STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	110 W PIKE ST MARTINSVILLE, IN 46151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a full recertification and state licensure survey. This visit included the investigation of complaints #IN00157027 and #IN00158326. Complaint #IN00157027: Substantiated. Federal/state deficiencies related to the allegations are cited at W102, W104, W122, W149, W156, W157 and W189. Complaint #IN00158326: Substantiated. Federal/state deficiencies related to the allegations are cited at W102, W104, W122, W148, W149, W153, W154, W156, W157, W186, W189 and W460. Survey Dates: October 27, 28, 29, 30, 31, November 3 and 5, 2014 Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/13/14 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to implement its policies and procedures to prevent client to client abuse, staff to client neglect, report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, report the results of investigations to the administrator within 5 working days of the incident, conduct thorough investigations of incidents and take appropriate corrective actions to address the incidents at the group home involving abuse and neglect of the clients. The governing body failed to ensure the prompt notification of the clients' guardians of any significant incidents. The governing body failed to ensure staff received training to enable the staff to perform their duties effectively, efficiently and competently. The governing body failed to ensure client C was in need of and received active treatment services. The governing body	W000102	The Program Director was retrained on prompt notification of guardians of significant incidents on 11/24/14. The Program Director received retraining on investigation standards by the Area Director, and will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or /Quality Assurance Specialists or other designee. The Program Director was retrained on immediately notifying designated state agencies of reportable incidents in accordance with State law, on 11/24/14. The Program Director received retraining on investigation standards by the Area Director on 11/24/14. The Program Director was retrained on completing investigations and submitting findings to the Administrator within 5 working days of the date of the incident. Staff training was completed on 11/06/14 to address the staffing needs of the clients and staff location and	12/09/2014

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151	

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	failed to ensure the group home had an adequate food supply. The governing body failed to ensure there was sufficient staffing to meet the needs of the clients. Findings include: 1. Please refer to W104. For 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility's governing body failed to ensure the group home had an adequate food supply. The governing body failed to ensure there was sufficient staffing to meet the needs of the clients. The governing body failed to implement its policies and procedures to prevent client to client abuse, staff to client neglect, report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, report the results of investigations to the administrator within 5 working days of the incident, conduct thorough investigations of incidents and take appropriate corrective actions to address the incidents at the group home involving abuse and neglect of the clients. The governing body failed to ensure the prompt notification of the clients' guardians of any significant incidents. The governing body failed to ensure staff received training to enable the staff to perform their duties effectively, efficiently and competently. The		presence when clients are present. Staff in the home was re-trained on all clients current ISP, Behavior Support Plans, RMAP's, and Goals on 11/6/14, 11/10/14, and 11/20/14. Staff was retrained on the prevention of abuse, neglect, and exploitation on 11/6/14. On 11/24/14 the Program Director was retrained on notification of guardians, conducting IDT meetings and revision of client's plans as needed to ensure client safety. All reportable incidents will be sent to BDDS within the required timelines. Guardians will be contacted within 24 hours of the significant incident happening. The Area Director will review all investigations to ensure they are submitted timely and will follow up with necessary corrective action as needed at weekly PD/AD meeting. Program Director will review the bi-weekly schedule to ensure appropriate staffing levels are maintained and staffed accordingly. The Program Director will continue to monitor this completion on an ongoing basis. Program Director will conduct client IDT's meetings as needed on an ongoing basis but at least on a yearly basis. Administrative staff will complete observations to ensure implementation of client plan of care and all trainings are being implemented.	

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	governing body failed to ensure client C was in need of and received active treatment services. 2. Please refer to W122. For 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility's governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to ensure the rights of all clients to be free of abuse and neglect. The governing body failed to implement its policies and procedures prohibiting client abuse, neglect and/or mistreatment. The governing body failed to conduct thorough investigations. The governing body failed to report incidents of client abuse to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to report the results of investigations to the administrator within 5 working days of the incident. The governing body failed to take appropriate corrective actions to address the incidents at the group home involving abuse and neglect of the clients. The governing body failed to ensure the prompt notification of the clients' guardians of any significant incidents. The governing body failed to provide sufficient staffing to manage and supervise the clients in accordance with their individual program plans. The		Responsible Party: Home Manager, Program Director, Area Director, and Quality Assurance Specialist.	

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	governing body failed to ensure staff received training to enable the staff to perform their duties effectively, efficiently and competently. This federal tag relates to complaints #IN00157027 and #IN00158326. 9-3-1(a)			
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the governing body failed to implement its policies and procedures to prevent client to client abuse, staff to client neglect, report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, report the results of investigations to the administrator within 5 working days of the incident, conduct thorough investigations of incidents and take appropriate corrective actions to address the incidents at the group home involving abuse and neglect of the clients. The governing body failed to ensure the prompt notification of the clients'	W000104	The Program Director was retrained on prompt notification of guardians of significant incidents on 11/24/14. The Program Director received retraining on investigation standards by the Area Director, and will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or /Quality Assurance Specialists or other designee. The Program Director was retrained on immediately notifying designated state agencies of reportable incidents in accordance with State	12/09/2014

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	guardians of any significant incidents. The governing body failed to ensure staff received training to enable the staff to perform their duties effectively, efficiently and competently. The governing body failed to ensure client C was in need of and received active treatment services. The governing body failed to ensure the group home had an adequate food supply. The governing body failed to ensure there was sufficient staffing to meet the needs of the clients. Findings include: 1. Please refer to W148. For 2 of 3 clients in the sample with guardians (A and F), the governing body failed to ensure the prompt notification of the clients' guardians of any significant incidents. 2. Please refer to W149. For 20 of 31 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the governing body neglected to implement its policies and procedures to prevent client to client abuse, staff to client neglect, report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, report the results of investigations to the administrator within 5 working days of the incident, conduct thorough		law, on 11/24/14. The Program Director received retraining on investigation standards by the Area Director on 11/24/14. The Program Director was retrained on completing investigations and submitting findings to the Administrator within 5 working days of the date of the incident. Staff training was completed on 11/06/14 to address the staffing needs of the clients and staff location and presence when clients are present. Staff in the home was re-trained on all clients current ISP, Behavior Support Plans, RMAP's, and Goals on 11/6/14, 11/10/14, and 11/20/14. Staff was retrained on the prevention of abuse, neglect, and exploitation on 11/6/14. On 11/24/14 the Program Director was retrained on notification of guardians, conducting IDT meetings and revision of client's plans as needed to ensure client safety. All reportable incidents will be sent to BDDS within the required timelines. Guardians will be contacted within 24 hours of the significant incident happening. The Area Director will review all investigations to ensure they are submitted timely and will follow up with necessary corrective action as needed at weekly PD/AD meeting.. Program Director will review the bi-weekly schedule to ensure appropriate staffing levels are maintained and staffed accordingly.	

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	investigations of incidents and take appropriate corrective actions to address the incidents at the group home involving abuse and neglect of the clients. 3. Please refer to W153. For 4 of 31 incident/investigative reports reviewed affecting clients A, B, E, F and G, the governing body failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. 4. Please refer to W154. For 7 of 31 incident/investigative reports reviewed affecting clients A, B, D, E, F, G and H, the governing body to conduct thorough investigations. 5. Please refer to W156. For 20 of 31 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the governing body to report the results of investigations to the administrator within 5 working days of the incident. 6. Please refer to W157. For 20 of 31 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the governing body failed to implement effective corrective actions to address abuse, neglect and/or exploitation at the group home.		The Program Director will continue to monitor this completion on an ongoing basis. Program Director will conduct client IDT's meetings as needed on an ongoing basis but at least on a yearly basis. Administrative staff will complete observations to ensure implementation of client plan of care and all trainings are being implemented. Responsible Party: Home Manager, Program Director, Area Director, and Quality Assurance Specialist.	

