

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2013
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 MAXWELL ST BLOOMINGTON, IN 47401
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W000000	<p>This visit was for a post certification revisit (PCR) to the PCR (completed on 9/9/13) to the fundamental recertification and state licensure survey completed on 7/12/13.</p> <p>Survey Dates: December 12 and 13, 2013.</p> <p>Facility Number: 000888 Provider Number: 15G374 AIM Number: 100239700</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/19/13 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 4 of 4 clients living at the group home (#1, #3, #4 and #6), the governing body failed to exercise operating direction over the facility by failing to ensure the</p>	W000104	W104 Plan of Correction: The hole adjacent to light switch has been repaired. The facility is currently under construction and contractors are progressing in a specific order. The kitchen will be	01/12/2014

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

TITLE

(X6) DATE

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

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	<p>kitchen cabinets were cleaned and/or replaced, holes in the walls were repaired and patches on the walls were sanded and repainted.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/12/13 from 2:53 PM to 4:28 PM. During the observation, throughout the home, there were patches on the walls due to repairs to the walls. The patches were not sanded and painted. The kitchen cabinets were discolored and stained on the lower cabinets near the sink and the oven. There were non-functioning drawers in the kitchen cabinets from clients breaking the drawers and the hole being covered up with a piece of wood. The black trim in the kitchen was chipped, stained and discolored. In the hallway leading to the clients' bedrooms, there was a 4 inch by 4 inch hole in the wall adjacent to a light switch. In the bedroom used as the medication administration area, there was a 12 inch by 12 inch hole in the wall at the head of the bed in the room. The closet door had a 4 inch by 4 inch hole in it in the medication administration area. There was a 3 inch in diameter hole in the wall behind the door where the doorknob went through the drywall. This affected</p>		<p>completely remodeled, including replacement of cabinets. As of 12/31/13, contractors report the kitchen cabinets have been ordered. The holes, patches and painting will be addressed at the end of construction in the home. Staff will be retrained reporting concerns to maintenance department immediately for timely repairs. Plan of Prevention: Coordinator will complete an Internal Inspection on a quarterly basis to ensure the facility is meeting the need in the areas of health, safety, sanitation, maintenance and repair. Quality Assurance Monitoring: Director of SGL will review all Internal Inspections on a quarterly basis to ensure appropriate maintenance and repair of the facility.</p>		

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W000149	<p>clients #1, #3, #4 and #6.</p> <p>On 12/12/13 at 1:21 PM, the Chief Financial Officer (CFO) indicated the kitchen will be completely remodeled after the work was completed on the clients' bedrooms, office and bathrooms. The CFO indicated the kitchen would be getting new cabinets. The CFO indicated the holes, patches and painting would be addressed at the end of the construction in the home.</p> <p>This deficiency was cited on 9/9/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <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 for 10 of 81 incident/investigative reports reviewed affecting clients #1, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and conduct</p>	W000149	W149 Plan of Correction: The facility will follow agency policies to prevent client to client abuse, report incidents to BDDS in a timely manner, investigate client to client aggression, neglect and injuries unknown source. The agency will retrain school staff to report client aggression in a timely manner and to review the incident to ensure safety of clients	01/12/2014			

