Quality Assurance Team will be retrained on preventing abuse, neglect and exploitation by accurately reporting any allegation of incident to the Executive Director immediately and all state</p>				

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	<p>12-10-3 for clients A and C.</p> <p>The governing body failed to ensure the facility conducted a thorough investigation in regard to the allegations of abuse/neglect for clients A and C.</p> <p>The governing body failed to ensure the facility provided staffing as specified in the undated ESN (Extensive Support Needs) Guidelines to ensure enough were present to meet the clients' behavioral needs/challenges for clients A, B, C and D. Please W104.</p> <p>This federal tag relates to complaint #IN00107066.</p> <p>9-3-1(a)</p>		<p>agencies. The Quality Assurance Department will be retrained on investigation procedures to ensure a thorough investigation is completed and the rights of all clients are not violated. All cleaning supplies, including, laundry detergent will be unlocked for access to all clients. The Program Coordinator will be retrained that all clients have access to hand soap and paper towels in the bathroom. The Program Coordinator will be retrained that the staffing of the ESN (Extensive Support Needs) homes will include the updated reimbursement guideline which indicates that individuals living in residences under this category must be supervised at all time and the staffing pattern at full capacity should be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. Monitoring of Corrective Action: All staffing patterns in the ESN (Extensive Support Needs) residences will be reviewed and approved by the Executive Director to ensure compliance of the updated reimbursement guideline for the individuals living in the ESN homes is followed. The Director of SGL will review all investigations for completeness. The Operations Manager for SGL will make weekly checks in the home to ensure that clients have access to cleaning supplies,</p>		

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			including detergent, as well as hand soap and paper towels in the bathroom. The Program Director of SGL will monitor all investigation procedures to ensure proper protocol has been followed.	

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent abuse and/or neglect of clients. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility reported all allegations of abuse/neglect to state authorities, to conduct thorough investigations and to ensure the rights of clients were not violated. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility had sufficient staff to monitor/supervise the clients in the specialized behavioral group home.</p> <p>Findings include:</p> <p>1. 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 neglect of clients in regard to client to client</p>	W0104	<p>Corrective Action: (Specific) All staff will be retrained on preventing abuse, neglect, and exploitation by accurately reporting any allegation or incident to the Executive Director immediately and all state agencies. The Quality Assurance Team will be retrained on preventing abuse, neglect and exploitation by accurately reporting any allegation of incident to the Executive Director immediately and all state agencies. The Quality Assurance Department will be retrained on investigation procedures to ensure a thorough investigation is completed and the rights of the clients are not violated. All cleaning supplies, including, laundry detergent will be unlocked for access to all clients. The Program Coordinator will be retrained that all clients have access to hand soap andpaper towels in the bathroom. How others will be identified: (Systemic) All staff during orientation are trained on preventing abuse, neglect and exploitation by accurately reporting any allegation or incident to the Executive Director immediately and all state agencies. All staff are trained that all clients have access to</p>	06/03/2012			

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	<p>aggression involving clients A, B, C and D. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to a sexual incident at the workshop. Please see W149.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility failed to ensure clients had access to laundry detergent and cleaning supplies as they were locked in the group home for clients A, B, C and D. The governing body failed to exercise general policy and operating direction over the facility to ensure all clients had access to hand soap and paper towels in the bathroom for clients C and D. Please see W125.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility accurately reported an allegation of neglect in regard to a van accident and to report allegations of neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for clients A and C. Please see</p>		<p>cleaning supplies, hand soap, and paper towels in the bathroom. Measures to be put in place: All staff will be retrained on preventing abuse, neglect, and exploitation by accurately reporting any allegation or incident to the Executive Director immediately and all state agencies. The Quality Assurance Team will be retrained on preventing abuse, neglect and exploitation by accurately reporting any allegation of incident to the Executive Director immediately and all state agencies. The Quality Assurance Department will be retrained on investigation procedures to ensure a thorough investigation is completed and the rights of the clients are not violated. All cleaning supplies, including, laundry detergent will be unlocked for access to all clients. The Program Coordinator will be retrained that all clients have access to hand soap and paper towels in the bathroom.</p> <p>Monitoring of Corrective Action: The Director of SGL or the Executive Director will review all investigations for completeness. The Operations Manager for SGL will make weekly checks in the home to ensure that clients have access to cleaning supplies, including detergent, as well as hand soap and paper towels in the bathroom.</p>				

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	<p>W153.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted a thorough investigation in regard to the allegations of abuse/neglect for clients A and C. Please see W154.</p> <p>5. The governing body failed to exercise general policy, budget and operating direction over the facility to provide staffing as specified in the undated ESN (Extensive Support Needs) Guidelines to ensure enough were present to meet the clients' behavioral needs/challenges for clients A, B, C and D. Please see W186.</p> <p>This federal tag relates to complaint #IN00107066.</p> <p>9-3-1(a)</p>			

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D). The facility failed to implement its policy and procedures to prevent neglect and/or abuse of clients in regard to client to client aggression/clients targeting each other and in regard to a sexual incident at the workshop. The facility failed to implement its policy and procedures to conduct thorough investigations and to ensure all allegations of neglect and/or abuse were reported to state officials. The facility failed to ensure clients' rights were not violated due to locking cleaning and laundry supplies.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent abuse and neglect of clients in regard to client to client aggression involving clients A, B, C and D. The facility failed to implement its policy and procedures to prevent neglect of client A in regard to a sexual incident at the workshop. Please see W149.</p>	W0122	<p>Corrective Action: (Specific) All staff will be retrained that all clients are to have access to cleaning supplies, hand soap, and paper towels unless access is denied in a client's BSP. All clients will be retrained on exercising their rights, including the right to file complaints, and the right to due process. How others will be identified: (Systemic) All clients upon admission and at their annual ISP meeting are trained on exercising their rights, including the right to file complaints, and the right to due process. Measures to be put in place: All staff will be retrained that all clients are to have access to cleaning supplies, hand soap, and paper towels unless access is denied in a client's BSP. All clients will be retrained on exercising their rights, including the right to file complaints, and the right to due process. Monitoring of Corrective Action: The Operations Manager for SGL will make weekly visits to the home to ensure that clients have access to cleaning supplies, hand soap, and paper towels.</p>	06/03/2012			

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	<p>2. The facility failed to ensure clients had access to laundry detergent and cleaning supplies as they were locked in the group home for clients A, B, C and D. The facility failed to ensure all clients had access to hand soap and paper towels in the bathroom for clients C and D. Please see W125.</p> <p>3. The facility failed to accurately report an allegation of neglect in regard to a van accident and to report an allegation of neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for clients A and C. Please see W153.</p> <p>4. The facility failed to conduct a thorough investigation in regard to the allegations of abuse/neglect for clients A and C. Please see W154.</p> <p>This federal tag relates to complaint #IN00107066.</p> <p>9-3-2(a)</p>				

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the facility failed to allow clients to have access to laundry detergent and cleaning supplies as they were locked in the group home. The facility failed to ensure all clients had access to hand soap and paper towels in the bathroom for clients C and D.</p> <p>Findings include:</p> <p>1. During the 4/25/12 observation period between 6:17 AM and 8:10 AM, at the group home, facility staff was observed to open a pad lock on the double door cabinet in the laundry room. The double door cabinet contained a pad lock on each side of the cabinet. The cabinets had different cleaning supplies and laundry detergent locked in the cabinets. Interview with staff #6 on 4/25/12 at 6:47 AM indicated the laundry detergent and cleaning supplies were kept locked in the cabinets. Staff #6 indicated only staff had keys to the cabinets. When asked why the</p>	W0125	<p>Corrective Action: (Specific) All staff will be retrained that all clients are to have access to cleaning supplies, hand soap, and paper towels unless access is denied in a client's BSP. All clients will be retrained on exercising their rights, including the right to file complaints, and the right to due process. How others will be identified: (Systemic) All clients upon admission and at their annual ISP meeting are trained on exercising their rights, including the right to file complaints, and the right to due process. Measures to be put in place: All staff will be retrained that all clients are to have access to cleaning supplies, hand soap, and paper towels unless access is denied in a client's BSP. All clients will be retrained on exercising their rights, including the right to file complaints, and the right to due process. Monitoring of Corrective Action: The Operations Manager for SGL will make weekly visits to the home to ensure that clients have access to cleaning supplies, hand soap, and paper towels.</p>	06/03/2012			

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	<p>cabinets were locked, staff #6 stated "Due to a client who used to live here. He had problems with drinking them." Staff #6 indicated the client who caused the items to be locked had moved to another one of the ESN (Extensive Support Needs) group homes. Staff #6 indicated clients A, B, C and D did not have problems with PICA (ingestion of inedible objects).</p> <p>Client B's record was reviewed on 4/25/12 at 1:00 PM. Client B's 3/16/12 Individual Support Plan (ISP) did not indicate client B had a need to have laundry and/or cleaning supplies locked.</p> <p>Client A's record was reviewed on 4/25/12 at 1:35 PM. Client A's 2/17/12 ISP did not indicate client A had a need to have laundry and/or cleaning supplies locked.</p> <p>Client C's record was reviewed on 4/26/12 at 11:07 PM. Client C's 2/6/12 ISP did not indicate client C had a need to have laundry and/or cleaning supplies locked.</p> <p>Client D's record was reviewed on 4/26/12 at 1:14 PM. Client D's 1/27/12 ISP did not indicate client D had a need to have laundry detergent and/or cleaning supplies locked.</p>			

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	<p>Interview with LPN #1 and the Behavior Clinician (BC) on 4/27/12 at 9:40 AM indicated clients A, B, C and D did not carry a diagnosis of PICA. The BC indicated he did not know why the items were being locked.</p> <p>2. During the 4/25/12 observation period between 6:17 AM and 8:10 AM, at the group home, the bathroom near clients C and D's bedroom did not have hand soap and/or paper towels in the bathroom. Interview with staff #6 on 4/25/12 at 7:30 AM indicated soap and paper towels were no longer kept in the bathroom due to client C's behavior. Staff #6 indicated client C would throw the paper towel rack and/or had torn the rack off the inside of the cabinet. Staff #6 indicated the clients could wash their hands but they would have to give clients C and D soap and the clients would have to come out of the bathroom and use paper towels that sat on window sill in the kitchen area.</p> <p>Client C's record was reviewed on 4/26/12 at 11:07 PM. Client C's 2/6/12 ISP did not indicate client C should not have access to hand soap and/or paper towels in the bathroom.</p> <p>Client D's record was reviewed on 4/26/12 at 1:14 PM. Client D's 1/27/12 ISP did not indicate client D should not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>have access to hand soap and/or paper towels in the bathroom.</p> <p>Interview with the BC and LPN #1 on 4/27/12 at 9:40 AM indicated they were not aware clients C and D did not have access to soap and paper towels in the bathroom. The BC indicated he would have to find out why.</p> <p>9-3-2(a)</p>			

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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 observation, interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the facility neglected to implement its written policy and procedures to prevent abuse and neglect of clients in regard to client to client aggression involving clients A, B, C and D. The facility neglected to implement its policy and procedures to prevent neglect of client A in regard to a sexual incident at the workshop.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 4/11/12 reportable incident report indicated "[Client B] and [client A] started to argue. [Client B] through (sic) a cup at [client A] and client [client A] chased after him and knocked him down to the floor. Staff separated the two clients and they were redirected to different areas of the home. Both consumers were assessed by staff; [client A] sustained no injuries from the accident. [Client B's] hip was hurting him</p>	W0149	<p>Corrective Action: (Specific) All staff will be retrained on the policy and procedure to prevent abuse and neglect in regards to preventing client aggression involving clients A, B, C, and D. Client A's BSP will be reviewed and revised to define the One on One staffing at the home and the workshop, and will specifically address Client A antagonizing Client D. Client B's BSP will be reviewed and revised to assist the client not to speak in a loud tone of voice. Client B's ISP will be revised to include a risk plan/nursing plan for his fractured pelvis. All staff will be retrained on all client BSPs. All staff will be trained on Client B's risk plan/nursing plan for his fractured pelvis. How others will be identified: (Systemic) All client BSPs will be revised as needed to address any concerns/behaviors that develop. All risk plans/nursing plans will be revised as needed to meet changing health concerns of each client Measures to be put in place: All staff will be retrained on the policy and procedure to prevent abuse and neglect in regards to preventing client aggression involving clients A, B, C, and D. Client A's BSP will be reviewed and revised to define</p>	06/03/2012			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>and staff took him to his PCP (primary care physician) for evaluation. The staff counseled [client A] and [client B] on appropriate interactions between one another. The program coordinator will meet with staff to determine if any changes need to be made to [client A] or [client B's] BSP's (Behavior Support Plans) (sic). At [client B's] appointment, x-rays were done to evaluate his hip. He was diagnosed with a hair line fracture and is scheduled to have a cat scan on 4-17-2012...." The reportable incident report indicated the incident occurred at 8:43 PM.</p> <p>The facility's 4/12/12 Client to Client Aggression Investigation indicated "[Client A] and [client B] were arguing over day that [client B] had (sic). [Client B] got upset and threw Kool-Aid at [client A]. [Client A] then chased [client B] through the house, when he caught up with he pushed him down to the floor (sic)...." The 4/12/12 client to client investigation indicated there was enough staff present at the time of the incident, but did not indicate the exact number of staff who were present. The 4/12/12 investigation indicated "Recommendations: Staff will place themselves between the 2 of them until the team meets to decide how to resolve the matter."</p>		<p>the One on One staffing at the home and the workshop, and will specifically address Client A antagonizing Client B. Client B's BSP will be reviewed and revised to assist the client not to speak in a loud tone of voice. Client B's ISP will be revised to include a risk plan/nursing plan for his fractured pelvis. All staff will be retrained on all client BSPs. All staff will be trained on Client B's risk plan/nursing plan for his fractured pelvis. Monitoring of Corrective Action: The Operations Manager for SGL will make weekly visits to the home to ensure staff follow all BSPs. At the workshop, the Program Coordinator or designee (Administrative Staff) will monitor staff daily to ensure the one on one staffing occurs. A check list will be used to verify the staff know where Client A is at all times, and staff are providing the one on staffing as specified in the BSP. The Behavior Clinician will ensure during visits that staff follow all BSPs. The Nurse will develop risk</p>				