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	7. Please refer to W186. For 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the governing body failed to provide sufficient staffing to manage and supervise the clients in accordance with their individual program plans. 8. Please refer to W189. For 2 of 4 clients in the sample (C and G) and one additional client (B), the governing body failed to ensure staff received training to enable the staff to perform their duties effectively, efficiently and competently. 9. Please refer to W198. For 1 of 4 clients in the sample (C), the governing body failed to ensure client C was in need of and received active treatment services. 10) Observations were conducted at the group home on 10/27/14 from 3:57 PM to 6:13 PM and 10/28/14 from 6:16 AM to 7:32 AM. During the observations, there was a minimal amount of food at the group home. The group home had the food for the items on the menu for 10/27/14 and 10/28/14. The cabinets in the kitchen contained a few canned goods. The refrigerator contained a partial gallon of milk and a vegetable tray. After the clients packed their lunches on 10/28/14, there was no fresh			

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	fruit left at the group home. Confidential interview #1 (CI #1) indicated two weekends ago there was no food in the group home on Friday and Saturday. CI #1 indicated the Program Director (PD) brought groceries to the group home on Sunday after the staff called the PD to report there was not enough food. Confidential interview #2 (CI #2) indicated there were numerous times the group home did not have enough food to provide the items from the menu. CI #2 indicated two weekends ago the group home did not have any food. CI #2 indicated both the PD and Home Manager (HM) were contacted with no response from either of them. CI #2 indicated the group home had to order pizza. CI #2 indicated the PD did respond and went shopping on Sunday for groceries. CI #2 indicated the issue was related to the facility not having enough staff to go shopping. CI #2 stated, "It's not that the home isn't willing to buy food just difficult to get to the store to shop due to a lack of staffing." CI #2 indicated there was not enough food to follow the menu for the clients' snacks. CI #2 indicated the main items on the menu were being purchased but not snacks and breakfast items like			

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	cereal. CI #2 indicated the clients pack bologna or lunch meat for their lunches. CI #2 indicated the lunch meat was not healthy for the clients. Client F's guardian indicated on 10/28/14 at 1:59 PM the group home did not have enough food for meals. The guardian indicated when she was there on 10/20/14 she read the menu. The clients were to have sub sandwiches but client F had a bologna sandwich instead. The guardian indicated there were times when the group home ran out of food due to not having enough staff to go to the store. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the reports of the group home running low or out of food were not accurate. The PD indicated she went there two weekends ago to take the clients to church. When she arrived, the staff reported there was not enough food. The PD indicated she went to the store to get some groceries for chicken pot pie. The PD stated the ingredients were already there, the staff needed to "think outside the box." The PD indicated staff #3 ordered pizza two Saturdays ago. The PD indicated she was there the next day and there was food in the house although the supply was low. On 10/29/14 at 2:14 PM, the Home			

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	Manager (HM) indicated staff #5 went grocery shopping every Tuesday and several times throughout the week. The HM indicated he was aware of one time when the food supply was low after client G destroyed food from the freezer. The HM indicated the food was replaced the next day. This federal tag relates to complaints #IN00157027 and #IN00158326. 9-3-1(a)			
W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all clients to be free of abuse and neglect. The facility failed to implement its policies and procedures prohibiting client abuse, neglect and/or mistreatment. The facility failed to conduct thorough investigations. The facility failed to report incidents of client abuse to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.	W000122	The Program Director was retrained on prompt notification of guardians of significant incidents on 11/24/14. The Program Director received retraining on investigation standards by the Area Director, and will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or /Quality Assurance Specialists or other designee. The Program Director	12/09/2014

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	The facility failed to report the results of investigations to the administrator within 5 working days of the incident. The facility failed to take appropriate corrective actions to address the incidents at the group home involving abuse and neglect of the clients. The facility failed to ensure the prompt notification of the clients' guardians of any significant incidents. The facility failed to provide sufficient staffing to manage and supervise the clients in accordance with their individual program plans. The facility failed to ensure staff received training to enable the staff to perform their duties effectively, efficiently and competently. Findings include: 1. Please refer to W148. For 2 of 3 clients in the sample with guardians (A and F), the facility failed to ensure the prompt notification of the clients' guardians of any significant incidents. 2. Please refer to W149. For 20 of 31 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility neglected to implement its policies and procedures to prevent client to client abuse, staff to client neglect, report incidents to the Bureau of Developmental Disabilities Services		was retrained on immediately notifying designated state agencies of reportable incidents in accordance with State law, on 11/24/14. The Program Director received retraining on investigation standards by the Area Director on 11/24/14. The Program Director was retrained on completing investigations and submitting findings to the Administrator within 5 working days of the date of the incident. Staff training was completed on 11/06/14 to address the staffing needs of the clients and staff location and presence when clients are present. Staff in the home was re-trained on all clients current ISP, Behavior Support Plans, RMAP's, and Goals on 11/6/14, 11/10/14, and 11/20/14. Staff were retrained on the prevention of abuse, neglect, and exploitation on 11/6/14. The Program Director was retrained on notification of guardians, conducting IDT meetings and revision of client's plans as needed to ensure client safety. All reportable incidents will be sent to BDDS within the required timelines. Guardians will be contacted within 24 hours of the significant incident happening. The Area Director will review all investigations to ensure they are submitted timely at weekly PD/AD meeting. Program Director will review the bi-weekly schedule to ensure appropriate staffing levels are maintained and staffed	

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	(BDDS) in a timely manner, report the results of investigations to the administrator within 5 working days of the incident, conduct thorough investigations of incidents and take appropriate corrective actions to address the incidents at the group home involving abuse and neglect of the clients. 3. Please refer to W153. For 4 of 31 incident/investigative reports reviewed affecting clients A, B, E, F and G, the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. 4. Please refer to W154. For 7 of 31 incident/investigative reports reviewed affecting clients A, B, D, E, F, G and H, the facility to conduct thorough investigations. 5. Please refer to W156. For 20 of 31 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility to report the results of investigations to the administrator within 5 working days of the incident. 6. Please refer to W157. For 20 of 31 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed to implement		accordingly. The Program Director will continue to monitor this completion on an ongoing basis. Program Director will conduct client IDT's meetings as needed on an ongoing basis but at least on a yearly basis. Administrative staff will complete observations to ensure implementation of all trainings. Responsible Party: Home Manager, Program Director, Area Director.	

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	effective corrective actions to address abuse, neglect and/or exploitation at the group home. 7. Please refer to W186. For 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to provide sufficient staffing to manage and supervise the clients in accordance with their individual program plans. 8. Please refer to W189. For 2 of 4 clients in the sample (C and G) and one additional client (B), the facility failed to ensure staff received training to enable the staff to perform their duties effectively, efficiently and competently. This federal tag relates to complaints #IN00157027 and #IN00158326. 9-3-2(a)			
W000126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on interview and record review for 1 of 4 clients in the sample (G) and one additional client (E), the facility failed to ensure the clients' rights by failing to	W000126	Staff in the home were re-trained on 11/06/14 on goal implementation, financial objectives, and client	12/09/2014

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	ensure the clients had the opportunity to conduct their own banking. Findings include: Confidential interview #2 (CI) indicated the clients did not get to do their own banking. CI #2 indicated when the clients went to the bank, staff drive through the drive through window. CI #2 indicated this occurred every time the clients went to the bank. The CI #2 stated, "Clients are not going in and not learning anything." A review of client G's record was conducted on 10/29/14 at 12:25 PM. Client G's 6/6/14 Individualized Support Plan (ISP) indicated, "Increase financial skills through a formal goal: Weekly, [client G] will withdraw money from his bank account." A review of client E's ISP was conducted on 10/30/14 at 10:36 AM. Client E's 3/14/14 ISP indicated, "Increase financial skills and independence through a formal goal: Bimonthly, [client E] will deposit 35% of his paycheck at minimum into his personal savings account." On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated since he had worked at the group home banking		banking process. IDT meetings have been held to discuss client's use of a bank card to access their funds and guardians will be contacted for approval. Observations will be completed to ensure implementation of client plans. Administrative staff will continue to monitor this completion on an ongoing basis. Responsible Party: Home Manager, Program Director, and Area Director.	

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	consisted of the clients being driven through the drive through window. The HM indicated this was the way the facility conducted banking when he started and he did not change how banking was being conducted. The HM stated the clients were "not learning anything." 9-3-2(a)			
W000148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Based on record review and interview for 2 of 3 clients in the sample with guardians (A and F), the facility failed to ensure the prompt notification of the clients' guardians of any significant incidents. Findings include: A review of the facility's incident/investigative reports was conducted on 10/27/14 at 1:28 PM and indicated the following:	W000148	The Program Director was retrained on prompt notification of guardians of significant incidents on 11/24/14. Guardians will be contacted within 24 hours of the significant incident happening. Responsible Party: Program Director, Area Director.	12/09/2014

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	1) On 10/15/14 at 7:30 AM (reported to BDDS on 10/20/14), client F refused to take his lunch box with him to the day program. Client B offered to put the lunch box in the front seat of the van. Staff took the lunch box and put it in between the front seats of the van. Client F was sitting in the front passenger seat of the van. Client F threw his lunch box into the back of the van hitting client B. Client B threw the lunch box back hitting client F in the head. Client B reached up and struck client F on the side of the head multiple times before staff could separate the two. The BDDS report indicated client F's guardian was notified on the incident on 10/20/14. On 10/28/14 at 1:59 PM, client F's guardian indicated her brother was hurt a few weeks ago. She indicated she stopped by the group home to visit him and noticed he had red and yellow bruising on the right side of his face. The guardian indicated she had not been informed of an incident prior to arriving at the home on 10/20/14. The guardian indicated she contacted the Home Manager (HM). The guardian indicated the HM told her client F was not hit during the incident. The guardian indicated she informed the HM she read a report indicating client F was hit by			

