

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2015
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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 Post Certification Revisit (PCR) to the investigation of complaint #IN00179719 completed on 9/21/15.</p> <p>This visit was in conjunction with the PCR to the PCR (completed on 9/21/15) to the extended recertification and state licensure survey completed on 8/5/15.</p> <p>Complaint #IN00179719: Not Corrected.</p> <p>Survey Dates: October 27, 28, 29 and 30, 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 11/2/15.</p>	W 0000		
W 0149 Bldg. 00	<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</p>	W 0149	To correct the deficient practice	11/29/2015

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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	<p>4 of 9 incident/investigative reports reviewed affecting clients A, B and C, the facility neglected to implement its policies and procedures to prevent client to client abuse involving clients A, B and C, clients A and B from engaging in sexual activity at the group home and client B from eloping from the group home. The facility failed to conduct a thorough investigation of client B's elopement. The facility failed to identify client B's elopement as possible neglect. The facility failed to identify the staff did not immediately report client B's elopement to the administrator. The facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>On 10/27/15 at 1:39 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 10/6/15 at 10:00 PM (reported to BDDS on 10/9/15 for clients A and B), client A told staff that last week (unknown date) client B came into client A's bedroom naked. Client A indicated client B pulled down client A's pants and touched his penis. Client A indicated in the BDDS report they "rubbed their</p>		<p>and ensure it does not continue, staff will be trained on a regular, ongoing basis on ANE topics during regular staff meetings (no less than monthly). Staff will also be re-trained on the requirement to report all allegations immediately, and the requirement that all BDDS reports are to be filed within 24 hours of learning of the incident. All supervisory staff responsible for either completing investigations, or implementing investigation recommendations, will be trained on investigation processes and procedures. The LifeDesigns investigation summary will be revised to include whether or not the staff immediately reported the allegation to an administrator, and if not, corrective action to be taken. The Services Leadership Team will review, and revise, if necessary, the agency investigation policy to ensure it provides guidance to what types of incidents may constitute alleged neglect, including elopement. Supervisory staff will be re-trained on examples of alleged neglect incidents. To provide ongoing monitoring, the Director of Support Services will monitor all BDDS incident reports to ensure BDDS reports are filed within 24 hours, and that investigation policies and procedures are implemented as written. The Services Leadership Team, which includes all Directors of Services, the Chief</p>	

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	<p>penises together." At that point, client A said, "no, get out of my room" and client B left client A's bedroom. The BDDS report indicated, "LifeDesigns is seeking HRC (Human Rights Committee) approval for a bell on [client B's] door to use at night to alert staff to him exiting his room. Safety measures of random observations by administrative staff are already in place per a POC (Plan of Correction). Routine bed checks at night will continue to be done. Additionally, an IDT (interdisciplinary team meeting) will convene to discuss the incident and determine what if any further action is needed...."</p> <p>The Investigation Summary for Peer to Peer Incidents, dated 10/13/15, indicated, in part, "Writer spoke with [client A] regarding the incident, and he said he could not remember exactly when it happened, but it was when his housemate [client C] was visiting home (which would have been Sept. 25-27). Writer asked [client A] why he didn't push [client B] away, and [client A] said he thought if he pushed him away he would be arrested by the police. [Client A] said [client B] did stop and leave his room when [client A] asked him to. [Client A] said he did not know why he did not tell staff sooner. When asked about the incident, [client B] said he did go into</p>		Services Officer and Chief Executive Office, meet at least twice monthly to review all reportable incidents and the status of investigations to ensure relative followup is completed.	