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>During the 4/23/12 observation period between 4:05 PM and 7:25 PM, at the group home, client A was standing outside unsupervised without staff talking on a cell phone upon arrival to the house. Client A was standing outside the gate/fenced area of the group home. Upon being let into the group home, 3 staff (staff #1, #4 and #5) and client B were sitting at the dining room table. During the above mentioned observation period, client A had a staff person following the client around or did not have staff with him. There were 3 staff to 4 clients in the group home. At 4:22 PM, staff #5 left with client B to go to the store while client A was sitting in the living room with client C, who was watching TV and drinking a soft drink. No staff was present in the living room at that time. At 5:07 PM, staff #4 left with client D to go for a walk leaving staff #1 to monitor/supervise clients A and C. Client A went back outside past the fenced area to use his cell phone leaving staff #1 in the house with client C. At one point, client A could not be seen as the client had left the fenced area. At 5:15 PM, client A came back in the house and walked into the living room where client C was sitting. No staff was in the living room when client A returned inside the house. At 5:23 PM, staff #4 returned</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>and started following client A. Client A sat down on the same couch with client C. Staff #4 sat down on a separate couch near client A. The staff did not sit in between the clients. At 5:25 PM, client C reached over and scratched client A. At 6:09 PM, client A walked from the kitchen to the living room area, where client D was sitting, to client D's bedroom. Client A then came out of client D's bedroom and went back into the kitchen. No staff was following and/or with client A when he left the kitchen and went to the living room and client D's bedroom. Interview with staff #1 on 4/23/12 at 5:00 PM stated client A had "One on One staffing (one staff to one client). Staff has to stay between him and others."</p> <p>Client B's record was reviewed on 4/25/12 at 1:00 PM. Client B's 4/12/12 Doctor's Orders And Progress Notes indicated "Tenderness over RT (right) buttocks. Xray (+) (positive) for hair line Fx (fracture) in pelvis. (+) for hip module NOS (no other symptoms). 1). Donut pillow (with) sitting x (times) 6 weeks. IBU (Ibuprofen) 300 mg (milligrams) 2) CT (cat scan) of RT hip."</p> <p>Client B's 4/12/12 Nurses Observation Record indicated "Home visit today. Client had c/o (complaint of) (Rt) hip</p>						

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>pain R/T being shoved down. Client sent to doctor today. N.O. (new order) for doughnut pillow x (times) 6 weeks while sitting for pelvic, (R) (right) hip fx. Client ambulating well, has 0 (zero) distress at this time. CT scan to be done next week. Staff will continue to monitor."</p> <p>Client B's 3/16/12 Individual Support Plan neglected to indicate a risk plan/nursing care plan for client B's fractured pelvis.</p> <p>Client B's Interdisciplinary Team (IDT) Meeting notes indicated the following:</p> <p>-4/3/12 "The team met to discuss the incident that occurred on 4.10.12 between [client B] and a housemate. [Client B] threw a cup of koolaid at house mate (sic) because he didn't like what the housemate said. This caused the housemate to run to [client B] and push him. This caused [client B] to fall...."</p> <p>-4/3/12 IDT note indicated "...on 4/2/12 when [client B] made statements about harming himself and then eventually attempted to elope. [Client B] stated that he was upset over comments that another consumer (client A) had made...."</p> <p>Client A's record was reviewed on</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>4/25/12 at 1:38 PM. Client A's 4/11/12 Progress Note indicated "...(2) Another client (client B) threw a coffee cup at [client A]. [Client A] chased other client through house and knocked him down in front of the office. Then [client A] spit on other client. Later on other client tried to apologize but [client A] refused to accept it." Client A's 4/21/12 Progress Note indicated staff caught client A with client B's radio in client A's room which resulted in client A screaming, cursing and threatening staff.</p> <p>Client A's IDT Meeting notes indicated the following:</p> <p>-4/12/12 "The team discussed the episode where another client was arguing with [client A]. The other client threw a cup at [client A]. [Client A] chased the other client and knocked him to the floor. The client received a hair line fracture in his pelvic area..(sic) Immediately after the incident to ensure safety, staff made sure that the clients were separated for the rest of the night. The team decided that a 1 on 1 staffing will be placed on [client A] during waking hours to ensure his housemates' safety until the team meets again in 1 week. The 1 on 1 is defined as staff positioning themselves in between [client A] and his housemates to ensure their safety...."</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>-4/24/12 "Team met to discuss [client A's] progress over the past 2 weeks. During that time he had 1 episode of Physical Aggression in which he had a client to client with another consumer (client D)...He stated that he wanted off 1:1 staffing, but everyone was in agreement that he should remain 1:1 for now until he proved himself."</p> <p>Client A's 4/12/12 Behavior Support Plan (BSP) indicated client A demonstrated physical aggression (hitting, punching, pushing and kicking). The section of client A's BSP entitled "Preventative Procedures" indicated "1. [Client A] will be assigned a staff member on each shift. a. The assigned staff member is not a 1:1, as the staff member maybe assigned another consumer while being assigned to [client A] during each shift...12. [Client A] will be in line of sight of staff at all times, except when he is in his room or bathroom to redirect him if he begins to have any target behaviors...."</p> <p>Interview with staff #3 on 4/25/12 at 7:21 AM stated "[Client A] is so strong. He can hurt you." Staff #3 indicated clients A and B had several verbal altercations since client B had moved into the group home. Staff #3 indicated 3 staff worked on the day shift and 3 staff worked on the</p>			
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>evening shift. Staff #3 indicated staff #1 would make the third staff as the facility was short of staff. Staff #3 stated client A was on one to one staffing due to "shoving [client B] down and hurting his hip." When asked how one on one staffing was defined, staff #3 stated "Not allowed to interact with others unless staff present. Normally compliant with that."</p> <p>Interview with client B on 4/25/12 at 9:40 AM indicated he recently moved into the group home. When asked how client B got along with client A, client B stated "We have had a couple of incidents. This past Saturday he went in my room and stole my radio out of room. I got mad at him." Client B indicated he (client B) exchanged words with client A. Client B indicated stated "I was trying to run into the office. He (client A) knocked me down and spit on me." Client B indicated the two of them had been arguing as client A had made him upset.</p> <p>Interview with LPN #1 and the Behavior Clinician on 4/27/12 at 9:40 AM indicated client A had been aggressive toward other clients in the group home. The Behavior Clinician stated "IDT put in place immediate protection measures after incident with [clients A and B]." When asked how client A was to be monitored/supervised, the Behavior</p>						

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>Clinician stated facility staff needed to be in the "common areas with individual (client A). The behavior clinician indicated he was not able to explain why client A's 4/12/12 BSP indicated the client did not require one on one staffing while client A's 4/12/12 IDT indicated the client would be placed on one to one staffing. The Behavior Clinician indicated facility staff should be with client A when he was walking around the house and other clients were present. The Behavior Clinician stated "One on one staff should be in same common areas and close enough to intervene." The Behavior Clinician indicated he was aware of one additional incident since client A had been placed on the one to one staffing. The Behavior Clinician indicated client A's one on one staffing needed to be clearly defined. The Behavior Clinician and LPN #1 indicated the group home had worked 3 staff on day and evening shifts as they did prior to the 4/11/12 incident. LPN #1 and the Behavior Clinician indicated clients A, B, C and D demonstrated behaviors which required staff supervision and monitoring as well. LPN #1 indicated client B had a hairline fracture to his pelvis. LPN #1 indicated client B was to use a donut pillow when sitting on a surface for pressure. LPN #1 indicated she told facility staff to monitor client B and to encourage him to use the</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>pillow. When asked if client B had a risk plan for his fractured pelvis, LPN #1 indicated she did not write a risk plan for his pelvic fracture.</p> <p>Interview with administrative staff #1 and #2 on 4/27/12 at 11:55 AM indicated client A was to have one on one staffing at the group home due to the 4/11/12 incident with client B. Administrative staff #1 indicated he did not know why client A's 4/12/12 BSP differed from the 4/12/12 IDT note in defining the client's one to one staffing. Administrative staff stated "It has to be a typo."</p> <p>Administrative staff #1 indicated the group home had 3 staff who worked the day and evening shifts and 2 staff who worked on the overnight shift.</p> <p>Administrative staff #1 indicated this was the staffing pattern before the 4/11/12 incident. When asked if the number of staff had been increased since client A required one to one staffing, administrative staff indicated the facility continued to run the same staffing pattern as before. Administrative staff #1 indicated one of the three staff would be assigned to client A. Administrative staff #1 indicated staff #1 would fill in as the third staff to ensure the staffing level at the group home.</p> <p>2. The facility's reportable incident</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
--	---

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	<p>reports, internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's internal and reportable incident reports and/or investigations indicated the following:</p> <p>-4/17/12 "On 4/17/2012 [client A] was working in his assigned area when another consumer (client D) started to display physical aggression towards him. The other consumer hit him with a box of work supplies. [Client A] retaliated and started yelling and charging consumer across the workflow. The other consumer ran to the other side of the workflow with [client A] chasing him. [Client A] then caught the other consumer, picked him up and slammed him into the ground. [Client A] and the other consumer were then separated and [client A] was restrained using the properly trained technique by 4 staff per his Behavior Support Plan for physical aggression...."</p> <p>The facility's 4/17/12 Client to Client Aggression Investigation indicated client A had one on one staffing at the time of the incident. The facility's investigation indicated "...Yes, this is a pattern between the two...." The facility's investigation indicated "...6. Do any changes need to be made in an attempt to prevent occurrences? Even though these 2 have</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>separate areas, they are too close together at work." The 4/17/12 investigation did not include any recommendations.</p> <p>-4/12/12 Client A came into the office yelling and cursing staff. Client D then went after client A. The internal incident report indicated the staff blocked client D from getting to client A.</p> <p>-3/27/12 "[Client A] was eating lunch when he started showing verbal aggression towards staff which led to verbal aggression toward consumer (client D). The other consumer proceeded to throw water bottles, tables, and Tupperware towards [client A]. [Client A] then attempted to charge consumer resulting with a [name of workshop] staff having to step in between him and the other consumer. [Client A] started to threaten [name of workshop] staff with violence and push up into staffs (sic) face."</p> <p>The facility's 3/27/12 Client to Client Aggression Investigation indicated "...7. Is there a pattern of occurrences between these two clients? Yes...."</p> <p>-3/20/12 "[Client D] saw [client A] in the bathroom and moved toward him in an aggressive manner. [Staff #3] stepped in front of him to block and to shut the door.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/04/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>[Client D] yelled out in anger because he couldn't get to [client A]. He doubled up his fists and struck [staff #3] in the face near his right eye. [Client D] was redirected to his room. He beat on his doors, walls and windows and yelled for about 5 min (minutes) and then calmed down."</p> <p>-2/15/12 "[Client D] walked into the kitchen to get water for meds and was talking to staff. [Client D] was in the kitchen window. [Client D] started to try to throw items at [client A]. Staff got [client A] out of the kitchen while other staff blocked [client D's] attempts to throw items...."</p> <p>-2/17/12 Client D was at the workshop doing work when client D became physically aggressive toward client A. The internal incident report indicated client D threw items at client A, but staff blocked and escorted client D away from the area.</p> <p>-10/7/11 "[Client A] was on an outing and upset that he could not stay out longer. When he came home he hit [client D]. [Client A] was redirected and counseled on appropriate interactions between house mates and [client D] was checked for injuries, none were found. The Program coordinator will meet with the team to</p>						