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	<p>investigations of client to client abuse and neglect.</p> <p>Findings include:</p> <p>On 12/12/13 at 1:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 9/14/13 at 7:20 PM, client #1 went into his room and found client #4 lying in his bed. The Stone Belt ARC, Inc. Incident Report, dated 9/14/13, indicated client #1 began touching client #4's feet. Client #1 was in his room for 2-3 minutes unsupervised alone with client #4. When staff walked into client #1's room, staff observed client #1 humping the ground while touching client #4's feet. Staff intervened and escorted both clients out of client #1's room. Client #1 ran to the front room and "threw a fit." The report indicated, "[Client #1] came back and apologized about 20 minutes later for his behavior. He knows it is wrong but either cannot at this point resist his impulses during, or knowingly takes advantage of moments in which all staff are otherwise occupied by client behavior. (e.g. short staffed)." The incident report there were two staff on duty at the time of the incident. The incident was not reported</p>		<p>and that behavior plans are being followed. Behavior Specialist is currently working with school behaviorist to ensure consistent implementation of client's behavior plan. On 1/10/13, facility staff will be trained on identifying initial signs of client agitation and how to intervene to ensure client safety. Program Support staff was retrained on reporting to BDDS in a timely manner, completed on: 12/31/13. Plan of Prevention: Facility staff will be retrained on Prevention of Abuse, Neglect, Exploitation and Incident Reporting on 1/3/13. The agency has implemented a new internal incident reporting system designed to address various failures in implementing the agency's procedures on reporting and investigation allegation A/N/E. The implementation of an electronic system delivers reports quickly to multiple members of the support team. The department has arranged for staff training in incident reporting and investigations from an outside expert. Quality Assurance Monitoring: The new internal incident reporting system includes the option for Coordinators to review and document follow up on incidents and will be reviewed by Director of SGL. The QA team process will be revised to include a review of all ISDH surveys; a review and report of all SGL A/N/E investigations by third party QA team member and the QA</p>				

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	<p>to the Bureau of Developmental Disabilities Services (BDDS) and was not investigated. There was no documentation in the "Supervisor must document action taken" section.</p> <p>2) On 9/16/13 at 11:36 AM (reported to BDDS on 9/18/13), client #6 was walking with staff at school. Client #6 passed another student and slapped the student on the left side of his face. The report indicated staff stepped in between the two and client #6 was taken to the calm room. While in the calm room client #6's removed all of his clothes, headbutted the door four times, bit his own arm two times, kicked and hit the wall, and urinated in the room. Client #6 was administered a PRN (as needed) medication. There was no documentation the incident was investigated.</p> <p>3) On 10/3/13 at 6:35 AM, client #6 walked up behind client #1 and hit him in the back. The BDDS report, dated 10/4/13, indicated, "Staff got up to prevent further incident. [Client #6] then walked over and kicked [client #5]." There was no documentation the incident was investigated.</p> <p>4) On 10/24/13 at 9:20 AM, client #4 was walking by a male peer at the</p>		team will recommend and monitor corrective actions.		

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	<p>facility-operated day program while holding a magazine. The peer grabbed the magazine. The peer hit client #4 in the back with a closed fist. The peer continued to attempt to take the magazine from client #4 until the clients were separated.</p> <p>5) On 10/25/13 at 7:00 AM, client #6 ran up to client #5 and slapped him on the stomach with an open hand. There was no documentation the facility investigated the incident.</p> <p>6) On 10/30/13 at 4:30 PM, client #5 refused his medications. The BDDS report, dated 10/31/13, indicated, "Staff returned to try to get client #5 to take his medications. Staff observed a set of sharp, metal poles (which were later revealed to be the legs from a portable chair which [client #5] had broken, taken apart, wrapped with tape, and hidden in his room). Staff 1 asked if he would be ready to take his medications soon, and [client #5] shook his head in a negative response. Staff 1 asked what he was holding and asked to see it, extending his hand. [Client #5] then raised the weapon into a stabbing motion and yelled. Staff 1 backed away and [client #5] began stabbing the wall and screaming 'Get out!' as staff 1 attempted to calm [client #5] and ask if</p>			

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	<p>he could give up the weapon. Staff 1 notified the emergency pager, and left the room. At that point, staff 1 switched out with staff 2. Staff 2 approached [client #5] cheerfully in his room. [Client #5] showed staff 2 the two sticks, and staff 2 asked if they were drumsticks. He said they were parts of a chair that he had thrown away. Staff 2 chatted with [client #5] until he relaxed and let go of the two rods. Staff 2 then grabbed the rods. [Client #5] became angry again. Staff 2 said they were his sticks, and asked if he wanted to talk about why he was angry. [Client #5] continued to express anger and aggression. [Client #5] then stripped down his bed and threw his curtain and its rod and his linens out his window. Staff 2 exited his room, and was informed by staff 1 that 911 had been called. Staff 2 kept [client #5] in line of sight as much as possible during this incident. [Client #5] began slamming his door, doing so approximately fifty times. He then came into the hallway and shut the fire door, separating himself, and one of his roommates from staff. Staff 2 picked up the curtain rod and secured it with other dangerous objects, then came around the side door. Periodically, staff 2 offered to talk with [client #5]. [Client #5] responded to each request by yelling 'no.' Staff 2 kept</p>			