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	<p>[client A's] room but he could not remember the night. He said he took off his clothes because he wanted to cuddle. [Client B] said [client A] took off his clothes too and they were kissing. [Client B] said [client A] did ask him to leave, and so he did. [Client B] was very apologetic about the incident, and said he would never go into a housemate's room at night again...." The investigation indicated, "Based on information available, this writer cannot confirm that the incident was not consensual. [Clients B and A] are adolescent boys with minimal opportunity to experience intimacy. [Client A] exhibits a number of attention seeking behaviors, which have increased in the last couple of weeks, likely due to an increase in negative behaviors from another housemate, requiring extra attention from staff and others. He may have chosen to tell staff about the incident as a way to refocus attention on himself. [Clients B and A] do appear comfortable around each other." The investigation indicated in the section "Was the incident reported timely? (BDDS and Administrator)." The "no" checkbox was selected.</p> <p>The facility failed to submit the BDDS report within 24 hours. The facility failed to ensure the investigation included documentation of a review of client A</p>			

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	<p>and B's sleep records.</p> <p>On 10/28/15 at 12:26 PM, the Director of Support Services (DOSS) indicated BDDS reports should be submitted within 24 hours. The DOSS indicated when she initiated the investigation, she realized the incident had not been reported to BDDS and informed the Director of Residential Services (DRS). On 10/29/15 at 10:54 AM, the DOSS indicated she reviewed the clients' sleep logs but did not know the exact date she was looking for since the clients and staff did not know when the incident occurred.</p> <p>On 10/27/15 at 3:26 PM, the Chief Services Officer (CSO) indicated BDDS reports should be submitted within 24 hours.</p> <p>On 10/27/15 at 4:12 PM, the Director of Residential Services (DRS) stated the incident was "possibly consensual." The DRS indicated both clients were minors with guardians. The DRS indicated client A reported the incident as he was returning from the hospital due to suicidal ideation. The DRS indicated client A was not admitted to the hospital. The DRS indicated client A reported client B came into his bedroom, naked, and the clients rubbed their penises together. The DRS indicated client B</p>			

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	<p>confirmed the incident occurred. The DRS indicated client B indicated he kissed client A as well. The DRS indicated client A reported when he told client B "no," client B left client A's bedroom. The DRS indicated neither client could tell exactly when the incident occurred and the overnight staff was not aware of the incident. The DRS indicated a door alarm was installed on client B's bedroom door. On 10/29/15 at 10:43 AM, the DRS indicated the facility should submit BDDS reports within 24 hours.</p> <p>2) On 10/6/15 at 5:00 AM according to the Unusual Incident Report dated 10/6/15, "During the overnight, [client B] snuck into the spare room and climbed out of (sic) window. He walked down the street and then decided to come back. When staff asked [client B] why he left, he responded by saying, 'I wanted to go home and I am tired of waiting for my parents to pick me up.' Morning staff then calmed [client B] down and he went back to his room. Staff then notified NDQ (Network Director/Qualified Intellectual Disabilities Professional) of the incident."</p> <p>The Immediate Investigation, dated 10/6/15, indicated the incident occurred "around" 5:00 AM. The Immediate</p>			

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	<p>Investigation indicated the administrator was notified of the incident on 10/6/15 "around" 8:00 AM. The investigation indicated "...[Client B] admitted to leaving through the spare (room) window."</p> <p>The BDDS report, submitted to BDDS on 10/9/15, indicated, in part, "IDT will convene to discuss the incident and determine a plan of correction. Staff will continue to follow [client B's] BSP (Behavior Support Plan) as written. The incident will be investigated by LifeDesigns (sic) staff and findings forwarded to all relevant parties." The facility failed to submit the incident report to BDDS within 24 hours.</p> <p>The interview with staff #9 who was working at the time of the incident indicated, "What went on with [client B] the night he eloped? I just remember hearing a tapping on the door. The sirens were all on but he was outside. Did you hear him go out the window? No I didn't. I didn't hear anything. I was watching TV in the living room. I don't even remember what time it was. Early in the night or closer to morning? Closer to morning... I can't recall the exact time. I opened the door and I didn't know who could be at the door. I looked to (sic) the window and it was [client B]. I asked</p>			

