

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/07/2013
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383		
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W000000	<p>This visit was for the investigation of Complaint #IN00129055.</p> <p>Complaint #IN00129055: Substantiated, federal/state deficiencies related to the allegation are cited at W149, W249 and W289.</p> <p>Dates of Survey: May 29, 31 and June 7, 2013.</p> <p>Facility number: 000698 Provider number: 15G163 AIM number: 100248790</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/17/13 by Ruth Shackelford, QIDP.</p>	W000000			

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

TITLE

(X6) DATE

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

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement its abuse/neglect policy, to protect 2 of 3 sampled clients, (clients A and B) from being improperly physically restrained by a group home staff resulting in injury.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/31/13 at 11:45 A.M.. A review of 2 of 8 of the facility's internal incident reports from 4/1/13 to 5/31/13 indicated the following:</p> <p>1. Incident dated 5/10/13: "[Client A] showed his school teacher and principal injuries on his right shoulder and temple on right side of his head. The injuries appear to be rug burns. [Client A] stated that group home staff [Staff #2] hurt him during a restraint. He said the same thing happened to his housemate [client B]...Plan to Resolve: [Staff #2] was immediately suspended and an investigation has begun."</p> <p>2. Incident dated 5/10/13 with client B's name listed as "Consumer Information":</p>	W000149	All instances of suspected abuse, neglect or mistreatment of consumers shall be reported immediately and an investigation will begin per policy. Responsible persons: Marcetta Walton, Group Home Manager & Traci Hardesty, QDDP. Staff involved in this incident was terminated for not following our policies and procedures as written and as he had been trained. Responsible person: Traci Hardesty, QDDP. All staff will be retrained in our abuse policy, which includes to protect clients from being improperly physically restrained by staff resulting in injury. Responsible person: Traci Hardesty, QDDP. Staff will complete a reliability on abuse/neglect and reporting to ensure competency. Responsible person: Traci Hardesty, QDDP. To ensure future compliance, Staff will continue to be trained on abuse and neglect/mistreatment upon hire and at least annually there after. Responsible persons: Ruth Fields, Training Coord., Marcetta Walton, Group Home Manager & Traci Hardesty, QDDP.	07/05/2013			

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	"[Client A] showed his school teacher and principal injuries on his right shoulder and temple on right side of his head. The injuries appear to be rug burns. [Client A] stated that group home staff [Staff #2] hurt him during a restraint. He said the same thing happened to his housemate [client B]...Plan to Resolve: [Staff #2] was immediately suspended and an investigation has begun." Further review indicated a "Follow-Up" report dated 5/20/13 which indicated: "[Client B] did not have the use of restraints in his BSP (Behavior Support Plan) at the time of this incident but due to that aggressive and destructive behavior, plus others that have happened since, the team agreed to outline the use of restraints in his plan. In-Pact's Human Rights Committee meets today and is expected to approve the restraint. Since I did an IR (Incident Report) for both consumers and stated [client B] was the one who told us about the restraint, I felt that meant it was reported. At that time, the investigation had not begun and I did not know any specific details other than an allegation had been made. [Client B]'s restraint was an appropriate response to extremely aggressive behavior. He became agitated when instructed by staff to wash dishes. He began overturning furniture and attempted to strike staff. However, the staff performed an unapproved hold				

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	<p>which was part of the reason he was terminated...The allegation was substantiated and the staff was terminated on 5-16-13. He remained on suspension during the iunvestigation (sic) so there was no contact with the consumers. [Client B] did not have any injuries from the restraint. He was assessed by staff and again the next day when the Group Home Manager was informed about the incident."</p> <p>A review of 1 of 1 investigation record submitted for review was conducted on 5/31/13 at 12:30 P.M.. Review of the investigation record dated 5/10/13 indicated:</p> <p>"[Group Home staff #3] (over phone, interviewed twice by [Qualified Intellectual Disability Professional])- [Group Home staff #3] heard staff redirecting [client A] to his room while [client B] was being restrained. She entered the living room and saw [client A] kicking [Group Home staff #2] and yelling 'Let him the f--- up.'" She redirected [client A] but he continued. After [client B] was calm (he was in a restraint), [Group Home staff #2] had to arm wrap then restrain [client A] because he continued to kick [Group Home staff #2]. [QIDP] called [Group Home staff #3] back later that day with a few more</p>						

