

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/20/2015
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151
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W 000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00169153.</p> <p>Complaint #IN00169153 - Substantiated, Federal/state deficiencies related to the allegation are cited at W122, W149, W154, and W157.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: April 16, 17 and 20, 2015</p> <p>Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 1 of 4 non-sampled clients (H), the facility's governing body failed to exercise operating direction over the facility by failing to ensure a hole in client H's bedroom wall was repaired in a</p>	W 104	The hole in Client H's bedroom wall has been repaired. The weekly home checklist completed by the Home Manager has been updated to include checking client bedrooms for maintenance issues not immediate apparent upon initial inspection of	05/20/2015

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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W 122 Bldg. 00	<p>timely manner.</p> <p>Findings include:</p> <p>On 4/16/15 from 4:10 PM to 5:59 PM, an observation was conducted at the group home. On 4/16/15 at 4:42 PM, a 5 inch by 6 inch hole was observed on the left hand side of client H's bedroom wall. Client H stated the hole had been in the wall for a "long time." Client H indicated he had recently rearranged his bedroom exposing the hole in the wall which was previously behind a piece of furniture.</p> <p>On 4/17/15 at 11:37 AM, the Program Director (PD) indicated she was not aware of the hole in client H's bedroom wall. The PD indicated the hole should be repaired in a timely manner.</p> <p>On 4/17/15 at 12:26 PM, the Area Director (AD) indicated he was not aware of the hole in client H's bedroom wall. The AD indicated the hole should be repaired in a timely manner.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p>		<p>the bedroom (i.e. behind furniture). The Program Director (QIDP) will review the checklist weekly to ensure maintenance concerns are addressed timely for the health and safety of the clients in the home and to ensure they live in a comfortable environment.</p> <p>Person Responsible: Home Manager, Program Director (QIDP)</p>	

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	<p>Based on observation, record review and interview for 8 of 52 incident/investigative reports reviewed affecting clients A, B, C, D, F, G and H, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to provide appropriate supervision to the clients to prevent incidents of client to client abuse. The facility failed to implement its policies and procedures to prevent client to client abuse, submit an incident report to BDDS in a timely manner and take appropriate corrective actions to address incidents of inappropriate touching, client to client abuse and client G's attempts to enter the office area through openings above the doors. The facility failed to ensure staff implemented client F's plan as written for supervision to prevent inappropriate sexual contact. The facility failed to reassess clients D and F following incidents of inappropriate sexual contact. The facility failed to ensure client D had a plan to address inappropriate sexual contact.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 8 of 52 incident/investigative reports reviewed affecting clients A, B, C, D, F, G and H, the facility neglected to implement its</p>	W 122	<p>Staff in the home were retrained on 4/28/15 on preventing client to client abuse. Staff will receive corrective action for any future incidents that the outcome is determined that staff failed to follow client plans to prevent client to client abuse.</p> <p>Observations will be completed by supervisory staff at least three times per week for four weeks and weekly ongoing thereafter to monitor that staff are following client plans and implementing preventative measures.</p> <p>Panels will be secured above the office doors to prevent openings from being accessed.</p> <p>Staff in the home were retrained on 4/28/15 on reportable incidents. Staff in the home were also retrained on 4/28/15 on reporting incidents immediately to the administrator. Staff will receive corrective action for any future incidents that are not reported timely to the administrator.</p> <p>The Program Director (QIDP) and Area Director will meet weekly for four weeks and then at least monthly ongoing, to review all incidents to ensure corrective actions have been taken and safeguards are in place following incidents in the home.</p> <p>Staff in the home were retrained on 4/28/15 on Client F's plan for supervision.</p> <p>Observations will be completed by supervisory staff at least three times</p>	05/20/2015

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	<p>policies and procedures to prevent client to client abuse, submit an incident report to BDDS in a timely manner and take appropriate corrective actions to address incidents of inappropriate touching, client to client abuse and client G's attempts to enter the office area through openings above the doors.</p> <p>2) Please refer to W153. For 1 of 52 incident/investigative reports reviewed affecting clients D and F, the facility failed to ensure staff immediately reported an allegation of inappropriate touching between the clients to the administrator. The facility failed to ensure the Bureau of Developmental Disabilities Services incident report was submitted in a timely manner.</p> <p>3) Please refer to W154. For 3 of 52 incident/investigative reports reviewed affecting clients A, D, F, G and H, the facility failed to conduct thorough investigations.</p> <p>4) Please refer to W157. For 4 of 52 incident/investigative reports reviewed affecting clients A, D, F, G and H, the facility failed to take appropriate corrective action to address incidents.</p> <p>5) Please refer to W214. For 2 of 4 clients in the sample (D and F), the</p>		<p>per week for four weeks and weekly ongoing thereafter to monitor that staff are following and implementing Client F's plan for supervision. Sexual Assessments will be completed for Clients D and F. Plans will be updated as needed based on the assessment findings. Staff will be trained on updated plans for both clients.</p> <p>Observations will be completed by supervisory staff at least three times per week for four weeks and weekly ongoing thereafter to monitor that staff are following and implementing Client D and F's updated plans. The Program Director (QIDP) along with the Behavior Analyst is developing a Behavior Support Plan to address inappropriate sexual contact for Client D. A training objective for Client D will be developed to assist him with learning and knowing sexual boundaries with others. After the Behavior Support is developed and written consents are obtained, staff will be trained to implement the plan and training objective.</p> <p>Observations will be completed by supervisory staff at least weekly to monitor that staff are following and implementing Client D's plan and training objective appropriately. The Program Director received retraining on how to conduct a thorough investigation by ensuring all details and pertinent information is included on each investigation on 5/4/15. All future investigations will</p>	

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W 149 Bldg. 00	<p>facility failed to ensure the clients were assessed following two incidents of inappropriate sexual contact.</p> <p>6) Please refer to W227. For 1 of 4 clients in the sample (D), the facility failed to ensure client D had a plan to address incidents of sexually inappropriate behavior with a housemate.</p> <p>7) Please refer to W249. For 2 of 4 clients in the sample (D and F), the facility failed to ensure staff implemented client F's plan for supervision.</p> <p>This federal tag relates to complaint #IN00169153.</p> <p>9-3-2(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 observation, record review and interview for 8 of 52 incident/investigative reports reviewed affecting clients A, B, C, D, F, G and H, the facility neglected to implement its policies and procedures to prevent incidents of client to client abuse, submit</p>	W 149	<p>be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialist or other designee.</p> <p>Responsible Party: Home Manager, Program Director (QIDP), Area Director, Quality Assurance Specialist</p> <p>Staff in the home were retrained on 4/28/15 on preventing client to client abuse. Staff will receive corrective action for any future incidents that the outcome is determined that staff failed to follow client plans to prevent client to client abuse. Observations will be completed</p>	05/20/2015			

