

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/23/2014
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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311
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W000000	<p>This visit was for the investigation of complaint #IN00157984.</p> <p>Complaint #IN00157984: Substantiated, Federal and state deficiencies related to the allegations are cited at W149, W153, W154 and W157.</p> <p>Dates of Survey: 10/20, 10/21 and 10/23/14</p> <p>Facility number: 001179 Provider number: 15G608 AIM number: 100240130</p> <p>Surveyor: Paula Eastmond, QIDP-TC</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/28/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 3 of 3 sampled clients (A, B and C) and for 1 additional client (E), the facility</p>	W000149	No other clients were affected. We review/train survey finding/corrections at	11/21/2014

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>failed to implement its policy and procedures to conduct a thorough investigation of an allegation of staff to client abuse/mistreatment of clients. The facility also failed to implement its written policy and procedures to report an allegation of client to client abuse immediately to the administrator for clients A and E and to report a second allegation of staff to client abuse involving client B. The facility failed to implement its written policy and procedures in regard to ensuring corrective actions/measures were implemented/followed involving retraining of staff to report all allegations of neglect/abuse to the administrator/facility.</p> <p>Findings include:</p> <p>The facility's policy and procedures were reviewed on 10/21/14 at 12:40 PM. The facility's undated policy and procedure entitled Policy On Reporting And Investigating Incidents And Allegations Of Abuse And Neglect indicated "...Consumers must not be subjected to abuse by anyone, including, but not limited to, facility staff, other consumers, consultants, volunteers, staff or other agencies serving the consumer, family members or legal guardians, friends or other individuals. Until the incident is</p>		<p>our Management meeting to ensure that we are doing things the same and correctly according to the regulations across the board. All management staff will be re-trained on the abuse/neglect policy, which includes what is abuse, reporting, thorough investigations and corrective action to prevent recurrence. This would also include doing all of the same steps/documentation if a second allegation is uncovered.</p> <p>Responsible person: Sheila O'Dell, Group Home Director. Staff will be re-trained on the abuse/neglect policy. Responsible person: Patti Harris, QDDP. A reliability/test will be completed to show competency. Responsible person: Patti Harris, QDDP The manager will review internal incident reports daily.</p> <p>Responsible person: Dana Hesse, Group Home Manager. To ensure future compliance, weekly all state incident reports are reviewed monthly at the safety committee meeting. The committee will determine if all steps of the investigation has been completed and if there are any additional recommendations to prevent recurrence.</p> <p>Responsible person: Sheila O'Dell, Group Home Services Director & Patti Harris, QDDP. To ensure future compliance, staff will continue to be trained on abuse and neglect upon hire and at least annually thereafter.</p>				

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	<p>reported and investigated, one may not be able to determine whether it is abuse (willful), neglect or mistreatment but the incident must be treated as an allegation of abuse, neglect or mistreatment and follow the regulations for reporting, responding, investigating and correcting...." The undated policy indicated "...any staff member witnessing or suspecting abuse, neglect of a consumer or consumers either within the home or another environment is required to immediately report the incident for investigation to the Program Director/Administrator who will immediately notify the Program Manager. It is mandatory all In-Pact personnel follow the provisions of this policy. This includes: reporting of incidents immediately upon becoming aware of them, completing all forms as required by this policy...." The facility's undated policy indicated a "...preliminary investigation will be initiated including getting statements from all staff working at the time of the incident. A list of staff having worked with the consumer the previous 24 hours is to be compiled and written statements are required from each of these staff relative to their knowledge of the consumer during the time of their shift...."</p> <p>The facility failed to ensure the</p>		<p>Responsible person: Ruth Estrada, Training Coord. To ensure future compliance, all internal incident reports will be reviewed at least monthly. Responsible person: Patti Harris, QDDP and Sheila O'Dell, Group Home Director</p>				