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>determine if any programming changes are needed."</p> <p>The facility's 10/12/11 Client to Client Aggression Investigation indicated "[Client A] grabbed [client D] and started punching [client D] until staff got [client A] off [client D]." "...6. Do any changes need to be made in an attempt to prevent future occurrences? [Client A]/[client D] need 3 staff kept between them at all times. 7. Is there a pattern of occurrences between these two clients? Yes Recommendations: We will try at all times to keep the 2 apart by halving (sic) a staff member between the two at all times."</p> <p>The facility's 10/25/11 follow-up report indicated "Staff will try and keep from having both consumers in the office at the same time and there will always be one staff member between the two consumers to ensure the safety of everyone. Staff will also redirect [client D] when he is trying to give [client A] a hug or handshake."</p> <p>-5/17/11 "[Client A] was upset for no unknown reason and attempted to hit [client D] (sic). [Client D] then hit [client A] back. Staff used Your Safe, I'm Safe technique to separate the two consumers. Both consumers were counseled on</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>appropriate interactions between housemates and checked for injuries, none were found. The program coordinator will meet with the team to determine if any programming changes are needed."</p> <p>The facility's 5/17/11 Client to Client Aggression Investigation indicated client D hit client A in the nose to defend himself. The investigation indicated "Yes, There was enough staff. 2 staff were in the office & (and) a 3rd (third) staff was in the living room on the other side of the house with another client." The facility neglected to ensure facility staff were deployed in a manner to supervise clients' behaviors. The 5/17/11 investigation indicated there was a pattern of occurrence between the clients. The facility's investigation indicated "...We need to keep the two apart as much as possible...."</p> <p>The facility's 7/5/11 follow-up report indicated "...The team met and decided that staff should stand between the two clients anytime they are in the room together. The two clients will not sit on the van next to eat (sic) other and never be left alone together."</p> <p>During the 4/23/12 observation period between 4:05 PM and 7:25 PM, at the</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>group home at 6:02 PM, client D was setting the table and retrieving items from the window. Client A, who was in the kitchen, mouthed something under his breath to client D, when client D came to the window. Client A looked directly at client D when he made the gestures/comments. Staff #4, who was in the kitchen with client A as his one on one staff, did not see client A say something to client D.</p> <p>During the 4/25/12 observation period between 9:25 AM and 10:45 AM, at the workshop, client A had one on one staffing. Clients A and D were located at the front of the workshop in an isolated area from the other clients. Clients A and D were located next to each other within the workshop with a blue tarp which hung in between them. The clients could easily walk around and/or through the blue tarp to target each other. There were 3 staff to 4 clients at the workshop on 4/25/12.</p> <p>Client D's record was reviewed on 4/26/12 at 1:14 PM. Client D's Progress Notes indicated the following:</p> <p>-3/21/12 "[Client D]...was doing alright until he saw a certain other client (client A) then went beszert (sic) for about 10 min."</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126		
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	<p>-3/20/12 Client D "Had behavior toward [client A] & redirected to bed."</p> <p>Client D's IDT notes indicated the following:</p> <p>-4/18/12 "Team met to discuss client to client that occurred at the workshop on 4/17/12. [Client D] had gotten up and went after another consumer (client A) (sic). The other consumer is 1:1 so staff was there to block it. [Client D] still managed to pick up a bag of parts and throw it at the other consumer. The other consumer reacted and chased [client D] and grabbed him & slung him to the floor...[Client D] had a small scrape on his elbow...."</p> <p>-3/28/12 "Team met to discuss incident between [client D] and another consumer (client A). [Client A] was upset w/(with) the other consumer. We feel there is a history between the 2. The other consumer started to become loud and verbal toward [client D] that led to this. [Client D] started got upset & started throwing things toward other consumer. Staff will Remain (sic) Between (sic) the 2 of them at all times to avoid and (sic) altercation."</p> <p>-1/19/12 "Team met to discuss [client D's] increase in behaviors. Dr. suggested</p>				

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>that he increase his Abilify (behavior) to 20 milligrams (mg) BID. He was taking 15 mg twice daily...."</p> <p>Client D's 1/27/12 ISP/BSP and/or above mentioned IDT notes neglected to specifically address client D's targeting and/or being a target of client A.</p> <p>Client A's record was reviewed on 4/25/12 at 1:38 PM. Client A's IDT Meeting notes indicated the following:</p> <p>-4/18/12 Client A's IDT met to review the incident with client D at the workshop. The IDT note indicated "...The other consumer (client D) had gotten up to approach him in his area. Because [client A] is 1:1 staff stepped Between (sic) the 2, to avoid a confrontation. The other consumer then picked up a package of parts that was laying nearby and threw it at [client A], [client A] reacted running through 2 staff knocking them aside and chased the other consumer until he caught up w/ him. He (client A) then grabbed him and started hitting him...Everyone agrees that he should remain 1:1 until further notice."</p> <p>-3/28/12 "Team met to discuss client to client incident on 3/27/12. [Client A] was very verbal toward another consumer that led to the other consumer throwing things</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>at him. Everyone agree (sic) that [client A] should not have been yelling to upset the other consumer. Plan of action is that staff will remain between the 2 to avoid any conflicts."</p> <p>Client A's 3/30/12 Doctor's Orders and Progress Notes indicated client A saw his psychiatrist on 3/30/12 due to increased physical aggression. The 3/30/12 progress note indicated client A's behavioral medications were changed as Topamax and Seroquel were started and Risperdal and Cogentin were discontinued.</p> <p>Client A's 4/12/12 BSP indicated "...In the past, he (client A) has used his size as an intimidation tool to get what he wants...." Client A's 4/12/12 ISP indicated client A demonstrated physical aggression (hitting, punching, pushing and kicking). Client A's BSP also indicated client A demonstrated verbal aggression defined as "cursing; calling others names; entering others' personal space, verbally stating he is going to become aggressive (raising his fist)...." The section of client A's BSP entitled "Preventative Procedures" indicated "1. [Client A] will be assigned a staff member on each shift. a. The assigned staff member is not a 1:1, as the staff member maybe assigned another consumer while being assigned to [client</p>			

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	<p>A] during each shift...12. [Client A] will be in line of sight of staff at all times, except when he is in his room or bathroom to redirect him if he begins to have any target behaviors...." Client A's 4/12/12 BSP/ISP and/or above mentioned IDT Meeting notes neglected to specifically indicate how client A was to be monitored to prevent aggression toward others at the workshop and/or neglected to address client A's targeting client D and/or being a target of client D's. Client A's 4/12/12 ISP/BSP also did not specifically address client A's antagonizing client D.</p> <p>Interview with staff #1 on 4/23/12 at 5:00 PM stated "[Client A] sets [client D] off." Staff #1 stated client A "barreled through me and another staff to get to [client D]." Staff #1 indicated this occurred on 4/17/12 at the workshop.</p> <p>Interview with staff #3 on 4/25/12 at 7:21 AM indicated client D was having behaviors at the workshop.</p> <p>Interview with staff #6 on 4/25/12 at 7:30 AM indicated client A would be aggressive with client D. Staff #6 indicated client A would do things to upset client D which then caused client D to have behaviors.</p>				

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>Interview with workshop staff #1 and #2 on 4/25/12 at 9:00 AM indicated client A was verbally aggressive to workshop staff and/or other clients. Workshop staff #1 and #2 stated client A and client D would "get into it." Workshop staff #1 stated client A would "antagonize" client D and others. Workshop staff #1 and #2 stated "[Client D] does not care for him (client A). He (client D) hears his voice and that will set him off." Workshop staff #1 stated in a recent incident between the clients, client A "chased [client D] and slammed him to the ground." Workshop staff #1 and #2 indicated client D did well at the workshop when client A did not come. Workshop staff #1 and #2 indicated they would start fighting while on the van coming to the workshop and then the workshop would have problems between the clients. When asked if client A's antagonizing client D was being addressed, workshop staff #1 stated "They were supposed to be addressing." Administrative staff #2 indicated the facility's BC had been coming to the workshop to monitor the clients, and was in the process of trying to see if he could get clients A and D transported in two different vans.</p> <p>Interview with LPN #1 and the Behavior Clinician (BC) on 4/27/12 at 9:40 AM indicated client A had been placed on one</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>to one staffing since he had a client to client incident with client B on 4/12/12. The BC indicated client A was to be monitored with in line of sight while at the day program as well. The BC indicated client A had an incident of aggression with client D since he was started on 1 to 1 staffing on 4/12/12. The BC indicated the clients were to be separated at the workshop. When asked how a blue tarp would keep the clients apart/separated, the BC indicated the clients should not be next to each other as the tarp would not stop the clients from aggressing against each other. The BC indicated the workshop was to build a wall/office area to keep the clients separate. LPN #1 and the BC indicated client A's ISP/BSP neglected to specifically indicate how the facility addressed client A's antagonizing client D which caused client D to have increased behaviors. The BC stated there was "an ongoing assessment" in regard to clients A and D's targeting each other and client A's antagonizing client D.</p> <p>3. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 3/1/12 reportable incident report and/or investigation indicated "On 3/1/12 staff noticed [client A] and a</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>female consumer exiting the same bathroom together. When [client A] was questioned by staff he insisted that they had not been in the same restroom together but restrooms next door to each other. He stated that when he tried to go to the restroom to wash his hands and brush his hair the female consumer was standing outside the restroom putting her hand down her pants and looking at him. He stated that he did not want anything to do with that and just went into the restroom. Female consumer is stating that [client A] did come into the same bathroom and that there was a sexual encounter...."</p> <p>The facility's 3/27/12 follow-up report indicated client A had a history of "inappropriate sexual behavior." The follow-up report indicated the police had been contacted and client A had been placed on one on one supervision at the workshop since the 3/1/12 incident.</p> <p>The facility's 3/7/12 Incident Investigation Review indicated "CONCLUSION AND FINDINGS: It is the conclusion of the investigation committee that the allegation of [client F] and [client A] having sexual intercourse was unsubstantiated. The allegation was unsubstantiated due to results of her exam at [name of medical center]." The</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>facility's 3/7/12 investigation indicated clients A and F were interviewed and one workshop staff. The investigation indicated the following (not all inclusive):</p> <p>"...[Client F], Individual stated that she was using the bathroom and [client A] came and knocked on the bathroom door and asked if anyone was around and walked into the bathroom and locked the door. She stated that "[Client A] put it my front butt and back butt."</p> <p>[Client A], Individual stated [client F] was staring at him all day and that when he walked into the bathroom she followed him. He stated that he and [client F] were never in the bathroom together and no sexual contact happened between them.</p> <p>[Client F] was transported to [name of medical center] where she was checked out. The [name of medical center] physician stated that there weren't any signs of penetration and no semen was found on [client F]. The physician reported that upon examination he noted redness and irritation to the labia. [Client F] does masturbate and the redness could be related to the masturbation." The witness statement of client F indicated client F was in the bathroom when she heard a knock at the door. Client F's witness statement indicated "...She</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
--	---

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	<p>opened the door and saw [client A] and told him she wanted to use the bathroom by herself. She reports that he wouldn't listen and he came in, made sure no one was around, and locked the door with the two of them in there. [Client F's] pants were down at the time and he unzipped his zipper pulling down his pants and underpants to his ankles. He asked [client F] if she wanted to 'hold it'...She states that he also asked her if she wanted to 'lick' or 'kiss it.' She did not lick or kiss, however she did hold it. She states that she didn't know what to do. She reports that he then put his pelvis in her 'front butt' and then told her to sit on the toilet and again put it in her 'front butt' twice. He told her to stand against the wall. He put his pelvis on her 'back butt' and it was sore and also 'sticky and icky' per [client F]. [Client A] told [client F] not to tell anyone at [name of workshop]...[Client F] reported the incident to staff @ (at) [name of workshop]." The facility's 3/7/12 investigation indicated typed witness statements from clients A and F. There were no other witness statements attached to the investigation. The facility neglected to interview and/or provide any documentation of workshop staff, clients and/or facility staff interviews. The facility's investigation neglected to conduct a thorough investigation in regard to the allegation of sexual abuse as the</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
--	---

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	<p>facility did not investigate where the Extensive Support Needs (ESN) staff were at the time of the incident at the workshop regarding supervision of the ESN client.</p> <p>The facility's 9/8/11 reportable incident report indicated client A had a previous allegation of sexual abuse on 9/8/11 where "[Client G] reported to staff that [client A] touched her breast when he walked by her at the workshop and make (sic) an inappropriate sexual comment to her." The facility's 9/8/11 investigation indicated "CONCLUSIONS AND FINDINGS: It is the conclusion of the investigation committee that the allegation of [client A] touching [client G] and making an inappropriate comment to her is substantiated." The facility's 9/29/11 follow-up report indicated "... [Client A] does have a history of inappropriate sexual behaviors and it is addressed in his Behavior support plan (sic). The IDT (interdisciplinary team) met and decided that [client A] will not hug anyone while at workshop...."</p> <p>Client A's record was reviewed on 4/25/12 at 1:38 PM. Client A's 3/5/12 Counsel Progress Note indicated client A saw his counselor and "Discussed recent boundary trespasses here at office and goals to 1) recognize boundaries between</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>his stuff/space and other's space 2) stay on his side of the line. Also discussed how he inappropriately handled flirting bx (behavior) from female peer in the workplace by hugging her...."</p> <p>Client A's IDT Meeting notes indicated the following:</p> <p>-3/1/12 "Team met to discuss [client A's] behaviors at workshop. They are having issues on him wandering out of his work area and not staying on task. They agreed to move him to his own secluded area away from other clients where he won't get distracted...."</p> <p>-3/6/12 Client A's IDT met "To discuss the episode on 3/1/12 where staff saw [client A] exit the bathroom with a female consumer at [name of workshop]...where a female client alleged that [client A] had sexual relations with him (sic). [Client A] denies that any sexual contact happened. The team reviewed his sexual assessment and confirmed the assessment is still appropriate. [Client A] was counseled on the consequences of having sex. [Client A] understands this, and stated he knows it is wrong to touch people without their consent. At the workshop, [client A] is in a designated area where staff can monitor him. He will also have less distraction so he can</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	concentrate more on completing his job/assignments." C			