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	<p>an incident report to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and take appropriate corrective actions to address incidents of inappropriate touching, client to client abuse and client G's attempts to enter the office area through openings above the doors.</p> <p>Findings include:</p> <p>On 4/16/15 at 1:47 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/6/15 at 6:40 PM, client G was running through the house screaming and attempted to rip the television off the wall. Client G put his head through an overhead opening into the office area (opening above the door). Client G got a chair and held himself in the air by holding onto the box surrounding the television. Client G was administered a PRN (as needed) medication. On 2/6/15 at 7:50 PM, client G was administered a second PRN medication after running into the dining room and breaking the leg off the dining room table. He hit and broke the Plexiglas covering the television. Client G pulled the television off the wall and broke it on the floor. Client G cut his hands and wrists while</p>		<p>by supervisory staff at least three times per week for four weeks and weekly ongoing thereafter to monitor that staff are following client plans and implementing preventative measures. Panels will be secured above the office doors to prevent openings from being accessed. Staff in the home were retrained on 4/28/15 on reportable incidents. Staff in the home were also retrained on 4/28/15 on reporting incidents immediately to the administrator. Staff will receive corrective action for any future incidents that are not reported timely to the administrator. The Program Director (QIDP) and Area Director will meet weekly for four weeks and then at least monthly ongoing, to review all incidents to ensure corrective actions have been taken and safeguards are in place following incidents in the home. Staff in the home were retrained on 4/28/15 on Client F's plan for supervision. Observations will be completed by supervisory staff at least three times per week for four weeks and weekly ongoing thereafter to monitor that staff are following and implementing Client F's plan for supervision. Responsible Party: Home Manager, Program Director (QIDP), Area Director</p>		

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	<p>breaking the television. Staff called 911 for an ambulance due to his injuries. On 2/7/15 at 1:00 AM, client G was admitted to the hospital on a 24 hour hold. Client G received stitches for his injuries (the BDDS report dated 2/7/15 did not indicate the number). There was no documentation the facility investigated the incidents.</p> <p>On 4/17/15 at 11:37 AM, the Program Director (PD) indicated she did not conduct an investigation of the incidents. The PD indicated she was involved in a survey at another group home and did not conduct an investigation of the incidents.</p> <p>2) On 2/27/15 at 7:15 AM, client A stated to client C, as indicated in the BDDS report dated 2/27/15, "give me that back and let me have it." Staff #8 entered the kitchen from the office area. Staff #8 heard a smacking noise and then observed client A punch client C. Client C had a scratch on his eye. Client C was given an ice pack for his eye.</p> <p>On 4/17/15 at 11:37 AM, the Program Director (PD) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p>			

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	<p>On 4/17/15 at 12:26 PM, the Area Director (AD) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>3) On 3/5/15 at 6:24 PM, client G was at a community dinner when he became upset when asked if he wanted ice cream. Staff #2 escorted client G out of the community center. Client G headbutted staff #2 causing staff #2's tooth to cut client G's head. Client G got in the van. The other clients returned to the van. As the group home van was driving back to the group home, client G was physically aggressive toward client A. Client G had client A in a headlock. Client G bit client A's hand causing a break in the skin. Staff #2 separated the clients. Client G hit client H on the arm and hand. The van pulled over and the clients were removed from the van as client G's behavior continued. Staff #1 and #2 applied client G's weighted vest and client G calmed within 5 minutes. Client A was taken to the emergency room due to the bite. Client A was prescribed antibiotics due to the human bite. Client H had a quarter size bruise on his arm and was given ice. Client G was taken to</p>			

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	<p>the emergency room due to the cut on his head. Client G received stitches to close the wound. The BDDS report, dated 3/6/15, did not indicate the number of stitches needed to close the wound. The investigation, dated 3/11/15, indicated in staff #2's statement that client G "got a couple of stitches in his head." There was no additional information in the investigation indicating the number of stitches client G received to close the wound.</p> <p>The Investigation Summary, dated 3/11/15, indicated staff #2 reported client G attempted to hit a volunteer at the community center. Staff #2 escorted client G out of the community center. The Conclusion section of the investigation indicated, "Evidence supports staff intervened appropriately. Evidence supports staff followed protocol(s)." The investigation did not address that staff did not take appropriate safety measures when client G was upset to prevent an incident of client to client abuse. The facility did not transport client G to the group home in the van by himself. The facility did not separate the clients from client G to prevent an incident of client to client abuse.</p> <p>On 4/17/15 at 1:32 PM, a review of client G's Behavioral Support Plan, dated</p>			

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	<p>10/23/14, indicated he had a targeted behavior of physical aggression (PA). PA was defined as attempted or actual purposeful attacks directed at other people that may include: striking, kicking, pulling hair, ripping clothing, biting, breaking eyewear, or throwing objects at someone. The plan indicated in the Expected Caregiver Behaviors section, "Upon entering an environment or while planning an outing staff should be aware, alert, and position themselves in a manner that would allow them to react appropriately should a target behavior occur."</p> <p>On 4/16/15 at 4:15 PM, staff #2 indicated client G became antsy once the community center staff indicated they would be serving ice cream. Staff #2 indicated he escorted client G from the center. Staff #2 indicated as they were walking out, client G threw his head back and headbutted staff #2 in the face causing a cut to client G's head. Staff #2 indicated the other clients started coming out to the van, eating their ice cream, shortly after he took client G out to the van. Staff #2 indicated he attempted to redirect the other clients away from the van however the others did not respond to the redirection. Staff #2 indicated he thought client G was calm when the others entered the van. Client G bit client</p>			

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	<p>A and hit client H. Staff #2 indicated client G usually did not aggress toward other clients. Staff #2 indicated the incident could have been prevented if the other clients had not entered the van shortly after client G was taken to the van. Staff #2 indicated client G received stitches to close the wound.</p> <p>An observation was conducted at the group home on 4/16/15 from 4:10 PM to 5:59 PM. At 5:07 PM when the clients and staff were in the van to go to the community center, client G was in the back seat of the van on the driver's side. Client A was sitting next to him. Client H was sitting in front of client G. The staff in the back of the van was sitting in the bench seat in front of client G on the passenger side of the van. There was no change in the van's seating arrangement since the 3/5/15 incident. The staff was not positioned to be able to prevent another incident of client to client abuse involving clients A, G and H.</p> <p>On 4/16/15 at 3:12 PM, the Program Director (PD) indicated the staff should have prevented the incident. The PD stated "in the heat of the moment" staff tried to get client G back home where it was more secure. The PD stated, "Staff act on impulse instead of stopping and thinking about it." The PD stated,</p>						

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	<p>"Trying to get staff to think proactively instead of reactively." On 4/17/15 at 11:37 AM, the PD indicated there was no change to the seating arrangement in the van following the incident. The PD indicated the seating arrangement was followed on 4/16/15 when the surveyor observed the clients and staff, including the PD, in the van prior to going to the community center. The PD indicated the seating arrangement was not included in the clients' plans however a copy of the seating arrangement was on a clipboard in the van. The PD indicated the staff did not sit next to client G in the van. The PD indicated the staff sit in the middle seat (of three) in the back of the van to be centralized to all the clients. The PD indicated the staff should have had clients A and H wait to get onto the van until client G had more time to calm down. The PD indicated the staff should have prevented the incident.</p> <p>On 4/17/15 at 12:26 PM, the Area Director (AD) indicated there was a seating arrangement in the van. The AD indicated he thought there was a staff next to client G on the seating arrangement. The AD indicated client G should have a staff sit next to him in the van to ensure if he aggressed on another client, the staff could react, redirect and block. The AD indicated the incident</p>			

