

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/21/2015
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00179719.</p> <p>Complaint #IN00179719: Substantiated, Federal and State deficiencies related to the allegation(s) cited at W148, W149, W154, W157, W186 and W214.</p> <p>This visit was in conjunction with the Post Certification Revisit (PCR) to the extended recertification and state licensure survey completed on 8/5/15.</p> <p>Survey Dates: September 17, 18 and 21, 2015</p> <p>Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/28/15.</p>	W 0000		
W 0148 Bldg. 00	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant</p>			

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>incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (D), the facility failed to ensure an arranged appointment with client D's guardian was held as scheduled, financial documentation was provided to the guardian, as requested, personnel changes at the group home were reported to the guardian and there was documentation the facility reported two incidents of elopement to the guardian.</p> <p>Findings include:</p> <p>On 9/17/15 at 12:22 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/4/15, indicated the incident time was 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff #5 was in the living room (adjacent to the dining room) with client B. The door alarm sounded</p>	W 0148	To correct the deficient practice and prevent it from recurring, the Director of Residential Services will re-train all Network Director/ QDDPs on the expectation of a minimum monthly contact with all guardians, as well as contacting them any time a significant event, supervisory staffing change or BDDS reportable incident occurs. All contacts will be documented on a communication log, to be maintained in the customer record. Monthly information will be sent to each guardian that includes banking information,	10/21/2015

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	<p>and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was one staff on shift. The staff called the non-emergency dispatch number to go retrieve [client D]. [Client D] came back</p>		<p>appointments, programmatic changes, etc. Ongoing monitoring will be accomplished by the DRS monthly review of communication logs to ensure documentation of ongoing, regular communication.</p>		

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	<p>to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told them [client D] came back after 15 minutes."</p> <p>The facility failed to document reporting the incidents of elopement to client D's guardian in client D's record.</p> <p>On 9/18/15 at 11:53 AM, the facility was requested to send documentation of the communication from the facility to client D's guardian for the past 3 months. On 9/18/15 at 2:58 PM, the facility provided documentation of communication with client D's guardian on 7/21/15 (email</p>			

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	<p>regarding an incident in which client D was hit in the face by a peer) and 7/22/15 (guardian wanted to speak to the Home Manager about the incident on 7/21/15 and expressed she wanted to move client D to another setting). The Director of Residential Services (DRS) indicated in an email dated 9/18/15 at 12:26 PM, "I'm going to have to get with [name of former Home Manager] to have her forward he (sic) calls and emails." There was no additional documentation of client D's guardian being contacted in three months.</p> <p>On 9/18/15 at 11:04 AM, the Director of Residential Services (DRS) indicated the former Home Manager (HM) was making most of the contact with the clients' guardians. The DRS stated, "there was a gap in communication with the guardians" when the former Network Director (ND) left as well the the HM. The DRS indicated he had an appointment with client D's guardian to meet her on a Sunday (did not know the date) at the group home. The DRS indicated he was working at another group home at the time of the arranged meeting and could not meet client D's guardian at the group home. The DRS indicated it was not a formal meeting but he had scheduled a time to meet client D's guardian in person for the first time while she was at the group home. The</p>			

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	<p>DRS indicated he was not aware of any other missed appointments or meetings with guardians. The DRS indicated personnel changes should be reported to the guardians. The DRS indicated he was going to send out a letter informing the guardians of the change in the Network Director position on 9/21/15.</p> <p>On 9/18/15 at 1:29 PM, client D's guardian indicated she arranged to meet the DRS at the group home during one of her visits to the group home on a Sunday (did not know the date). The DRS indicated the Team Lead attempted to call the DRS several times. The guardian indicated she waited at the group home for two hours before the DRS answered his phone and told the Team Lead he forgot he had an appointment to meet the guardian at the home. The guardian indicated she was not aware the Home Manager had recently resigned. The guardian indicated she was not informed. The guardian indicated she was not aware there was a new Network Director at the group home. The guardian indicated she was not informed. The guardian indicated she had requested financial documentation for her son a long time ago but the information was not provided to her. The guardian indicated she wanted to be informed when there were staffing changes at the group home. The</p>			