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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 interview and record review for 2 of 11 allegations of abuse and/or neglect reviewed, the facility failed to accurately report an allegation of neglect in regard to a van accident and to report an allegation of neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for clients A and C.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 4/8/12 reportable incident report indicated "[Client C] and [client A] were on their way to church in the van when they rear-ended another vehicle. There were no apparent injuries, but as a precautionary measure, the individuals were taken to the ER (emergency room) for evaluation. [Client C] and [client A]</p>	W0153	<p>Corrective Action: (Specific) The Quality Assurance Team will be retrained on preventing abuse, neglect and exploitation by accurately reporting any allegation or incident to the Executive Director immediately and all state agencies. How others will be identified: (Systemic) All staff are trained during initial orientation and at annuals meetings on reporting all allegations of abuse, neglect, and exploitation immediately to the Executive Director. Measures to be put in place: The Quality Assurance Team will be retrained on preventing abuse, neglect and exploitation by accurately reporting any allegation or incident to the Executive Director immediately and all state agencies. Monitoring of Corrective Action: The Director of SGL will review all reportable incidents to ensure that the Executive Director and all state agencies have been notified.</p>	06/03/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/04/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>were both assessed by the physician in the ER. It was determined that [client C] and [client A] sustained no injuries from the accident...."</p> <p>The 4/8/12 Indiana's Officer's Standard Crash Report was reviewed on 4/25/12 at 3:05 PM. The crash report indicated staff #7 was involved in an "Improper Lane usage." The crash report indicated the weather conditions were clear, dry and it happened during the day light at 10:51 AM. The crash report indicated "Driver of V1 (vehicle 1) was heading South on US 31 near [name of street] when he stated a bug flew into the vehicle and around his face, caused the vehicle to swerve right into a parked truck in front of 322 US 31." The crash report indicated "...Safety Equipment Effective (air bags deployed)..." and lap and harness belts were used. The 4/8/12 crash report indicated the group home's front part of the van was damaged and had to be towed. The crash report indicated the back part of the parked vehicle was damaged. The 4/8/12 crash report indicated "Total Estimate of all damage in the Crash: \$10001 TO \$25000."</p> <p>Interview with client A on 4/25/12 at 7:52 AM and at 10:05 AM indicated facility staff wrecked the van while they were going to church one Sunday. Client A</p>						

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	<p>indicated the air bags on the van deployed. Client A indicated he was in the front seat of the van when staff hit a parked truck. Client A stated "Van is messed up." Client A indicated he was not hurt.</p> <p>Interview with administrative staff #5 on 4/26/12 at 2:30 PM indicated he reported the van accident to BDDS as he thought facility staff had backed into a parked vehicle in a church parking lot. Administrative staff #5 indicated drug tests were performed on staff who was involved in the vehicle accident. Administrative staff #5 stated he thought staff #7's drug test came back "positive."</p> <p>Interview with staff #1 on 4/26/12 at 2:40 PM stated the van was "totaled." Staff #1 indicated the parked car was also damaged in the accident and the accident took place on a street in a residential area. Staff #1 stated the air bags deployed and the "grill was pushed back to the front seat."</p> <p>Interview with administrative staff #6 on 4/26/12 at 2:44 PM stated "[Staff #7] told me a bug flew into the car and into his eye." Administrative staff #6 indicated the staff person swerved and hit a parked car. Administrative staff #6 stated staff #7 told her he was going "a couple of</p>			

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	<p>miles over the speed limit 32." Administrative staff #6 indicated the hospital conducted a drug test on staff #7 which came back positive for Marijuana. Administrative staff #6 stated staff #7 was "adamant" he had not done any drugs. Administrative staff #6 indicated the facility then sent him out to be tested, a second time, to a different site. Administrative staff #6 indicated staff #7 left the drug test site as he had told the site he was not able to use the bathroom with someone watching him.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 8/1/11 Incident Investigation Review indicated the facility investigated an allegation of possible neglect "It was reported to QA (Quality Assurance) that a staff member was sleeping at [name of fast food restaurant] while a consumer was working their shift." The 8/1/11 investigation indicated "On 7/25/11 [staff #8] transported [client A] to his shift at the [name of town fast food restaurant]. [Name of restaurant Manager] stated that when she walked out to the dining room she noticed [staff #8] asleep in the booth with his head down and the table (sic). [Name of assistant manager at name of fast food restaurant] also stated that she</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>saw [staff #8] asleep in the booth." The facility's 8/1/11 investigation indicated the allegation of neglect (staff sleeping) was substantiated.</p> <p>Review of the facility's reportable incident reports from 4/11 to 4/12 indicated the facility did not report the above mentioned allegation of neglect to BDDS and/or APS per state law.</p> <p>Interview with administrative staff #7 on 4/25/12 at 2:00 PM indicated the above mentioned allegation of neglect was not reported to BDDS. Administrative staff #7 stated the facility did not see this as an allegation of neglect as the staff person was "not on the clock" which was determined from their investigation.</p> <p>9-3-2(a)</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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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. Based on interview and record review for 2 of 11 allegations of abuse and/or neglect reviewed, the facility failed to conduct a thorough investigation in regard to the allegations of abuse/neglect for clients A and C.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 3/1/12 reportable incident report and/or investigation indicated "On 3/1/12 staff noticed [client A] and a female consumer exiting the same bathroom together. When [client A] was questioned by staff he insisted that they had not been in the same restroom together but restrooms next door to each other. He stated that when he tried to go to the restroom to wash his hands and brush his hair the female consumer was standing outside the restroom putting her hand down her pants and looking at him. He stated that he did not want anything to do with that and just went into the restroom. Female consumer is stating that [client A] did come into the same</p>	W0154	<p>Corrective Action: (Specific) The Quality Assurance staff will be retrained that allegations of mistreatment, neglect or abuse (which includes any client sexual inappropriateness and van accidents) be thoroughly investigated. How others will be identified: (Systemic) During orientation training and during the annual training all staff are trained on the Abuse and Neglect and Exploitation Policy and Procedure. Measures to be put in place: The Quality Assurance staff will be retrained that allegations of mistreatment, neglect or abuse (which includes any client sexual inappropriateness and van accidents) be thoroughly investigated. Monitoring of Corrective Action: The Director of SGL will review all reportable incidents to ensure that the Executive Director and all state agencies have been notified.</p>	06/03/2012			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>bathroom and that there was a sexual encounter...."</p> <p>The facility's 3/27/12 follow-up report indicated client A had a history of "inappropriate sexual behavior." The follow-up report indicated the police had been contacted and client A had been placed on one on one supervision at the workshop since the 3/1/12 incident.</p> <p>The facility's 3/7/12 Incident Investigation Review indicated "CONCLUSION AND FINDINGS: It is the conclusion of the investigation committee that the allegation of [client F] and [client A] having sexual intercourse was unsubstantiated. The allegation was unsubstantiated due to results of her exam at [name of medical center]." The facility's 3/7/12 investigation indicated clients A and F were interviewed and one workshop staff. The investigation indicated the following (not all inclusive):</p> <p>"...[Client F], Individual stated that she was using the bathroom and [client A] came and knocked on the bathroom door and asked if anyone was around and walked into the bathroom and locked the door. She stated that "[Client A] put it in my front butt and back butt."</p> <p>[Client A], Individual stated [client F]</p>						

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>was staring at him all day and that when he walked into the bathroom she followed him. He stated that he and [client F] were never in the bathroom together and no sexual contact happened between them.</p> <p>[Client F] was transported to [name of medical center] where she was checked out. The [name of medical center] physician stated that there weren't any signs of penetration and no semen was found on [client F]. The physician reported that upon examination he noted redness and irritation to the labia. [Client F] does masturbate and the redness could be related to the masturbation." The witness statement of client F indicated client F was in the bathroom when she heard a knock at the door. Client F's witness statement indicated "...She opened the door and saw [client A] and told him she wanted to use the bathroom by herself. She reports that he wouldn't listen and he came in, made sure no one was around, and locked the door with the two of them in there. [Client F's] pants were down at the time and he unzipped his zipper pulling down his pants and underpants to his ankles. He asked [client F] if she wanted to 'hold it'...She states that he also asked her if she wanted to 'lick' or 'kiss it.' She did not lick or kiss, however she did hold it. She states that she didn't know what to do. She reports</p>						

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>that he then put his pelvis in her 'front butt' and then told her to sit on the toilet and again put it in her 'front butt' twice. He told her to stand against the wall. He put his pelvis on her 'back butt' and it was sore and also 'sticky and icky' per [client F]. [Client A] told [client F] not to tell anyone at [name of workshop]...[Client F] reported the incident to staff @ (at) [name of workshop]." The facility's 3/7/12 investigation indicated typed witness statements from clients A and F. There were no other witness statements attached to the investigation. The facility neglected to interview and/or provide any documentation of workshop staff, clients and/or facility staff interviews. The facility's investigation neglected to conduct a thorough investigation in regard to the allegation of sexual abuse as the facility did not investigate where the Extensive Support Needs (ESN) staff were at the time of the incident at the workshop regarding supervision of the ESN client.</p> <p>The facility's 9/8/11 reportable incident report indicated client A had a previous allegation of sexual abuse on 9/8/11 where "[Client G] reported to staff that [client A] touched her breast when he walked by her at the workshop and make (sic) an inappropriate sexual comment to her." The facility's 9/8/11 investigation</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>indicated "CONCLUSIONS AND FINDINGS: It is the conclusion of the investigation committee that the allegation of [client A] touching [client G] and making an inappropriate comment to her is substantiated." The facility's 9/29/11 follow-up report indicated "... [Client A] does have a history of inappropriate sexual behaviors and it is addressed in his Behavior support plan (sic). The IDT (interdisciplinary team) met and decided that [client A] will not hug anyone while at workshop...."</p> <p>Client A's record was reviewed on 4/25/12 at 1:38 PM. Client A's 3/5/12 Counsel Progress Note indicated client A saw his counselor and "Discussed recent boundary trespasses here at office and goals to 1) recognize boundaries between his stuff/space and other's space 2) stay on his side of the line. Also discussed how he inappropriately handled flirting bx (behavior) from female peer in the workplace by hugging her...."</p> <p>Client A's 3/6/12 IDT met "To discuss the episode on 3/1/12 where staff saw [client A] exit the bathroom with a female consumer at [name of workshop]...where a female client alleged that [client A] had sexual relations with him (sic). [Client A] denies that any sexual contact happened. The team reviewed his sexual</p>			

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	<p>assessment and confirmed the assessment is still appropriate. [Client A] was counseled on the consequences of having sex. [Client A] understands this, and stated he knows it is wrong to touch people without their consent. At the workshop, [client A] is in a designated area where staff can monitor him. He will also have less distraction so he can concentrate more on completing his job/assignments."</p> <p>Client A's 2/17/12 Lifestyle Plan indicated "...[Client A] is occasionally socially inappropriate at times when introduced to other people. He has the tendency to say or behave inappropriately with others, especially female individuals...."</p> <p>Client A's 4/12/12 Behavior Support Plan (BSP) indicated client A demonstrated "Inappropriate Sexual Interaction defined as when [client A] touches others without consensual agreement to the sexual interaction."</p> <p>Interview with staff #5 on 4/25/12 at 7:21 AM indicated client A had a history of sexually inappropriate behavior. Staff #5 stated client A had "grabbed staff's (female) butt" and had a sexual incident at the workshop with a female client.</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>Interview with staff #6 on 4/25/12 at 7:30 AM indicated client A demonstrated inappropriate sexual behavior. Staff #6 stated "Stares at women" and "Others say he will lick his lips."</p> <p>Interview with workshop staff #1 and #2 on 4/25/12 at 9:00 AM stated "He (client A) is in a segregated area due to interaction with female clients as he is not always appropriate." Workshop staff #1 and #2 stated client A would demonstrate the "inappropriate behavior whenever he is around females. Occurs daily." Workshop staff #1 indicated client A did not feel his behavior was inappropriate. Workshop staff #1 and #2 stated client A would make a statement like "Call me Mr. sexy, grope himself, and rub up against other consumers." Workshop staff #1 indicated this would make other female consumers feel uncomfortable. Workshop staff #1 and #2 indicated the female client went to the bathroom and client A knocked on the door of the bathroom and the female client let him in. Workshop staff #1 stated "Hard to determine if consensual or intimidation. Res-Care did investigation." Workshop staff #1 and #2 indicated client A had a history of inappropriate sexual behavior and would look for opportunities to take advantage of others. When asked if Res-care staff were present in the</p>						

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126		
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	<p>workshop on that day, workshop staff #1 stated "Yes." Workshop staff #1 stated Res-Care group homes would sometimes "share staff" at the workshop. Workshop staff #1 and #2 indicated it was workshop staff who saw the female and client A come out of the bathroom. Administrative staff #1 stated "shortly after the incident [client A] went to one on one staffing."</p> <p>Interview with the Behavior Clinician (BC) on 4/25/12 at 7:52 AM indicated he did not know if facility staff were present at the workshop on 3/1/12. The BC indicated facility staff normally went to the workshop with the clients. The BC indicated client A demonstrated inappropriate sexual behavior toward females. The BC indicated client A was placed on one one staffing after a client to client incident with another client. The BC indicated client A's ISP/BSP did not clearly indicate how client A was to be monitored at the workshop. The BC indicated client A was in a separate area from the other clients and facility staff were to remain with the client.</p> <p>Interview with administrative staff #1 and #2 on 4/27/12 at 11:55 AM indicated the facility did not conduct a thorough investigation as the facility did not look at the staffing at the workshop in regard to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/04/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>the 3/1/12 sexual incident.</p> <p>Administrative staff #1 indicated group home staff should have gone to the workshop with the clients.</p> <p>Administrative staff #1 indicated he did not know how many staff went that day and/or where/what staff was doing when the incident took place. Administrative staff #1 indicated the doctor indicated the female client was not penetrated, so the facility did not substantiate sexual abuse occurred. Administrative staff #1 and #2 indicated client A had a history of inappropriate sexual behavior toward females.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 4/8/12 reportable incident report indicated "[Client C] and [client A] were on their way to church in the van when they rear-ended another vehicle. There were no apparent injuries, but as a precautionary measure, the individuals were taken to the ER (emergency room) for evaluation. [Client C] and [client A] were both assessed by the physician in the ER. It was determined that [client C] and [client A] sustained no injuries from the accident..." No additional information and/or investigation was included/attached.</p>						