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	<p>could have been prevented if the staff took client G home separately from the other clients. The AD indicated the other clients could have visited another group home down the street from the community center. The AD indicated the staff should have prevented the incident.</p> <p>4) On 3/8/15 at 7:50 PM (reported to BDDS on 3/12/15), staff #4 observed clients D and F in the downstairs bathroom together. The BDDS report indicated, "It appeared that [client F] was fondeling (sic) [client D's] genatalia (sic). The men were seperated (sic) and asked what was going on. [Client F] admitted that he had touched [client D's] private parts. When [client D] was asked he made hand gestures of masturbating." The BDDS report indicated, "Please note that this is being reported late because of staff giving different accounts of the incident and wether (sic) or not it was cosensial (sic)."</p> <p>The Investigation Summary, dated 3/13/15, indicated the staff reported the incident to administrative staff on 3/12/15. The interview with staff #4 indicated, "[Staff #4] stated she didn't know this was a reportable incident since she had heard that the two of them had done this in the past and thought since it was consensual that it didn't have to be</p>			

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	<p>reported to the home manager or PD (Program Director). [Staff #4] reported that she told [staff #9] about the incident a few night (sic) later when [staff #9] was coming on to the shift and [staff #9] asked her if she had reported it to anyone and [staff #4] stated that she had not and so [staff #9] reported the incident to PD on call." The investigation indicated in the Conclusion section, "Evidence supports that staff intervened appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "PD and HM (Home Manager) discussed what is reportable and not reportable. PD and Home Manager discussed with [staff #4] that it is always better to report something than to not report at all." The investigation did not address staff failed to implement client F's Behavior Support Plan as written.</p> <p>5) On 3/21/15 at 8:45 PM, staff #4 was in the office when she heard client F whispering in the kitchen. Staff #4 opened the door and observed client F's hands were down client D's pants.</p> <p>The Investigation Summary, dated 3/27/15, indicated in the Conclusion section, "Evidence supports staff did not follow protocol(s)." The Recommendations section indicated,</p>			

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	<p>"Staff training will be completed to keeping (sic) [clients D and F] in line of sight anytime that [client D] is down stairs or [client F] happens to be upstairs. Staff will keep [clients D and F] in line of sight at all times to try and prevent this incident from happening again."</p> <p>On 4/17/15 at 11:01 AM, a review of client F's Risk Management Assessment Plan (RMAP), dated 5/2/14, indicated, in part, "Associates consequences with actions: [Client F] does not always associate consequences with actions when he has behaviors. Staff to assist [client F] in understanding appropriate actions." Client F's RMAP indicated, "Bells are also on [client F's] bedroom doors due to a roommate's elopement behavior." The RMAP indicated, "Person requires 24 hour awake supervision." The RMAP indicated client F did not present a risk for "displays behaviors which may provoke abuse by others including consumers." There was no documentation in client F's RMAP indicating he engaged in sexually inappropriate behavior at the group home. Client F's 5/2/14 Individual Support Plan (ISP) indicated client F had a guardian. The ISP indicated, in part, "Sexuality awareness: [Client F] is sexually aware and knowledgeable but is not sexually active." The ISP indicated</p>						

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	<p>client F had a Behavior Support Plan (BSP) which included a targeted behavior of inappropriate sexual behavior. Client F's 4/1/14 BSP defined inappropriate sexual behavior as, "Any attempts to touch or actual touching or penetration of another's genitals without his/her consent." The plan indicated in the Responding to Targeted Problem Behaviors section, "[Client F] should be kept in line of sight when he and his previously targeted housemate are not in common areas where staff can see them in order to assure the safety of his housemate. [Client F] is to be checked on every 15 minutes to assure the safety of everyone in the home."</p> <p>On 4/17/15 at 11:08 AM, a review of client D's RMAP, dated 1/16/15, indicated, in part in the Sexual section, "[Client D] may have difficulties defending himself against abuse due to a lack of reaction and response towards the abuse. Staff are to assist as needed to ensure [client D's] safety and ensure he is free from abuse." Client D's RMAP indicated he did not present a risk of reporting abuse to the appropriate party. Client D's RMAP indicated, "Person needs 24 hour plan of care (may not require supervision at all times but there is someone identified/assigned that is responsible and accessible to the</p>						

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	<p>consumer in case of emergency. 24 hour plan of care required for individuals in ICF-MR and waiver eligible individuals)." Client D's 1/16/15 ISP indicated, in part, "Sexuality awareness: [client D] knows the difference between different genders and appears to be sexually aware." Client D's ISP indicated he did not have a BSP. The ISP indicated client D had a guardian. The ISP indicated, "Assessment of his/her supervision needs: Requires 24-hour supervision."</p> <p>On 4/16/15 at 2:54 PM, the Program Director (PD) indicated clients D and F had a history of inappropriate touching. The PD indicated there was an alarm on client F's bedroom door for this reason. The PD indicated there was an incident several months ago between the two. Clients D and F attempted to go into the bathroom together. The PD indicated client D indicated he enjoyed the touching. The PD indicated both clients have guardians. The PD indicated there was no training provided to the clients. The PD indicated client F's plan addressed inappropriate touching. The PD indicated client F initiated the contact. The PD indicated neither client was assessed to be able to give consent for the behavior. On 4/17/15 at 11:37 AM, the PD indicated staff #4 was new</p>			

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	<p>to the field. The PD stated staff #4 "thought since the clients were enjoying themselves" it did not need to be a BDDS report. The PD indicated staff #4 reported the incident to staff #9 who told staff #4 to report it. The PD indicated she was aware of the incident on 3/11/15. On 4/17/15 at 1:46 PM, the PD indicated client F had a Behavior Support Plan the staff failed to implement as written for supervision. The PD indicated client F's Behavior Plan referred to a previously targeted housemate. The PD indicated the housemate was client D.</p> <p>On 4/17/15 at 12:26 PM, the AD indicated the staff were supposed to be supervising the clients and know where they were in the group home. The AD stated client D "doesn't mind" the touching by client F. The AD indicated there have been incidents similar to this in the past between clients D and F. The AD stated, "staff need to keep an eye on them."</p> <p>6) On 3/11/15 at 3:45 PM, client B punched client G in the face. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 3/12/15, did not indicate whether or not client G was injured.</p> <p>On 4/17/15 at 11:37 AM, the PD</p>			

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	<p>indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 4/17/15 at 12:26 PM, the AD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>7) On 3/11/15 at 6:45 PM, client G grabbed client A's drink. Client A punched client G on the eye. Client G had a bruise on his left eye.</p> <p>On 4/17/15 at 11:37 AM, the PD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 4/17/15 at 12:26 PM, the AD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>8) On 3/15/15 at 6:00 PM, client G finished his dinner. He took his plate to</p>			

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	<p>the kitchen. Client G jumped up on the counter and attempted to stick his head above the office door (there is an opening above the office door from the kitchen into the office). Staff #4 attempted to verbally redirect client G. Client G was physically assisted by staff #1 and staff #2. Client G pulled away and attempted to hit the staff. Client G fell off the counter onto staff #2. Client G's face hit the floor. Client G's nose had a small amount of blood. The staff contacted the emergency pager and was told to monitor client G. Client G's eye started to bruise. Client G was taken to the emergency room due to the fall. Client G's nose had a fracture. There was no documentation the facility took steps to address the openings from the dining room and kitchen into the office area.</p> <p>On 4/16/15 at 3:20 PM, the Program Director (PD) stated client G was "obsessed" with trying to get into the office area due to the electronics. The PD indicated client G was trying to destroy the items in the office. The PD indicated client G had repeatedly attempted to get through the opening above the door into the office area. The PD stated she had requested "many times" to close the openings at the tops of the doors into the office area. The PD indicated she was told it was a fire safety</p>			