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	another client multiple times. The guardian indicated client F did not receive medical treatment and she would have wanted him checked out due to his age. The guardian stated, "I want to know when something happens." The guardian indicated she wanted more communication from the group home. The guardian indicated in order for her to find out what's going on at the group home she had to go to the group home. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the staff inaccurately reported the incident initially. The HM indicated the staff reported client F refused to carry his lunch box, threw his lunch box at client B, and client B threw the lunch box back at client F. The HM indicated he was not informed of client B hitting client F multiple times. The HM indicated from the report he received there was no reason for him to believe there was an incident of client to client abuse. The HM indicated on 10/20/14 when client F's guardian notified him of the incident, he reviewed the notes and retrained staff on documentation. The HM indicated he did not observe the bruising on client F prior to the guardian observing the injuries due to the HM not being in the home from 10/15/14 to 10/20/14. The HM indicated the guardian should have			

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	been notified within 24 hours of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the PD and the HM were not given all the information regarding the incident from the staff. The PD indicated from the information they received, a lunch box was thrown. There was no information relayed regarding client to client abuse. The PD indicated after speaking with client F's guardian on 10/20/14, it was reported client F was hit on the head by client B. The PD indicated she observed client F on 10/20/14 and did not observe the bruising. The PD indicated the Area Director also assessed client F and did not observe bruising. The PD indicated the guardian should have been notified within 24 hours of the incident. 2) On 8/30/14 at 6:58 PM (reported to BDDS on 9/1/14), client E punched client A in the face. Client A's glasses were broken. There was no documentation of an investigation. On 10/29/14 at 10:42 AM, client A's guardian indicated notification regarding the incident was not received. Client A's guardian indicated she and her husband wanted to be notified as soon as possible regarding incidents at the group home.			

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	3) On 3/30/14 at 7:45 PM, client A was upset due to a housemate's behavior. The BDDS report indicated, "He finally snapped when [client G] started having a behavior over the TV and tried to run up (sic) steps. Staff blocked him and when they turned around [client A] was standing there and punched [client G] twice once on the right eye and one time on the lip... [Client G] (sic) eye was a little swollen but is acting normal." The investigation, dated 4/3/14, indicated, "[Client G] was trying to get upstairs in the home and staff was trying to redirect him to another activity. [Client A] walked up on the situation and became upset and hit [client G] twice before staff could separate the two clients." On 10/29/14 at 10:42 AM, client A's guardian indicated notification regarding the incident was not received. Client A's guardian indicated she and her husband wanted to be notified as soon as possible regarding incidents at the group home. 4) On 1/8/14 at 6:30 PM, clients A and E hit each other. Client A's glasses were broken during the incident. Client A sustained a small bruise on his forehead.			

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	On 10/29/14 at 10:42 AM, client A's guardian indicated notification regarding the incident was not received. Client A's guardian indicated she and her husband wanted to be notified as soon as possible regarding incidents at the group home. 5) On 11/24/13 at 12:40 PM, client G urinated on his blankets. Client G attempted to get his soiled blankets. Staff redirected client G. Client G attempted to hit staff. Client A punched client G in the side of the head and face on the left side. Client G was not injured. On 10/29/14 at 10:42 AM, client A's guardian indicated notification regarding the incident was not received. Client A's guardian indicated she and her husband wanted to be notified as soon as possible regarding incidents at the group home. Client A's guardian stated she "never gets a call back" when she contacted the Area Director (AD). The guardian indicated the AD did not respond to her messages 50% of the time. She indicated she emailed the AD with no response to her emails. The guardian indicated, at times, she would be told something would be checked into and the staff would call her back. The guardian indicated the staff did not call her back. The guardian indicated client A went through 4 pairs of glasses this past year. The facility did not			

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	notify her of the incidents. The guardian stated, "Get a call once or twice a year." The guardian indicated she and her husband were not receiving notifications of the incidents at the group home. Client A's guardian stated "once in a while we are contacted for a meeting." The guardian stated, "we would like to be informed of what's going on." The guardian indicated she was not being contacted when medications were changed (indicated she was contacted about 3 weeks after the change). The guardian indicated she requested diabetes testing due to a history of diabetes in client A's family. The guardian indicated she was not informed if the testing was completed. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the clients' guardians should be notified of the things they want to be notified of. The HM indicated the guardians should be contacted regarding any incident occurring at the group home. The HM indicated the guardians should be contacted within 24 hours. The HM indicated he had on-going issues with contacting some of the clients' guardians. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated it was ultimately her responsibility to notify the clients'			

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	guardians of the things the guardians wanted to know about. The PD indicated the clients' guardians should be notified within 24 hours of an incident. The PD stated client A's guardians were "hard to communicate with." The PD indicated the guardians should receive financial documentation if requested. This federal tag relates to complaint #IN00158326. 9-3-2(a)			
W000149	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 20 of 31 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility neglected to implement its policies and procedures to prevent client to client abuse, staff to client neglect, report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, report the results of investigations to the administrator within 5 working days of the incident, conduct thorough investigations of incidents and take	W000149	The Program Director received retraining on investigation standards by the Area Director on 11/24/14. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or /Quality Assurance Specialists or other designee. The Area Director will review all investigations to ensure they are	12/09/2014

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	appropriate corrective actions to address the incidents at the group home involving abuse and neglect of the clients. Findings include: A review of the facility's incident/investigative reports was conducted on 10/27/14 at 1:28 PM and indicated the following: 1) On 10/15/14 at 7:30 AM (reported to BDDS on 10/20/14), client F refused to take his lunch box with him to the day program. Client B offered to put the lunch box in the front seat of the van. Staff took the lunch box and put it in between the front seats of the van. Client F was sitting in the front passenger seat of the van. Client F threw his lunch box into the back of the van hitting client B. Client B threw the lunch box back hitting client F in the head. Client B reached up and struck client F on the side of the head multiple times before staff could separate the two. The BPR (Behavior Progress Record) - Narrative Notes, dated 10/15/14, indicated, in part, "Incident(s): Physical assault... [Client F] left his lunch box in walkway so another client tried giving the client his lunchbox. [Client F] refused to take it which made other client		submitted timely and will follow up with necessary corrective action as needed.. Responsible Party: Home Manager, Program Director, Area Director	

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	upset so he threw (sic) lunch box at [client F]. [Client F] then hit client and threw lunch box back at client. Client then begin (sic) hitting [client F] in the face multiple times, and calling him an 'old f------ hag.'" The Investigation Summary, dated 10/22/14, indicated, "[Client B] reported that [client F] was grumpy the morning of the incident and [client B] stated he felt like [client F] was 'giving staff a hard time.' [Client B] reported that [client F] didn't want to carry his lunch box out to the van. [Client B] reported he carried [client F's] lunch box for him. [Client B] stated that when he got out to the van he gave staff [client F's] lunch box and they put it in between the two front seat of the van. [Client B] reported that he got in the van and [client F] threw his lunch box at him and 'I got pissed and threw it back.' [Client B] reported he was upset and hit [client F] in the head but couldn't report how many times he hit (him). [Client B] reported that [staff #10 and staff #2] told him to get off [client F] and he did. [Client B] reported he went to day program after that... [Staff #2] reported that [client F] refused to carry his lunch box out to the van. [Staff #2] reported that [client B] carried the lunch box and gave it to her and she put it in between the front seats of the van. [Staff			

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	#2] reported that [staff #10] was sitting in the back seat of the van. [Staff #2] reported that [client F] grabbed his lunch box and threw it into the back seat. [Staff #2] reported that [client B] became upset and yelled a profane name at [client F] and then threw the lunch box back up front. [Staff #2] reported she was verbally redirecting both clients. [Staff #2] reported that the next thing she knew [client B] was hitting [client F] in the side of the head and she was separating the two clients. [Staff #2] reported that the two clients separated and there was no further incident." The Recommendations section indicated, "New seating chart for van to keep [clients F and B] separated. Lunch boxes will be kept in the rear of the van." There was no documentation in the BDDS reports, investigation and BPR Narrative Notes indicating client F sustained bruising on the right side of his face from his forehead to his ear. The Investigation Summary did not include documentation indicating when the results of the investigation were reported to the administrator. The BDDS reports, investigation and BPR Narrative Notes did not address the late guardian notification of the incident. The BDDS reports, investigation and BPR Narrative Notes did not address the initial report to			

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	the Home Manager regarding the incident did not include information of client B hitting client F multiple times causing injuries. On 10/28/14 at 1:59 PM, client F's guardian indicated her brother was hurt a few weeks ago. She indicated she stopped by the group home to visit him and noticed he had red and yellow bruising on the right side of his face. The guardian indicated she had not been informed of an incident prior to arriving at the home on 10/20/14. The guardian indicated she contacted the Home Manager (HM). The guardian indicated the HM told her client F was not hit during the incident. The guardian indicated she informed the HM she read a report indicating client F was hit by another client multiple times. The guardian indicated client F did not receive medical treatment and she would have wanted him checked out due to his age. The guardian stated, "I want to know when something happens." On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the staff inaccurately reported the incident initially. The HM indicated the staff reported client F refused to carry his lunch box, threw his lunch box at client B, and client B threw the lunch box back			