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	<p>The 4/8/12 Indiana's Officer's Standard Crash Report was reviewed on 4/25/12 at 3:05 PM. The crash report indicated staff #7 was involved in an "Improper Lane usage." The crash report indicated the weather conditions were clear, dry and it happened during the day light at 10:51 AM. The crash report indicated "Driver of V1 (vehicle 1) was heading South on US 31 near [name of street] when he stated a bug flew into the vehicle and around his face, caused the vehicle to swerve right into a parked truck in front of 322 US 31." The crash report indicated "...Safety Equipment Effective (air bags deployed)..." and lap and harness belts were used. The 4/8/12 crash report indicated the group home's front part of the van was damaged and had to be towed. The crash report indicated the back part of the parked vehicle was damaged. The 4/8/12 crash report indicated "Total Estimate of all damage in the Crash: \$10001 TO \$25000."</p> <p>Interview with client A on 4/25/12 at 7:52 AM and at 10:05 AM indicated facility staff wrecked the van while they were going to church one Sunday. Client A indicated the air bags on the van deployed. Client A indicated he was in the front seat of the van when staff hit a parked truck. Client A stated "Van is</p>			
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	<p>messed up." Client A indicated he was not hurt.</p> <p>Interview with client B on 4/25/12 at 9:40 AM indicated the group home did not have a van as the van had been wrecked by staff. Client B indicated the van was wrecked on Easter Sunday as facility staff hit a parked car. Client B indicated they had been without a van for 3 weeks.</p> <p>Interview with administrative staff #5 on 4/26/12 at 2:30 PM indicated he did not conduct an investigation in regard to the 4/8/12 incident. Administrative staff #5 indicated he thought staff had backed into a parked vehicle in a church parking lot. Administrative staff #5 indicated drug tests were performed on staff who was involved in a vehicle accident. Administrative staff #5 stated he thought staff #7's drug test came back "positive."</p> <p>Interview with staff #1 on 4/26/12 at 2:40 PM stated the van was "totaled." Staff #1 indicated the parked car was also damaged in the accident and the accident took place on a street in a residential area. Staff #1 stated the air bags deployed and the "grill was pushed back to the front seat."</p> <p>Interview with administrative staff #6 on 4/26/12 at 2:44 PM stated "[Staff #7] told</p>			

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	<p>me a bug flew into the car and into his eye." Administrative staff #6 indicated the staff person swerved and hit a parked car. Administrative staff #6 stated staff #7 told her he was going "a couple of miles over the speed limit 32." Administrative staff #6 indicated the hospital conducted a drug test on staff #7 which came back positive for Marijuana. Administrative staff #6 stated staff #7 was "adamant" he had not done any drugs. Administrative staff #6 indicated the facility then sent him out to be tested a second time to a different site. Administrative staff #6 indicated staff #7 left the drug test site as he had told the site he was not able to use the bathroom with someone watching him. Administrative staff #6 indicated she conducted an investigation in regard to the incident. Administrative staff #6 indicated she thought there were 2 clients in the van who were not able to be interviewed (clients C and D). Administrative staff #6 indicated she did not interview client A who was actually in the van with client C. No other staff interviews and/or client interviews were conducted in regard to the accident and/or the staff's driving skills/abilities since staff #7 was hired on 3/19/12.</p> <p>Interview with the Property Manager on 4/26/12 at 3:08 PM indicated the group</p>			

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	<p>home van was involved in an accident. When asked if staff totaled the van, the Property Manager indicated she was still waiting to hear from the insurance company. The Property Manager indicated the group home was to receive a new van on 4/25/12.</p> <p>9-3-2(a)</p>			

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W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 4 of 4 clients living in the home (clients A, B, C and D), the facility failed to provide staffing as specified in the undated ESN (Extensive Support Needs) Guidelines to ensure facility staff met the clients' behavioral needs.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 4/11/12 reportable incident report indicated "[Client B] and [client A] started to argue. [Client B] through (sic) a cup at [client A] and client [client A] chased after him and knocked him down to the floor. Staff separated the two clients and they were redirected to different areas of the home. Both consumers were assessed by staff; [client A] sustained no injuries from the accident. [Client B's] hip was hurting him</p>	W0186	<p>Corrective Action: (Specific) The Program Coordinator will be retrained that the staffing of the ESN (Extensive Support Needs) home will include the updated reimbursement guideline which indicates that individuals living in residences under this category must be supervised at all time and the staffing pattern at full capacity should be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. How others will be identified: All homes that are classified ESN (Extensive Support Needs) residences will have a staffing pattern of three (3) on the day shift, three (3) on the evening shift, and two (2) on the night shift. Measures to be put in place: All staffing patterns in the ESN (Extensive Support Needs) residences will be reviewed and approved by the Executive Director to ensure compliance of the updated reimbursement guideline for individuals living in the ESN homes is followed. Monitoring of</p>	06/03/2012	

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	<p>and staff took him to his PCP (primary care physician) for evaluation. The staff counseled [client A] and [client B] on appropriate interactions between one another. The program coordinator will meet with staff to determine if any changes need to be made to [client A] or [client B's] BSP's (Behavior Support Plans) (sic). At [client B's] appointment, x-rays were done to evaluate his hip. He was diagnosed with a hair line fracture and is scheduled to have a cat scan on 4-17-2012...."</p> <p>The facility's 4/12/12 Client to Client Aggression Investigation indicated "[Client A] and [client B] were arguing over day that [client B] had. [Client B] got upset and threw Kool-Aid at [client A]. [Client A] then chased [client B] through the house, when he caught up with he pushed him down to the floor (sic)...." The 4/12/12 client to client investigation indicated there was enough staff present at the time of the incident, but did not indicate the exact number of staff who were present. The 4/12/12 investigation indicated "Recommendations: Staff will place themselves between the 2 of them until the team meets to decide how to resolve the matter."</p> <p>During the 4/23/12 observation period</p>		<p>Corrective Action: All staffing patterns in the ESN (Extensive Support Needs) residences will be reviewed and approved by the Executive Director to ensure compliance of the updated reimbursement guideline for individuals living in the ESN homes is followed.</p>		

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	<p>between 4:05 PM and 7:25 PM, at the group home, there were three staff to 4 clients (A, B, C and D) at the group home. Upon arrival to the group home, client A was standing outside unsupervised without staff talking on a cell phone. Client A was standing outside the gate/fenced area of the group home. Upon being let into the group home, 3 staff (staff #1, #4 and #5) and client B were sitting at the dining room table. During the above mentioned observation period, client A had a staff person following the client around or did not have staff with him. At 4:22 PM, staff #5 left with client B to go to the store while client A was sitting in the living room with client C, who was watching TV and drinking a soft drink. No staff was present in the living room at that time. At 5:07 PM, staff #4 left with client D to go for a walk leaving staff #1 to monitor/supervise clients A and C. Client A went back outside past the fenced area to use his cell phone leaving staff #1 in the house with client C. At one point, client A could not be seen as the client had left the fenced area. At 5:15 PM, client A came back in the house and walked into the living room where client C was sitting. No staff was in the living room when client A returned inside the house. At 5:23 PM, staff #4 returned and started following client A. At 6:09 PM,</p>			

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	<p>client A walked from the kitchen to the living room area, where client D was sitting, to client D's bedroom. Client A then came out of client D's bedroom and went back into the kitchen. No staff was following and/or with client A when he left the kitchen and went to the living room and client D's bedroom. Interview with staff #1 on 4/23/12 at 5:00 PM stated client A had "One on One staffing (one staff to one client). Staff has to stay between him and others."</p> <p>Client A's record was reviewed on 4/25/12 at 1:38 PM. Client A's IDT Meeting notes indicated the following:</p> <p>-4/12/12"The team discussed the episode where another client was arguing with [client A]. The other client threw a cup at [client A]. [Client A] chased the other client and knocked him to the floor. The client received a hair line fracture in his pelvic area..(sic) Immediately after the incident to ensure safety, staff made sure that the clients were separated for the rest of the night. The team decided that a 1 on 1 staffing will be placed on [client A] during waking hours to ensure his housemates' safety until the team meets again in 1 week. The 1 on 1 is defined as staff positioning themselves in between [client A] and his housemates to ensure their safety...."</p>			

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	<p>-4/24/12 "Team met to discuss [client A's] progress over the past 2 weeks. During that time he had 1 episode of Physical Aggression in which he had a client to client with another consumer (client D)...He stated that he wanted off 1:1 staffing, but everyone was in agreement that he should remain 1:1 for now until he proved himself."</p> <p>The facility time cards for the period of March 1, 2012 through April 22, 2012 for the direct care staff working with clients A, B, C and D were reviewed on 4/26/12 at 3:10 PM. The time cards indicated the facility failed to follow the Reimbursement Guidelines for the 24 hour Extensive Support Needs Residences, undated. The guidelines indicated "Individuals living in residences under this must be supervised at all times and the staffing pattern at full capacity should be a minimum of: three (3) staff on the day shift, three (3) staff on the evening shift; and two (2) staff on the night shift." The following dates and times did not follow the guidelines:</p> <p>3/1/12 - 6:00 AM to 2:00 PM - 2 staff, 2:00 PM to 4:00 PM - 1 staff, and 4:00 PM to 12:00 AM -2.</p> <p>3/2/12 - 2:00 PM to 12:00 AM - 2 staff.</p> <p>3/3/12 - 8:00 AM to 1 PM - 2 staff</p>						

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	<p>and 4 PM to 12:00 AM - 2 staff.</p> <p>3/4/12 - 12:00 AM to 8:00 AM - 1 staff, 8:00 AM to 1:00 PM - 2 staff, and 4:00 PM to 12:00 AM - 2 staff.</p> <p>3/5/12 - 12:00 AM to 5:00 AM - 1 staff, 12:00 PM to 2:00 PM - 2 staff, 2:00 PM to 4:00 PM - 1 staff and 4:00 PM to 12:00 AM - 2</p> <p>3/7/12 - 8 AM to 12:00 AM 2</p> <p>3/8/12 - 12:00 AM to 8:00 AM - 1 staff and 8:00 AM to 4:00 PM - 2 staff</p> <p>3/9/12 - 9:00 PM to 12:00 AM - 1 staff,</p> <p>3/10/12 - 8:00 AM to 12:00 AM - 2 staff</p> <p>3/12/12 - 8:00 AM to 12:00 AM - 2 staff</p> <p>3/13/12 - 8:00 AM to 4:00 PM - 2 staff</p> <p>3/14/12 - 8:00 AM to 12:00 AM - 2 staff</p> <p>3/15/12 - 8:00 AM to 4:00 PM - 2 staff</p> <p>3/16/12 - 8:00 AM to 4:00 PM - 2 staff</p> <p>3/17/12 -4:00 PM to 10:00 PM - 2 staff</p> <p>3/18/12 -8:00 AM to 12:00 AM - 2 staff</p> <p>3/19/12 - 12:00 AM to 8:00 AM - 1 staff, 8:00 AM to 10:00 AM - 2 staff, 4:00 PM to 12:00 AM - 2 staff</p> <p>3/21/12 - 12:00 AM to 8:00 AM - 1 staff</p>			

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	<p>3/23/12 - 4:00 PM to 12:00 PM - 2 staff</p> <p>3/24/12 - 8:00 AM to 12:00 PM - 2 staff</p> <p>3/25/12 - 8:00 AM to 12:00 PM - 2 staff and 4:00 PM to 12:00 PM - 2 staff</p> <p>3/26/12 - 8:00 AM to 4:00 PM - 2 staff</p> <p>3/29/12 -4:00 PM to 12:00 AM - 2 staff</p> <p>3/31/12 - 8:00 AM to 12:00 AM - 2 staff</p> <p>4/1/12 -8:00 AM to 4:00 PM - 1 staff, 4:00 PM to 12:00 PM - 2 staff</p> <p>4/2/12 - 8:00 AM to 9:00 PM - 2 staff</p> <p>4/3/12 - 8:00 AM to 4:00 PM - 2 staff</p> <p>4/4/12 - 8:00 AM to 4:00 PM - 2 staff</p> <p>4/5/12 -8:00 AM to 9:00 PM - 1 staff, 9:00 PM to 12:00 AM - 2 staff</p> <p>4/6/12 - 12:00 AM to 7:00 AM - 1 staff and 9:00 PM to 12:00 AM - 2 staff</p> <p>4/8/12 -6:00 PM to 12:00 AM - 2 staff</p> <p>4/9/12 - 8:00 AM to 12:00 AM - 2 staff</p> <p>4/10/12 -8:00 AM to 12:00 AM - 2 staff</p> <p>4/11/12- 6: 00 AM to 8:00 AM - 1 staff and 8:00 AM to 4:00 PM - 2 staff</p> <p>4/12/12 -8:00 AM to 12:00 AM - 2 staff</p> <p>4/13/12 - 8:00 AM to 12:00 AM - 2 staff</p> <p>4/14/12 - 8:00 AM to 4:00 PM - 2 staff and 7:00 PM to 12:00 AM - 2 staff</p>			