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	<p>questions. She did not see how [client B] was originally restrained, but what she saw was being done properly. However during the conversation, [Group Home staff #3] was not able to describe what she saw or how it was done and at one point said [Group Home staff #2] had [client A]'s arms behind his back. She also said that she did not see [client A] kicking [Group Home staff #2] but heard from another staff that he was."</p> <p>"[Group Home staff #1] wrote a detailed account of what happened and was then interviewed by [QIDP]. [Group Home staff #1] stated that the restraints on [client B] and [client A] did not start out as approved holds but ended that way. He said [Group Home staff #2] had [client A]'s arms behind his back. [Group Home staff #1] then came in and got the restraint going in the approved manner. [Group Home staff #1] said that [client A] was being verbally abusive but not physically aggressive and didn't think he needed to be restrained."</p> <p>"[Client A] felt that [Group Home staff #2] was hurting [client B]. He said that [client B] didn't want to do the dishes so [Group Home staff #2] grabbed [client B]'s hand and pulled his arm behind his back. During [client B]'s restraint, [client A] said he touched [Group Home staff</p>						

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	<p>#2]'s foot. Once [client B]'s restraint was over, [Group Home staff #2] tried to kick [client A]'s legs out from underneath him. [Group Home staff #1] was holding his feet and the restraint lasted about 3 minutes. [Client A] demonstrated how he was restrained at first with his right shoulder and right side of face on the rug and his arm behind him. [Client A] has what appears to be rug burns on the top of his right shoulder and right side of his face."</p> <p>"[Client B] was doing dishes but didn't want to finish them. [Group Home staff #2] was sitting at the table and then came up behind him, twisted his arm behind his back and pushed him to the ground. [Client B] said [Group Home staff #2] also hit him with his elbow on the neck. [Client B] said that [Group Home staff #1] was holding his legs. [Client A] came in and messed with [Group Home staff #2] touching [Group Home staff #2] while he was holding [client B]. Then [Group Home staff #2] did a restraint on [client A] but [client B] didn't see it because he was in his room by then."</p> <p>"[Group Home staff #2]-[Group home staff #2] was finishing eating dinner at the table. [Client B] asked who has me tonight and [Group Home staff #2] answered that it was [Group Home staff</p>			

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	#1]. [Group Home staff #2] then said your program is to do dishes and [client B] replied 'I don't have to do all these dishes. [Group Home staff #5] said I don't have to do dishes.' [Group Home staff #1] and [Group Home staff #2] informed [client B] that he needed to follow his schedule and he had to do some of the dishes but not all. [Client B] became upset, yelling and screaming, flipped over a desk in the family room, hitting himself and banging on walls. [Group Home staff #2] said that he and [Group Home staff #1] wanted to help him stop from hurting himself and grabbed him in an arm wrap. [Client B] became more aggressive so [Group Home staff #2] proceeded to a physical restraint. [Client B] made the restraint hard to hold him down due to fighting. [Client B] began trying to head butt [Group Home staff #2] and then banged his head on the floor. [Group Home staff #2] couldn't get him positioned on his side because [client B] was resisting. [Client A] entered the room and yelled 'Let him the f--- up' and began kicking [Group Home staff #2]. [Group Home staff #2] redirected [client A] back to his room but he refused and continued to kick [Group Home staff #2]. After [client B] was calm, [Group Home staff #2] did an arm wrap then physical restraint on [client A]. [QIDP] called [Group Home staff #2] to ask a few more			

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	<p>questions. [Group Home staff #2] said he could not hold [client A] in the restraint and that's how he got the rug burns. When [client B] was having an outburst, [Group Home staff #2] grabbed his arm and put his head on the back of [client B]'s neck to avoid being head butted. [Client B] was turned to his side during the restraint but was fighting and wiggling. He continued trying to head butt [Group Home staff #2] about 6 more times. [Group Home staff #2] said [client A] was kicking him to try and help [client B] get out of the restraint. [Group Home staff #2] said that [client A] is strong, he tried an arm wrap but it was unsuccessful. [Group Home staff #2] got [client A] down to the ground and on his side. [Group Home staff #1] came in to grab [client A]'s legs. [Group Home staff #2] again said [client A] is strong and comes at you like a boxer, so [Group Home staff #2] grabbed his hand and then got [client A] to his side."</p> <p>"Based on my assessment; [Group Home staff #2] used a technique that is not approved or trained by In-Pact. Staff that assisted with the intervention corrected the hold/restraint until consumer [client B] was calm. It was also felt that it was questionable if the other consumer, [client A] actually needed a restraint based off the behaviors described. Based off this</p>						