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	<p>him what he was doing and he said he missed his family and he wanted to see his family. It was a little chilly and he didn't have a coat so I wanted him to get inside. All the alarms were on? Yeah I'm pretty spetic (sic) about that. Did he say how he got out? He just said he missed his family, he wouldn't give me a direct answer..."</p> <p>The interview with client B indicated, "Did you go out your bedroom window the other night? Yeah. Was it your window or the spare bedroom? Spare one. I'm sorry. Why were you leaving? I wanted to see my mom and dad for a home visit. Who was working? I believe it was [staff #9]. Did he know you left? No, he didn't. How long were you gone? I don't know. How far did you go? I just walked around a bit. I came back though. What could we have done to help? I just want to visit my family."</p> <p>There was no documentation the facility reviewed documentation of bed checks being conducted to see when staff #9 last checked on client B. There was no documentation the facility identified in the investigation staff #9's failure to immediately report the incident to the administrator. There was no documentation the facility identified the incident as possible neglect.</p>			

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	<p>On 10/28/15 at 12:26 PM, the Director of Support Services (DOSS) indicated BDDS reports should be submitted within 24 hours.</p> <p>On 10/27/15 at 3:26 PM, the Chief Services Officer (CSO) indicated BDDS reports should be submitted within 24 hours. On 10/27/15 at 2:50 PM, the CSO indicated client B went to bed and attempted to go out a window. The CSO indicated client B went into an empty bedroom and went out the window but did not evade staff supervision. The CSO indicated client B was not out of staff's supervision.</p> <p>On 10/27/15 at 4:12 PM, the DRS indicated client B went out of a spare bedroom window. The DRS indicated staff #9 became aware of client B's elopement when client B knocked on the door to the group home. The DRS indicated staff #9 did not know how long client B was outside. The DRS indicated he was at the home on 10/7/15 and spoke to client B. Client B told the DRS he went out of the spare bedroom window. Client B indicated he walked to the street and then came back to the house. The DRS indicated client B's bedroom had door and window alarms installed and the spare bedroom was now locked. The</p>			

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	<p>DRS indicated client B had a history of elopement but not while living at the group home. On 10/29/15 at 10:43 AM, the DRS indicated the facility should submit BDDS reports within 24 hours. The DRS indicated the staff failed to immediately report the incident to the administrator. The DRS indicated the staff reported to the on-coming staff and to the administrator around 8:00 AM. The DRS indicated there was no additional investigation conducted besides the Immediate Investigation. The DRS stated the incident "could have" been looked at as neglect. The DRS indicated the incident was not looked at as possible neglect. The DRS indicated staff #9 reported he was watching television at the time of the incident. The DRS indicated the investigation "could have been more clear."</p> <p>3) On 10/4/15 at 1:56 PM, client C entered client B's bedroom. Client C spit on client B and sat on the bed threatening to punch client B. Client C took client B's hat and threw it into client B's face. On 10/4/15 at 3:40 PM, the Unusual Incident Report indicated, "[Client C] came into hallway (and) went after his housemate - [client B], who was standing with staff, staff tried to block [client B] from [client C]; but [client C] hit staff in the arm and then hit [client B] with his</p>			

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	<p>fist in the chest. [Client B] reports no pain and does not have bruising at this time...."</p> <p>The two incidents were combined into one investigation, dated 10/9/15. The investigation indicated there was willful intent to cause harm. The Recommendations of the investigation indicated, "Emergency psychiatric care has been recommended. [Client C] was removed from the house temporarily following continued aggression. IDT meeting has developed a plan to address his on-going issues."</p> <p>On 10/27/15 at 3:26 PM, the CSO indicated client to client aggression was considered abuse if the incidents were on-going, the facility knew there was a target for the aggression and the facility did not take steps to prevent abuse. The CSO indicated the facility had a policy prohibiting abuse of the clients. The CSO indicated the facility should prevent abuse of the clients.</p> <p>On 10/28/15 at 12:26 PM, the Director of Support Services (DOSS) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The DOSS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p>				