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	<p>4/15/12 - 8:00 AM to 3:00 PM - 1 staff, 3:00 PM to 12:00 AM - 2 staff</p> <p>4/16/12 -4:00 PM to 12:00 AM - 2 staff</p> <p>4/17/12 - 12:00 AM to 8:00 AM - 1 staff and 8:00 AM to 4:00 PM - 2 staff</p> <p>4/18/12 - 12:00 AM to 8:00 AM - 1 staff and 8:00 AM to 4:00 PM - 2 staff</p> <p>4/19/12 - 12:00 AM to 8:00 AM - 1 staff and 8:00 AM to 4:00 PM - 2 staff</p> <p>4/20/12 - 8:00 AM to 12:00 AM - 2 staff</p> <p>4/21/12 - 8:00 AM to 4:00 PM - 2 staff</p> <p>4/22/12 - 8:00 AM to 12:00 AM - 2 staff</p> <p>Interview with staff #3 on 4/25/12 at 7:21 AM indicated 3 staff worked on the day shift and 3 staff worked on the evening shift. Staff #3 indicated staff #1 would make the third staff as the facility was short of staff. Staff #3 stated "We are short handed. We have 2 new staff starting next week." Staff #3 stated client A was on one to one staffing due to "shoving [client B] down and hurting his hip."</p> <p>Interview with client B on 4/25/12 at 9:40 AM indicated he recently moved into the group home. When asked how many staff worked the day and/or evening shift, client B stated "2 to 3 in the PM and 3</p>			

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	<p>staff in the AM."</p> <p>Interview with staff #1 on 4/25/12 at 10:15 AM indicated the facility was down 4 to 5 staff. Staff #1 stated "Staff get burned out due to behaviors." Staff #1 indicated he would work to cover some of the shifts as direct care staff.</p> <p>The interview with administrative staff #4 was conducted on 4/26/12 at 3:38 PM. Administrative staff #4 indicated staffing was short for clients A, B, C and D's home and the Program Coordinator had been filling in for the missing staff. Administrative staff #4 indicated the Program Coordinator did not have a time card that showed the actual time he worked as a direct care staff because he was paid a salary.</p> <p>Interview with LPN #1 and the Behavior Clinician on 4/27/12 at 9:40 AM indicated client A had been aggressive toward other clients in the group home and had been placed on one to one staffing due to his aggression. The Behavior Clinician and LPN #1 indicated the group home had 3 staff who worked on the day and evening shifts as they did prior to the 4/11/12 incident. LPN #1 and the Behavior Clinician indicated clients A, B, C and D demonstrated behaviors which required staff supervision and</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>monitoring as well.</p> <p>Interview with administrative staff #1 and #2 on 4/27/12 at 11:55 AM indicated client A was to have one on one staffing at the group home due to the 4/11/12 incident with client B. Administrative staff #1 indicated the group home had 3 staff who worked the day and evening shifts and 2 staff who worked on the overnight shift. Administrative staff #1 indicated this was the staffing pattern before the 4/11/12 incident. When asked if the number of staff had been increased since client A required one to one staffing, administrative staff indicated the facility continued to run the same staffing pattern as before. Administrative staff #1 indicated one of the three staff would be assigned to client A. Administrative staff #1 and #2 indicated the Program Coordinator filled in as direct care staff, but there was nothing that would show the actual time the Program Coordinator worked as direct care staff to ensure the facility had sufficient staffing levels to supervise the ESN clients.</p> <p>Administrative staff #1 indicated the facility would try to determine what shifts the Program Coordinator covered. The facility did not provide this information as of 4/30/12.</p> <p>This federal tag relates to complaint</p>			
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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W0210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on interview and record review for 1 of 2 sampled clients (B), who was recently admitted to the group home, the client's interdisciplinary team (IDT) failed to obtain assessments within 30 days after being admitted to the group home.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 4/25/12 at 1:00 PM. Client B's 3/26/12 Nursing Admission Assessment indicated client B was admitted to the group home 3/26/12.</p> <p>Client B's 3/16/12 Individual Support Plan (ISP) and/or record indicated client B did not have dental, hearing, speech and/or sensorimotor assessments completed within 30 days of admission.</p> <p>Interview with LPN #1 on 4/27/12 at 9:40 AM indicated the above mentioned assessments had not been obtained. LPN #1 indicated staff #1 was in the process of getting the assessments scheduled.</p> <p>9-3-4(a)</p>	W0210	<p>The Program Coordinator and the Nurse will be retrained that accurate assessments, such as visual, dental, hearing, speech and/or sensorimotor assessments are obtained within 30 days of admission. How others will be identified: (Systemic) All Program Coordinators are trained that accurate assessments that are needed within 30 days of admission are obtained.</p> <p>Measures to be put in place: The Program Coordinator and the Nurse will be retrained that accurate assessments, such as visual, dental, hearing, speech and/or sensorimotor assessments are obtained within 30 days of admission. Monitoring of Corrective Action: The Director of Nursing and the Operations Manager for SGL will monitor the PC and the Nurse to ensure that all assessments needed within 30 days of admission are obtained.</p>	06/03/2012			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on interview and record review for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the clients' Individual Support Plans (ISPs) failed to address clients A and D's antagonizing/targeting each other to decrease the number/pattern of client to client incidents. The facility failed to address a training need in regard to client B's speaking in loud tone of voice which caused client C to target client B.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's internal and reportable incident reports and/or investigations indicated the following:</p> <p>-4/17/12 "On 4/17/2012 [client A] was working in his assigned area when another consumer (client D) started to display physical aggression towards him. The other consumer hit him with a box of work supplies. [Client A] retaliated and</p>	W0227	<p>Corrective Action: (Specific) Client A's BSP will be reviewed and revised to define the One on One staffing at the home and the workshop, and will specifically address Client A antagonizing Client D. All staff will be retrained on all client BSPs. Client B's BSP will be reviewed and revised to assist the client not to speak in a loud tone of voice. How others will be identified: (Systemic) All client BSPs will be revised as needed to address any concerns/behaviors that develop Measures to be put in place: Client A's BSP will be reviewed and revised to define the One on One staffing at the home and the workshop, and will specifically address Client A antagonizing Client D. All staff will be retrained on all client BSPs. Client B's BSP will be reviewed and revised to assist the client not to speak in a loud tone of voice.</p> <p>Monitoring of Corrective Action: The Operations Manager for SGL will make weekly visits to the home to ensure staff follow all BSPs. The Behavior Clinician will ensure during visits that staff follow all BSP's.</p>	06/03/2012

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	<p>started yelling and charging consumer across the workflow. The other consumer ran to the other side of the workflow with [client A] chasing him. [Client A] then caught the other consumer, picked him up and slammed him into the ground. [Client A] and the other consumer were then separated and [client A] was restrained using the properly trained technique by 4 staff per his Behavior Support Plan for physical aggression...."</p> <p>The facility's 4/17/12 Client to Client Aggression Investigation indicated client A had one on one staffing at the time of the incident. The facility's investigation indicated "...Yes, this is a pattern between the two...." The facility's investigation indicated "...6. Do any changes need to be made in an attempt to prevent occurrences? Even though these 2 have separate areas, they are too close together at work."</p> <p>-4/12/12 Client A came into the office yelling and cursing staff. Client D then went after client A. The internal incident report indicated the staff blocked client D from getting to client A.</p> <p>-3/27/12 "[Client A] was eating lunch when he started showing verbal aggression towards staff which led to verbal aggression toward consumer (client</p>			

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	<p>D). The other consumer proceeded to throw water bottles, tables, and Tupperware towards [client A]. [Client A] then attempted to charge consumer resulting with a [name of workshop] staff having to step in between him and the other consumer. [Client A] started to threaten [name of workshop] staff with violence and push up into staffs (sic) face."</p> <p>The facility's 3/27/12 Client to Client Aggression Investigation indicated "...7. Is there a pattern of occurrences between these two clients? Yes...."</p> <p>-3/20/12 "[Client D] saw [client A] in the bathroom and moved toward him in an aggressive manner. [Staff #3] stepped in front of him to block and to shut the door. [Client D] yelled out in anger because he couldn't get to [client A]. He doubled up his fists and struck [staff #3] in the face near his right eye. [Client D] was redirected to his room. He beat on his doors, walls and windows and yelled for about 5 min (minutes) and then calmed down."</p> <p>-2/15/12 "[Client D] walked into the kitchen to get water for meds and was talking to staff. [Client D] was in the kitchen window. [Client D] started to try to throw items at [client A]. Staff got</p>			

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	<p>[client A] out of the kitchen while other staff blocked [client D's] attempts to throw items...."</p> <p>-2/17/12 Client D was at the workshop doing work when client D became physically aggressive toward client A. The internal incident report indicated client D threw items at client A, but staff blocked and escorted client D away from the area.</p> <p>-10/7/11 "[Client A] was on an outing and upset that he could not stay out longer. When he came home he hit [client D]. [Client A] was redirected and counseled on appropriate interactions between house mates and [client D] was checked for injuries, none were found. The Program coordinator will meet with the team to determine if any programming changes are needed."</p> <p>The facility's 10/12/11 Client to Client Aggression Investigation indicated "[Client A] grabbed [client D] and started punching [client D] until staff got [client A] off [client D]." "...6. Do any changes need to be made in an attempt to prevent future occurrences? [Client A]/[client D] need 3 staff kept between them at all times. 7. Is there a pattern of occurrences between these two clients? Yes Recommendations: We will try at all</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>times to keep the 2 apart by halving (sic) a staff member between the two at all times."</p> <p>The facility's 10/25/11 follow-up report indicated "Staff will try and keep from having both consumers in the office at the same time and there will always be one staff member between the two consumers to ensure the safety of everyone. Staff will also redirect [client D] when he is trying to give [client A] a hug or handshake."</p> <p>-5/17/11 "[Client A] was upset for no unknown reason and attempted to hit [client D] (sic). [Client D] then hit [client A] back. Staff used Your Safe, I'm Safe technique to separate the two consumers. Both consumers were counseled on appropriate interactions between housemates and checked for injuries., none were found. The program coordinator will meet with the team to determine if any programming changes are needed."</p> <p>The facility's 5/17/11 Client to Client Aggression Investigation indicated client D hit client A in the nose to defend himself. The 5/17/11 investigation indicated there was a pattern of occurrences between the clients. The facility's investigation indicated "...We</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
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	<p>need to keep the two apart as much as possible...."</p> <p>During the 4/23/12 observation period between 4:05 PM and 7:25 PM, at the group home at 6:02 PM, client D was setting the table and retrieving items from the window. Client A, who was in the kitchen, mouthed something under his breath to client D, when client D came to the window. Client A looked directly at client D when he made the gestures/comments. Staff #4, who was in the kitchen with client A as his one on one staff, did not see client A say something to client D.</p> <p>During the 4/25/12 observation period between 9:25 AM and 10:45 AM, at the workshop, client A had one on one staffing. Clients A and D were located at the front of the workshop in an isolated area from the other clients. Clients A and D were located next to each other within the workshop with a blue tarp which hung in between them. The clients could easily walk around and/or through the blue tarp to target each other.</p> <p>Client D's record was reviewed on 4/26/12 at 1:14 PM. Client D's Progress Notes indicated the following:</p> <p>-3/21/12 "[Client D]...was doing alright</p>						