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W000153	<p>administrator was immediately notified of an allegation of client to client abuse/aggressive incident involving clients A and E, and in regard to an allegation of staff to client abuse/mistreatment involving client B to state officials per 460 IAC 9-3-1 (b)(5) and to Adult Protective Services (APS) per IC 12-10-3. Please see W153.</p> <p>The facility failed to conduct/document a thorough investigation of a second allegation of staff to client abuse/mistreatment made during a facility investigation involving clients B and C. Please see W154.</p> <p>The facility failed to ensure all staff were retrained in regard to reporting allegations timely as recommended by the facility's investigation involving client C. Please see W157.</p> <p>This federal tag relates to complaint #IN00157984.</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</p>			

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	<p>through established procedures.</p> <p>Based on interview and record review for 2 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure the administrator was immediately notified of an allegation of client to client abuse/aggressive incident involving clients A and E, and in regard to an allegation of staff to client abuse/mistreatment involving client B to state officials per 460 IAC 9-3-1 (b)(5) and to Adult Protective Services (APS) per IC 12-10-3.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/21/14 at 12:43 PM. The facility's 10/12/14 reportable incident report indicated "[Staff #2] called the house manager on Sunday to report suspected Abuse/Neglect of [client C]. She reported that another staff (staff #3) had informed her that on Friday morning after [client C] had a bowel movement on herself that a staff member had started to give [client C] a cold shower and stated that she did not get the privilege of a hot shower 'cause you s... up the house.' The other staff member present on Friday morning saw that [client C] appeared cold, and took over giving the shower at the proper temperature. An investigation</p>	W000153	<p>All management staff will be re-trained on the abuse/neglect policy, which includes reporting any allegation of mistreatment, neglect or abuse, as well as injuries of unknown source timely. This would also include doing all of the same steps/documentation if a second allegation is uncovered.</p> <p>Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy, which includes reporting any allegation of mistreatment, neglect or abuse, as well as injuries of unknown source timely.</p> <p>Responsible person: Patti Harris, QDDP. A reliability will be completed to ensure competency by all staff. Staff #3 will also complete a reliability weekly for one month. Responsible person: Dana Hesse, Group Home Manager. To ensure future compliance, Manager will review all internal reports daily.</p> <p>Responsible person: Dana Hesse, Group Home Manager.</p>	11/21/2014			

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	<p>is being done."</p> <p>The facility's 10/14/14 Investigation of Injury/Incidents of Unknown Origin or any Allegation of Mistreatment, Abuse/Neglect or Death, SIB (self-injurious behavior) or Peer to Peer Aggression indicated the incident occurred on 10/10/14. The facility's 10/10/14 investigation indicated client B was interviewed in regard to the allegation of staff to client abuse. Client B's undated witness statement indicated "[Staff #3] asked [client B] if she (client B) wanted to pick up poop. 'I (client B) said hecky (sic) no.' [Client C] had 2 showers that morning because she had a 'pooping problem.' I didn't see her shower. I was worried about my lunch. [Staff #3] helped her shower I think. It was a mess here." Client B's undated witness statement indicated on 10/10/14 the same morning of the staff to client allegation of abuse, "...I (client B) threw my lunchbag (sic) at the back door. I was upset and yelling-the whole house heard me. I was yelling at her (staff #4) for what she did. [Staff #4] took my water out of my lunch bag. I was yelling. She yelled for me to 'Go get it!' About my lunch bag...[Staff #4] squished my sandwich with her foot, threw the sandwich to the floor and then squished it. She threw the lunch bag across my</p>						

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	<p>room. My drink, sandwich, and chips all ruined. Sandwich went under bed, chips under her foot, and lid off the juice...."</p> <p>Client B's undated witness statement indicated "...I don't know how the lunch bag got into my room. Wait...I brought it in there myself. [Staff #4] unzipped it for me. She threw everything out of it. I threw my lunch bag back at her because I was mad at her. Sandwich on the floor. Chips on floor. [Staff #4] throws it at [client B's] door. 'You don't need nothing for lunch.' She let her make a fresh lunch...." The facility's initial 10/12/14 reportable incident report and/or 10/17/14 follow-up report did not indicate the facility reported the second allegation of abuse/mistreatment involving client B.</p> <p>Interview with staff #1 on 10/21/14 at 11:07 AM indicated an investigation had been conducted in regard to an allegation of staff abuse involving client C. Staff #1 indicated she reported the allegation of abuse to Bureau of Developmental Disabilities Services (BDDS).</p> <p>Interview with administrative staff #1 and the QIDP on 10/21/14 at 2:29 PM indicated the QIDP indicated the second allegation of abuse was made when client B was interviewed in regard to the allegation of abuse with client C. The QIDP indicated she asked staff questions</p>						