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	<p>a distance of 15 feet from [client #5] at all time. Staff 2 also locked [client #5's] roommate's door to prevent [client #5] from harming him. The police arrived and were directed to [client #5] sitting near the fire door. The police then interviewed staff and spoke with the support team upon their arrival (Coordinator, Nurse, Behaviorist, and Social Worker). Police determined that [client #5] should be taken to the hospital. [Client #5] was taken to the [name of hospital], where he was admitted to the psychiatric unit." There was no documentation the incident was investigated by the facility to ensure the staff were not negligent or abusive. There was no documentation the facility investigated the incident to ensure the staff implemented client #5's behavior plan.</p> <p>7) On 10/30/13 at 8:25 PM, client #1 was talking with staff in the kitchen. Client #3 stepped forward and hit client #1 twice in the right shoulder, using both of his hands. Client #3 ran to his room. There was no documentation the facility investigated the incident.</p> <p>8) On 11/5/13, staff observed a green bruise on client #1's upper right arm. Staff asked client #1 how he got the bruise. Client #1 indicated he fell. Staff</p>						

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	<p>asked if someone hit him. Client #1 stated "yes." When staff asked who, client #1 stated, "I dunno." Staff asked if he fell or if someone hit him. Client #1 indicated he fell. There was no documentation the incident was investigated.</p> <p>9) On 11/6/13 at 7:15 PM, client #3 ran into the living room and hit client #1 with both hands in a fist position on his left shoulder. Client #3 ran to his room.</p> <p>10) On 11/13/13 at 10:00 PM, client #5 finished eating a snack. The BDDS report, dated 11/14/13, indicated staff picked up client #5's cup thinking client #5 was finished with it. Client #5 knocked items off of the kitchen counter. Client #5 tore the phone wires out of the wall and knocked things over in the dining and living rooms. The report indicated, "He then barricaded himself in the hallway by shutting the hallway door. [Client #5's] roommates were all in their rooms sleeping. Staff went outside and around the house, and in a back door to gain entrance to the hallway. Staff locked all of [client #5's] roommates' doors. Staff then talked with [client #5], attempting to de-escalate the situation, for about 15 minutes. The emergency pager was called. Staff reports that while staff was</p>						

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	<p>talking to the Coordinator on call, [client #5] had calmed down, and was no longer aggressive. The emergency pager then informed the Psych pager of the situation. After calling back to the residence, and noting that [client #5] had calmed down, the emergency pager felt that there was no need to the Psych pager to make a house call, but would keep the Psych pager informed of any continuing developments. [Client #5] then took his meds, and went to his room. Throughout the night, [client #5] repeated a process of becoming aggressive, pushing, throwing and breaking items throughout the house, barricading himself in the hallway, yelling at staff, and then de-escalating and calming down for a short period of time. This cycle repeated itself three times until staff felt like they were in danger, at which point emergency pager and 911 was (sic) called. Police arrived. The Psych pager arrived, and spoke with [client #5]. The police left, not needing to file a report. [Client #5] and the psych pager then talked as they put some of the strewn about items away. The Psych pager also noticed that [client #5] had been performing SIB (self-injurious behavior), in the form of a sore on his foot. The Psych pager had [client #5] put a band aid on the sore. Shortly after, [client #5] went to sleep." There was no</p>				

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	<p>documentation the facility investigated the incident to ensure the staff was not negligent or abusive. There was no documentation the facility investigated the incident to ensure the staff implemented client #5's behavior plan.</p> <p>11) On 12/3/13 at 11:55 AM (reported to BDDS on 12/5/13), client #6 finished his lunch, stood up, took one step toward client #4 and headbutted client #4 as he sat in his chair. There was no documentation the incident was investigated.</p> <p>A review of the facility's abuse and neglect policy, dated September 2013, was conducted on 12/12/13 at 2:37 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of</p>			