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>until he saw a certain other client (client A) then went beszert (sic) for about 10 min."</p> <p>-3/20/12 Client A "Had behavior toward [client D] & redirected to bed."</p> <p>Client D's IDT notes indicated the following:</p> <p>-4/18/12 "Team met to discuss client to client that occurred at the workshop on 4/17/12. [Client D] had gotten up and went after another consumer (client A). The other consumer is 1:1 so staff was there to block it. [Client D] still managed to pick up a bag of parts and throw it at the other consumer. The other consumer reacted and chased [client D] and grabbed him & slung him to the floor...[Client D] had a small scrape on his elbow...."</p> <p>-3/28/12 "Team met to discuss incident between [client D] and another consumer (client A). [Client A] was upset w/(with) the other consumer. We feel there is a history between the 2. The other consumer started to become loud and verbal toward [client D] that led to this. [Client D] got upset & started throwing things toward other consumer. Staff will Remain (sic) Between (sic) the 2 of them at all times to avoid and (sic) altercation."</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>Client D's 1/27/12 ISP/BSP and/or above mentioned IDT notes failed to specifically address client D's targeting and/or being a target of client A.</p> <p>Client A's record was reviewed on 4/25/12 at 1:38 PM. Client A's IDT Meeting notes indicated the following:</p> <p>-4/18/12 Client A's IDT met to review an incident with client D at the workshop. The IDT note indicated "...The other consumer (client D) had gotten up to approach him in his area. Because [client A] is 1:1 staff stepped Between (sic) the 2, to avoid a confrontation. The other consumer then picked up a package of parts that was laying nearby and threw it at [client A], [client A] reacted by running through 2 staff and knocking them aside and chased the other consumer until he caught up w/ him. He (client A) then grabbed him and started hitting him...Everyone agrees that he should remain 1:1 until further notice."</p> <p>-3/28/12 "Team met to discuss client to client incident on 3/27/12. [Client A] was very verbal toward another consumer that led to the other consumer throwing things at him. Everyone agree that [client A] should not have been yelling to upset the other consumer. Plan of action is that staff will remain between the 2 to avoid</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>any conflicts."</p> <p>Client A's 4/12/12 BSP indicated "...In the past, he (client A) has used his size as an intimidation tool to get what he wants...."</p> <p>Client A's 4/12/12 ISP indicated client A demonstrated physical aggression (hitting, punching, pushing and kicking). Client A's BSP also indicated client A demonstrated verbal aggression defined as "cursing; calling other's names; entering others personal space, verbally stating he is going to become aggressive (raising his fist)...." Client A's 4/12/12 BSP/ISP and/or above mentioned IDT Meeting notes failed to address client A's targeting client D and/or being a target of client D's. Client A's 4/12/12 ISP/BSP also did not specifically address client A's antagonizing client D.</p> <p>Interview with staff #1 on 4/23/12 at 5:00 PM stated "[Client A] sets [client D] off." Staff #1 stated client A "barreled through me and another staff to get to [client D]." Staff #1 indicated this occurred on 4/17/12 at the workshop.</p> <p>Interview with staff #6 on 4/25/12 at 7:30 AM indicated client A would be aggressive with client D. Staff #6 indicated client A would do things to upset client D which then caused client D to have behaviors.</p>			
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>Interview with workshop staff #1 and #2 on 4/25/12 at 9:00 AM indicated client A was verbally aggressive to workshop staff and/or other clients. Workshop staff #1 and #2 stated client A and client D would "get into it." Workshop staff #1 stated client A would "antagonize" client D and others. Workshop staff #1 and #2 stated "[Client D] does not care for him (client A). He (client D) hears his voice and that will set him off." Workshop staff #1 stated in a recent incident between the clients, client A "chased [client D] and slammed him to the ground." Workshop staff #1 and #2 indicated client D did well at the workshop when client A did not come. Workshop staff #1 and #2 indicated they would start fighting while on the van coming to the workshop and then the workshop would have problems between the clients. When asked if client A's antagonizing client D was being addressed, workshop staff #1 stated "They were supposed to be addressing." Administrative staff #2 indicated the facility's BC had been coming to the workshop to monitor the clients, and was in the process of trying to see if he could get clients A and D transported in two different vans.</p> <p>Interview with LPN #1 and the Behavior Clinician (BC) on 4/27/12 at 9:40 AM</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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	<p>indicated clients A and D were to be separated at the workshop. When asked how a blue tarp would keep the clients apart/separated, the BC indicated the clients should not be next to each other as the tarp would not stop the clients from aggressing against each other. The BC indicated the workshop was to build a wall/office area to keep the clients separate. LPN #1 and the BC indicated client A's ISP/BSP failed to specifically address how the facility addressed client A's antagonizing client D which caused client D to have increased behaviors. The BC stated there was "an ongoing assessment" in regard to clients A and D's targeting each other and client A's antagonizing client D.</p> <p>2. During the 4/23/12 observation period between 4:05 PM and 7:25 PM, at the group home, client B showed the surveyor an injury on his upper chest/neck area. Client B had 2 two inch raised and red scratches on his upper chest/neck area. Interview with client B on 4/23/12 at 5:23 PM indicated client C scratched him. At 6:37 PM, client B moved next to the surveyor when client C entered the dining room. Client B leaned over to the surveyor and stated "I stay out of his way."</p> <p>The facility's reportable incident reports,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2012
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	<p>internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p> <p>-4/16/12 "[Client C] was walking on the patio. [Client B] came outside and sat down at picnic table. [Client C] walked up to [client B] very fast and grabbed at [client B's] throat. [Client C] scraped the skin on [client B's] neck, but the skin was not broken." The 4/16/12 Client to Client Aggression Investigation indicated "...7. Is there a pattern of occurrences between these two individuals? [Client B] talks in a very loud voice and it seems to irritate [client C]." The facility's investigation recommended "Try to get [client B] to talk quieter."</p> <p>-4/1/12 "[Client C] went after [client B] and scratched his neck." The facility's investigation indicated "...[Client B was doing nothing to provoke the aggression." The investigation indicated there was no pattern between the 2 clients.</p> <p>Client C's record was reviewed on 4/26/12 at 11:07 AM. Client C's 3/25/12 Progress Note indicated "[Client C] went after [client B] this evening. Was redirected to room...."</p>			

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	<p>Client C's 3/4/11 Interdisciplinary Team Meeting (IDT) note indicated "There was a client to client incident on 3/31/12 that occurred in which [client C] came out of his room and grabbed another consumer (client B), scratching his neck. We feel as though this was an isolated incident between the 2.... We feel as though the other client was not a target there at that time. Staff will continue to be alert and monitor the 2 while they are in the same room."</p> <p>Client C's 4/18/12 IDT meeting note indicated "Team met to discuss Incident that occurred on 4/14/12 when [client C] grabbed another consumer by the shirt causing a scratch on his neck. We feel as though the other consumer could have gotten a little loud and that possibly caused the behavior...."</p> <p>Client B's record was reviewed on 4/25/12 at 1:00 PM. Client B's 4/3/12 IDT note indicated client B needed to be more alert when client C was in the area.</p> <p>Client B's 3/16/12 ISP and/or 3/15/12 BSP indicated the client's ISP/BSP failed to address and/or include a support to assist the client not to speak in a loud tone of voice.</p>			

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	<p>Interview with client B on 4/25/12 at 9:40 AM stated "[Client C] tried to come after me the other day. I pushed the door in front of him so he could not get to me. He has grabbed me 2 or 3 times on throat and chest.</p> <p>Interview with the BC on 4/27/12 at 9:40 AM indicated he did not think client C was targeting client B. The BC indicated client B's ISP/BSP did not address client B being loud which could cause client C's aggression toward client B.</p> <p>9-3-4(a)</p>			

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B), the clients' Individual Support Plans (ISPs) failed to indicate how facility staff were to monitor client A at the workshop due to a sexual incident, and to clearly define a client's one one staffing pattern (one staff to one client) to ensure the safety of others due to client A's aggression. Client B's ISP failed to indicate how a client was to be supervised/monitored when the client made suicidal threats.</p> <p>Findings include:</p> <p>1. The facility's reportable incident report, internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 4/11/12 reportable incident report indicated "[Client B] and [client A] started to argue. [Client B] through (sic) a cup at [client A] and client [client A] chased after him and knocked him down to the floor. Staff separated the two clients and they were redirected to different areas of the home...[Client B's] hip was hurting him and staff took him to his PCP (primary care physician) for</p>	W0240	<p>Corrective Action: (Specific) Client A's BSP will be reviewed and revised to define the One on One staffing at the home and the workshop and how staff are to monitor Client A when he has suicidal threats and/or suicidal ideations. Client A's BSP will be reviewed and revised to indicate how staff are to monitor the client when he makes threats to harm himself. How others will be identified: (Systemic) All BSPs will be revised as needed to address any concerns/behaviors that develop. Measures to be put in place: Client A's BSP will be reviewed and revised to define the One on One staffing at the home and the workshop and how staff are to monitor Client A when he has suicidal threats and/or suicidal ideations. Client A's BSP will be reviewed and revised to indicate how staff are to monitor the client when he makes threats to harm himself. Monitoring of Corrective Action: The Operations Manager for SGL will make weekly visits to the home to ensure staff follow all BSPs. The Behavior Clinician will ensure during visits that staff follow all BSPs</p>	06/03/2012			

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	<p>evaluation...At [client B's] appointment, x-rays were done to evaluate his hip. He was diagnosed with a hair line fracture...."</p> <p>The facility's 4/12/12 Client to Client Aggression Investigation indicated "[Client A] and [client B] were arguing over day that [client B] had. [Client B] got upset and threw Kool-Aid at [client A]. [Client A] then chased [client B] through the house, when he caught up with he pushed him down to the floor (sic)...." The 4/12/12 investigation indicated "Recommendations: Staff will place themselves between the 2 of them until the team meets to decide how to resolve the matter."</p> <p>During the 4/23/12 observation period between 4:05 PM and 7:25 PM, at the group home, client A was standing outside unsupervised without staff talking on a cell phone upon arrival to the house. Client A was standing outside the gate/fenced area of the group home. Upon being let into the group home, 3 staff (staff #1, #4 and #5) and client B were sitting at the dining room table. During the above mentioned observation period, client A had a staff person following the client around or did not have staff with him. There were 3 staff to 4 clients in the group home. At 4:22 PM, staff #5 left with client B to go to the</p>			

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	<p>store while client A was sitting in the living room with client C, who was watching TV and drinking a soft drink. No staff was present in the living room at that time. At 5:07 PM, staff #4 left with client D to go for a walk leaving staff #1 to monitor/supervise clients A and C. Client A went back outside past the fenced area to use his cell phone leaving staff #1 in the house with client C. At one point, client A could not be seen as the client had left the fenced area. At 5:15 PM, client A came back in the house and walked into the living room where client C was sitting. No staff was in the living room when client A returned inside the house. At 5:23 PM, staff #4 returned and started following client A. Client A sat down on the same couch with client C. Staff #4 sat down on a separate couch near client A. The staff did not sit in between the clients. At 5:25 PM, client C reached over and scratched client A. At 6:09 PM, client A walked from the kitchen to the living room area, where client D was sitting, to client D's bedroom. Client A then came out of client D's bedroom and went back into the kitchen. No staff was following and/or with client A when he left the kitchen and went to the living room and client D's bedroom. Interview with staff #1 on 4/23/12 at 5:00 PM stated client A had "One on One staffing (one staff to one</p>			

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	<p>client). Staff has to stay between him and others."</p> <p>Client A's record was reviewed on 4/25/12 at 1:38 PM. Client A's IDT Meeting notes indicated the following:</p> <p>-4/12/12 "The team discussed the episode where another client was arguing with [client A]. The other client threw a cup at [client A]. [Client A] chased the other client and knocked him to the floor. The client received a hair line fracture in his pelvic area..(sic) Immediately after the incident to ensure safety, staff made sure that the clients were separated for the rest of the night. The team decided that a 1 on 1 staffing will be placed on [client A] during waking hours to ensure his housemates' safety until the team meets again in 1 week. The 1 on 1 is defined as staff positioning themselves in between [client A] and his housemates to ensure their safety...."</p> <p>-4/24/12 "Team met to discuss [client A's] progress over the past 2 weeks. During that time he had 1 episode of Physical Aggression in which he had a client to client with another consumer (client D)...He stated that he wanted off 1:1 staffing, but everyone was in agreement that he should remain 1:1 for now until he proved himself."</p>			

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	<p>Client A's 4/12/12 Behavior Support Plan (BSP) indicated client A demonstrated physical aggression (hitting, punching, pushing and kicking). The section of client A's BSP entitled "Preventative Procedures" indicated "1. [Client A] will be assigned a staff member on each shift.</p> <p>a. The assigned staff member is not a 1:1, as the staff member maybe assigned another consumer while being assigned to [client A] during each shift...12. [Client A] will be in line of sight of staff at all times, except when he is in his room or bathroom to redirect him if he begins to have any target behaviors...."</p> <p>Interview with staff #3 on 4/25/12 at 7:21 AM stated "[Client A] is so strong." Staff #3 stated client A was on one to one staffing due to "shoving [client B] down and hurting his hip." When asked how one on one staffing was defined, staff #3 stated "Not allowed to interact with others unless staff present. Normally compliant with that."</p> <p>Interview with LPN #1 and the Behavior Clinician on 4/27/12 at 9:40 AM indicated client A had been aggressive toward other clients in the group home. The Behavior Clinician stated "IDT put in place immediate protection measures after incident with [clients A and B]." When</p>			

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	<p>asked how client A was to be monitored/supervised, the Behavior Clinician stated facility staff needed to be in the "common areas with individual (client A)." The behavior clinician indicated he was not able to explain why client A's 4/12/12 BSP indicated the client did not require one on one staffing while client A's 4/12/12 IDT indicated the client would be placed on one to one staffing. The Behavior Clinician indicated facility staff should be with client A when he was walking around the house and other clients were present. The Behavior Clinician stated "One on one staff should be in same common areas and close enough to intervene." The Behavior Clinician indicated client A's one on one staffing needed to be clearly defined in the client's ISP/BSP</p> <p>Interview with administrative staff #1 and #2 on 4/27/12 at 11:55 AM indicated client A was to have one on one staffing at the group home due to the 4/11/12 incident with client B. Administrative staff #1 indicated he did not know why client A's 4/12/12 BSP differed from the 4/12/12 IDT note in defining the client's one to one staffing. Administrative staff stated "It has to be a typo."</p> <p>2. The facility's reportable incident reports, internal incident reports and/or</p>			
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	<p>investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 3/1/12 reportable incident report and/or investigation indicated "On 3/1/12 staff noticed [client A] and a female consumer exiting the same bathroom together. When [client A] was questioned by staff he insisted that they had not been in the same restroom together but restrooms next door to each other. He stated that when he tried to go to the restroom to wash his hands and brush his hair the female consumer was standing outside the restroom putting her hand down her pants and looking at him. He stated that he did not want anything to do with that and just went into the restroom. Female consumer is stating that [client A] did come into the same bathroom and that there was a sexual encounter...."</p> <p>The facility's 3/27/12 follow-up report indicated client A had a history of "inappropriate sexual behavior." The follow-up report indicated the police had been contacted and client A had been placed on one on one supervision at the workshop since the 3/1/12 incident.</p> <p>Client A's record was reviewed on 4/25/12 at 1:38 PM. Client A's IDT Meeting notes indicated the following:</p>			