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	<p>information from the staff/consumers and their account of this incident, [Group Home staff #2]'s employment with In-Pact was terminated."</p> <p>A review of the facility's records was conducted at the facility's administrative office on 5/31/13 at 10:50 A.M.. Review of the facility's undated "28. POLICY ON REPORTING AND INVESTIGATING INCIDENTS AND ALLEGATIONS OF ABUSE AND NEGLECT", indicated, in part, the following: "Purpose: To establish prompt, accurate and effective procedures for the reporting and investigating of all allegations of abuse or neglect...Consumers must not be subjected to abuse by anyone, including, but not limited to, facility staff, other consumers...Until the incident is reported and investigated, one may not be able to determine whether it is abuse (willful), neglect, or mistreatment but the incident must be treated as an allegation of abuse, neglect or mistreatment and follow the regulations for reporting, responding, investigating and correcting... The term 'willful' does not have to do with 'competence' but with 'intent' to cause harm. Someone with a mental illness or mental retardation can willfully inflict harm to someone who has been bothering them, even though they may not be considered 'competent'... It is mandatory</p>			

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	<p>in all situations involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights that there is notification made to legal representative, guardian/parent, if applicable, Case Manager, if applicable, BDDS (Bureau of Developmental Disabilities Services), APS/CPS (Adult Protection Services/Child Protection Services) and other person the (sic) designated by the consumer."</p> <p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 6/7/13 at 1:30 P.M.. The QIDP indicated the facility's Abuse and Neglect policy is to be followed at all times. The QIDP further indicated the group home staff involved in the mentioned incidents was terminated because he did not follow the facility's policy.</p> <p>This federal tag relates to complaint #IN00129055.</p> <p>9-3-2(a)</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, for 2 of 3 sampled clients (clients A and B), the facility failed to ensure the clients' Behavior Support Plans (BSP) were implemented as written.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/31/13 at 11:45 A.M.. A review of 2 of 8 of the facility's internal incident reports from 4/1/13 to 5/31/13 indicated the following:</p> <p>1. Incident dated 5/10/13: "[Client A] showed his school teacher and principal injuries on his right shoulder and temple on right side of his head. The injuries appear to be rug burns. [Client A] stated that group home staff [Staff #2] hurt him during a restraint. He said the same thing happened to his housemate [client B]...Plan to Resolve: [Staff #2] was immediately suspended and an investigation has begun."</p>	W000249	All staff will be retrained on client A & B's BSP. Responsible person: Traci Hardesty, QDDP. Staff will complete a reliability on client A & B's BSP to ensure competency. Responsible person: Traci Hardesty, QDDP. To ensure future compliance, Staff will continue to be trained on Behavior support plans upon hire and at least annually there after. Responsible persons: Ruth Fields, Training Coord., Marcetta Walton, Group Home Manager & Traci Hardesty, QDDP. To ensure future compliance, all reportable are investigated and reviewed monthly to ensure implementation of the BSP as written. Responsible persons: Karen Warner, Behaviorist, Sheila O'Dell, Group Home Director, Traci Hardesty, QDDP.	07/05/2013			