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	<p>about client B's allegation in regard to her lunch. The QIDP indicated facility staff told her client B was taking an extra lunch for a friend at the workshop and became upset when staff tried to tell her she could not do that. The QIDP and/or administrative staff #1 did not provide any additional documentation in regard to the second allegation of abuse being reported to BDDS per state law.</p> <p>2. Client A's record was reviewed on 10/21/14 at 1:55 PM. Client A's 10/17/14 In-Pact, Inc. (incorporated) Behavior Data Sheet indicated "[Client A] heard [client E] say 'f...u' (you) and she (client A) went in [client E's] room and smacked her...The next morning [client E] had fresh scratch marks on the left side of her neck...."</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/21/14 at 12:43 PM. The facility's reportable incident reports from 8/1/14 to the present did not indicate facility staff reported the allegation of client to client abuse/aggression to the administrator.</p> <p>Interview with administrative staff #1 and the QIDP on 10/21/14 at 2:29 PM indicated they were not aware of the client to client incident. Administrative staff #1 and the QIDP indicated facility</p>			

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W000154	<p>staff should have reported the allegation of abuse on 10/17/14.</p> <p>This federal tag relates to complaint #IN00157984.</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 interview and record review for 2 of 3 sampled clients (B and C), the facility failed to conduct/document a thorough investigation of a second allegation of staff to client abuse/mistreatment made during a facility investigation involving clients B and C.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/21/14 at 12:43 PM. The facility's 10/12/14 reportable incident report indicated "[Staff #2] called the house manager on Sunday to report suspected Abuse/Neglect of [client C]. She reported that another staff (staff #3) had informed her that on Friday morning after [client C] had a bowel movement on</p>	W000154	<p>All management staff and QDDPs will be re-trained on the abuse/neglect policy, which includes thorough investigations. It also includes doing all of the same steps/documentation if a second allegation is uncovered. Responsible person: Sheila O'Dell, Group Home Director. The manager will review internal incident reports daily. Responsible person: Dana Hesse, Group Home Manager. If there are any allegations, unknown injury &/or peer to peer aggression, a thorough investigation will be completed, which includes interview every staff/consumer even if they were not present. Responsible person: Dana Hesse, Group Home Manager and Patti Harris, QDDP. Investigation packets will be used to make sure all of the steps to a thorough investigation is completed. These packets</p>	11/21/2014

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	<p>herself that a staff member had started to give [client C] a cold shower and stated that she did not get the privilege of a hot shower 'cause you s... up the house.' The other staff member present on Friday morning saw that [client C] appeared cold, and took over giving the shower at the proper temperature. An investigation is being done."</p> <p>The facility's 10/17/14 follow-up report indicated "A thorough investigation was completed interviewing all staff and consumers. The determination was that the abuse/neglect was unsubstantiated. This was determined due to these factors: [Client C] knows how to turn the water temp (temperature) to hot and turns it to the left (hot) when she gets in. The shower head is on the wall where she doesn't have to stand under the water. The staff that accused the other staff said that the staff she was accusing was not forcing her under the cold water that was reported. Also, no one else heard the exchange, therefore, it is one person's word against another person's word. The consumer was assisted in having a warm shower, dressed and provided care. Staff asked her if there was anything they could do for her, but she is non-verbal and did not respond. They assisted in having a structured day that she is accustomed to, There will be retraining</p>		<p>contain visual assessment of injury, review of behavioral data, assess the environment, review of house logs, communication with staff and clients, etc. Responsible person: Traci Hardesty, QDDP. To ensure future compliance, all internal incident reports will also be reviewed at least monthly to ensure a reportable has not been missed. Responsible person: Patti Harris, QDDP and Sheila O'Dell, Group Home Director. To ensure future compliance, at least monthly all state incident reports will be reviewed by our Safety Committee. They also will determine if there should be any additional recommendations. Responsible person: Sheila O'Dell, Group Home Director.</p>		