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	<p>mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a client, parent/guardian, advocate, staff member, or other involved party."</p> <p>On 12/13/13 at 1:02 PM, the Coordinator indicated the facility considered client to client aggression as abuse. The Coordinator indicated client to client abuse should be investigated. The Coordinator indicated he conducted inquiries into client to client abuse and submitted them to the Director. The Coordinator indicated he did not conduct investigations of incidents at school. The Coordinator indicated he was unsure who conducted the investigations at school. The Coordinator indicated the facility should report incidents to BDDS within 24</p>			

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	<p>hours.</p> <p>On 12/13/13 at 12:06 PM, the Director of Supported Group Living (DSGL) indicated the facility had a policy and procedure prohibiting client abuse and neglect. The DSGL indicated client to client incidents should be investigated. The DSGL indicated the facility should prevent client to client abuse. The DSGL indicated injuries of unknown origin should be investigated. The DSGL indicated the incident on 9/14/13 should have been looked into as sexual acting out. The DSGL indicated the incidents involving client #5 and the police should have been investigated. The DSGL indicated the timeframe for reporting incidents to BDDS was 24 hours. The DSGL indicated she was not aware the facility needed to investigate incidents which occurred at school.</p> <p>This deficiency was cited on 9/9/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 81 incident/investigative reports reviewed affecting clients #1, #4, and #6, the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include: On 12/12/13 at 1:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 9/14/13 at 7:20 PM, client #1 went into his room and found client #4 lying in his bed. The Stone Belt ARC, Inc. Incident Report, dated 9/14/13, indicated client #1 began touching client #4's feet. Client #1 was in his room for 2-3 unsupervised alone with client #4. When staff walked into client #1's room, staff observed client #1 humping the ground while touching client #4's feet. Staff intervened and escorted both clients out of client #1's room. Client #1</p>	W000153	W153 Plan of Correction: Clinical staff was retrained on documenting sexual acting out incidents in a timely manner. Administrative staff was retrained on reporting incidents to BDDS within 24 hours. Plan of Prevention: The facility has developed a new electronic incident reporting system to ensure that all allegations of mistreatment, abuse, neglect and injuries of unknown source are reported immediately to the administrator or designated staff in accordance with state law. The department has arranged for staff training in incident reporting and investigations form an outside expert. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA member including failure to comply with state law regarding A/N/E reports and the QA team will recommend and monitor corrective actions.	01/12/2014	

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	<p>ran to the front room and "threw a fit." The report indicated, "[Client #1] came back and apologized about 20 minutes later for his behavior. He knows it is wrong but either cannot at this point resist his impulses during, or knowingly takes advantage of moments in which all staff are otherwise occupied by client behavior. (e.g. short staffed)." The incident report there were two staff on duty at the time of the incident. The incident was not reported to the Bureau of Developmental Disabilities Services (BDDS).</p> <p>2) On 12/3/13 at 11:55 AM (reported to BDDS on 12/5/13), client #6 finished his lunch, stood up, took one step toward client #4 and headbutted client #4 as he sat in his chair.</p> <p>On 12/13/13 at 12:06 PM, the Director of Supported Group Living (DSGL) indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>On 12/13/13 at 1:02 PM, the Coordinator indicated the facility should report incidents to BDDS within 24 hours.</p> <p>This deficiency was cited on 9/9/13. The facility failed to implement a systemic plan of correction to prevent</p>						

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W000154	<p>recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 9 of 81 incident/investigative reports reviewed affecting clients #1, #3, #4, #5 and #6, the facility failed to conduct investigations of client to client abuse and neglect, an injury of unknown origin and incidents where staff called the police involving client #5.</p> <p>Findings include:</p> <p>On 12/12/13 at 1:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 9/14/13 at 7:20 PM, client #1 went into his room and found client #4 lying in his bed. The Stone Belt ARC, Inc. Incident Report, dated 9/14/13, indicated client #1 began touching client #4's feet. Client #1 was in his room for 2-3 unsupervised alone with client #4. When staff walked into client #1's room, staff observed client #1 humping the</p>	W000154	<p>Deficiency W154 Plan of Correction: The facility has developed a new electronic incident reporting system to ensure that all allegations of mistreatment, abuse, neglect, injuries of unknown source, and elopement are reported immediately to the administrator or designated staff in accordance with state law. The department has arranged for staff training in incident reporting and investigations form an outside expert. Incidents involving sexual acting out behavior will be assessed and documented by clinical staff in a timely manner.</p> <p>Plan of Prevention: The new electronic incident reporting system allows for Qs to document follow up on incidents as needed and includes investigative documentation for client to client aggression and injuries of unknown source. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA member including</p>	01/12/2014			