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W 0149 Bldg. 00	<p>guardian indicated she wanted the financial documentation for her son's accounts provided to her on a regular basis.</p> <p>This federal tag relates to complaint #IN00179719.</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 record review and interview for 2 of 3 incident/investigative reports reviewed affecting client D, the facility neglected to implement its policies and procedures to prevent client D from eloping from the group home on consecutive days, conduct thorough investigations and take appropriate corrective actions to address client D's elopement incidents in a plan. The facility failed to ensure staff was deployed appropriately to prevent elopement.</p> <p>Findings include: On 9/17/15 at 12:22 PM, a review of the</p>	W 0149	To correct the deficient practice, investigations have been completed for the incidents that occurred on 8/3/15 and 8/4/15. The IST met to review the incidents, and no incidents of elopement have occurred since 8/4/15. Client D's Behavior Support Plan will be revised to include elopement,	10/21/2015

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	<p>facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/4/15, indicated the incident time was 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff #5 was in the living room (adjacent to the dining room) with client B. The door alarm sounded and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to</p>		<p>and all staff will be trained on the updated plan. An additional staff has been scheduled to work in the mornings to ensure adequate staffing while individuals are preparing to go to school. To ensure the deficient practice does not continue, and to provide ongoing monitoring, the Director of Support Services will monitor all BDDS incident reports and investigations to ensure follow up actions are completed within the required timeframes, and will follow up with the responsible party on an ongoing basis until follow up is completed.</p>	

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	<p>monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The facility failed to conduct an investigation into the incident of elopement. The facility failed to reassess client D's behavior following the incident. The facility failed to revise and update client D's plan to address elopement. The facility failed to identify the incidents as potential neglect.</p> <p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was one staff on shift. The staff called the non-emergency dispatch number to go retrieve [client D]. [Client D] came back to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p>		<p>The Services Leadership Team, which includes all Directors of Services, the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative follow up is completed.</p>	

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	<p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told them [client D] came back after 15 minutes."</p> <p>The facility failed to conduct an investigation into the incident of elopement. The facility failed to reassess client D's behavior following the incident. The facility failed to revise and update client D's plan to address elopement. The facility failed to identify the incidents as potential neglect.</p> <p>On 9/17/15 at 1:34 PM, a review of client D's 8/18/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression, sexual aggression, self-injurious behavior, food seeking and public masturbation. There was no documentation in the plan addressing elopement. The BSP did not include a targeted behavior of elopement. The BSP indicated, in part, "Restrictive</p>			

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	<p>Measures 1. Door alarms: Due to issues of elopement with a roommate, door alarms are located and active on all door (sic) leading to the outside...."</p> <p>On 9/17/15 at 4:16 PM, staff #5 indicated she was working at the group home during the incidents by herself on 8/3/15 and 8/4/15. Staff #5 indicated on 8/3/15, she heard the alarm sound so she went to see why the alarm was going off. Staff #5 indicated she observed client D running across the road to the neighbor's house across the street and to the left of the group home. Staff #5 indicated she went after client D and observed him go around the back of the house and attempt to enter the back door, which was locked. Staff #5 indicated she called the Team Lead to get assistance since client D was not responding to her prompts to return to the group home. Staff #5 indicated client D returned to the group home about 15 minutes later with her. Staff #5 indicated she did not know why client D attempted to go to the neighbor's house. Staff #5 indicated client D did not communicate what he wanted at the neighbor's house. Staff #5 indicated she was working by herself with several clients but could not remember who was home at the time of the incident. Staff #5 indicated the former House Manager told her to call the non-emergency number written on the</p>			