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	<p>2. Incident dated 5/10/13 with client B's name listed as "Consumer Information": "[Client A] showed his school teacher and principal injuries on his right shoulder and temple on right side of his head. The injuries appear to be rug burns. [Client A] stated that group home staff [Staff #2] hurt him during a restraint. He said the same thing happened to his housemate [client B]...Plan to Resolve: [Staff #2] was immediately suspended and an investigation has begun." Further review indicated a "Follow-Up" report dated 5/20/13 which indicated: "[Client B] did not have the use of restraints in his BSP (Behavior Support Plan) at the time of this incident but due to that aggressive and destructive behavior, plus others that have happened since, the team agreed to outline the use of restraints in his plan. In-Pact's Human Rights Committee meets today and is expected to approve the restraint. Since I did an IR (Incident Report) for both consumers and stated [client B] was the one who told us about the restraint, I felt that meant it was reported. At that time, the investigation had not begun and I did not know any specific details other than an allegation had been made. [Client B]'s restraint was an appropriate response to extremely aggressive behavior. He became agitated when instructed by staff to wash dishes. He began overturning furniture and</p>			

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	<p>attempted to strike staff. However, the staff performed an unapproved hold which was part of the reason he was terminated...The allegation was substantiated and the staff was terminated on 5-16-13. He remained on suspension during the investigation (sic) so there was no contact with the consumers. [Client B] did not have any injuries from the restraint. He was assessed by staff and again the next day when the Group Home Manager was informed about the incident."</p> <p>A review of 1 of 1 investigation record submitted for review was conducted on 5/31/13 at 12:30 P.M.. Review of the investigation record dated 5/10/13 indicated:</p> <p>"[Group Home staff #3] (over phone, interviewed twice by [Qualified Intellectual Disability Professional])- [Group Home staff #3] heard staff redirecting [client A] to his room while [client B] was being restrained. She entered the living room and saw [client A] kicking [Group Home staff #2] and yelling 'Let him the f-- up.'" She redirected [client A] but he continued. After [client B] was calm (he was in a restraint), [Group Home staff #2] had to arm wrap then restrain [client A] because he continued to kick [Group Home staff</p>			

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	<p>#2]. [QIDP] called [Group Home staff #3] back later that day with a few more questions. She did not see how [client B] was originally restrained, but what she saw was being done properly. However during the conversation, [Group Home staff #3] was not able to describe what she saw or how it was done and at one point said [Group Home staff #2] had [client A]'s arms behind his back. She also said that she did not see [client A] kicking [Group Home staff #2] but heard from another staff that he was."</p> <p>"[Group Home staff #1] wrote a detailed account of what happened and was then interviewed by [QIDP]. {Group Home staff #1] stated that the restraints on [client B] and [client A] did not start out as approved holds but ended that way. He said [Group Home staff #2] had [client A]'s arms behind his back. [Group Home staff #1] then came in and got the restraint going in the approved manner. [Group Home staff #1] said that [client A] was being verbally abusive but not physically aggressive and didn't think he needed to be restrained."</p> <p>"[Client A] felt that [Group Home staff #2] was hurting [client B]. He said that [client B] didn't want to do the dishes so [Group Home staff #2] grabbed [client B]'s hand and pulled his arm behind his</p>						

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	<p>back. During [client B]'s restraint, [client A] said he touched [Group Home staff #2]'s foot. Once [client B]'s restraint was over, [Group Home staff #2] tried to kick [client A]'s legs out from underneath him. [Group Home staff #1] was holding his feet and the restraint lasted about 3 minutes. [Client A] demonstrated how he was restrained at first with his right shoulder and right side of face on the rug and his arm behind him. [Client A] has what appears to be rug burns on the top of his right shoulder and right side of his face."</p> <p>"[Client B] was doing dishes but didn't want to finish them. [Group Home staff #2] was sitting at the table and then came up behind him, twisted his arm behind his back and pushed him to the ground. [Client B] said [Group Home staff #2] also hit him with his elbow on the neck. [Client B] said that [Group Home staff #1] was holding his legs. [Client A] came in and messed with [Group Home staff #2] touching [Group Home staff #2] while he was holding [client B]. Then [Group Home staff #2] did a restraint on [client A] but [client B] didn't see it because he was in his room by then."</p> <p>"[Group Home staff #2]-[Group home staff #2] was finishing eating dinner at the table. [Client B] asked who has me</p>						