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	at client F. The HM indicated he was not informed of client B hitting client F multiple times. The HM indicated from the report he received there was no reason for him to believe there was an incident of client to client abuse. The HM indicated on 10/20/14 when client F's guardian notified him of the incident, he reviewed the notes and retrained staff on documentation. The HM indicated he did not observe the bruising on client F prior to the guardian observing the injuries due to the HM not being in the home from 10/15/14 to 10/20/14. The HM indicated the guardian should have been notified within 24 hours of the incident. The HM indicated client to client aggression was considered abuse. The HM indicated the facility should prevent abuse. The HM indicated the facility had a policy and procedure prohibiting abuse. The HM indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the PD and the HM were not given all the information regarding the incident from the staff. The PD indicated from the information they received, a lunch box was thrown. There was no information relayed regarding client to client abuse. The PD indicated after speaking with client F's guardian on			

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	10/20/14, it was reported client F was hit on the head by client B. The PD indicated she observed client F on 10/20/14 and did not observe the bruising. The PD indicated the Area Director also assessed client F and did not observe bruising. The PD indicated the guardian should have been notified within 24 hours of the incident. The PD indicated client to client aggression was considered abuse. The PD indicated the facility should prevent abuse. The PD indicated the facility had a policy and procedure prohibiting abuse. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours. The PD indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 2) This incident report was received by email on 10/30/14 at 3:53 PM. The facility was asked to provide the incident report and investigation regarding this incident on 10/30/14 at 3:38 PM. The email to the Area Director indicated, "You indicated there was an incident in which the mayor showed up to the house. In the reports I received, there was no such incident. Please forward the documentation regarding the incident to me. Thank you." The facility did not provide documentation of an investigation.			

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	15G300	A. BUILDING 00 B. WING	11/05/2014

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	On 10/7/14 at 6:55 PM, the BDDS report, dated 10/8/14, indicated, "On 10/7 at approximately 6:45 pm the tornado sirens sounded in [name of city]. Clients and staff, [staff #5 and #7] followed the tornado protocol and all clients and staff went into the basement of the group home. While in the basement [client G] started obsessing over the freezer and started swinging at staff. Staff used agency approved PIA (Physical Intervention Alternatives) blocking techniques to block [client G]. [Client G] then started charging at staff and staff [#5] used agency approved PIA blocking and one arm restraint. [Staff #7] called Program Director [name] for approval of PRN (as needed) Ativan 2mg (milligrams) at approximately 6:55 pm. [Client G] continued to swing at staff and other clients in the basement. [Client B] became upset at this point and targeted [client G]. [Staff #5] had [client G] in a hold and [client B] charged at [client G] and grabbed [client G's] neck. [Staff #5] verbally redirected [client B] to release [client G's] neck and to remove himself from around [client G]. [Staff #5] released [client G] from the hold to physically get in between the two clients and then [client B] released [client G's] neck and then punched [client G] in the face two times while staff was trying to			

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	keep them separated. [Client G] then started charging at staff again and agency approved two arm hold was implemented at this time. [Client E] told [client B], 'That was f------ uncalled for you didn't need to choke him.' [Client B] responded and said, "Shut the f--- up fa----' and charged at [client E]. [Client B] swung and made contact with [client E] and staff, [staff #7] attempted to get in between the two clients. [Client B] bit [client E] on the back and [client E] punched [client B] in the eye causing laceration to his eye. [Client G] had been released from his hold at this point. Police were called to assist as staff [#7 and #5] were unable to get the two clients separated. Staff finally got the two separated after about 30 seconds. Program Director [name] was contacted at this point to let her know the police were called. [Staff #2] was called to the home to assist as well as Home Manager [name] and [staff #4]. [Client G] ran upstairs and [staff #5] ran after him. Police were at the door when [client G] got upstairs. [Client G] ran back down stairs and [staff #7] was still down stairs. Police stopped [staff #5] from going down stairs to ask him questions. Two officers followed [client G] down stairs and [client G] targeted the			

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	two police officers so they handcuffed [client G] and brought him back upstairs. They had [client G] sit in the chair in handcuffs while [staff #5] explained what was going on to the police. [Staff #2] arrived at the home. While [staff #5] was trying to explain why the police were called [client G] continued to get up and resist the police. [Staff #5] and [staff #2] explained to the police that they were able to care for [client G] and had a behavior plan to follow as well as agency approved physical interventions and that [clients E and B] needed the medical attention. Police were getting ready to leave at this point. [Client G] started swinging at staff and biting at staff. [Staff #5] put [client G] in a two arms hold and (client G) bit [staff #5] on the arm and wiggled out of the hold and bit [staff #5] on the leg. [Staff #2] attempted to assist [staff #5] with taking over the hold and the police then took over and got [client G] in the chair in the living room and held him. [Client G] continued to resist the police. [Staff #2] explained to the police that they could leave and that staff could take care of [client G] that [clients E and B] just needed to be checked out. EMT's (emergency medical technicians) explained that they both [clients E and B] needed to go to the emergency room. [Staff #7] took [client E] to the emergency room and [Home			

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	Manager] took [client B] to the emergency room. The police were leaving and (they were) out on the porch. [Client G] got back up and started swinging and biting at staff again. [Staff #2] and [staff #5] put [client G] in a hold once again and the police came back into the home as they must have seen from the living room windows that staff were restraining [client G] again. Police came back into the home and told [staff #2] to get off [client G] and two police officers assisted [staff #5] with the hold and then told [staff #5] to get off [client G] that they would take over. One of the officers told staff, 'This is ridiculous, we can't babysit and this guy shouldn't be living here. We are going to call the big boss.' [Staff #5] asked, 'Who is that?' and one of the police responded, 'The Mayor.' Police informed staff that [client G] would either have to go to the hospital or that they were taking him to jail. [Staff #2] called PD (Program Director) to report what the police said about either taking him to jail or to the hospital. PD told [staff #2] to tell the police that he could not go to jail that the hospital was the only option. PD called [Area Director] to inform him of the situation and that she would keep him up to date about what was going on. [Client G] continued to			

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	resist the police, and police were not allowing staff to assist at this point. The Mayor showed up at the home and came into the home. He told staff that this has happened multiple times that [client G] had gotten into the [name of bar] before, [name of gas station] and that by what he could see going on that the group home was not a good enough facility for him that he needed to be at a different facility to be placed in and that he was going to see to it that he would not be coming back to the group home in [name of city]. [Staff #5] reported that the Mayor stated that 'we would do whatever it took to get him out of this community and it should have happened years ago and enough is enough.' [Client G] continued to target police and they got him in a hold on the ground. Program Director [name] arrived at the group (sic) at that point. [Client G] was on the ground and police were physically restraining him at this point. Police then got him up off the ground about 30 seconds after PD arrived at the home and assisted him with getting in the chair. The mayor asked [PD] to speak to a supervisor, PD told him that she was the supervisor and he told her that he wanted to talk to her boss. PD [name] called [Area Director] and gave the phone to the Mayor at this point. [Client G] kept			

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	trying to get up out of the chair and police kept having him sit back down. [Client G] then got up and moved towards the couch. Police started to hold him and [staff #2] stated he is trying to get to the couch. Police allowed him to move to the couch and [staff #2] got him a pillow and blanket. Program Director [name] gave approval to [staff #2] to give a second PRN medication. Ativan 2mg was given. The Mayor then came back in and told police to call [name] transport that he was being transported to [name of hospital]. [Staff #2] rode in the ambulance with [client G] and PD [name] followed in personal vehicle. [Client G] was taken to [name of hospital] per police and [name of city] Mayor request. [Staff #16] contacted Program Director as she was taking another client home and saw the police at the group home and asked if she needed to go back once she dropped off the client she was working with. PD [name] told [staff #16] to go back and assist [staff #4] with other clients. [Program Director] contacted Program Nurse [name] to report that [client G] was being taken to [name of hospital] and contacted [Area Director] to report as well. Program Director also contacted [client G's guardian] to report the incident. [Client E's guardian] was contacted to report the			

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	incident." On 10/27/14 at 12:54 PM, the Area Director (AD) indicated the police were not called due to client G's behavior but due to client B and E's behavior. The AD indicated the incident occurred during a tornado warning. The AD stated client G was "cycling" and this was the time of year his behaviors increased. The AD indicated the mayor of the city wanted client G moved out of the group home due to being a danger to the community. The AD indicated client G was not going to move. Client G was admitted to the hospital following the incident due to being given two options: jail or the hospital. Client G was discharged from the hospital and returned to the group home. The AD indicated the facility ordered client G a weighted blanket to assist with calming him. The AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The AD indicated client to client abuse should be investigated. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the			