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	<p>ground while touching client #4's feet. Staff intervened and escorted both clients out of client #1's room. Client #1 ran to the front room and "threw a fit." The report indicated, "[Client #1] came back and apologized about 20 minutes later for his behavior. He knows it is wrong but either cannot at this point resist his impulses during, or knowingly takes advantage of moments in which all staff are otherwise occupied by client behavior. (e.g. short staffed)." The incident report there were two staff on duty at the time of the incident. The incident was not investigated. There was no documentation in the "Supervisor must document action taken" section.</p> <p>2) On 9/16/13 at 11:36 AM (reported to BDDS on 9/18/13), client #6 was walking with staff at school. Client #6 passed another student and slapped the student on the left side of his face. The report indicated staff stepped in between the two and client #6 was taken to the calm room. While in the calm room client #6's removed all of his clothes, headbutted the door four times, bit his own arm two times, kicked and hit the wall, and urinated in the room. Client #6 was administered a PRN (as needed) medication. There was no documentation the incident was</p>		<p>failure to do follow up investigations on allegations A/N/E, injuries of unknown source, and client elopement and the QA team will recommend and monitor corrective action.</p>				

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	<p>investigated.</p> <p>3) On 10/3/13 at 6:35 AM, client #6 walked up behind client #1 and hit him in the back. The BDDS report, dated 10/4/13, indicated, "Staff got up to prevent further incident. [Client #6] then walked over and kicked [client #5]." There was no documentation the incident was investigated.</p> <p>4) On 10/25/13 at 7:00 AM, client #6 ran up to client #5 and slapped him on the stomach with an open hand. There was no documentation the facility investigated the incident.</p> <p>5) On 10/30/13 at 4:30 PM, client #5 refused his medications. The BDDS report, dated 10/31/13, indicated, "Staff returned to try to get client #5 to take his medications. Staff observed a set of sharp, metal poles (which were later revealed to be the legs from a portable chair which [client #5] had broken, taken apart, wrapped with tape, and hidden in his room). Staff 1 asked if he would be ready to take his medications soon, and [client #5] shook his head in a negative response. Staff 1 asked what he was holding and asked to see it, extending his hand. [Client #5] then raised the weapon into a stabbing motion and yelled. Staff 1 backed away</p>				

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	and [client #5] began stabbing the wall and screaming 'Get out!' as staff 1 attempted to calm [client #5] and ask if he could give up the weapon. Staff 1 notified the emergency pager, and left the room. At that point, staff 1 switched out with staff 2. Staff 2 approached [client #5] cheerfully in his room. [Client #5] showed staff 2 the two sticks, and staff 2 asked if they were drumsticks. He said they were parts of a chair that he had thrown away. Staff 2 chatted with [client #5] until he relaxed and let go of the two rods. Staff 2 then grabbed the rods. [Client #5] became angry again. Staff 2 said they were his sticks, and asked if he wanted to talk about why he was angry. [Client #5] continued to express anger and aggression. [Client #5] then stripped down his bed and threw his curtain and its rod and his linens out his window. Staff 2 exited his room, and was informed by staff 1 that 911 had been called. Staff 2 kept [client #5] in line of sight as much as possible during this incident. [Client #5] began slamming his door, doing so approximately fifty times. He then came into the hallway and shut the fire door, separating himself, and one of his roommates from staff. Staff 2 picked up the curtain rod and secured it with other dangerous objects, then came around the side door.			