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	<p>issue to close the openings due to the sprinklers. The PD indicated the openings needed to be closed to prevent client G from attempting to enter the kitchen from the openings above the two doors into the office area.</p> <p>The facility's policy and procedures related to abuse and neglect were reviewed on 4/16/15 at 2:55 PM. The facility's Quality and Risk Management policy dated April 2011 indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The policy defined neglect as, "e. Failure to provide appropriate supervision, care or training; f. Failure to provide a safe, clean and sanitary environment; g. Failure to provide food and medical services as needed; h. Failure to provide medical supplies or safety equipment as indicated in the ISP." The Human Rights policy, dated April 2011, indicated, in part, "The following actions are prohibited by employees of Indiana MENTOR: abuse, neglect, exploitation or mistreatment of an individual including misuse of an</p>			

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W 153 Bldg. 00	<p>individual's funds; or violation of an individual's rights."</p> <p>This federal tag relates to complaint #IN00169153.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 52 incident/investigative reports reviewed affecting clients D and F, the facility failed to ensure staff immediately reported an allegation of inappropriate touching between the clients to the administrator. The facility failed to ensure the Bureau of Developmental Disabilities Services incident report was submitted within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 4/16/15 at 1:47 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p>	W 153	<p>Staff in the home were retrained on 4/28/15 on reportable incidents. Staff in the home were also retrained on 4/28/15 on reporting incidents immediately to the administrator. Staff will receive corrective action for any future incidents that are not reported timely to the administrator.</p> <p>The Program Director (QIDP) and Area Director will meet weekly for four weeks and then at least monthly ongoing, to review all incidents to ensure corrective actions have been taken and safeguards are in place following incidents in the home. esponsible Party: Home Manager, Program Director (QIDP), Area Director</p>	05/20/2015

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	<p>On 3/8/15 at 7:50 PM (reported to BDDS on 3/12/15), staff #4 observed clients D and F in the downstairs bathroom together. The BDDS report indicated, "It appeared that [client F] was fondeling (sic) [client D's] genatalia (sic). The men were seperated (sic) and asked what was going on. [Client F] admitted that he had touched [client D's] private parts. When [client D] was asked he made hand gestures of masturbating." The BDDS report indicated, "Please note that this is being reported late because of staff giving different accounts of the incident and wether (sic) or not it was cosensial (sic)."</p> <p>The Investigation Summary, dated 3/13/15, indicated the staff reported the incident to administrative staff on 3/12/15. The interview with staff #4 indicated, "[Staff #4] stated she didn't know this was a reportable incident since she had heard that the two of them had done this in the past and thought since it was consensual that it didn't have to be reported to the home manager or PD (Program Director). [Staff #4] reported that she told [staff #9] about the incident a few night (sic) later when [staff #9] was coming on to the shift and [staff #9] asked her if she had reported it to anyone and [staff #4] stated that she had not and</p>			

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	<p>so [staff #9] reported the incident to PD on call." Staff #9's interview in the investigation indicated staff #4 told her about the incident on 3/11/15 during shift change. The investigation indicated in the Conclusion section, "Evidence supports that staff intervened appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "PD and HM (Home Manager) discussed what is reportable and not reportable. PD and Home Manager discussed with [staff #4] that it is always better to report something than to not report at all."</p> <p>The facility failed to ensure staff immediately reported the incident to administrative staff on 3/8/15 and the facility failed to submit the BDDS report within 24 hours, in accordance with state law.</p> <p>On 4/17/15 at 11:37 AM, the Program Director (PD) indicated the staff failed to immediately report the incident to the administrator on 3/8/15. The PD indicated she became aware of the incident on 3/11/15 when she was contacted by staff. The PD indicated the facility should submit BDDS reports within 24 hours.</p> <p>9-3-2(a)</p>						

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W 154 Bldg. 00	<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 observation, record review and interview for 3 of 52 incident/investigative reports reviewed affecting clients A, D, F, G and H, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>On 4/16/15 at 1:47 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/6/15 at 6:40 PM, client G was running through the house screaming and attempted to rip the television off the wall. Client G put his head through an overhead opening into the office area (opening above the door). Client G got a chair and held himself in the air by holding onto the box surrounding the television. Client G was administered a PRN (as needed) medication. On 2/6/15 at 7:50 PM, client G was administered a second PRN medication after running into the dining room and breaking the leg</p>	W 154	<p>The Program Director received retraining on how to conduct a thorough investigation by ensuring all details and pertinent information is included on each investigation on 5/4/15. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialist or other designee.</p> <p>Responsible Party: Home Manager, Program Director (QIDP), Area Director, Quality Assurance Specialist</p>	05/20/2015

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	<p>off the dining room table. He hit and broke the Plexiglas covering the television. Client G pulled the television off the wall and broke it on the floor. Client G cut his hands and wrists while breaking the television. Staff called 911 for an ambulance due to his injuries. On 2/7/15 at 1:00 AM, client G was admitted to the hospital on a 24 hour hold. Client G received stitches for his injuries (the BDDS report dated 2/7/15 did not indicate the number). There was no documentation the facility investigated the incidents.</p> <p>On 4/17/15 at 11:37 AM, the Program Director (PD) indicated she did not conduct an investigation of the incidents. The PD indicated she was involved in a survey at another group home and did not conduct an investigation of the incidents.</p> <p>2) On 3/5/15 at 6:24 PM, client G was at a community dinner when he became upset when asked if he wanted ice cream. Staff #2 escorted client G out of the community center. Client G headbutted staff #2 causing staff #2's tooth to cut client G's head. Client G got in the van. The other clients returned to the van. As the group home van was driving back to the group home, client G was physically aggressive toward client A. Client G had client A in a headlock. Client G bit client</p>			

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	<p>A's hand causing a break in the skin. Staff #2 separated the clients. Client G hit client H on the arm and hand. The van pulled over and the clients were removed from the van as client G's behavior continued. Staff #1 and #2 applied client G's weighted vest and client G calmed within 5 minutes. Client A was taken to the emergency room due to the bite. Client A was prescribed antibiotics due to the human bite. Client H had a quarter size bruise on his arm and was given ice. Client G was taken to the emergency room due to the cut on his head. Client G received stitches to close the wound. The BDDS report, dated 3/6/15, did not indicate the number of stitches needed to close the wound. The investigation, dated 3/11/15, indicated in staff #2's statement that client G "got a couple of stitches in his head." There was no additional information in the investigation indicating the number of stitches client G received to close the wound.</p> <p>The Investigation Summary, dated 3/11/15, indicated in the Conclusion section, "Evidence supports staff intervened appropriately. Evidence supports staff followed protocol(s)." The investigation failed to address that staff did not take appropriate safety measures when client G was upset to prevent an</p>			
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151		
(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>incident of client to client abuse. The facility did not transport client G to the group home in the van by himself. The facility did not separate the clients from client G to prevent an incident of client to client abuse.</p> <p>On 4/17/15 at 1:32 PM, a review of client G's Behavioral Support Plan, dated 10/23/14, indicated he had a targeted behavior of physical aggression (PA). PA was defined as attempted or actual purposeful attacks directed at other people that may include: striking, kicking, pulling hair, ripping clothing, biting, breaking eyewear, or throwing objects at someone. The plan indicated in the Expected Caregiver Behaviors section, "Upon entering an environment or while planning an outing staff should be aware, alert, and position themselves in a manner that would allow them to react appropriately should a target behavior occur."</p> <p>On 4/16/15 at 4:15 PM, staff #2 indicated client G became antsy once the community center staff indicated they would be serving ice cream. Staff #2 indicated he escorted client G from the center. Staff #2 indicated as they were walking out, client G threw his head back and headbutted staff #2 in the face causing a cut to client G's head. Staff #2</p>				