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	<p>tonight and [Group Home staff #2] answered that it was [Group Home staff #1]. [Group Home staff #2] then said your program is to do dishes and [client B] replied 'I don't have to do all these dishes. [Group Home staff #5] said I don't have to do dishes.' [Group Home staff #1] and [Group Home staff #2] informed [client B] that he needed to follow his schedule and he had to do some of the dishes but not all. [Client B] became upset, yelling and screaming, flipped over a desk in the family room, hitting himself and banging on walls. [Group Home staff #2] said that he and [Group Home staff #1] wanted to help him stop from hurting himself and grabbed him in an arm wrap. [Client B] became more aggressive so [Group Home staff #2] proceeded to a physical restraint. [Client B] made the restraint hard to hold him down due to fighting. [Client B] began trying to head butt [Group Home staff #2] and then banged his head on the floor. [Group Home staff #2] couldn't get him positioned on his side because [client B] was resisting. [Client A] entered the room and yelled 'Let him the f--- up' and began kicking [Group Home staff #2]. [Group Home staff #2] redirected [client A] back to his room but he refused and continued to kick [Group Home staff #2]. After [client B] was calm, [Group Home staff #2] did an arm wrap then physical</p>			

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	<p>restraint on [client A]. [QIDP] called [Group Home staff #2] to ask a few more questions. [Group Home staff #2] said he could not hold [client A] in the restraint and that's how he got the rug burns. When [client B] was having an outburst, [Group Home staff #2] grabbed his arm and put his head on the back of [client B]'s neck to avoid being head butted. [Client B] was turned to his side during the restraint but was fighting and wiggling. He continued trying to head butt [Group Home staff #2] about 6 more times. [Group Home staff #2] said [client A] was kicking him to try and help [client B] get out of the restraint. [Group Home staff #2] said that [client A] is strong, he tried an arm wrap but it was unsuccessful. [Group Home staff #2] got [client A] down to the ground and on his side. [Group Home staff #1] came in to grab [client A]'s legs. [Group Home staff #2] again said [client A] is strong and comes at you like a boxer, so [Group Home staff #2] grabbed his hand and then got [client A] to his side."</p> <p>"Based on my assessment; [Group Home staff #2] used a technique that is not approved or trained by In-Pact. Staff that assisted with the intervention corrected the hold/restraint until consumer [client B] was calm. It was also felt that it was questionable if the other consumer, [client</p>						

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	<p>A] actually needed a restraint based off the behaviors described. Based off this information from the staff/consumers and their account of this incident, [Group Home staff #2]'s employment with In-Pact was terminated."</p> <p>A review of client A's record was conducted on 6/7/13 at 7:30 A.M.. Review of client A's BSP dated 1/25/13 did not indicate physical restraints/holds were to be implemented for client A's identified behaviors.</p> <p>A review of client B's record was conducted on 6/7/13 at 7:40 A.M.. Review of client B's BSP dated 11/19/12 did not indicate physical restraints/holds were to be implemented for client B's identified behaviors.</p> <p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 6/7/13 at 1:30 P.M.. The QIDP indicated clients A and B's BSPs did not include physical restraints/holds for physical/verbal aggression. The QIDP further indicated the BSPs only included prompting, redirection and loss of privileges.</p> <p>This federal tag relates to complaint #IN00129055.</p>						

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W000289	<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 record review and interview for 2 of 3 sampled clients (clients A and B), the facility failed to ensure systematic interventions (physical holds) in the Behavior Support Plans (BSP) were specifically written/described.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/31/13 at 11:45 A.M.. A review of 2 of 8 of the facility's internal incident reports from 4/1/13 to 5/31/13 indicated the following:</p> <p>1. Incident dated 5/10/13: "[Client A] showed his school teacher and principal injuries on his right shoulder and temple on right side of his head. The injuries appear to be rug burns. [Client A] stated that group home staff [Staff #2] hurt him during a restraint. He said the same thing happened to his housemate [client B]...Plan to Resolve: [Staff #2] was immediately suspended and an investigation has begun."</p>	W000289	All systematic interventions (physical holds) are specifically written/described in our policies and procedures. Responsible person: Ruth Fields, Training Coord.Client A & B now has the interventions specifically written/described in their BSP. Responsible person: Karen Warner, Behaviorist. Staff will complete a reliability on client A & B's BSP to ensure competency. Responsible person: Traci Hardesty, QDDP.To ensure future compliance, Staff will continue to be trained in crisis intervention, which include all the approved holds/restraints upon hire and at least annually there after. Responsible persons: Ruth Fields, Training Coord., Marcetta Walton, Group Home Manager & Traci Hardesty, QDDP.	07/05/2013			