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	clients. The PD indicated the facility had a policy and procedure prohibiting abuse. The PD indicated incidents of client to client abuse should be investigated. On 10/31/14 at 12:01 PM, the PD indicated an investigation was conducted and the facility should have given the surveyor the investigation to review. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The HM indicated incidents of client to client abuse should be investigated. 3) On 9/23/14 at 12:45 AM, client G went into the basement of the home, took a television out into the back yard and destroyed it. The BDDS report, dated 9/24/14, indicated, "[Former staff #11] then reported that he was on the porch smoking a cigarette to calm down after the incident and when he went back inside [client G] was gone. [Staff #11] then reported he started making phone calls and got ahold (sic) of [staff #6] and [staff #5] for assistance. Police arrived at the home and talked to [staff #11] about what was going on and staff reported that he was able to get [client G] in the home. [Staff #11] then reported he went inside			

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	the home and [client G] was gone. [Staff #11] then reported that the police called the home to report they had found [client G] at [name of gas station] gas station on [name of street] and that an ambulance was on its way. [Staff #5 and #6] arrived at the home and notified [staff #11] that [staff #5] had notified [Home Manager] who was also on his way to the home. [Home Manager] contacted [staff #6] and instructed her to administer a PRN (as needed), Ativan 2 mg (milligrams), per PRN protocol once she got to the [name of gas station]. [Staff #6] explained to police that [client G] had a PRN medication to assist him when he was agitated. Ambulance arrived on the scene and transported [client G] to the hospital. [Home Manager], [staff #5], [staff #6] all arrived at the hospital and [client G] was released to their care. During the incident [client G] sustained numerous superficial wounds while he was at [name of gas station]. [Staff #11] was suspended pending investigation. Team met on 9/23 and team implemented double staffing during the overnights for two weeks. Team will meet again on 10/7. Nurse, [name], contacted psychiatrist, [name] to discuss the situation and the increase in [client G's] agitation. [Psychiatrist] increased Clozapine (psychotropic medication) from 350 mg daily to 400 mg daily."			

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	The investigation, dated 9/30/14, indicated, in part, "Brief summary of the incident: [Client G] eloped from the home and ran to the [name] gas station a few blocks away and committed property damage. [Staff #11] was supervising at the time of the incident and reportedly did not realize [client G] had eloped. Following the incident, [staff #11] was suspended by the Home Manager [name]... [Staff #5] stated that after [client G] was in bed, he asked [staff #11] what happened and [staff #11], 'acted scared, said he was smoking a cigarette and had headphones on listening to music and cops showed up,' then said he was watching [client G's door] to see if he got up but [client G] must have gone out through the hallway door and down the basement stairs and he didn't see him. [Staff #5] stated that all the blinds were closed when he got to the house so he didn't know how [staff #11] could see in the house except through the high glass section on one of the doors that is the only part not frosted. [Staff #5] reported that through that section you can only see the living room and not into [client G's] bedroom. [Staff #5] stated that he is tall and can't see into [client G's] room through that window. [Staff #5] stated that the alarms were working on all the doors when he was in the home after the			

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	incident. [Staff #5] stated that during his shift on 9/22/14, [client G] had behaviors but hadn't tried to elope at any time. [Staff #5] stated that [client G] was in bed when he left at 10pm...". The investigation indicated, "[Staff #6] stated that she worked in the home on 9/22/14 from 2pm until 12:15am. She stated that she was to be off work at 12am and [staff #11] was to relieve her but she was about 10-15 minutes late and she left at 12:14am or 12:15am... She stated that she went in the room and checked on him at 11:30pm and [client G] was sleeping and then checked on him again right before she left the house and he was asleep and snoring. [Staff #6] stated that no other clients were awake when she left the home and [client G's] roommate [client F] was also asleep. [Staff #6] stated that she left the home after [staff #11] arrived and went home and [staff #11] called her at 12:36am and said '[client G's] gone.' She stated that she asked him what he was talking about and if he had called anyone to report it and [staff #11] said she had tried to 'call everyone and no one would answer.' [Staff #6] stated that she immediately went to the house to help look for [client G] and got there in about 5 minutes and [staff #11] was outside the house by the driveway along the road 'pacing.' [Staff			

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	#6] stated she went into the house to look for [client G] and saw the 'mess in the basement' of all the items [client G] had destroyed, and checked around the yard and couldn't find [client G]. She stated that she found [client G's] pants outside in the backyard. She stated that she had been searching about 6-7 minutes when the police called the house and said [client G] was at [gas station]... [Staff #6] stated that while she was at the hospital, the police talked to her and told her they had received a phone call at 12:22am from a neighbor complaining about someone tearing up a TV in the backyard. They said that they arrived at the house and [staff #11] was on the front porch and they asked him what was going on and [staff #11] replied with 'nothing, at work.' They said that they told [staff #11] they had gotten a call about someone tearing up a TV in the backyard and [staff #11] ran into the house and looked everywhere for [client G] then came back to them and said 'he's gone, can you help?' and they left the house to start looking for [client G]. [Staff #6] stated that the police told her [staff #11] was on the front porch smoking... [Staff #6] stated that when [staff #11] arrived at the house that night to relieve her, he was getting his headphones out of his pocket and untangling them and plugging them into his phone. She stated that she did			

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	not see the headphones in his ears but didn't know 'how else he couldn't have heard [client G] tearing stuff up.'" The investigation indicated, "[Staff #11] stated that his shift started at 12am on 9/23/14. He stated that he arrived at the house at 12am. When asked if he was late, he stated that he wasn't. He stated that [staff #6] was leaving her shift and stayed about 5-10 minutes telling him about [client G's] behaviors he had during her shift. [Staff #11's] time sheet states that he arrived at work at 12am. [Staff #11] stated that [client G] was in bed when he arrived. He stated that [staff #6] said [client G] was asleep and he went and checked and he looked asleep to him. He stated that [client G's] roommate was getting ready for bed and didn't know if he had awakened [client G] during this time. [Staff #11] stated that he was putting some stuff away and [client G] got up and went to use the bathroom and got a drink and [staff #11] told him to go back to bed. He stated that [client G] started laughing, walked back to his bedroom and shoved [staff #11] and then ran out of the back door of the house. [Staff #11] stated that he got [client G] back into the house and into bed. He stated that [client G] just kept laughing then got back up and ran downstairs and started tearing stuff up			

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	and pulling things out of the freezer and cabinets. [Staff #11] stated that he didn't want to get hurt and didn't want [client G] to get hurt. He stated that he yelled for [client C], a housemate, to open the basement door so it would be easier to get [client G] back up the stairs to his bedroom. [Staff #11] stated that [client C] never came to the door. [Staff #11] stated that he got [client G] back into his bed and he laid down. [Staff #11] stated that he called [Home Manager] about 10 times and got no answer. [Staff #11] stated that he then went to the front porch while trying to call [Home Manager] and the police showed up and said they had a complaint of noise in the back yard. [Staff #11] stated that he thought the noise that was reported had been from earlier when he was trying to get [client G] back in (sic) house. [Staff #11] stated that he thought he had locked the basement door earlier after that incident. [Staff #11] stated that he ran in the house and searched for [client G] and couldn't find him and told the police who [client G] was and they left to go look for him. He stated that he found [client G's] clothes in the back yard... When asked about the time he was on the front porch, [staff #11] stated that he was smoking a cigarette and [client G] was in bed after the basement incident. He stated that he was trying to call [Home Manager] from			

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	his cell phone and the house phone to report the incident. [Staff #11] stated that he was watching for [client G] to get up through the window of the doors to the house and went to the side porch to make sure he didn't try to go out his bedroom window... When asked if at any time he had headphones in his ears, [staff #11] stated that he had his 'left headphone in' attached to his cell phone because he was trying to make a call on his cell phone while he used the house phone with his other ear trying to call people. He stated that he also called his girlfriend during this time because she usually brings him some dinner when she gets off work and he wanted to let her know what it wasn't 'safe' to bring him dinner that night due to [client G's] behaviors... When asked why [Home Manager] or [Program Director's] phones did not show any missed calls from him, he stated that he didn't know why they didn't. [Staff #11] stated that he also sent [Home Manager] a text message saying something like 'call me asap (as soon as possible). [Client G] having behaviors...'. When asked if he could show this interviewer the text, he stated that he recently upgraded his iPhone and it wiped out all of his calls and texts and other information and he had to take it to [name of company] to be fixed so he had no information to share."			