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	<p>indicated the other clients started coming out to the van, eating their ice cream, shortly after he took client G out to the van. Staff #2 indicated he attempted to redirect the other clients away from the van however the others did not respond to the redirection. Staff #2 indicated he thought client G was calm when the others entered the van. Client G bit client A and hit client H. Staff #2 indicated client G usually did not aggress toward other clients. Staff #2 indicated the incident could have been prevented if the other clients had not entered the van shortly after client G was taken to the van. Staff #2 indicated client G received stitches to close the wound.</p> <p>An observation was conducted at the group home on 4/16/15 from 4:10 PM to 5:59 PM. At 5:07 PM when the clients and staff were in the van to go to the community center, client G was in the back seat of the van on the driver's side. Client A was sitting next to him. Client H was sitting in front of client G. The staff in the back of the van was sitting in the bench seat in front of client G on the passenger side of the van. There was no change in the van's seating arrangement since the 3/5/15 incident. The staff was not positioned to be able to prevent another incident of client to client abuse involving clients A, G and H.</p>			

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	<p>On 4/16/15 at 3:12 PM, the Program Director (PD) indicated the staff should have prevented the incident. The PD stated "in the heat of the moment" staff tried to get client G back home where it was more secure. The PD stated, "Staff act on impulse instead of stopping and thinking about it." The PD stated, "Trying to get staff to think proactively instead of reactively." On 4/17/15 at 11:37 AM, the PD indicated there was no change to the seating arrangement in the van following the incident. The PD indicated the seating arrangement was followed on 4/16/15 when the surveyor observed the clients and staff, including the PD, in the van prior to going to the community center. The PD indicated the seating arrangement was not included in the clients' plans however a copy of the seating arrangement was on a clipboard in the van. The PD indicated the staff did not sit next to client G in the van. The PD indicated the staff sit in the middle seat (of three) in the back of the van to be centralized to all the clients. The PD indicated the staff should have had clients A and H wait to get onto the van until client G had more time to calm down. The PD indicated the investigation should have addressed alternative ways to transport client G to the group home.</p>			

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	<p>3) On 3/8/15 at 7:50 PM, staff #4 observed clients D and F in the downstairs bathroom together. The BDDS report indicated, "It appeared that [client F] was fondeling (sic) [client D's] genatalia (sic). The men were seperated (sic) and asked what was going on. [Client F] admitted that he had touched [client D's] private parts. When [client D] was asked he made hand gestures of masturbating." The BDDS report indicated, "Please note that this is being reported late because of staff giving different accounts of the incident and wether (sic) or not it was cosensial (sic)."</p> <p>The Investigation Summary, dated 3/13/15, indicated the staff reported the incident to administrative staff on 3/12/15. The interview with staff #4 indicated, "[Staff #4] stated she didn't know this was a reportable incident since she had heard that the two of them had done this in the past and thought since it was consensual that it didn't have to be reported to the home manager or PD (Program Director). [Staff #4] reported that she told [staff #9] about the incident a few night (sic) later when [staff #9] was coming on to the shift and [staff #9] asked her if she had reported it to anyone and [staff #4] stated that she had not and so [staff #9] reported the incident to PD on call." The investigation indicated in</p>			

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W 157 Bldg. 00	<p>the Conclusion section, "Evidence supports that staff intervened appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "PD and HM (Home Manager) discussed what is reportable and not reportable. PD and Home Manager discussed with [staff #4] that it is always better to report something than to not report at all." The investigation did not address staff failed to implement client F's Behavior Support Plan as written.</p> <p>This federal tag relates to complaint #IN00169153.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 4 of 52 incident/investigative reports reviewed affecting clients A, D, F, G and H, the facility failed to take appropriate corrective action to address incidents.</p> <p>Findings include: On 4/16/15 at 1:47 PM, a review of the</p>	W 157	The Program Director (QIDP) and Area Director will meet weekly for four weeks and then at least monthly ongoing, to review all incidents to ensure corrective actions have been taken and safeguards are in place following incidents in the home. Responsible Party: Home Manager, Program Director (QIDP), Area Director	05/20/2015

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	<p>facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/6/15 at 6:40 PM, client G was running through the house screaming and attempted to rip the television off the wall. Client G put his head through an overhead opening into the office area (opening above the door). Client G got a chair and held himself in the air by holding onto the box surrounding the television. Client G was administered a PRN (as needed) medication. On 2/6/15 at 7:50 PM, client G was administered a second PRN medication after running into the dining room and breaking the leg off the dining room table. He hit and broke the Plexiglas covering the television. Client G pulled the television off the wall and broke it on the floor. Client G cut his hands and wrists while breaking the television. Staff called 911 for an ambulance due to his injuries. On 2/7/15 at 1:00 AM, client G was admitted to the hospital on a 24 hour hold. Client G received stitches for his injuries (the BDDS report dated 2/7/15 did not indicate the number).</p> <p>On 4/17/15 at 11:37 AM, the Program Director (PD) indicated there was no corrective action taken following the incident.</p>						

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	<p>2) On 3/5/15 at 6:24 PM, client G was at a community dinner when he became upset when asked if he wanted ice cream. Staff #2 escorted client G out of the community center. Client G headbutted staff #2 causing staff #2's tooth to cut client G's head. Client G got in the van. The other clients returned to the van. As the group home van was driving back to the group home, client G was physically aggressive toward client A. Client G had client A in a headlock. Client G bit client A's hand causing a break in the skin. Staff #2 separated the clients. Client G hit client H on the arm and hand. The van pulled over and the clients were removed from the van as client G's behavior continued. Staff #1 and #2 applied client G's weighted vest and client G calmed within 5 minutes. Client A was taken to the emergency room due to the bite. Client A was prescribed antibiotics due to the human bite. Client H had a quarter size bruise on his arm and was given ice. Client G was taken to the emergency room due to the cut on his head. Client G received stitches to close the wound. The BDDS report, dated 3/6/15, did not indicate the number of stitches needed to close the wound. The investigation, dated 3/11/15, indicated in staff #2's statement that client G "got a couple of stitches in his head." There</p>			