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	<p>4) On 9/30/15 "around" 6:30 AM, clients A, B and C were waiting for their bus. Client C was verbally aggressive and upset due to not wanting to ride the bus. Client C wanted staff to take and print pictures. Staff prompted him it was not time for pictures and he needed to go to school. Client C left the kitchen area and went toward his bedroom with staff following him. Client C returned to the area where clients A and B were located and swung his backpack at client A. Client A lifted his arm to block the bag and was hit on the forearm. Client A was upset by getting hit. Client A did not have any marks or bruises and left for school. Client C then stepped over to hit client B with his backpack. Client B was hit on the shoulder. Staff stepped in between clients B and C. Client B was upset but not injured. Client B left for school on the bus. Client C was transported to school by staff after he calmed down once his peers left for school.</p> <p>The Investigation Summary for Peer to Peer incidents, dated 10/6/15, indicated there was willful intent to cause harm. The investigation indicated the staffing pattern was not adequate per the clients' plans. The investigation indicated, "Second staff overslept resulting in less</p>			

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	<p>than optimal staffing. Continue to follow BSP and consult with psychiatrist about recent aggression. Review schedule to assure staffing. Counseling memo (memorandum) to absent staff." The Investigation Summary indicated the staffing ratio at the time of the incident was 1 staff to 4 clients.</p> <p>The facility failed to provide sufficient staff to manage and implement the clients' program plans to prevent client to client abuse.</p> <p>On 10/27/15 at 3:26 PM, the CSO indicated client to client aggression was considered abuse if the incidents were on-going, the facility knew there was a target for the aggression and the facility did not take steps to prevent abuse. The CSO indicated the facility had a policy prohibiting abuse of the clients. The CSO indicated the facility should prevent abuse of the clients.</p> <p>On 10/28/15 at 12:26 PM, the Director of Support Services (DOSS) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The DOSS indicated the facility had a policy and procedure prohibiting abuse of the clients. On 10/29/15 at 10:54 AM, the DOSS indicated the staffing level at the home</p>			

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	<p>during awake hours was 2 staff to 4 clients.</p> <p>On 10/29/15 at 10:43 AM, the DRS indicated one staff was sufficient, at times, but not during the this incident.</p> <p>On 10/27/15 at 2:54 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</p>			

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	<p>violations of rights," indicated the 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... 16. The report shall consist of: e. The person responsible for monitoring will ensure: the actions are completed within the time</p>			

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W 0153 Bldg. 00	<p>frame, all concerns/issues reported or discovered have been addressed, and documentation is forwarded to the employee personnel file and investigation file...."</p> <p>This deficiency was cited on 9/21/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00179719.</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 2 of 9 incident/investigative reports reviewed affecting clients A and B, the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law and ensure staff immediately reported client B's elopement to the administrator.</p> <p>Findings include:</p>	W 0153	To correct the deficient practice and ensure it does not continue, staff will be trained on a regular, ongoing basis on ANE topics during regular staff meetings (no less than monthly). Staff will also be re-trained on the requirement to report all allegations immediately, and the requirement that all BDDS reports are to be filed within 24 hours of learning of the incident. To provide ongoing monitoring, the Director of Support Services will monitor all	11/29/2015

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	<p>On 10/27/15 at 1:39 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 10/6/15 at 10:00 PM (reported to BDDS on 10/9/15 for clients A and B), client A told staff that last week (unknown date) client B came into client A's bedroom naked. Client A indicated client B pulled down client A's pants and touched his penis. Client A indicated in the BDDS report they "rubbed their penises together." At that point, client A said, "no, get out of my room" and client B left client A's bedroom. The BDDS report indicated, "LifeDesigns is seeking HRC (Human Rights Committee) approval for a bell on [client B's] door to use at night to alert staff to him exiting his room. Safety measures of random observations by administrative staff are already in place per a POC (Plan of Correction). Routine bed checks at night will continue to be done. Additionally, an IDT (interdisciplinary team meeting) will convene to discuss the incident and determine what if any further action is needed...."</p> <p>The facility failed to submit the BDDS report within 24 hours.</p>		<p>BDDS incident reports to ensure BDDS reports are filed within 24 hours, and that investigation policies and procedures are implemented as written. To provide ongoing monitoring, if a BDDS report is not filed within the 24-hour timeframe, the Director of Support Services will follow up with the supervisor responsible for the late report.</p>	