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	<p>dry erase board if client D eloped in the future. Staff #5 indicated the former House Manager told her to not follow client D if there were other clients at home when client D eloped.</p> <p>Staff #5 indicated on 8/4/15 when client D eloped for the second time, she was assisting client E with brushing his teeth. Staff #5 heard the alarm go off and observed client D running across the street again to the same neighbor's house. Staff #5 called the non-emergency number on the dry erase board to ask for assistance in getting client D back to the house. Prior to the police arriving, client D returned home about 15 minutes after he left. Staff #5 indicated following the two elopement incidents, the staff was not retrained on what to do if client D eloped and client D's plan was not updated to address elopement. Staff #5 indicated client D needed a plan to address elopement. Staff #5 indicated client D had not eloped prior to these two incidents.</p> <p>On 9/17/15 at 3:59 PM, the Network Director (ND) indicated client D eloped two times from the group home. The ND indicated she was not the ND at the time of the incidents. The ND indicated the facility has door alarms. The ND indicated the staff was instructed to keep</p>			

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	<p>client D engaged in activities. The ND indicated additional staff was added to the schedule in the morning. The ND indicated client D's plan should address elopement either as a historical reference for staff or as a targeted behavior. The ND indicated the facility needed to update client D's plan to include elopement and the use of door alarms to address elopement. The ND indicated client D's plan needed to clarify client D was an elopement risk and door alarms were part of the plan to address elopement.</p> <p>On 9/18/15 at 11:04 AM, the Director of Residential Services (DRS) indicated the facility did not conduct full investigations into the incidents. The DRS indicated full investigations should have been conducted. The DRS indicated the alarms were in use for a peer's elopement behavior but since the incidents the alarms were now in place for client D as well. The DRS indicated client D's plan should have been updated to indicate the alarms were in place for him. The DRS indicated elopement should have been included in client D's plan. On 9/21/15 at 11:01 AM, the DRS indicated he was unsure how many clients were at the group home at the time of the incidents. The DRS indicated the staff was not in position to prevent the incident on 8/4/15.</p>			

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	<p>The DRS indicated client D's elopement on 8/3/15 was the first time he had ever left the group home. The DRS indicated the clients required 24 hour supervision by the staff.</p> <p>On 9/17/15 at 12:43 PM, the facility's policy, Individual Rights and Protections, dated 1/1/12, indicated, in part, "Customers have the right: To be free from all forms of discrimination, harassment, humiliation and cruel or unusual punishment, including forced physical activity and practices that deny an individual of sleep, shelter, physical movement for extended periods of time and/or use of bathroom facilities. To be treated with consideration and respect with recognition of his/ her dignity and individuality. To be free from emotional, verbal, and physical abuse/neglect/exploitation including but not limited to hitting, pinching and application of painful or noxious stimuli." The policy indicated, in part, "Neglect: Placing a customer in a situation that may endanger his or her life or health; abandoning or cruelly confining a customer; depriving a customer of necessary support including food, shelter, medical care, or technology." The facility's policy titled, "Investigating suspected cases of violations of rights," indicated the</p>			

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	purpose of the policy was to "To ensure thorough, timely investigations and appropriate review." The policy indicated, in part, "1. Suspected violation of rights must be reported to a Network Director/QDDP (Qualified Developmental Disabilities Professional) and Director of Services. 2. The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP (Qualified Developmental Disabilities Professional) and a copy given to the Director of Support Services. 3. The staff receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. The Director of Support Services will ensure the investigation is initiated within 24 hours of the initial report. The incident may be investigated by the Quality Assurance Director, Director of Services, or other designated administrator... 10. Any staff member or consultant suspected of violating customer rights shall be suspended pending completion of the investigation... 13. The investigation			

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W 0154 Bldg. 00	<p>must be initiated within 24 hours of the initial report."</p> <p>This federal tag relates to complaint #IN00179719.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 3 incident/investigative reports reviewed affecting client D, the facility to conduct thorough investigations of two incidents of client D eloping from the group home on consecutive days.</p> <p>Findings include:</p> <p>On 9/17/15 at 12:22 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/4/15, indicated the incident time was 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was</p>	W 0154	To correct the deficient practice, investigations have been completed for the incidents that occurred on 8/3/15 and 8/4/15. The IST met to review the incidents, and no incidents of elopement have occurred since 8/4/15. Client D's Behavior Support Plan will be revised to include elopement, and all staff will be trained on the updated plan. An additional	10/21/2015			