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	<p>was no additional information in the investigation indicating the number of stitches client G received to close the wound.</p> <p>The Investigation Summary, dated 3/11/15, indicated in the Conclusion section, "Evidence supports staff intervened appropriately. Evidence supports staff followed protocol(s)." The investigation did not address that staff did not take appropriate safety measures when client G was upset to prevent an incident of client to client abuse. The facility did not transport client G to the group home in the van by himself. The facility did not separate the clients from client G to prevent an incident of client to client abuse. There was no documentation the facility implemented corrective action to address the incident.</p> <p>On 4/17/15 at 1:32 PM, a review of client G's Behavioral Support Plan, dated 10/23/14, indicated he had a targeted behavior of physical aggression (PA). PA was defined as attempted or actual purposeful attacks directed at other people that may include: striking, kicking, pulling hair, ripping clothing, biting, breaking eyewear, or throwing objects at someone. The plan indicated in the Expected Caregiver Behaviors section, "Upon entering an environment</p>			

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	<p>or while planning an outing staff should be aware, alert, and position themselves in a manner that would allow them to react appropriately should a target behavior occur."</p> <p>On 4/16/15 at 4:15 PM, staff #2 indicated client G became antsy once the community center staff indicated they would be serving ice cream. Staff #2 indicated he escorted client G from the center. Staff #2 indicated as they were walking out, client G threw his head back and headbutted staff #2 in the face causing a cut to client G's head. Staff #2 indicated the other clients started coming out to the van, eating their ice cream, shortly after he took client G out to the van. Staff #2 indicated he attempted to redirect the other clients away from the van however the others did not respond to the redirection. Staff #2 indicated he thought client G was calm when the others entered the van. Client G bit client A and hit client H. Staff #2 indicated client G usually did not aggress toward other clients. Staff #2 indicated the incident could have been prevented if the other clients had not entered the van shortly after client G was taken to the van. Staff #2 indicated client G received stitches to close the wound.</p> <p>An observation was conducted at the</p>			

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	<p>group home on 4/16/15 from 4:10 PM to 5:59 PM. At 5:07 PM when the clients and staff were in the van to go to the community center, client G was in the back seat of the van on the driver's side. Client A was sitting next to him. Client H was sitting in front of client G. The staff in the back of the van was sitting in the bench seat in front of client G on the passenger side of the van. There was no change in the van's seating arrangement since the 3/5/15 incident. The staff was not positioned to be able to prevent another incident of client to client abuse involving clients A, G and H.</p> <p>On 4/16/15 at 3:12 PM, the Program Director (PD) stated, "Staff act on impulse instead of stopping and thinking about it." The PD stated, "Trying to get staff to think proactively instead of reactively." On 4/17/15 at 11:37 AM, the PD indicated there was no change to the seating arrangement in the van following the incident. The PD indicated the seating arrangement was followed on 4/16/15 when the surveyor observed the clients and staff, including the PD, in the van prior to going to the community center. The PD indicated the seating arrangement was not included in the clients' plans however a copy of the seating arrangement was on a clipboard in the van. The PD indicated the staff did</p>			

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	<p>not sit next to client G in the van. The PD indicated the staff sit in the middle seat (of three) in the back of the van to be centralized to all the clients. The PD indicated the staff should have had clients A and H wait to get onto the van until client G had more time to calm down.</p> <p>3) On 3/8/15 at 7:50 PM, staff #4 observed clients D and F in the downstairs bathroom together. The BDDS report indicated, "It appeared that [client F] was fondeling (sic) [client D's] genatalia (sic). The men were seperated (sic) and asked what was going on. [Client F] admitted that he had touched [client D's] private parts. When [client D] was asked he made hand gestures of masturbating." The BDDS report indicated, "Please note that this is being reported late because of staff giving different accounts of the incident and wether (sic) or not it was cosensial (sic)."</p> <p>The Investigation Summary, dated 3/13/15, indicated the staff reported the incident to administrative staff on 3/12/15. The interview with staff #4 indicated, "[Staff #4] stated she didn't know this was a reportable incident since she had heard that the two of them had done this in the past and thought since it was consensual that it didn't have to be reported to the home manager or PD</p>			

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	<p>(Program Director). [Staff #4] reported that she told [staff #9] about the incident a few night (sic) later when [staff #9] was coming on to the shift and [staff #9] asked her if she had reported it to anyone and [staff #4] stated that she had not and so [staff #9] reported the incident to PD on call." The investigation indicated in the Conclusion section, "Evidence supports that staff intervened appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "PD and HM (Home Manager) discussed what is reportable and not reportable. PD and Home Manager discussed with [staff #4] that it is always better to report something than to not report at all." The investigation did not address staff failed to implement client F's Behavior Support Plan as written. There was no documentation the staff received retraining on implementing client F's Behavior Support Plan as written.</p> <p>4) On 3/15/15 at 6:00 PM, client G finished his dinner. He took his plate to the kitchen. Client G jumped up on the counter and attempted to stick his head above the office door (there is an opening above the office door from the kitchen into the office). Staff #4 attempted to verbally redirect client G. Client G was physically assisted by staff #1 and staff</p>			

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	<p>#2. Client G pulled away and attempted to hit the staff. Client G fell off the counter onto staff #2. Client G's face hit the floor. Client G's nose had a small amount of blood. The staff contacted the emergency pager and was told to monitor client G. Client G's eye started to bruise. Client G was taken to the emergency room due to the fall. Client G's nose had a fracture. There was no documentation the facility took corrective action to address the openings from the dining room and kitchen into the office area to prevent a similar incident from recurring.</p> <p>On 4/16/15 at 3:20 PM, the Program Director (PD) stated client G was "obsessed" with trying to get into the office area due to the electronics. The PD indicated client G was trying to destroy the items in the office. The PD indicated client G had repeatedly attempted to get through the opening above the door into the office area. The PD stated she had requested "many times" to close the openings at the tops of the doors into the office area. The PD indicated she was told it was a fire safety issue to close the openings due to the sprinklers. The PD indicated the openings needed to be closed to prevent client G from attempting to enter the kitchen from the openings above the two doors into the office area.</p>			

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W 214 Bldg. 00	<p>This federal tag relates to complaint #IN00169153.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on record review and interview for 2 of 4 clients in the sample (D and F), the facility failed to assess the clients following two incidents of inappropriate sexual contact.</p> <p>Findings include:</p> <p>On 4/16/15 at 1:47 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 3/8/15 at 7:50 PM, staff #4 observed clients D and F in the downstairs bathroom together. The BDDS report indicated, "It appeared that [client F] was fondeling (sic) [client D's] genatalia (sic). The men were seperated (sic) and asked what was going on. [Client F] admitted that he had touched</p>	W 214	<p>Sexual Assessments will be completed for Clients D and F. Plans will be updated as needed based on the assessment findings. Staff will be trained on updated plans for both clients.</p> <p>Observations will be completed by supervisory staff at least three times per week for four weeks and weekly ongoing thereafter to monitor that staff are following and implementing Client D and F's updated plans. The Program Director (QIDP) along with the Behavior Analyst is developing a Behavior Support Plan to address inappropriate sexual contact for Client D. A training objective for Client D will be developed to assist him with learning and knowing sexual boundaries with others. After the Behavior Support is developed and written consents are obtained, staff will be trained to implement the plan and training objective.</p>	05/20/2015