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	<p>on Monday, October 20, 2014 for need and timeliness of reporting. Staff will also be taught that in times where there is a lot going on, they need to slow down and focus on what needs to be done, not just trying to rush through to get out of the house to workshops on time."</p> <p>The facility's 10/13/14 internal incident report indicated "I [staff #2] was told that [client C] was giving (sic) a cold shower. Once I was told I called my manager."</p> <p>The facility's 10/14/14 Investigation of Injury/Incidents of Unknown Origin or any Allegation of Mistreatment, Abuse/Neglect or Death, SIB (self-injurious behavior) or Peer to Peer Aggression indicated the incident occurred on 10/10/14. The facility's 10/10/14 investigation indicated facility staff and other clients of the group home were interviewed. The facility's investigation indicated "This incident was found to be unsubstantiated. All steps of the reporting policy was (sic) followed once date of knowledge. It was one staffs word against anothers (sic) and [client C] was unable to tell us what happened. All staff knows (sic) that [client C] loves hot showers and she can turn the water temp herself to hot (water temp is set to 110 (degrees). Staff witness did not see staff move water</p>						

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	<p>temp nor did she have her hands on the shower head or on [client C]. Due to these factors is how we came to our conclusion (sic). Based on our findings, the staff who did not report immediately will receive a disciplinary note along w/ (with) a reminder that [client C] needs on-going supervision while in the shower due to seizures." The conclusion was signed by the facility's Program Director/Administrator.</p> <p>Staff #3's 10/13/14 witness statement indicated client C walked into the living room and sat down in a chair. Staff #3's witness statement indicated client #3 "...sat in chair leaving lots of poop in the chair. So I put her in the shower...When I walked back into big bathroom [staff #4] was giving her a cold shower saying that she pooped up the house. You don't get to take a hot bath. I then took over her shower and she (staff #4) left and came back around and said [client C] your (sic) lucky you got [staff #3] because you would have been taking a titanic bath." Staff #3's 10/14/14 witness statement indicated "I (staff #3) started the shower. I left [client C] in bathroom alone. I went out to pick up poop. I returned to the bathroom (sic) [staff #4] was showering/spraying [client C] with cold water, I took over [sic] [Staff #4] left out of bathroom. I</p>						

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	<p>completed shower. I also took her to room and dressed her...."</p> <p>Staff #4's 10/13 and 10/14/14 witness statement indicated she did not make any statement about giving client C a "titanic bath."</p> <p>Staff #6's 10/13/14 witness statement indicated the staff person worked the day the incident occurred. Staff #6's witness statement indicated she did not see staff #4 go into the bathroom with client C. Staff #6's witness statement indicated staff #4 did not give client C a shower as staff #6 and staff #4 were in the living room. Staff #6 indicated she did not know anything about "cold water." The facility's 10/14/14 investigation indicated additional staff were interviewed but they had not witnessed any abuse/neglect in the group home.</p> <p>The facility's investigation indicated clients A, C, D and E were interviewed but no information was able to be obtained. The facility's 10/14/14 investigation indicated client B was interviewed in regard to the allegation of staff to client abuse. Client B's undated witness statement indicated "[Staff #3] asked [client B] if she (client B) wanted to pick up poop. 'I (client B) said hecky (sic) no.' [Client C] had 2 showers that</p>						

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	<p>morning because she had a 'pooping problem.' I didn't see her shower. I was worried about my lunch. [Staff #3] helped her shower I think. It was a mess here." Client B's undated witness statement indicated on 10/10/14 the same morning of the staff to client allegation of abuse, "...I (client B) threw my lunchbag (sic) at the back door. I was upset and yelling-the whole house heard me. I was yelling at her (staff #4) for what she did. [Staff #4] took my water out of my lunch bag. I was yelling. She yelled for me to 'Go get it!' About my lunch bag...[Staff #4] squished my sandwich with her foot, threw the sandwich to the floor and then squished it. She threw the lunch bag across my room. My drink, sandwich, and chips all ruined. Sandwich went under bed, chips under her foot, and lid off the juice...." Client B's undated witness statement indicated "...I don't know how the lunch bag got into my room. Wait...I brought it in there myself. [Staff #4] unzipped it for me. She threw everything out of it. I threw my lunch bag back at her because I was mad at her. Sandwich on the floor. Chips on floor. [Staff #4] throws it at [client B's] door. 'You don't need nothing for lunch.' She let her make a fresh lunch...."</p> <p>Additional handwritten investigation notes were reviewed on 10/21/14 at 2:40</p>						