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	The investigation indicated in the Additional information section, "All alarms on all doors were working when the investigator was at the home on 9/30/14... The police report dated 9/28/14, stated that they received a call from a neighbor at 12:22am on 9/23/14. The officers arrived at the home (at approximately 12:30am based on the incident timeline) and asked [staff #11] what was going on and he replied 'just working.' The police report states that they told [staff #11] they had received a call about someone smashing something in the back of the residence and [staff #11] immediately ran into the residence. The police report states that the officers followed him into the home and [staff #11] then stated 'I need your guys' help, [client G] is out.' The police report states that the officers left the home and began driving around the area in an attempt to locate [client G]. The police report states that a short while later (approximately 10-15 minutes after they were at the home), dispatch advised that there was a man in the [gas station] on [name of street] that was destroying the inside of the store. The report states that when they arrived at the store, they found [client G] in a t-shirt and underwear pulling products off of shelves and throwing them and they restrained him.			

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	The report states that he was then transported to [hospital]...". The investigation's Conclusion indicated, "There is evidence to support that [staff #11] was outside the home on the front porch when [client G] eloped from the home through the basement door and that this supports an allegation of neglect. There is no evidence to support that [staff #11] made phone calls to either of his supervisors and instead contacted his coworkers." On 10/30/14 at 1:26 PM, a review of a Termination Notice, dated 10/1/14, indicated staff #11 was terminated on 10/20/14. The notice indicated, in part, "Indiana MENTOR is terminating [staff #11's] employment due to [staff #11] not following the proper supervision level of a client." On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated he was contacted by staff #5 at 1:00 AM. Staff #5 told the HM staff #5 was on the way to the house due to receiving a call from staff #6 indicating client G had eloped. The HM indicated once the Area Director (AD) was contacted, the AD made the decision to suspend staff #11 at 4:00 AM. Staff #5 was still at the house with staff #11. The HM indicated staff #11 was on			

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	the front porch during the incident unaware the incident was taking place. On 10/27/14 at 12:54 PM, the Area Director (AD) indicated staff #11 indicated he arrived to work on time but he was late. Staff #11 reported client G had an incident in the basement and the staff #11 went to smoke a cigarette. The AD indicated a neighbor contacted police due to a disturbance in the backyard. The AD indicated staff #11 indicated he had a headphone in while watching client G through a window while waiting for his girlfriend to bring him dinner. Client G eloped to a gas station. The AD indicated he thought client G went into the basement, got into the food, took the television from the basement and threw it into the neighbor's backyard and went to the gas station. The AD indicated it was his belief staff #11 was not aware of incident until the police showed up. When the police arrived, staff #11 was on the front porch. Staff #11 told the police he was working. Police indicated there was a disturbance. Staff #11 ran into the house, checked the basement and told the police client G was gone. The AD indicated he did not believe staff #11 was aware client G was gone until the police arrived. The AD indicated client G exited the house through the basement door, which had a functioning alarm.			

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	The AD indicated the facility has had two overnight staff since the incident. The AD indicated client G caused damage at the gas station. Client G ate a lot of food and then threw it up. The AD indicated staff #11 was terminated due to neglect. 4) On 9/21/14 at 4:08 PM (reported to BDDS on 9/23/14), client G was obsessing over the television and ran up the stairs to get into his roommates' bedrooms to get their electronics. Client G got a fork from the kitchen and tried to stab the TV cord, which was unplugged. Client G tried to stab staff with the fork. Client G was going up the stairs and staff #5 was attempting to block his way. Client G lost his balance and both client G and the staff fell. Client G received a rug burn on his forehead and rib area. Client G was given a PRN. Client G was prompted to take a shower and he did. Staff attempted to take him on a van ride. He refused and started obsessing over the TV again and tried to tear it off the wall. Client G went upstairs and tried to destroy a housemate's CPAP (continuous positive airway pressure) machine. Client G was blocked. Client G knocked his housemate's TV off the stand it broke. Client G also broke the cable box. Client G ran into another client's bedroom and broke his cable box. Client G was			

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	assisted downstairs. A second PRN medication was administered. The facility did not conduct an investigation into the incident to ensure the PRN medications were administered appropriately as well as to investigate how client G sustained rug burns on his forehead and rib area. On 10/31/14 at 12:01 PM, the Program Director (PD) indicated she thought the incident was investigated. The PD indicated the incident should have been investigated. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the timeframe for reporting incidents to BDDS was 24 hours. 5) On 8/31/14 at 1:00 PM, client H was upset over his housemate's behavior. Client H reported to staff he punched a hole in the wall. Staff checked client H's hand and put ice on it. Later in the day, client H's hand was discolored and he reported it was sore. Staff took client H to the emergency room. Client H's hand was broken. The investigation, dated 9/6/14,			

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	indicated, "[Client H] reported to staff that he had punched the wall because he was upset about roommates (sic) behavior. Staff did not witness [client H] punch the wall... [Client H] reported he was 'mad because [client G] was being a butt.' [Client H] reported that no one saw him punch the wall. [Client H] reported he did tell staff that he punched the wall after he got done." The investigation was not conducted within 5 working days and the results of the investigation were not reported to the administrator. On 10/27/14 at 12:54 PM, the Area Director (AD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 6) On 8/31/14 at 12:45 PM, client G was climbing on cabinets and writing on his bedroom walls. Staff administered a PRN medication. The investigation, dated 9/6/14, indicated, "Evidence supports staff intervened appropriately." The			

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	investigation was not conducted within 5 working days and the results of the investigation were not reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 7) On 8/31/14 at 12:05 PM, client G was climbing on cabinets. Staff urged him to write it down to communicate to staff. Client G was given a PRN medication. The investigation, dated 9/6/14, indicated, "Evidence supports staff intervened appropriately." The investigation was not conducted within 5 working days and the results of the investigation were not reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The PD indicated			

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	investigations should be completed within 5 working days. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The AD indicated investigations should be completed within 5 working days. 8) On 8/30/14 at 6:58 PM (reported to BDDS on 9/1/14), client E punched client A in the face. Client A's glasses were broken. There was no documentation of an investigation. On 10/27/14 at 12:54 PM, the AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The AD indicated client to client abuse should be investigated. The AD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. The PD indicated incidents of client to			

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	client abuse should be investigated. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The HM indicated incidents of client to client abuse should be investigated. The HM indicated the timeframe for reporting incidents to BDDS was 24 hours. 9) On 8/21/14 at 5:00 PM, client B was on his way to a church dinner in the van. Client B was obsessing about dessert since his doctor wanted him to go on a diet. Client B had a seizure. Staff pulled the van over while the other staff attended to client B. Staff called the Home Manager (HM) since client B had been in a seizure for 4 minutes. The HM directed the staff to call 911 since they were out of town and it would take some time for the ambulance to get there. When the ambulance arrived on scene, client B was having trouble breathing. The paramedics attempted to give him oxygen but he was combative. Another group home manager arrived to assist. She was able to get client B calmed down and into the ambulance. Client B was in			

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	the emergency room for 3 hours and an EKG (electrocardiogram) was conducted. The hospital sent client B to another hospital to receive care from a cardiologist. Client B's heart rate and blood pressure were elevated. Client B was admitted to the hospital on 8/21/14. There was no documentation an investigation was completed to ensure staff followed client B's plan and appropriate care was given. On 10/31/14 at 12:01 PM, the Program Director (PD) indicated the incident was not investigated. The PD indicated the incident should have been investigated to ensure the staff provided the appropriate care and implemented client B's risk plan for seizures as written. 10) On 8/17/14 at 12:32 PM, client G was wanting to watch television and ended up breaking the remote control. The BDDS report, dated 8/18/14, indicated, "He continued by pounding on the TV and [client A] got up and punched [client G]." The investigation, dated 8/24/14, was not completed timely. There was no documentation the investigation results were reported to the administrator. On 10/27/14 at 12:54 PM, the AD			

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	indicated investigations should be completed within 5 working days and the results of the investigation should be reported to the administrator within 5 working days. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 11) On 8/16/14 at 6:58 PM (reported to BDDS on 8/18/14), client G was obsessing over the television and ran over to the bedroom wall and kicked and hit the wall. Client G kicked out the window and crawled out of it and ran down the sidewalk. Staff #5 was able to calm client G down and returned with him to the home. Client G received a PRN (as needed) medication. The investigation, dated 8/22/14, indicated, "Evidence supports staff intervened appropriately." There was no documentation the results of the investigation were reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of			

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	the incident. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The AD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the timeframe for reporting incidents to BDDS was 24 hours. 12) On 5/12/14 at 8:30 AM, client H was charging at staff and staff was blocking him using agency-approved techniques. Client H walked up to staff and smacked staff across the face before staff could block him. Staff became upset and called 911. Police arrived and talked to client H and left. The investigation, dated 5/14/14, indicated, "[Staff #5] reported he was trying to assist client with getting ready for day program. [Staff #5] reported that '[client H] seemed to be in a bad mood and was cussing at everyone.' [Staff #5] reported that [client H] was refusing to get on the van which was causing			

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	everyone else to be late for day program. [Staff #5] reported that when [client H] slapped him he was very upset and he called the police. [Staff #5] reported that he was not going to press charges against [client H] that he was just upset at the time and that 'I shouldn't have called the police I was just mad when he slapped me across the face.' [Staff #5] reported 'I could have handled it differently.'" There was no documentation the results of the investigation were reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 13) On 4/8/14 at 8:34 PM, the BDDS report, dated 4/9/14, indicated, "HM (Home Manager) called oncall (sic) PD (Program Director) and reported that [client F] locked himself in the bathroom with [client D] and wouldn't (sic) let staff in. When they got in [client D] said [client F] touched him in his groin."			