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	<p>-3/1/12 "Team met to discuss [client A's] behaviors at workshop. They are having issues on him wandering out of his work area and not staying on task. They agreed to move him to his own secluded area away from other clients where he won't get distracted...."</p> <p>-3/6/12 Client A's IDT met "To discuss the episode on 3/1/12 where staff saw [client A] exit the bathroom with a female consumer at [name of workshop]...where a female client alleged that [client A] had sexual relations with him (sic). [Client A] denies that any sexual contact happened. The team reviewed his sexual assessment and confirmed the assessment is still appropriate. [Client A] was counseled on the consequences of having sex. [Client A] understands this, and stated he knows it is wrong to touch people without their consent. At the workshop, [client A] is in a designated area where staff can monitor him. He will also have less distraction so he can concentrate more on completing his job/assignments."</p> <p>Client A's 4/12/12 Behavior Support Plan (BSP) indicated client A demonstrated "Inappropriate Sexual Interaction defined as when [client A] touches others without consensual agreement to the sexual interaction." The section of client A's</p>			

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	<p>BSP entitled "Preventative Procedures" indicated "1. [Client A] will be assigned a staff member on each shift. a. The assigned staff member is not a 1:1, as the staff member maybe assigned another consumer while being assigned to [client A] during each shift...." Client A's 4/12/12 BSP/ISP and/or above mentioned IDT notes did not clearly indicate how client A would be monitored and/or supervised at the workshop to prevent the client from sexually abusing female clients and/or acting in an inappropriate manner.</p> <p>Interview with staff #6 on 4/25/12 at 7:30 AM indicated client A demonstrated inappropriate sexual behavior. Staff #6 stated "Stares at women" and "Others say he will lick his lips."</p> <p>Interview with workshop staff #1 and #2 on 4/25/12 at 9:00 AM stated "He (client A) is in a segregated area due to interaction with female clients as he is not always appropriate." Workshop staff #1 and #2 stated client A would demonstrate the "inappropriate behavior whenever he is around females. Occurs daily." Workshop staff #1 indicated client A did not feel his behavior was inappropriate. Workshop staff #1 and #2 stated client A would make a statement like "Call me Mr. sexy, grope himself, and rub up against</p>			

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	<p>other consumers." Workshop staff #1 indicated this would make other female consumers feel uncomfortable. Workshop staff #1 and #2 indicated client A had a history of inappropriate sexual behavior and would look for opportunities to take advantage of others. Workshop staff #1 and #2 indicated it was workshop staff who saw the female and client A come out of the bathroom. Administrative staff #1 stated "shortly after the incident [client A] went to one on one staffing."</p> <p>Interview with the Behavior Clinician (BC) on 4/25/12 at 7:52 AM indicated he did not know if facility staff were present at the workshop on 3/1/12. The BC indicated facility staff normally went to the workshop with the clients. The BC indicated client A demonstrated inappropriate sexual behavior toward females. The BC indicated client A was placed on one one staffing after a client to client incident with another client. The BC indicated client A's ISP/BSP did not clearly indicate how client A was to be monitored at the workshop. The BC indicated client A was in a separate area from the other clients and facility staff were to remain with the client.</p> <p>3. The facility's reportable incident reports, internal incident reports and/or</p>						

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	<p>investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 4/2/12 internal incident report indicated "[Client B] was making statements ABt (about) wanting to kill himself. Then his behavior escalated to eloping from the house. Staff caught up to him and escorted him back to the house. [Client B] was put on 24 hr (hour) suicide protocol. And (sic) staff talked to [client B] ABt what happened."</p> <p>Client B's record was reviewed on 4/25/12 at 1:00 PM. Client B's 4/3/12 Interdisciplinary Team Meeting (IDT) note indicated "...The second incident occurred on 4/2/12 when [client B] made statements about harming himself and then eventually attempted to Elope....Everyone agrees the self-injury protocol would be lifted, and everything will go back to the way it was."</p> <p>Client B's 3/15/12 BSP indicated client B demonstrated "Suicidal Ideations: any time he makes any statements that he wants to kill himself or is verbally telling staff he wants to kill himself." Client B's reactive strategies for the suicidal ideations indicated the following:</p> <p>"-Immediately notify the PC (Program Coordinator) -Follow instructions set by the PC</p>			

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	<p>-Let him know that staff are there to assist him and help keep him safe." Client B's 3/15/12 BSP did not indicate how facility staff should monitor/supervise the client when he made suicidal threats and/or had suicidal ideations.</p> <p>Interview with the BC and LPN #1 on 4/27/12 at 9:40 AM indicated client B had made threats to harm self in the past. The BC stated "Whenever threat made, staff notify PC and me and initiate Suicide Protocol." The BC and LPN #1 indicated client B's 3/12 BSP did not specifically indicate how facility staff were to monitor the client when he made threats to harm self.</p> <p>This federal tag relates to complaint #IN00107066.</p> <p>9-3-4(a)</p>			

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W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (A), the facility failed to ensure the client was taught to keep his hygiene supplies and electric toothbrush in his bedroom to increase the client's independence.</p> <p>Findings include:</p> <p>During the 4/25/12 observation period between 6:17 AM and 8:10 AM, at the group home, client A walked into the staff's office and retrieved his electric razor from an unlocked cabinet in the office. Client A's hygiene supply kit was also in the cabinet in the office.</p> <p>Client A's 2/17/12 Individual Support Plan (ISP) indicated client A's diagnosis included Mild Mental Retardation. Client A's 2/17/12 LifeStyle Plan indicated client A had good reading skills and verbal communication skills.</p> <p>Interview with staff #6 on 4/25/12 at 7:30 AM indicated client A wanted to keep his electric razor in the office cabinet. Staff #6 stated the client's hygiene supply kit was kept in the office as it was a "habit to bring back to the same spot." Staff #6</p>	W0268	<p>Corrective Action: (Specific) The Program Coordinator will retrain all staff that all clients' electric razors and hygiene boxes will be kept in their own bedrooms. How others will be identified: All clients will have their razors and hygiene boxes in their own bedrooms, unless otherwise stated in the client BSP to restrict these supplies.</p> <p>Measures to be put in place: The Program Coordinator will retrain all staff that all clients' electric razors and hygiene boxes will be kept in their own bedrooms. Monitoring of Corrective Action: The Program Coordinator will monitor the staff to ensure that all client razors and hygiene boxes are kept in their own bedrooms.</p>	06/03/2012			

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	<p>indicated the client had the skills to keep the items in his bedroom.</p> <p>Interview with the Behavior Clinician (BC) and LPN #1 on 4/27/12 at 9:40 AM indicated they were not sure why client A's hygiene supply kit and/or electric razor would be kept in the office. The BC indicated client A should be encouraged to keep his personal items in his bedroom.</p> <p>9-3-5(a)</p>			

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the client's Individual Support Plan (ISP) and/or Behavior Support Plan (BSP) failed to include the use of calling 911/the police to assist in dealing with client A's physical aggression toward others.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p> <p>-3/27/12 "[Client A] was eating lunch when he started showing verbal aggression towards staff which led to verbal aggression toward another consumer. The other consumer proceeded to throw water bottles, tables, and Tupperware towards [client A]. [Client A] then attempted to charge consumer resulting with a [name of</p>	W0289	<p>Corrective Action: (Specific) Client A's BSP will be reviewed and revised to include the use of calling 911/the police to assist in dealing with Client A's physical aggression toward others. How others will be identified: (Systemic) All BSPs will be revised as needed to address any concerns/behaviors that develop, including calling the police.</p> <p>Measures to be put in place: All BSPs will be revised as needed to address any concerns/behaviors that develop. Monitoring of Corrective Action: The Operations Manager for SGL will weekly visits to the home to ensure staff follow all BSPs. The Behavior Clinician will ensure during visits that staff follow all BSP.</p>	06/03/2012			

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	<p>workshop staff] having to step in between him and the other consumer. [Client A] then started to threaten [name of workshop] staff with violence and push up into staff's face. Staff attempted to redirect [client A] through strategies presented in his BSP. [Client A] did not accept redirection and continued to remain agitated until staff mentioned that they might have to call the police if [client A] did not regain control. At this point, [client A] sat down in the lunch area and calmed down until going back to the work floor...."</p> <p>-3/17/12 "[Client A] was exhibiting verbal aggression, property destruction and attempted physical aggression toward house mates and staff. Staff followed BSP and attempted to redirect [client A] with no success. Staff felt there was an immediate threat to the health and safety of the house mates and staff at the home so local law enforcement was called to assist. When the officer arrived at the home (sic) [client A] continued to display behaviors and was verbal with the officer so he was arrested and transported to the [name of county jail]. He remains in the [name of county jail] and we are working on getting him out and back to the home."</p> <p>-3/1/12 "Everyone was in the van heading to go to [name of workshop]."</p>			

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	<p>[Client A] just out of moving van, started walking up the hwy (highway) back home. Staff called the police to talk to him about the danger of what happens."</p> <p>-1/27/12 "[Client A] was talking to staff and suddenly had a behavior. He tackled and hit the staff. Staff intervened and were able to verbally redirect [client A]. He calmed down and staff contacted the police to come to the house. The police did not arrest [client A] but did talk to him about appropriate interactions with others. The program coordinator will meet with staff to determine if any changes need to be made to his BSP."</p> <p>Client A's record was reviewed on 4/25/12 at 1:38 PM. Client A's 2/17/12 ISP and 4/12/12 BSP indicated client A demonstrated physical aggression which was defined as hitting, punching, pushing and/or kicking. Client A's 4/12/12 BSP indicated "...If [client A] engages in Physical Aggression or Property Disruption: -Immediately ensure the safety of [client A's] peers -Block physical aggression and property destruction -If [client A] is continuing to place him or others in jeopardy, use Your Safe I am Safe procedures in the following order: -One person hold</p>			

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	<p>-Two person Hold</p> <p>When using these holds, be aware that [client A] may attempt to bite, position yourself so that you are safe." Client A's 4/12/12 BSP did not include and/or incorporate calling 911/the police to assist/deal with client A's physical aggression/behaviors.</p> <p>Interview with the Behavior Clinician (BC) and LPN #1 on 4/27/12 at 9:40 AM indicated client A demonstrated physical aggression and would try to hurt others. LPN #1 indicated on 1/27/12, there were only 2 staff in the group home when client A attacked staff. The BC indicated client A's BSP did not include/incorporate the systemic use of calling the police.</p> <p>9-3-5(a)</p>			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (B), the facility's nursing services failed to ensure a risk plan/nursing protocol was put in place for the client's fractured pelvis.</p> <p>Findings include:</p> <p>During the 4/23/12 observation, period between 4:05 PM and 7:25 PM, at the group home, client B sat on a covered donut pillow in a wooden chair with arms.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/24/12 at 12:12 PM and on 4/25/12 at 3:22 PM. The facility's 4/11/12 reportable incident report indicated "[Client B] and [client A] started to argue. [Client B] through (sic) a cup at [client A] and client [client A] chased after him and knocked him down to the floor. Staff separated the two clients and they were redirected to different areas of the home. Both consumers were assessed by staff; [client A] sustained no injuries from the accident. [Client B's] hip was hurting him and staff took him to his PCP (primary</p>	W0331	<p>Corrective Action: (Specific) Client B's ISP will be revised to include a risk plan/nursing plan for his fractured pelvis. All staff will be trained on the risk plan/nursing plan for Client B's risk plan/nursing plan for his fractured pelvis.How others will be identified: (Systemic) All risk plans/nursing plans will be revised as needed to meet changing health concerns of each client.Measures to be put in place: Client B's ISP will be revised to include a risk plan/nursing plan for his fractured pelvis. All staff will be trained on the risk plan/nursing plan for Client B's risk plan/nursing plan for his fractured pelvis. Monitoring of Corrective Action: All risk plans/nursing plans will be revised as needed to meet changing health concerns of each client</p>	06/03/2012			

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	<p>care physician) for evaluation...At [client B's] appointment, x-rays were done to evaluate his hip. He was diagnosed with a hair line fracture...."</p> <p>Client B's record was reviewed on 4/25/12 at 1:00 PM. Client B's 4/12/12 Doctor's Orders And Progress Notes indicated "Tenderness over RT (right) buttocks. Xray (+) (positive) for hair line Fx (fracture) in pelvis. (+) for hip module NOS (no other symptoms). 1). Donut pillow (with) sitting x (times) 6 weeks. IBU (Ibuprofen) 300 mg (milligrams) 2) CT (cat scan) of RT hip."</p> <p>Client B's 4/12/12 Nurses Observation Record indicated "Home visit today. Client had c/o (complaint of) (Rt) hip pain R/T being shoved down. Client sent to doctor today. N.O. (new order) for doughnut pillow x (times) 6 weeks while sitting for pelvic, (R) (right) hip fx. Client ambulating well, has 0 (zero) distress at this time. CT scan to be done next week. Staff will continue to monitor."</p> <p>Client B's 3/16/12 Individual Support Plan indicated client B did not have a risk plan/nursing care plan for client B's fractured pelvis.</p> <p>Interview with LPN #1 on 4/27/12 at 9:40</p>			

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	<p>AM indicated client B had a hairline fracture to his pelvis. LPN #1 indicated client B was to use a donut pillow when sitting on a surface for pressure. LPN #1 indicated she told facility staff to monitor client B and to encourage him to use the pillow. When asked if client B had a risk plan for his fractured pelvis, LPN #1 indicated she did not write a risk plan for his pelvic fracture.</p> <p>9-3-6(a)</p>			