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	<p>[client D's] private parts. When [client D] was asked he made hand gestures of masturbating."</p> <p>The Investigation Summary, dated 3/13/15, indicated the staff reported the incident to administrative staff on 3/12/15. The interview with staff #4 indicated, "[Staff #4] stated she didn't know this was a reportable incident since she had heard that the two of them had done this in the past and thought since it was consensual that it didn't have to be reported to the home manager or PD (Program Director). [Staff #4] reported that she told [staff #9] about the incident a few night (sic) later when [staff #9] was coming on to the shift and [staff #9] asked her if she had reported it to anyone and [staff #4] stated that she had not and so [staff #9] reported the incident to PD on call." The investigation indicated in the Conclusion section, "Evidence supports that staff intervened appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "PD and HM (Home Manager) discussed what is reportable and not reportable. PD and Home Manager discussed with [staff #4] that it is always better to report something than to not report at all." The investigation did not indicate an assessment was recommended for clients</p>		<p>Observations will be completed by supervisory staff at least weekly to monitor that staff are following and implementing Client D's plan and training objective appropriately. Responsible Party: Home Manager, Program Director (QIDP), Area Director</p>				

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	<p>D and F.</p> <p>2) On 3/21/15 at 8:45 PM, staff #4 was in the office when she heard client F whispering in the kitchen. Staff #4 opened the door and observed client F's hands were down client D's pants.</p> <p>The Investigation Summary, dated 3/27/15, indicated in the Conclusion section, "Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "Staff training will be completed to keeping (sic) [clients D and F] in line of sight anytime that [client D] is down stairs or [client F] happens to be upstairs. Staff will keep [clients D and F] in line of sight at all times to try and prevent this incident from happening again." There was no documentation indicating assessments were recommended for clients D and F.</p> <p>On 4/17/15 at 11:01 AM, a review of client F's Risk Management Assessment Plan (RMAP), dated 5/2/14, indicated, in part, "Associates consequences with actions: [Client F] does not always associate consequences with actions when he has behaviors. Staff to assist [client F] in understanding appropriate actions." Client F's RMAP indicated, "Bells are also on [client F's] bedroom</p>						

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	doors due to a roommate's elopement behavior." The RMAP indicated, "Person requires 24 hour awake supervision." The RMAP indicated client F did not present a risk for "displays behaviors which may provoke abuse by others including consumers." There was no documentation in client F's RMAP indicating he engaged in sexually inappropriate behavior at the group home. Client F's 5/2/14 Individual Support Plan (ISP) indicated client F had a guardian. The ISP indicated , in part, "Sexuality awareness: [Client F] is sexually aware and knowledgeable but is not sexually active." The ISP indicated client F had a Behavior Support Plan (BSP) which included a targeted behavior of inappropriate sexual behavior. Client F's 4/1/14 BSP defined inappropriate sexual behavior as, "Any attempts to touch or actual touching or penetration of another's genitals without his/her consent." The plan indicated in the Responding to Targeted Problem Behaviors section, "[Client F] should be kept in line of sight when he and his previously targeted housemate are not in common areas where staff can see them in order to assure the safety of his housemate. [Client F] is to be checked on every 15 minutes to assure the safety of everyone in the home."			

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	<p>On 4/17/15 at 11:08 AM, a review of client D's RMAP, dated 1/16/15, indicated, in part in the Sexual section, "[Client D] may have difficulties defending himself against abuse due to a lack of reaction and response towards the abuse. Staff are to assist as needed to ensure [client D's] safety and ensure he is free from abuse." Client D's RMAP indicated he did not present a risk of reporting abuse to the appropriate party. Client D's RMAP indicated, "Person needs 24 hour plan of care (may not require supervision at all times but there is someone identified/assigned that is responsible and accessible to the consumer in case of emergency. 24 hour plan of care required for individuals in ICF-MR and waiver eligible individuals)." Client D's 1/16/15 ISP indicated, in part, "Sexuality awareness: [client D] knows the difference between different genders and appears to be sexually aware." Client D's ISP indicated he did not have a BSP. The ISP indicated client D had a guardian. The ISP indicated, "Assessment of his/her supervision needs: Requires 24-hour supervision."</p> <p>On 4/16/15 at 2:54 PM, the Program Director (PD) indicated clients D and F had a history of inappropriate touching. The PD indicated there was an alarm on</p>			

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W 227 Bldg. 00	<p>client F's bedroom door for this reason. The PD indicated there was an incident several months ago between the two. Clients D and F attempted to go into the bathroom together. The PD indicated client D indicated he enjoyed the touching. The PD indicated both clients have guardians. The PD indicated there was no training provided to the clients. The PD indicated client F's plan addressed inappropriate touching. The PD indicated client F initiated the contact. The PD indicated neither client was reassessed following the incidents.</p> <p>9-3-4(a)</p> <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. Based on record review and interview for 1 of 4 clients in the sample (D), the facility failed to ensure client D had a plan to address incidents of sexually inappropriate behavior with a housemate.</p> <p>Findings include: On 4/16/15 at 1:47 PM, a review of the</p>	W 227	Staff in the home were retrained on 4/28/15 on Client F's plan for supervision. Sexual Assessments will be completed for Clients D and F. Plans will be updated as needed based on the assessment findings. Staff will be trained on updated plans for both clients. Observations will be completed by supervisory staff at least three times per week for four weeks	05/20/2015

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	<p>facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 3/8/15 at 7:50 PM (reported to BDDS on 3/12/15), staff #4 observed clients D and F in the downstairs bathroom together. The BDDS report indicated, "It appeared that [client F] was fondeling (sic) [client D's] genatalia (sic). The men were seperated (sic) and asked what was going on. [Client F] admitted that he had touched [client D's] private parts. When [client D] was asked he made hand gestures of masturbating." The BDDS report indicated, "Please note that this is being reported late because of staff giving different accounts of the incident and wether (sic) or not it was cosensial (sic)."</p> <p>2) On 3/21/15 at 8:45 PM, staff #4 was in the office when she heard client F whispering in the kitchen. Staff #4 opened the door and observed client F's hands were down client D's pants.</p> <p>The Investigation Summary, dated 3/27/15, indicated in the Conclusion section, "Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "Staff training will be completed to keeping (sic) [clients D and F] in line of</p>		<p>and weekly ongoing thereafter to monitor that staff are following and implementing Client D and F's updated plans. The Program Director (QIDP) along with the Behavior Analyst is developing a Behavior Support Plan to address inappropriate sexual contact for Client D. A training objective for Client D will be developed to assist him with learning and knowing sexual boundaries with others. After the Behavior Support is developed and written consents are obtained, staff will be trained to implement the plan and training objective. Observations will be completed by supervisory staff at least weekly to monitor that staff are following and implementing Client D's plan and training objective appropriately. Responsible Party: Home Manager, Program Director (QIDP), Area Director</p>	

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	<p>sight anytime that [client D] is down stairs or [client F] happens to be upstairs. Staff will keep [clients D and F] in line of sight at all times to try and prevent this incident from happening again."</p> <p>On 4/17/15 at 11:08 AM, a review of client D's RMAP, dated 1/16/15, indicated, in part in the Sexual section, "[Client D] may have difficulties defending himself against abuse due to a lack of reaction and response towards the abuse. Staff are to assist as needed to ensure [client D's] safety and ensure he is free from abuse." Client D's RMAP indicated he did not present a risk of reporting abuse to the appropriate party. Client D's RMAP indicated, "Person needs 24 hour plan of care (may not require supervision at all times but there is someone identified/assigned that is responsible and accessible to the consumer in case of emergency. 24 hour plan of care required for individuals in ICF-MR and waiver eligible individuals)." Client D's 1/16/15 ISP indicated, in part, "Sexuality awareness: [client D] knows the difference between different genders and appears to be sexually aware." Client D's ISP indicated he did not have a BSP. The ISP indicated client D had a guardian. The ISP indicated, "Assessment of his/her supervision needs: Requires 24-hour</p>			