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	<p>2. Incident dated 5/10/13 with client B's name listed as "Consumer Information": "[Client A] showed his school teacher and principal injuries on his right shoulder and temple on right side of his head. The injuries appear to be rug burns. [Client A] stated that group home staff [Staff #2] hurt him during a restraint. He said the same thing happened to his housemate [client B]...Plan to Resolve: [Staff #2] was immediately suspended and an investigation has begun." Further review indicated a "Follow-Up" report dated 5/20/13 which indicated: "[Client B] did not have the use of restraints in his BSP (Behavior Support Plan) at the time of this incident but due to that aggressive and destructive behavior, plus others that have happened since, the team agreed to outline the use of restraints in his plan. In-Pact's Human Rights Committee meets today and is expected to approve the restraint. Since I did an IR (Incident Report) for both consumers and stated [client B] was the one who told us about the restraint, I felt that meant it was reported. At that time, the investigation had not begun and I did not know any specific details other than an allegation had been made. [Client B]'s restraint was an appropriate response to extremely aggressive behavior. He became agitated when instructed by staff to wash dishes. He began overturning furniture and</p>				

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	<p>attempted to strike staff. However, the staff performed an unapproved hold which was part of the reason he was terminated...The allegation was substantiated and the staff was terminated on 5-16-13. He remained on suspension during the investigation (sic) so there was no contact with the consumers. [Client B] did not have any injuries from the restraint. He was assessed by staff and again the next day when the Group Home Manager was informed about the incident."</p> <p>A review of 1 of 1 investigation record submitted for review was conducted on 5/31/13 at 12:30 P.M.. Review of the investigation record dated 5/10/13 indicated:</p> <p>"[Group Home staff #3] (over phone, interviewed twice by [Qualified Intellectual Disability Professional])- [Group Home staff #3] heard staff redirecting [client A] to his room while [client B] was being restrained. She entered the living room and saw [client A] kicking [Group Home staff #2] and yelling 'Let him the f-- up.'" She redirected [client A] but he continued. After [client B] was calm (he was in a restraint), [Group Home staff #2] had to arm wrap then restrain [client A] because he continued to kick [Group Home staff</p>			

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	<p>#2]. [QIDP] called [Group Home staff #3] back later that day with a few more questions. She did not see how [client B] was originally restrained, but what she saw was being done properly. However during the conversation, [Group Home staff #3] was not able to describe what she saw or how it was done and at one point said [Group Home staff #2] had [client A]'s arms behind his back. She also said that she did not see [client A] kicking [Group Home staff #2] but heard from another staff that he was."</p> <p>"[Group Home staff #1] wrote a detailed account of what happened and was then interviewed by [QIDP]. [Group Home staff #1] stated that the restraints on [client B] and [client A] did not start out as approved holds but ended that way. He said [Group Home staff #2] had [client A]'s arms behind his back. [Group Home staff #1] then came in and got the restraint going in the approved manner. [Group Home staff #1] said that [client A] was being verbally abusive but not physically aggressive and didn't think he needed to be restrained."</p> <p>"[Client A] felt that [Group Home staff #2] was hurting [client B]. He said that [client B] didn't want to do the dishes so [Group Home staff #2] grabbed [client B]'s hand and pulled his arm behind his</p>			

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	<p>back. During [client B]'s restraint, [client A] said he touched [Group Home staff #2]'s foot. Once [client B]'s restraint was over, [Group Home staff #2] tried to kick [client A]'s legs out from underneath him. [Group Home staff #1] was holding his feet and the restraint lasted about 3 minutes. [Client A] demonstrated how he was restrained at first with his right shoulder and right side of face on the rug and his arm behind him. [Client A] has what appears to be rug burns on the top of his right shoulder and right side of his face."</p> <p>"[Client B] was doing dishes but didn't want to finish them. [Group Home staff #2] was sitting at the table and then came up behind him, twisted his arm behind his back and pushed him to the ground. [Client B] said [Group Home staff #2] also hit him with his elbow on the neck. [Client B] said that [Group Home staff #1] was holding his legs. [Client A] came in and messed with [Group Home staff #2] touching [Group Home staff #2] while he was holding [client B]. Then [Group Home staff #2] did a restraint on [client A] but [client B] didn't see it because he was in his room by then."</p> <p>"[Group Home staff #2]-[Group home staff #2] was finishing eating dinner at the table. [Client B] asked who has me</p>				