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	<p>Periodically, staff 2 offered to talk with [client #5]. [Client #5] responded to each request by yelling 'no.' Staff 2 kept a distance of 15 feet from [client #5] at all time. Staff 2 also locked [client #5's] roommate's door to prevent [client #5] from harming him. The police arrived and were directed to [client #5] sitting near the fire door. The police then interviewed staff and spoke with the support team upon their arrival (Coordinator, Nurse, Behaviorist, and Social Worker). Police determined that [client #5] should be taken to the hospital. [Client #5] was taken to the [name of hospital], where he was admitted to the psychiatric unit." There was no documentation the incident was investigated by the facility to ensure the staff were not negligent or abusive. There was no documentation the facility investigated the incident to ensure the staff implemented client #5's behavior plan.</p> <p>6) On 10/30/13 at 8:25 PM, client #1 was talking with staff in the kitchen. Client #3 stepped forward and hit client #1 twice in the right shoulder, using both of his hands. Client #3 ran to his room. There was no documentation the facility investigated the incident.</p> <p>7) On 11/5/13, staff observed a green</p>						

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	<p>bruise on client #1's upper right arm. Staff asked client #1 how he got the bruise. Client #1 indicated he fell. Staff asked if someone hit him. Client #1 stated "yes." When staff asked who, client #1 stated, "I dunno." Staff asked if he fell or if someone hit him. Client #1 indicated he fell. There was no documentation the incident was investigated.</p> <p>8) On 11/13/13 at 10:00 PM, client #5 finished eating a snack. The BDDS report, dated 11/14/13, indicated staff picked up client #5's cup thinking client #5 was finished with it. Client #5 knocked items off of the kitchen counter. Client #5 tore the phone wires out of the wall and knocked things over in the dining and living rooms. The report indicated, "He then barricaded himself in the hallway by shutting the hallway door. [Client #5's] roommates were all in their rooms sleeping. Staff went outside and around the house, and in a back door to gain entrance to the hallway. Staff locked all of [client #5's] roommates' doors. Staff then talked with [client #5], attempting to de-escalate the situation, for about 15 minutes. The emergency pager was called. Staff reports that while staff was talking to the Coordinator on call, [client #5] had calmed down, and was no</p>						

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	longer aggressive. The emergency pager then informed the Psych pager of the situation. After calling back to the residence, and noting that [client #5] had calmed down, the emergency pager felt that there was no need to the Psych pager to make a house call, but would keep the Psych pager informed of any continuing developments. [Client #5] then took his meds, and went to his room. Throughout the night, [client #5] repeated a process of becoming aggressive, pushing, throwing and breaking items throughout the house, barricading himself in the hallway, yelling at staff, and then de-escalating and calming down for a short period of time. This cycle repeated itself three times until staff felt like they were in danger, at which point emergency pager and 911 was (sic) called. Police arrived. The Psych pager arrived, and spoke with [client #5]. The police left, not needing to file a report. [Client #5] and the psych pager then talked as they put some of the strewn about items away. The Psych pager also noticed that [client #5] had been performing SIB (self-injurious behavior), in the form of a sore on his foot. The Psych pager had [client #5] put a band aid on the sore. Shortly after, [client #5] went to sleep." There was no documentation the facility investigated the incident to ensure the staff was not						

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	<p>negligent or abusive. There was no documentation the facility investigated to ensure the staff implemented client #5's behavior plan.</p> <p>9) On 12/3/13 at 11:55 AM (reported to BDDS on 12/5/13), client #6 finished his lunch, stood up, took one step toward client #4 and headbutted client #4 as he sat in his chair. There was no documentation the incident was investigated.</p> <p>On 12/13/13 at 12:06 PM, the Director of Supported Group Living (DSGL) indicated client to client incidents should be investigated. The DSGL indicated injuries of unknown origin should be investigated. The DSGL indicated the incident on 9/14/13 should have been looked into as sexual acting out. The DSGL indicated the incidents involving client #5 and the police should have been investigated. The DSGL indicated she was not aware the facility needed to investigate incidents which occurred at school.</p> <p>On 12/13/13 at 1:02 PM, the Coordinator indicated client to client abuse should be investigated. The Coordinator indicated he conducted inquiries into client to client abuse and submitted them to the Director. The</p>				

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W009999	Coordinator indicated he did not conduct investigations of incidents at school. The Coordinator indicated he was unsure who conducted the investigations at school. 9-3-2(a)	W009999	I am typing a response in this because the system will not let me submit.	01/12/2014	