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	The investigation, dated 4/10/14, indicated, "Door knob on bathroom door was changed to a lock that staff can unlock easy (sic) from the outside. Door chime was put on the bedroom door of [client F's] and roommates (sic) bedroom which leads to the bathroom. Door alarms speakers were placed in the kitchen and living room." There was no documentation the results of the investigation were reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 14) On 3/30/14 at 7:45 PM, client A was upset due to a housemate's behavior. The BDDS report indicated, "He finally snapped when [client G] started having a behavior over the TV and tried to run up (sic) steps. Staff blocked him and when they turned around [client A] was standing there and punched [client G] twice once on the right eye and one time on the lip... [Client G] (sic) eye was a			

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	little swollen but is acting normal." The investigation, dated 4/3/14, indicated, "[Client G] was trying to get upstairs in the home and staff was trying to redirect him to another activity. [Client A] walked up on the situation and became upset and hit [client G] twice before staff could separate the two clients." There was no documentation the investigation results were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse.			

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	On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. 15) On 3/23/14 at 5:00 PM (reported to the Home Manager on 3/25/14), client C reported staff #15 took some of the clients to the park to play basketball. While at the park, a friend of staff #15's asked client C if he "wanted to buy any pot." Client C indicated he told the person no and walked away. Staff #15 continued to spend time with the person until they left the park. Client C indicated he did not report the incident due to not wanting to get anyone into trouble. Staff #15 was suspended. The investigation, dated 4/2/14 (not completed within 5 working days), indicated client C recanted his allegation. Client C indicated the person he met at the park did not have marijuana and did not ask him to buy any. The investigation's Conclusion indicated, "There is no evidence to support that [staff #15] was interacting inappropriately around any of the clients." The investigation was not signed by the investigator. There was no documentation indicating the results of			

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	the investigation were reported the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 16) On 3/2/14 at 8:45 PM, client H and staff #14 went to pick up client D from his relative's house. As client D was putting his items into the van, client H said something (staff did not hear) to client D. The BDDS report, dated 3/3/14, indicated, "[Client D] became upset at what [client H] said and [client D] physically aggressed on [client H]. [Client H] jumped out of the van before staff could separate them." Client H had a small scratch (1/4 inch) under his left eye and basic first aid was administered. The investigation, dated 3/7/14, indicated in the conclusion section, "Evidence supports staff did not intervene appropriately." The Recommendations section indicated, "Retraining of staff that staff will get out of the van and assist			

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	[client D] with putting his things in the van to try and prevent any further incidents of this nature in the future." The investigation had conflicting information regarding the date(s) of the investigation. The section for Dates of Investigation indicated 4/9/14 and 4/10/14. The date completed section indicated the investigation was completed on 3/7/14. There was no documentation the results of the investigation were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The AD indicated client to client abuse should be thoroughly investigated. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client			

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	aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. 17) On 2/13/14 at 6:30 PM, client G asked for a snack right after dinner. Staff redirected client G to take a shower. After his shower, client G saw an empty soda can on the living room table. Client G ran over and stuck his finger into the opening, cutting his finger. Staff #5 attempted to get the can. Client G swung at staff and missed. Client G swung again and then body slammed into staff #5. Staff #5 and client G fell to the floor. Staff #5 and client G hit their heads together during the fall. Client G received a cut about his right eye and staff could not get it to stop bleeding. Staff #5 contacted the nurse who instructed staff to take client G to the emergency room. The emergency room indicated client G had a minor concussion and they glued the cut. On the way out of the emergency room, client G "attacked" the soda machine and attempted to "attack" staff. A PRN (as needed) medication was administered after client G arrived home due to continued aggression toward staff. The investigation, dated 2/18/14, indicated, "Evidence supports that staff			

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	followed [client G's] BSP (behavior support plan) and PRN protocol when PRN Ativan 2mg was administered to [client G]." There was no documentation the results of the investigation were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 18) On 1/12/14 at 3:30 PM (clients reported to the Program Director on 1/13/14), clients B, E and H indicated former staff #12 asked them if they wanted to go to the mall. On the way to the mall, staff #12 stopped at former staff #13's house. While at staff #13's house, staff #13 asked clients B, E and H if they wanted to see her gun. Staff #13 showed it to them. Staff #12 and clients B, E and H went to the mall. After leaving the mall, staff #12 took the clients back to staff #13's house. Staff #12 went in but left the clients in the van for 5-10 minutes. Staff #13 came out to the van with staff #12 and showed the clients a			

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	"certificate of college." Staff #13 stated to the clients, "This is why I shouldn't be working with you f---tards." Client B reported staff #13 stated, "She was smarter than us." Both staff were suspended. The investigation, dated 1/17/14, indicated staff #12 quit his job after his shift on 1/12/14. The Conclusion of the investigation indicated, "There is evidence to support that [staff #13] called the clients an inappropriate name while at her house." There was no documentation of the action taken by the facility to address this incident. The investigation did not indicate staff #13 quit prior to corrective actions being implemented. There was no documentation the results of the investigation were reported to the administrator within 5 working days of the incident. On 10/30/14 at 1:21 PM, the Area Director indicated in an email, "[Staff #13] quit before any corrective action was done." On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program			

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	Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 19) On 1/8/14 at 6:30 PM, clients A and E hit each other. Client A's glasses were broken during the incident. Client A sustained a small bruise on his forehead. On 10/27/14 at 12:54 PM, the AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. 20) On 11/24/13 at 12:40 PM, client G urinated on his blankets. Client G attempted to get his soiled blankets. Staff			

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	redirected client G. Client G attempted to hit staff. Client A punched client G in the side of the head and face on the left side. Client G was not injured. On 10/27/14 at 12:54 PM, the AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. A review of the facility's abuse and neglect policy dated April 2011 was conducted on 10/27/14 at 1:17 PM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or			

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	Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights." The policy indicated, "Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. 1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident." The facility's policy and procedures were reviewed on 10/27/14 at 1:17 PM. The facility's Quality and Risk Management policy dated April 2011 indicated, "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services			

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	through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The April 2011 policy indicated, "Indiana Mentor follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to Adult Protective Services or Child Protective Services as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider. This may include: (a.) physical abuse, including but not limited to: (i.) intentionally touching another person in a rude, insolent, or angry manner.... (e.) Failure to provide appropriate supervision, care or training...". The April 2011 policy indicated, "(f.) Event with the potential for causing significant harm or injury.... (p.) Inadequate staff support for an individual including inadequate supervision, with the potential for (1.) Significant harm or injury to an individual." The policy indicated, "An			

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	initial report regarding an incident shall be submitted within twenty four (24) hours of: (a.) the occurrence of the incident; or (b.) the reporter becoming aware of or receiving information about an incident." This federal tag relates to complaints #IN00157027 and #IN00158326. 9-3-2(a)			
W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 4 of 31 incident/investigative reports reviewed affecting clients A, B, E, F and G, the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. Findings include: A review of the facility's incident/investigative reports was conducted on 10/27/14 at 1:28 PM and indicated the following:	W000153	The Program Director was retrained on immediately notifying designated state agencies of reportable incidents in accordance with State law, on 11/24/14. All reportable incidents will be sent to BDDS within the required timelines. Area Director and Quality Assurance will monitor to ensure incident reports are being submitted in a timely manner and any necessary corrective action will be taken as needed. Responsible Party: Program Director, Area Director, and Quality Assurance Specialist.	12/09/2014

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	1) On 10/15/14 at 7:30 AM (reported to BDDS on 10/20/14), client F refused to take his lunch box with him to the day program. Client B offered to put the lunch box in the front seat of the van. Staff took the lunch box and put it in between the front seats of the van. Client F was sitting in the front passenger seat of the van. Client F threw his lunch box into the back of the van hitting client B. Client B threw the lunch box back hitting client F in the head. Client B reached up and struck client F on the side of the head multiple times before staff could separate the two. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the staff inaccurately reported the incident initially. The HM indicated the staff reported client F refused to carry his lunch box, threw his lunch box at client B, and client B threw the lunch box back at client F. The HM indicated he was not informed of client B hitting client F multiple times. The HM indicated from the report he received there was no reason for him to believe there was an incident of client to client abuse. The HM indicated on 10/20/14 when client F's guardian notified him of the incident, he reviewed the notes and retrained staff on documentation. HM indicated the timeframe for reporting incidents to			

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	BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the PD and the HM were not given all the information regarding the incident from the staff. The PD indicated from the information they received, a lunch box was thrown. There was no information relayed regarding client to client abuse. The PD indicated after speaking with client F's guardian on 10/20/14, it was reported client F was hit on the head by client B. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours. 2) On 9/21/14 at 4:08 PM (reported to BDDS on 9/23/14), client G was obsessing over the television and ran up the stairs to get into his roommates' bedrooms to get their electronics. Client G got a fork from the kitchen and tried to stab the TV cord, which was unplugged. Client G tried to stab staff with the fork. Client G was going up the stairs and staff #5 was attempting to block his way. Client G lost his balance and both client G and the staff fell. Client G received a rug burn on his forehead and rib area. Client G was given a PRN. Client G was prompted to take a shower and he did. Staff attempted to take him on a van ride. He refused and started obsessing over the TV again and tried to tear it off the wall.			