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	<p>PM. The hand written notes indicated staff #3, #4 and #6 were interviewed in regard to client B's allegation of abuse/mistreatment (involving the client's lunch) made during the 10/14/14 investigation of staff #4. The 10/14/14 hand written notes indicated client B was upset as she had taken extra food for a friend for lunch. Staff #3's statement indicated "[Staff #4] and [client B] were arguing but I didn't see anyone throw or step on food. I was busy cleaning up poop." Staff #4's statement via phone indicated she did not yell at client B and/or step on the client's lunch. Staff #4's statement indicated "...I was asking her to remove the doubles to not take them for her friend. I never stepped on her food." Staff #6's statement indicated she did not hear staff #4 yell at client B about the sandwich or client B's lunch. The facility failed to interview all staff who worked with staff #4 and client B in regard to staff treatment of clients in regard to lunches. The facility's investigation indicated the facility did not attempt to interview clients A, D and E, who have some verbal skills, in regard to client B's allegation of abuse/mistreatment and/or how facility staff treated them and/or others. The facility's initial 10/12/14 reportable incident report and/or 10/17/14 follow-up report did not indicate the facility</p>						

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	<p>reported the second allegation of abuse/mistreatment involving client B.</p> <p>The facility's inservice/training record was reviewed on 10/21/14 at 2:40 PM. The facility's 10/20/14 typed note indicated "Any act that you see as possible mistreatment of a consumer needs to be reported immediately to management. If [staff #1] doesn't answer, leave a message, and if that staff member is still there, then call [Qualified Intellectual Disabilities Professional-QIDP], [administrative staff #2], [administrative staff #3] to make sure we address the situation immediately. If that staff member is not working and there is no immediate need, you may wait a few hours for [staff #1] to return your call. This is vital to working with and protecting our consumers." The 10/20/14 inservice record indicated staff #1, #2, #7 and #9 were present at the meeting. The inservice record indicated staff #3, #4, #5, #6 and #8 did not attend the inservice training.</p> <p>Interview with staff #9 on 10/20/14 at 6:35 PM indicated she had not observed staff abusing and/or neglecting other clients. Staff #9 indicated client C did not have a behavior of having bowel movements on herself. Staff #9 indicated client C would have bowel movements if</p>			

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	<p>the client had diarrhea.</p> <p>Interview with staff #7 on 10/20/14 at 6:40 PM stated she had not witnessed any abuse of clients, but had heard a staff gave a client a "cold shower."</p> <p>Interview with staff #1 on 10/21/14 at 11:07 AM indicated an investigation had been conducted in regard to an allegation of staff abuse involving client C.</p> <p>Interview with administrative staff #1 and the QIDP on 10/21/14 at 2:29 PM indicated the facility was not able to substantiate the allegation of staff to client abuse involving client C. Administrative staff #1 and the QIDP stated "It was one staff's word against another staff's word." Administrative staff #1 and the QIDP indicated client C was non-verbal (not able to talk) so they were not able to get any information from the client. Administrative staff #1 and the QIDP indicated no other staff and/or client was in the area when the alleged incident occurred. Administrative staff #1 and the QIDP indicated staff #3 told staff #2 of the incident and staff #2 reported the allegation to the administration. When asked why staff #3 did not report the allegation, administrative staff #1 and the QIDP stated "She (staff #3) did not think it was</p>				