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	<p>supervision." There was no documentation provided during the survey indicating client D had a plan to address inappropriate sexual contact with a housemate.</p> <p>On 4/16/15 at 2:54 PM, the Program Director (PD) indicated clients D and F had a history of inappropriate touching. The PD indicated there was an incident several months ago between the two. Clients D and F attempted to go into the bathroom together. The PD indicated client D indicated he enjoyed the touching. The PD indicated both clients have guardians. The PD indicated there was no training provided to the clients. The PD indicated client F's plan addressed inappropriate touching. The PD indicated client F initiated the contact. The PD indicated neither client was assessed to be able to give consent for the behavior. The PD indicated there was no plan for client D addressing inappropriate sexual contact with a housemate. On 4/20/15 at 1:56 PM, the PD indicated after the two incidents, client D needed to have a behavior plan to address inappropriate sexual behavior.</p> <p>9-3-4(a)</p>			
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W 249 Bldg. 00	<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 4 clients in the sample (D and F), the facility failed to ensure staff implemented client F's plan for supervision.</p> <p>Findings include:</p> <p>On 4/16/15 at 1:47 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 3/8/15 at 7:50 PM, staff #4 observed clients D and F in the downstairs bathroom together. The BDDS report indicated, "It appeared that [client F] was fondeling (sic) [client D's] genatalia (sic). The men were seperated (sic) and asked what was going on. [Client F] admitted that he had touched [client D's] private parts. When [client D] was asked he made hand gestures of masturbating." The BDDS report indicated, "Please note that this is being reported late because of staff giving different accounts of the incident and</p>			W 249	<p>Staff in the home were retrained on 4/28/15 on Client F's plan for supervision.</p> <p>Observations will be completed by supervisory staff at least three times per week for four weeks and weekly ongoing thereafter to monitor that staff are following and implementing Client F's plan for supervision.</p> <p>Responsible Party: Home Manager, Program Director (QIDP)</p>		05/20/2015

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	<p>wether (sic) or not it was cosensial (sic)."</p> <p>The Investigation Summary, dated 3/13/15, indicated the staff reported the incident to administrative staff on 3/12/15. The interview with staff #4 indicated, "[Staff #4] stated she didn't know this was a reportable incident since she had heard that the two of them had done this in the past and thought since it was consensual that it didn't have to be reported to the home manager or PD (Program Director). [Staff #4] reported that she told [staff #9] about the incident a few night (sic) later when [staff #9] was coming on to the shift and [staff #9] asked her if she had reported it to anyone and [staff #4] stated that she had not and so [staff #9] reported the incident to PD on call." The investigation indicated in the Conclusion section, "Evidence supports that staff intervened appropriately. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "PD and HM (Home Manager) discussed what is reportable and not reportable. PD and Home Manager discussed with [staff #4] that it is always better to report something than to not report at all."</p> <p>2) On 3/21/15 at 8:45 PM, staff #4 was in the office when she heard client F whispering in the kitchen. Staff #4</p>			

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	<p>opened the door and observed client F's hands were down client D's pants.</p> <p>The Investigation Summary, dated 3/27/15, indicated in the Conclusion section, "Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "Staff training will be completed to keeping (sic) [clients D and F] in line of sight anytime that [client D] is down stairs or [client F] happens to be upstairs. Staff will keep [clients D and F] in line of sight at all times to try and prevent this incident from happening again."</p> <p>On 4/17/15 at 11:01 AM, a review of client F's Risk Management Assessment Plan (RMAP), dated 5/2/14, indicated, in part, "Associates consequences with actions: [Client F] does not always associate consequences with actions when he has behaviors. Staff to assist [client F] in understanding appropriate actions." Client F's RMAP indicated, "Bells are also on [client F's] bedroom doors due to a roommate's elopement behavior." The RMAP indicated, "Person requires 24 hour awake supervision." The RMAP indicated client F did not present a risk for "displays behaviors which may provoke abuse by others including consumers." There was no documentation in client F's</p>				

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	<p>RMAP indicating he engaged in sexually inappropriate behavior at the group home. Client F's 5/2/14 Individual Support Plan (ISP) indicated client F had a guardian. The ISP indicated , in part, "Sexuality awareness: [Client F] is sexually aware and knowledgeable but is not sexually active." The ISP indicated client F had a Behavior Support Plan (BSP) which included a targeted behavior of inappropriate sexual behavior. Client F's 4/1/14 BSP defined inappropriate sexual behavior as, "Any attempts to touch or actual touching or penetration of another's genitals without his/her consent." The plan indicated in the Responding to Targeted Problem Behaviors section, "[Client F] should be kept in line of sight when he and his previously targeted housemate are not in common areas where staff can see them in order to assure the safety of his housemate. [Client F] is to be checked on every 15 minutes to assure the safety of everyone in the home."</p> <p>On 4/17/15 at 11:08 AM, a review of client D's RMAP, dated 1/16/15, indicated, in part in the Sexual section, "[Client D] may have difficulties defending himself against abuse due to a lack of reaction and response towards the abuse. Staff are to assist as needed to ensure [client D's] safety and ensure he is</p>			
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	<p>free from abuse." Client D's RMAP indicated he did not present a risk of reporting abuse to the appropriate party. Client D's RMAP indicated, "Person needs 24 hour plan of care (may not require supervision at all times but there is someone identified/assigned that is responsible and accessible to the consumer in case of emergency. 24 hour plan of care required for individuals in ICF-MR and waiver eligible individuals)." Client D's 1/16/15 ISP indicated, in part, "Sexuality awareness: [client D] knows the difference between different genders and appears to be sexually aware." Client D's ISP indicated he did not have a BSP. The ISP indicated client D had a guardian. The ISP indicated, "Assessment of his/her supervision needs: Requires 24-hour supervision."</p> <p>On 4/16/15 at 2:54 PM, the Program Director (PD) indicated clients D and F had a history of inappropriate touching. The PD indicated there was an alarm on client F's bedroom door for this reason. The PD indicated there was an incident several months ago between the two. Clients D and F attempted to go into the bathroom together. The PD indicated client D indicated he enjoyed the touching. The PD indicated both clients have guardians. The PD indicated there</p>			
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	<p>was no training provided to the clients. The PD indicated client F's plan addressed inappropriate touching. The PD indicated client F initiated the contact. The PD indicated neither client was assessed to be able to give consent for the behavior. On 4/17/15 at 1:46 PM, the PD indicated client F had a Behavior Support Plan the staff failed to implement as written for supervision. The PD indicated client F's Behavior Plan referred to a previously targeted housemate. The PD indicated the housemate was client D.</p> <p>On 4/17/15 at 12:26 PM, the AD indicated the staff were supposed to be supervising the clients and know where they were in the group home. The AD stated client D "doesn't mind" the touching by client F. The AD indicated there have been incidents similar to this in the past between clients D and F. The AD stated, "staff need to keep an eye on them."</p> <p>9-3-4(a)</p>			