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	<p>present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff #5 was in the living room (adjacent to the dining room) with client B. The door alarm sounded and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The facility failed to conduct an investigation into the incident of elopement.</p> <p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out</p>		<p>staff has been scheduled to work in the mornings to ensure adequate staffing while individuals are preparing to go to school. To ensure the deficient practice does not continue, and to provide ongoing monitoring, the Director of Support Services will monitor all BDDS incident reports and investigations to ensure follow up actions are completed within the required timeframes, and will follow up with the responsible party on an ongoing basis until follow up is completed. The Services Leadership Team, which includes all</p>				

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	<p>the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was one staff on shift. The staff called the non-emergency dispatch number to go retrieve [client D]. [Client D] came back to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told them [client D] came back after 15 minutes."</p> <p>The facility failed to conduct an</p>		<p>Directors of Services, the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative follow up is completed.</p>		

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	<p>investigation into the incident of elopement.</p> <p>On 9/17/15 at 1:34 PM, a review of client D's 8/18/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression, sexual aggression, self-injurious behavior, food seeking and public masturbation. There was no documentation in the plan addressing elopement. The BSP did not include a targeted behavior of elopement. The BSP indicated, in part, "Restrictive Measures 1. Door alarms: Due to issues of elopement with a roommate, door alarms are located and active on all door (sic) leading to the outside...."</p> <p>On 9/17/15 at 4:16 PM, staff #5 indicated she was working at the group home during the incidents by herself on 8/3/15 and 8/4/15. Staff #5 indicated on 8/3/15, she heard the alarm sound so she went to see why the alarm was going off. Staff #5 indicated she observed client D running across the road to the neighbor's house across the street and to the left of the group home. Staff #5 indicated she went after client D and observed him go around the back of the house and attempt to enter the back door, which was locked. Staff #5 indicated she called the Team Lead to get assistance since client D was</p>			

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	<p>not responding to her prompts to return to the group home. Staff #5 indicated client D returned to the group home about 15 minutes later with her. Staff #5 indicated she did not know why client D attempted to go to the neighbor's house. Staff #5 indicated client D did not communicate what he wanted at the neighbor's house. Staff #5 indicated she was working by herself with several clients but could not remember who was home at the time of the incident. Staff #5 indicated the former House Manager told her to call the non-emergency number written on the dry erase board if client D eloped in the future. Staff #5 indicated the former House Manager told her to not follow client D if there were other clients at home when client D eloped.</p> <p>Staff #5 indicated on 8/4/15 when client D eloped for the second time, she was assisting client E with brushing his teeth. Staff #5 heard the alarm go off and observed client D running across the street again to the same neighbor's house. Staff #5 called the non-emergency number on the dry erase board to ask for assistance in getting client D back to the house. Prior to the police arriving, client D returned home about 15 minutes after he left. Staff #5 indicated following the two elopement incidents, the staff was not retrained on what to do if client D</p>			

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	<p>eloped and client D's plan was not updated to address elopement. Staff #5 indicated client D needed a plan to address elopement. Staff #5 indicated client D had not eloped prior to these two incidents.</p> <p>On 9/18/15 at 11:04 AM, the Director of Residential Services (DRS) indicated the facility did not conduct full investigations into the incidents. The DRS indicated full investigations should have been conducted. On 9/21/15 at 11:01 AM, the DRS indicated he was unsure how many clients were at the group home at the time of the incidents. The DRS indicated investigations should have been conducted in order to determine the staff to client ratio at the time of the incidents. The DRS indicated the staff was not in position to prevent the incident on 8/4/15. The DRS indicated client D's elopement on 8/3/15 was the first time he had ever left the group home. The DRS indicated the clients required 24 hour supervision by the staff.</p> <p>This federal tag relates to complaint #IN00179719.</p> <p>9-3-2(a)</p>			