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	<p>On 10/28/15 at 12:26 PM, the Director of Support Services (DOSS) indicated BDDS reports should be submitted within 24 hours. The DOSS indicated when she initiated the investigation, she realized the incident had not been reported to BDDS and informed the Director of Residential Services (DRS).</p> <p>On 10/27/15 at 3:26 PM, the Chief Services Officer (CSO) indicated BDDS reports should be submitted within 24 hours.</p> <p>On 10/29/15 at 10:43 AM, the Director of Residential Services (DRS) indicated the facility should submit BDDS reports within 24 hours.</p> <p>2) On 10/6/15 at 5:00 AM according to the Unusual Incident Report dated 10/6/15, "During the overnight, [client B] snuck into the spare room and climbed out of (sic) window. He walked down the street and then decided to come back. When staff asked [client B] why he left, he responded by saying, 'I wanted to go home and I am tired of waiting for my parents to pick me up.' Morning staff then calmed [client B] down and he went back to his room. Staff then notified NDQ (Network Director/Qualified Intellectual Disabilities Professional) of the incident."</p>			

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W 0154	<p>The BDDS report, submitted to BDDS on 10/9/15, indicated, in part, "IDT will convene to discuss the incident and determine a plan of correction. Staff will continue to follow [client B's] BSP (Behavior Support Plan) as written. The incident will be investigated by LifeDesigns (sic) staff and findings forwarded to all relevant parties."</p> <p>The facility failed to submit the incident report to BDDS within 24 hours.</p> <p>On 10/28/15 at 12:26 PM, the Director of Support Services (DOSS) indicated BDDS reports should be submitted within 24 hours.</p> <p>On 10/27/15 at 3:26 PM, the Chief Services Officer (CSO) indicated BDDS reports should be submitted within 24 hours.</p> <p>On 10/29/15 at 10:43 AM, the DRS indicated the facility should submit BDDS reports within 24 hours.</p> <p>9-3-1(b)(5) 9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>				

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Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 9 incident/investigative reports reviewed affecting clients A and B, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>On 10/27/15 at 1:39 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 10/6/15 at 10:00 PM, client A told staff that last week (unknown date) client B came into client A's bedroom naked. Client A indicated client B pulled down client A's pants and touched his penis. Client A indicated in the BDDS report they "rubbed their penises together." At that point, client A said, "no, get out of my room" and client B left client A's bedroom. The BDDS report indicated, "LifeDesigns is seeking HRC (Human Rights Committee) approval for a bell on [client B's] door to use at night to alert staff to him exiting his room. Safety measures of random observations by administrative staff are already in place per a POC (Plan of Correction). Routine bed checks at night will continue to be</p>	W 0154	To correct the deficient practice and ensure it does not continue, staff will be trained on a regular, ongoing basis on ANE topics during regular staff meetings (no less than monthly). All supervisory staff responsible for either completing investigations, or implementing investigation recommendations, will be trained on investigation processes and procedures. The Services Leadership Team will review, and revise, if necessary, the agency investigation policy to ensure it provides guidance to what types of incidents may constitute alleged neglect, including elopement. Supervisory staff will be re-trained on examples of alleged neglect incident. To provide ongoing monitoring, the Director of Support Services will monitor all investigations to ensure that policies and procedures are implemented as written. 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.	11/29/2015