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	<p>tonight and [Group Home staff #2] answered that it was [Group Home staff #1]. [Group Home staff #2] then said your program is to do dishes and [client B] replied 'I don't have to do all these dishes. [Group Home staff #5] said I don't have to do dishes.' [Group Home staff #1] and [Group Home staff #2] informed [client B] that he needed to follow his schedule and he had to do some of the dishes but not all. [Client B] became upset, yelling and screaming, flipped over a desk in the family room, hitting himself and banging on walls. [Group Home staff #2] said that he and [Group Home staff #1] wanted to help him stop from hurting himself and grabbed him in an arm wrap. [Client B] became more aggressive so [Group Home staff #2] proceeded to a physical restraint. [Client B] made the restraint hard to hold him down due to fighting. [Client B] began trying to head butt [Group Home staff #2] and then banged his head on the floor. [Group Home staff #2] couldn't get him positioned on his side because [client B] was resisting. [Client A] entered the room and yelled 'Let him the f--- up' and began kicking [Group Home staff #2]. [Group Home staff #2] redirected [client A] back to his room but he refused and continued to kick [Group Home staff #2]. After [client B] was calm, [Group Home staff #2] did an arm wrap then physical</p>						

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	<p>restraint on [client A]. [QIDP] called [Group Home staff #2] to ask a few more question. [Group Home staff #2] said he could not hold [client A] in the restraint and that's how he got the rug burns. When [client B] was having an outburst, [Group Home staff #2] grabbed his arm and put his head on the back of [client B]'s neck to avoid being head butted. [Client B] was turned to his side during the restraint but was fighting and wiggling. He continued trying to head butt [Group Home staff #2] about 6 more times. [Group Home staff #2] said [client A] was kicking him to try and help [client B] get out of the restraint. [Group Home staff #2] said that [client A] is strong, he tried an arm wrap but it was unsuccessful. [Group Home staff #2] got [client A] down to the ground and on his side. [Group Home staff #1] came in to grab [client A]'s legs. [Group Home staff #2] again said [client A] is strong and comes at you like a boxer, so [Group Home staff #2] grabbed his hand and then got [client A] to his side."</p> <p>"Based on my assessment; [Group Home staff #2] used a technique that is not approved or trained by In-Pact. Staff that assisted with the intervention corrected the hold/restraint until consumer [client B] was calm. It was also felt that it was questionable if the other consumer, [client</p>						

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	<p>A] actually needed a restraint based off the behaviors described. Based off this information from the staff/consumers and their account of this incident, [Group Home staff #2]'s employment with In-Pact was terminated."</p> <p>A review of client A's record was conducted on 6/7/13 at 7:30 A.M.. Review of client A's BSP dated 5/20/13 indicated: "Aggression: a. If his behavior escalates or continues posing a risk to safety, an Arm Wrap should be used. b. If needed, move to a Full Body Physical Intervention to protect [client A] and others from harm." Further review of the BSP did not describe how to do an arm wrap and did not describe how to do a Full Body Physical Intervention.</p> <p>A review of client B's record was conducted on 6/7/13 at 7:40 A.M.. Review of client B's BSP dated 5/20/13 indicated: "If behavior escalates or continues, posing a safety risk, perform an Arm Wrap. 5. If necessary for safety, move into a Full Body Physical Intervention." Further review of the BSP did not describe how to do an arm wrap and did not describe how to do a Full Body Physical Intervention.</p> <p>An interview with the Qualified Intellectual Disability Professional</p>						

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	<p>(QIDP) was conducted on 6/7/13 at 1:30 P.M.. The QIDP indicated clients A and B's BSPs did not indicate how the holds/techniques would be implemented when needed. The QIDP further indicated they did not have the description of the holds to be used in the BSP for staff guidance to ensure proper implementation.</p> <p>This federal tag relates to complaint #IN00129055.</p> <p>9-3-5(a)</p>						