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W 0157 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 3 incident/investigative reports reviewed affecting client D, the facility failed to take appropriate corrective actions to address client D's elopement from the group home on consecutive days.</p> <p>Findings include:</p> <p>On 9/17/15 at 12:22 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/4/15, indicated the incident time was 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff #5 was in the living room (adjacent to the dining room) with client B. The door alarm sounded and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client</p>	W 0157	To correct the deficient practice, investigations have been completed for the incidents that occurred on 8/3/15 and 8/4/15. The IST met to review the incidents, and no incidents of elopement have occurred since 8/4/15. Client D's Behavior Support Plan will be revised to include elopement, and all staff will be trained on the updated plan. An additional staff has been scheduled to work in the mornings to ensure adequate staffing while individuals are preparing to go to school. To ensure the	10/21/2015			

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	<p>D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The facility failed to reassess client D's behavior following the incident. The facility failed to revise and update client D's plan to address elopement.</p> <p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was one staff on shift. The staff called the</p>		<p>deficient practice does not continue, and to provide ongoing monitoring, the Director of Support Services will monitor all BDDS incident reports and investigations to ensure follow up actions are completed within the required timeframes, and will follow up with the responsible party on an ongoing basis until follow up is completed. The Services Leadership Team, which includes all Directors of Services, the Chief Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations</p>		

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	<p>non-emergency dispatch number to go retrieve [client D]. [Client D] came back to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told them [client D] came back after 15 minutes."</p> <p>The facility failed to reassess client D's behavior following the incident. The facility failed to revise and update client D's plan to address elopement.</p> <p>On 9/17/15 at 1:34 PM, a review of client D's 8/18/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression,</p>		to ensure relative follow up is completed.		

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	<p>sexual aggression, self-injurious behavior, food seeking and public masturbation. There was no documentation in the plan addressing elopement. The BSP did not include a targeted behavior of elopement. The BSP indicated, in part, "Restrictive Measures 1. Door alarms: Due to issues of elopement with a roommate, door alarms are located and active on all door (sic) leading to the outside...."</p> <p>On 9/17/15 at 4:16 PM, staff #5 indicated she was working at the group home during the incidents by herself on 8/3/15 and 8/4/15. Staff #5 indicated on 8/3/15, she heard the alarm sound so she went to see why the alarm was going off. Staff #5 indicated she observed client D running across the road to the neighbor's house across the street and to the left of the group home. Staff #5 indicated she went after client D and observed him go around the back of the house and attempt to enter the back door, which was locked. Staff #5 indicated she called the Team Lead to get assistance since client D was not responding to her prompts to return to the group home. Staff #5 indicated client D returned to the group home about 15 minutes later with her. Staff #5 indicated she did not know why client D attempted to go to the neighbor's house. Staff #5 indicated client D did not communicate</p>			

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	<p>what he wanted at the neighbor's house. Staff #5 indicated she was working by herself with several clients but could not remember who was home at the time of the incident. Staff #5 indicated the former House Manager told her to call the non-emergency number written on the dry erase board if client D eloped in the future. Staff #5 indicated the former House Manager told her to not follow client D if there were other clients at home when client D eloped.</p> <p>Staff #5 indicated on 8/4/15 when client D eloped for the second time, she was assisting client E with brushing his teeth. Staff #5 heard the alarm go off and observed client D running across the street again to the same neighbor's house. Staff #5 called the non-emergency number on the dry erase board to ask for assistance in getting client D back to the house. Prior to the police arriving, client D returned home about 15 minutes after he left. Staff #5 indicated following the two elopement incidents, the staff was not retrained on what to do if client D eloped and client D's plan was not updated to address elopement. Staff #5 indicated client D needed a plan to address elopement. Staff #5 indicated client D had not eloped prior to these two incidents.</p>			

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	<p>On 9/17/15 at 3:59 PM, the Network Director (ND) indicated client D eloped two times from the group home. The ND indicated she was not the ND at the time of the incidents. The ND indicated the facility has door alarms. The ND indicated the staff was instructed to keep client D engaged in activities. The ND indicated additional staff was added to the schedule in the morning. The ND indicated client D's plan should address elopement either as a historical reference for staff or as a targeted behavior. The ND indicated the facility needed to update client D's plan to include elopement and the use of door alarms to address elopement. The ND indicated client D's plan needed to clarify client D was an elopement risk and door alarms were part of the plan to address elopement.</p> <p>On 9/18/15 at 11:04 AM, the Director of Residential Services (DRS) indicated the alarms were in use for a peer's elopement behavior but since the incidents the alarms were now in place for client D as well. The DRS indicated client D's plan should have been updated to indicate the alarms were in place for him. The DRS indicated elopement should have been included in client D's plan. On 9/21/15 at 11:01 AM, the DRS indicated he was unsure how many clients were at the</p>			