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	<p>done. Additionally, an IDT (interdisciplinary team meeting) will convene to discuss the incident and determine what if any further action is needed...."</p> <p>The Investigation Summary for Peer to Peer Incidents, dated 10/13/15, indicated, in part, "Writer spoke with [client A] regarding the incident, and he said he could not remember exactly when it happened, but it was when his housemate [client C] was visiting home (which would have been Sept. 25-27). Writer asked [client A] why he didn't push [client B] away, and [client A] said he thought if he pushed him away he would be arrested by the police. [Client A] said [client B] did stop and leave his room when [client A] asked him to. [Client A] said he did not know why he did not tell staff sooner. When asked about the incident, [client B] said he did go into [client A's] room but he could not remember the night. He said he took off his clothes because he wanted to cuddle. [Client B] said [client A] took off his clothes too and they were kissing. [Client B] said [client A] did ask him to leave, and so he did. [Client B] was very apologetic about the incident, and said he would never go into a housemate's room at night again...." The investigation indicated, "Based on information</p>			

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	<p>available, this writer cannot confirm that the incident was not consensual. [Clients B and A] are adolescent boys with minimal opportunity to experience intimacy. [Client A] exhibits a number of attention seeking behaviors, which have increased in the last couple of weeks, likely due to an increase in negative behaviors from another housemate, requiring extra attention from staff and others. He may have chosen to tell staff about the incident as a way to refocus attention on himself. [Clients B and A] do appear comfortable around each other." The investigation indicated in the section "Was the incident reported timely? (BDDS and Administrator)." The "no" checkbox was selected.</p> <p>The facility failed to ensure the investigation included documentation of a review of client A and B's sleep records.</p> <p>On 10/29/15 at 10:54 AM, the DOSS indicated she reviewed the clients' sleep logs but did not know the exact date she was looking for since the clients and staff did not know when the incident occurred.</p> <p>2) On 10/6/15 at 5:00 AM according to the Unusual Incident Report dated 10/6/15, "During the overnight, [client B] snuck into the spare room and climbed</p>			

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	<p>out of (sic) window. He walked down the street and then decided to come back. When staff asked [client B] why he left, he responded by saying, 'I wanted to go home and I am tired of waiting for my parents to pick me up.' Morning staff then calmed [client B] down and he went back to his room. Staff then notified NDQ (Network Director/Qualified Intellectual Disabilities Professional) of the incident."</p> <p>The Immediate Investigation, dated 10/6/15, indicated the incident occurred "around" 5:00 AM. The Immediate Investigation indicated the administrator was notified of the incident on 10/6/15 "around" 8:00 AM. The investigation indicated "...[Client B] admitted to leaving through the spare (room) window."</p> <p>The BDDS report, submitted to BDDS on 10/9/15, indicated, in part, "IDT will convene to discuss the incident and determine a plan of correction. Staff will continue to follow [client B's] BSP (Behavior Support Plan) as written. The incident will be investigated by LifeDesigns (sic) staff and findings forwarded to all relevant parties."</p> <p>The interview with staff #9 who was working at the time of the incident</p>			

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	<p>indicated, "What went on with [client B] the night he eloped? I just remember hearing a tapping on the door. The sirens were all on but he was outside. Did you hear him go out the window? No I didn't. I didn't hear anything. I was watching TV in the living room. I don't even remember what time it was. Early in the night or closer to morning? Closer to morning... I can't recall the exact time. I opened the door and I didn't know who could be at the door. I looked to (sic) the window and it was [client B]. I asked him what he was doing and he said he missed his family and he wanted to see his family. It was a little chilly and he didn't have a coat so I wanted him to get inside. All the alarms were on? Yeah I'm pretty spetic (sic) about that. Did he say how he got out? He just said he missed his family, he wouldn't give me a direct answer...."</p> <p>The interview with client B indicated, "Did you go out your bedroom window the other night? Yeah. Was it your window or the spare bedroom? Spare one. I'm sorry. Why were you leaving? I wanted to see my mom and dad for a home visit. Who was working? I believe it was [staff #9]. Did he know you left? No, he didn't. How long were you gone? I don't know. How far did you go? I just walked around a bit. I came back though.</p>			