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W000157	<p>a big deal when she saw it." Administrative staff #1 and the QIDP indicated staff #2 did not like staff #4. The QIDP indicated she asked staff questions about client B's allegation in regard to her lunch. The QIDP indicated facility staff told her (the QIDP) client B was taking an extra lunch for a friend at the workshop and became upset when staff tried to tell her she could not do that. The QIDP indicated staff were interviewed. The QIDP and administrative staff #1 indicated no additional documentation of an investigation was conducted in regard to the second allegation of abuse involving staff #4.</p> <p>This federal tag relates to complaint #IN00157984.</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 interview and record review for 1 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure all staff were retrained in regard to reporting allegations timely as recommended by</p>	W000157	The home had set up a training and not all staff were able to attend. The plan was to get another one set up or to meet individually, but the survey occurred prior to this getting completed. Since the survey, another meeting has been	11/21/2014

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	<p>the facility's investigation involving client C.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/21/14 at 12:43 PM. The facility's 10/12/14 reportable incident report indicated "[Staff #2] called the house manager on Sunday to report suspected Abuse/Neglect of [client C]. She reported that another staff (staff #3) had informed her that on Friday morning after [client C] had a bowel movement on herself that a staff member had started to give [client C] a cold shower and stated that she did not get the privilege of a hot shower 'cause you s... up the house.' The other staff member present on Friday morning saw that [client C] appeared cold, and took over giving the shower at the proper temperature. An investigation is being done."</p> <p>The facility's 10/17/14 follow-up report indicated "A thorough investigation was completed interviewing all staff and consumers. The determination was that the abuse/neglect was unsubstantiated. This was determined due to these factors: [Client C] knows how to turn the water temp (temperature) to hot and turns it to the left (hot) when she gets in. The</p>		<p>scheduled that is mandatory to attend or there will be disciplinary action. Responsible person: Patti Harris, QDDP & Dana Hesse, Group Home Manager. In the follow up report, it stated that Staff #3 will receive disciplinary action for not report immediately and to administration. This has been completed. Responsible person: Patti Harris, QDDP & Dana Hesse, Group Home Manager. A reliability will be completed to ensure competency by all staff. Staff #3 will also complete a reliability weekly for one month. Responsible person: Dana Hesse, Group Home Manager. To ensure future compliance, staff will continue to be trained on abuse and neglect policy upon hire and at least annually thereafter. Responsible person: Ruth Estrada, Training Coord. To ensure future compliance, Manager will review all internal reports daily. Responsible person: Dana Hesse, Group Home Manager.</p>		

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	<p>shower head is on the wall where she doesn't have to stand under the water. The staff that accused the other staff said that the staff she was accusing was not forcing her under the cold water that was reported. Also, no one else heard the exchange, therefore, it is one person's word against another person's word. The consumer was assisted in having a warm shower, dressed and provided care. Staff asked her if there was anything they could do for her, but she is non-verbal and did not respond. They assisted in having a structured day that she is accustomed to, There will be retraining on Monday, October 20, 2014 for need and timeliness of reporting. Staff will also be taught that in times where there is a lot going on, they need to slow down and focus on what needs to be done, not just trying to rush through to get out of the house to workshops on time."</p> <p>The facility's inservice/training record was reviewed on 10/21/14 at 2:40 PM. The facility's 10/20/14 typed note indicated "Any act that you see as possible mistreatment of a consumer needs to be reported immediately to management. If [staff #1] doesn't answer, leave a message, and if that staff member is still there, then call [Qualified Intellectual Disabilities Professional-QIDP], [administrative staff</p>						

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	<p>#2], [administrative staff #3] to make sure we address the situation immediately. If that staff member is not working and there is no immediate need, you may wait a few hours for [staff #1] to return your call. This is vital to working with and protecting our consumers." The 10/20/14 inservice record indicated staff #1, #2, #7 and #9 were present at the meeting. The inservice record indicated staff #3, #4, #5, #6 and #8 did not attend the inservice training.</p> <p>Interview with administrative staff #1 and the QIDP on 10/21/14 at 2:29 PM indicated the facility was not able to substantiate the allegation of staff to client abuse involving client C. The QIDP indicated they would still need to have another meeting/inservice on reporting as all staff were not at the meeting on 10/20/14. QIDP and administrative staff #1 indicated staff #3 had not been retrained on reporting as she was not at the meeting.</p> <p>This federal tag relates to complaint #IN00157984.</p> <p>9-3-2(a)</p>						