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W 0186 Bldg. 00	<p>group home at the time of the incidents.</p> <p>This federal tag relates to complaint #IN00179719.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 2 of 3 incident/investigative reports reviewed affecting client D, the facility failed to provide sufficient staff to monitor and supervise the clients in accordance with their individual support plans.</p> <p>Findings include:</p> <p>On 9/17/15 at 12:22 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p>	W 0186	To correct the deficient practice and prevent it from recurring, the Network Director/ QDDP (ND/Q) will revise the Behavior Support Plans for all individuals living in the home. The ND/Q and Director of Residential Services (DRS) will review the staffing patterns in conjunction	10/21/2015

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 RHINESTONE DR ELLETTSVILLE, IN 47429
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	<p>1) The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/4/15, indicated the incident date and time was 8/3/15 at 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff #5 was in the living room (adjacent to the dining room) with client B. The door alarm sounded and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p>		<p>with the revised BSPs to ensure staff are deployed in accordance with the BSPs. All staff will be retrained on the revised plans and schedules, as well as who to contact should another staff fail to show up for a shift, to ensure that a replacement can be made available. Ongoing monitoring will be accomplished by the DRS review of staff schedules on an ongoing basis to ensure staff are maintained at the identified ratios.</p>	

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	<p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was one staff on shift. The staff called the non-emergency dispatch number to go retrieve [client D]. [Client D] came back to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told them [client D] came back after 15</p>			

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	<p>minutes."</p> <p>The facility failed to ensure staff was deployed appropriately to prevent client D from eloping from the group home.</p> <p>On 9/17/15 at 1:34 PM, a review of client D's 8/18/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression, sexual aggression, self-injurious behavior, food seeking and public masturbation. There was no documentation in the plan addressing elopement. The BSP did not include a targeted behavior of elopement. The BSP indicated, in part, "Restrictive Measures 1. Door alarms: Due to issues of elopement with a roommate, door alarms are located and active on all door (sic) leading to the outside...."</p> <p>On 9/17/15 at 4:16 PM, staff #5 indicated she was working at the group home during the incidents by herself on 8/3/15 and 8/4/15. Staff #5 indicated she was unsure which clients were at the group home at the time of the incident but she indicated it was more than two clients. Staff #5 indicated on 8/3/15, she heard the alarm sound so she went to see why the alarm was going off. Staff #5 indicated she observed client D running across the road to the neighbor's house</p>			

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	<p>across the street and to the left of the group home. Staff #5 indicated she went after client D (and left the other clients unsupervised) and observed him go around the back of the house and attempt to enter the back door, which was locked. Staff #5 indicated she called the Team Lead to get assistance since client D was not responding to her prompts to return to the group home. Staff #5 indicated client D returned to the group home about 15 minutes later with her. Staff #5 indicated she did not know why client D attempted to go to the neighbor's house. Staff #5 indicated client D did not communicate what he wanted at the neighbor's house. Staff #5 indicated she was working by herself with several clients but could not remember who was home at the time of the incident. Staff #5 indicated the former House Manager told her to call the non-emergency number written on the dry erase board if client D eloped in the future. Staff #5 indicated the former House Manager told her to not follow client D if there were other clients at home when client D eloped.</p> <p>Staff #5 indicated on 8/4/15 when client D eloped for the second time, she was assisting client E with brushing his teeth. Staff #5 indicated she was at the home by herself with clients D and E. Staff #5 heard the alarm go off and observed</p>			