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	<p>What could we have done to help? I just want to visit my family."</p> <p>There was no documentation the facility reviewed documentation of bed checks being conducted to see when staff #9 last checked on client B. There was no documentation in the investigation the facility identified staff #9's failure to immediately report the incident to the administrator. There was no documentation the facility identified the incident as possible neglect. The investigation was not thorough.</p> <p>On 10/27/15 at 2:50 PM, the CSO indicated client B went to bed and attempted to go out a window. The CSO indicated client B went into an empty bedroom and went out the window but did not evade staff supervision. The CSO indicated client B was not out of staff's supervision.</p> <p>On 10/27/15 at 4:12 PM, the DRS indicated client B went out of a spare bedroom window. The DRS indicated staff #9 became aware of client B's elopement when client B knocked on the door to the group home. The DRS indicated staff #9 did not know how long client B was outside. The DRS indicated he was at the home on 10/7/15 and spoke to client B. Client B told the DRS he</p>			

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	<p>went out of the spare bedroom window. Client B indicated he walked to the street and then came back to the house. The DRS indicated client B's bedroom had door and window alarms installed and the spare bedroom was now locked. The DRS indicated client B had a history of elopement but not while living at the group home. On 10/29/15 at 10:43 AM, the DRS indicated the staff reported to the on-coming staff and to the administrator around 8:00 AM. The DRS indicated there was no additional investigation conducted besides the Immediate Investigation. The DRS stated the incident "could have" been looked at as neglect. The DRS indicated the incident was not looked at as possible neglect. The DRS indicated staff #9 reported he was watching television at the time of the incident. The DRS indicated the investigation "could have been more clear."</p> <p>This deficiency was cited on 9/21/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00179719.</p> <p>9-3-2(a)</p>			

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W 0186 Bldg. 00	<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 1 of 9 incident/investigative reports reviewed affecting clients A, B and C, the facility failed to ensure there was sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>On 10/27/15 at 1:39 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 9/30/15 "around" 6:30 AM, clients A, B and C were waiting for their bus. Client C was verbally aggressive and upset due to not wanting to ride the bus. Client C wanted staff to take and print pictures. Staff prompted him it was not time for pictures and he needed to go to school. Client C left the kitchen area and went toward his bedroom with staff following him. Client</p>	W 0186	<p>There were 2 staff scheduled for the morning shift on 9/30/15. When the second staff did not show for his shift, the first staff on shift did attempt to contact him. Due to the short timeframe of the shift, the first staff did not pursue contacting the emergency pager or finding a replacement for the second staff, because it was very likely the boys would already be on the school bus by the time another staff could get to the house. In order to ensure the deficient practice does not recur, staff will review all emergency procedures related to staffing to ensure they know who to contact if they are unable to make a shift, or if they are on shift and another staff does not show. 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>	11/29/2015	

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	<p>C returned to the area where clients A and B were located and swung his backpack at client A. Client A lifted his arm to block the bag and was hit on the forearm. Client A was upset by getting hit. Client A did not have any marks or bruises and left for school. Client C then stepped over to hit client B with his backpack. Client B was hit on the shoulder. Staff stepped in between clients B and C. Client B was upset but not injured. Client B left for school on the bus. Client C was transported to school by staff after he calmed down once his peers left for school.</p> <p>The Investigation Summary for Peer to Peer incidents, dated 10/6/15, indicated there was willful intent to cause harm. The investigation indicated the staffing pattern was not adequate per the clients' plans. The investigation indicated, "Second staff overslept resulting in less than optimal staffing. Continue to follow BSP and consult with psychiatrist about recent aggression. Review schedule to assure staffing. Counseling memo (memorandum) to absent staff." The Investigation Summary indicated the staffing ratio at the time of the incident was 1 staff to 4 clients.</p> <p>On 10/29/15 at 10:54 AM, the DOSS indicated the staffing level at the home</p>			

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	<p>during awake hours was 2 staff to 4 clients.</p> <p>On 10/29/15 at 10:43 AM, the DRS indicated one staff was sufficient, at times, but not during this incident.</p> <p>This deficiency was cited on 9/21/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00179719.</p> <p>9-3-3(a)</p>			