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	<p>client D running across the street again to the same neighbor's house. Staff #5 called the non-emergency number on the dry erase board to ask for assistance in getting client D back to the house. Prior to the police arriving, client D returned home about 15 minutes after he left. Staff #5 indicated following the two elopement incidents, the staff was not retrained on what to do if client D eloped and client D's plan was not updated to address elopement. Staff #5 indicated client D needed a plan to address elopement. Staff #5 indicated client D had not eloped prior to these two incidents.</p> <p>On 9/17/15 at 3:59 PM, the Network Director (ND) indicated client D eloped two times from the group home. The ND indicated she was not the ND at the time of the incidents. The ND indicated the facility has door alarms. The ND indicated the staff was instructed to keep client D engaged in activities. The ND indicated additional staff was added to the schedule in the morning following the incidents. The ND indicated client D's plan should address elopement either as a historical reference for staff or as a targeted behavior. The ND indicated the facility needed to update client D's plan to include elopement and the use of door alarms to address elopement. The ND</p>			

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	<p>indicated client D's plan needed to clarify client D was an elopement risk and door alarms were part of the plan to address elopement.</p> <p>On 9/18/15 at 11:04 AM, the Director of Residential Services (DRS) indicated the facility did not conduct full investigations into the incidents. The DRS indicated full investigations should have been conducted. The DRS indicated the alarms were in use for a peer's elopement behavior but since the incidents the alarms were now in place for client D as well. The DRS indicated client D's plan should have been updated to indicate the alarms were in place for him. The DRS indicated elopement should have been included in client D's plan. On 9/21/15 at 11:01 AM, the DRS indicated he was unsure how many clients were at the group home at the time of the incidents. The DRS indicated the staff was not in position to prevent the incident on 8/4/15. The DRS indicated client D's elopement on 8/3/15 was the first time he had ever left the group home. The DRS indicated the clients required 24 hour supervision by the staff.</p> <p>This federal tag relates to complaint #IN00179719.</p> <p>9-3-3(a)</p>			

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W 0214 Bldg. 00	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (D), the facility failed to reassess client D's behavioral management needs following two incidents of elopement on consecutive days.</p> <p>Findings include:</p> <p>On 9/17/15 at 12:22 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/4/15, indicated the incident time was 12:30 PM. The LifeDesigns Unusual Incident Report (UIR), written by staff #5 who was present during the incident, indicated the incident time was 8:40 AM to 9:00 AM. The UIR indicated client D was sitting at the kitchen table and staff #5 was in the</p>	W 0214	To correct the deficient practice, the ND/QDDP will complete a functional behavioral assessment to ensure client D's elopement behaviors are adequately addressed. The behavior support plan will be revised based on the FBA, and all staff trained on the revised BSP prior to implementation. Ongoing monitoring will be accomplished by ongoing review by the IST of behavior incidents when they	10/21/2015

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	<p>living room (adjacent to the dining room) with client B. The door alarm sounded and staff #5 ran to the door and observed client D running across the road to the neighbor's house. Staff #5 ran after client D. Client D ran up the stairs of the neighbor's back porch and tried to open the back door but the door was locked.</p> <p>The BDDS incident report indicated on 8/3/15 at 12:30 PM, client D was sitting at the kitchen table. Client D ran out of the door to the house to the neighbor's house. Client D went onto the back porch and attempted to open the back door but the door was locked. Staff followed client D and redirected him to the group home. The BDDS incident report, dated 8/4/15, indicated in the Plan to Resolve section, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>2) On 8/4/15 at 8:30 AM (the UIR indicated the time of the incident was 8:20 AM to 8:35 AM), client D ran out the door to the back of the neighbor's house, while staff was brushing [former client E's] teeth. The BDDS report, dated 8/4/15, indicated, "...Staff knew that [client D] left the house when the alarms to the doors went off. Only the two customers were at home and there was one staff on shift. The staff called the</p>		<p>occur to ensure they are adequately addressed by the BSP, and if not, complete an FBA each time a significant change in behavior occurs. Additionally, the DRS and ND/QDDP will meet monthly to review current progress and concerns for each individual and ensure all plans are sufficient to address individual support needs.</p>	

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	<p>non-emergency dispatch number to go retrieve [client D]. [Client D] came back to the house approximately 15 minutes after dispatch was called. Staff called dispatch to let them know that [client D] had returned back to the house." The BDDS incident report Plan to Resolve section indicated, "Staff will continue to monitor [client D's] whereabouts, through the use of door alarms."</p> <p>The 8/4/15 UIR indicated, in part, "[Client D] was listening to a song in the living room. Staff was in the bathroom helping [client E] brush his teeth. [Client D] ran to the neighbors (sic) house. Staff stayed at the house with [client E] since there was only one staff. Staff called the non-emergency dispatch number. Staff saw [client D] walk behind the neighbors (sic) house. Staff called the non emergency dispatch number and told them [client D] came back after 15 minutes."</p> <p>On 9/17/15 at 1:34 PM, a review of client D's 8/18/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression, sexual aggression, self-injurious behavior, food seeking and public masturbation. There was no documentation in the plan addressing elopement. The BSP did not include a</p>			

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	<p>targeted behavior of elopement. The BSP indicated, in part, "Restrictive Measures 1. Door alarms: Due to issues of elopement with a roommate, door alarms are located and active on all door (sic) leading to the outside...." There was no documentation client D's comprehensive functional assessment was updated following the 2 incidents of elopement.</p> <p>On 9/17/15 at 4:16 PM, staff #5 indicated she was working at the group home during the incidents by herself on 8/3/15 and 8/4/15. Staff #5 indicated on 8/3/15, she heard the alarm sound so she went to see why the alarm was going off. Staff #5 indicated she observed client D running across the road to the neighbor's house across the street and to the left of the group home. Staff #5 indicated she went after client D and observed him go around the back of the house and attempt to enter the back door, which was locked. Staff #5 indicated she called the Team Lead to get assistance since client D was not responding to her prompts to return to the group home. Staff #5 indicated client D returned to the group home about 15 minutes later with her. Staff #5 indicated she did not know why client D attempted to go to the neighbor's house. Staff #5 indicated client D did not communicate what he wanted at the neighbor's house.</p>			

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	<p>Staff #5 indicated she was working by herself with several clients but could not remember who was home at the time of the incident. Staff #5 indicated the former House Manager told her to call the non-emergency number written on the dry erase board if client D eloped in the future. Staff #5 indicated the former House Manager told her to not follow client D if there were other clients at home when client D eloped.</p> <p>Staff #5 indicated on 8/4/15 when client D eloped for the second time, she was assisting client E with brushing his teeth. Staff #5 heard the alarm go off and observed client D running across the street again to the same neighbor's house. Staff #5 called the non-emergency number on the dry erase board to ask for assistance in getting client D back to the house. Prior to the police arriving, client D returned home about 15 minutes after he left. Staff #5 indicated following the two elopement incidents, the staff was not retrained on what to do if client D eloped and client D's plan was not updated to address elopement. Staff #5 indicated client D needed a plan to address elopement. Staff #5 indicated client D had not eloped prior to these two incidents.</p> <p>On 9/17/15 at 3:59 PM, the Network</p>				

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	<p>Director (ND) indicated client D eloped two times from the group home. The ND indicated she was not the ND at the time of the incidents. The ND indicated the facility has door alarms. The ND indicated the staff was instructed to keep client D engaged in activities. The ND indicated additional staff was added to the schedule in the morning. The ND indicated client D's plan should address elopement either as a historical reference for staff or as a targeted behavior. The ND indicated the facility needed to update client D's plan to include elopement and the use of door alarms to address elopement. The ND indicated client D's plan needed to clarify client D was an elopement risk and door alarms were part of the plan to address elopement. On 9/18/15 at 12:07 PM, the ND indicated she was unsure if client D's comprehensive functional assessment (CFA) was updated following the two incidents of elopement. The ND indicated if the CFA was not updated and a reassessment completed, it should have been done. On 9/18/15 at 3:03 PM, the ND indicated she was unable to locate documentation indicating client D's behavioral assessment was updated or revised following the two incidents of elopement.</p> <p>This federal tag relates to complaint</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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