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	Client G went upstairs and tried to destroy a housemate's CPAP (continuous positive airway pressure) machine. Client G was blocked. Client G knocked his housemate's TV off the stand it broke. Client G also broke the cable box. Client G ran into another client's bedroom and broke his cable box. Client G was assisted downstairs. A second PRN medication was administered. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the timeframe for reporting incidents to BDDS was 24 hours. 3) On 8/30/14 at 6:58 PM (reported to BDDS on 9/1/14), client E punched client A in the face. Client A's glasses were broken. There was no documentation of an investigation. On 10/27/14 at 12:54 PM, the AD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the timeframe for reporting incidents to BDDS was 24			

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	hours. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the timeframe for reporting incidents to BDDS was 24 hours. 4) On 8/16/14 at 6:58 PM (reported to BDDS on 8/18/14), client G was obsessing over the television and ran over to the bedroom wall and kicked and hit the wall. Client G kicked out the window and crawled out of it and ran down the sidewalk. Staff #5 was able to calm client G down and returned with him to the home. Client G received a PRN (as needed) medication. On 10/27/14 at 12:54 PM, the AD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the timeframe for reporting incidents to BDDS was 24 hours. This federal tag relates to complaint #IN00158326.			

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	9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 7 of 31 incident/investigative reports reviewed affecting clients A, B, D, E, F, G and H, the facility to conduct thorough investigations. Findings include: A review of the facility's incident/investigative reports was conducted on 10/27/14 at 1:28 PM and indicated the following: 1) On 10/15/14 at 7:30 AM, client F refused to take his lunch box with him to the day program. Client B offered to put the lunch box in the front seat of the van. Staff took the lunch box and put it in between the front seats of the van. Client F was sitting in the front passenger seat of the van. Client F threw his lunch box into the back of the van hitting client B. Client B threw the lunch box back hitting	W000154	The Program Director received retraining on investigation standards by the Area Director on 11/24/14. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or /Quality Assurance Specialists or other designee and any necessary corrective action will be taken as needed. Responsible Party: Home Manager, Program Director, Area Director, and Quality Assurance Specialist.	12/09/2014

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	client F in the head. Client B reached up and struck client F on the side of the head multiple times before staff could separate the two. The BPR (Behavior Progress Record) - Narrative Notes, dated 10/15/14, indicated, in part, "Incident(s): Physical assault... [Client F] left his lunch box in walkway so another client tried giving the client his lunchbox. [Client F] refused to take it which made other client upset so he threw (sic) lunch box at [client F]. [Client F] then hit client and threw lunch box back at client. Client then begin (sic) hitting [client F] in the face multiple times, and calling him an 'old f------ hag.'" The Investigation Summary, dated 10/22/14, indicated, "[Client B] reported that [client F] was grumpy the morning of the incident and [client B] stated he felt like [client F] was 'giving staff a hard time.' [Client B] reported that [client F] didn't want to carry his lunch box out to the van. [Client B] reported he carried [client F's] lunch box for him. [Client B] stated that when he got out to the van he gave staff [client F's] lunch box and they put it in between the two front seat of the van. [Client B] reported that he got in the van and [client F] threw his lunch box at him and 'I got pissed and threw it			

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	back.' [Client B] reported he was upset and hit [client F] in the head but couldn't report how many times he hit (him). [Client B] reported that [staff #10 and staff #2] told him to get off [client F] and he did. [Client B] reported he went to day program after that... [Staff #2] reported that [client F] refused to carry his lunch box out to the van. [Staff #2] reported that [client B] carried the lunch box and gave it to her and she put it in between the front seats of the van. [Staff #2] reported that [staff #10] was sitting in the back seat of the van. [Staff #2] reported that [client F] grabbed his lunch box and threw it into the back seat. [Staff #2] reported that [client B] became upset and yelled a profane name at [client F] and then threw the lunch box back up front. [Staff #2] reported she was verbally redirecting both clients. [Staff #2] reported that the next thing she knew [client B] was hitting [client F] in the side of the head and she was separating the two clients. [Staff #2] reported that the two clients separated and there was no further incident." The Recommendations section indicated, "New seating chart for van to keep [clients F and B] separated. Lunch boxes will be kept in the rear of the van." There was no documentation in the BDDS reports, investigation and BPR			

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	Narrative Notes indicating client F sustained bruising on the right side of his face from his forehead to his ear. The Investigation Summary did not include documentation indicating when the results of the investigation were reported to the administrator. The BDDS reports, investigation and BPR Narrative Notes did not address the late guardian notification of the incident. The BDDS reports, investigation and BPR Narrative Notes did not address the initial report to the Home Manager regarding the incident did not include information of client B hitting client F multiple times causing injuries. On 10/27/14 at 12:54 PM, the AD indicated incidents of abuse, neglect and/or mistreatment should be thoroughly investigated. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the staff inaccurately reported the incident initially. The HM indicated the staff reported client F refused to carry his lunch box, threw his lunch box at client B, and client B threw the lunch box back at client F. The HM indicated he was not informed of client B hitting client F multiple times. The HM indicated from the report he received there was no reason for him to believe there was an			

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	incident of client to client abuse. The HM indicated on 10/20/14 when client F's guardian notified him of the incident, he reviewed the notes and retrained staff on documentation. The HM indicated he did not observe the bruising on client F prior to the guardian observing the injuries due to the HM not being in the home from 10/15/14 to 10/20/14. The HM indicated incidents of client to client abuse should be investigated. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the PD and the HM were not given all the information regarding the incident from the staff. The PD indicated from the information they received, a lunch box was thrown. There was no information relayed regarding client to client abuse. The PD indicated after speaking with client F's guardian on 10/20/14, it was reported client F was hit on the head by client B. The PD indicated she observed client F on 10/20/14 and did not observe the bruising. The PD indicated the Area Director also assessed client F and did not observe bruising. The PD indicated incidents of client to client abuse should be investigated. 2) This incident report was received by email on 10/30/14 at 3:53 PM. The facility was asked to provide the incident			

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	report and investigation regarding this incident on 10/30/14 at 3:38 PM. The email to the Area Director indicated, "You indicated there was an incident in which the mayor showed up to the house. In the reports I received, there was no such incident. Please forward the documentation regarding the incident to me. Thank you." The facility did not provide documentation of an investigation. On 10/7/14 at 6:55 PM, the BDDS report, dated 10/8/14, indicated, "On 10/7 at approximately 6:45 pm the tornado sirens sounded in [name of city]. Clients and staff, [staff #5 and #7] followed the tornado protocol and all clients and staff went into the basement of the group home. While in the basement [client G] started obsessing over the freezer and started swinging at staff. Staff used agency approved PIA (Physical Intervention Alternatives) blocking techniques to block [client G]. [Client G] then started charging at staff and staff [#5] used agency approved PIA blocking and one arm restraint. [Staff #7] called Program Director [name] for approval of PRN (as needed) Ativan 2mg (milligrams) at approximately 6:55 pm. [Client G] continued to swing at staff and other clients in the basement. [Client B] became upset at this point and targeted			

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	[client G]. [Staff #5] had [client G] in a hold and [client B] charged at [client G] and grabbed [client G's] neck. [Staff #5] verbally redirected [client B] to release [client G's] neck and to remove himself from around [client G]. [Staff #5] released [client G] from the hold to physically get in between the two clients and then [client B] released [client G's] neck and then punched [client G] in the face two times while staff was trying to keep them separated. [Client G] then started charging at staff again and agency approved two arm hold was implemented at this time. [Client E] told [client B], 'That was f------ uncalled for you didn't need to choke him.' [Client B] responded and said, "Shut the f--- up fa----' and charged at [client E]. [Client B] swung and made contact with [client E] and staff, [staff #7] attempted to get in between the two clients. [Client B] bit [client E] on the back and [client E] punched [client B] in the eye causing laceration to his eye. [Client G] had been released from his hold at this point. Police were called to assist as staff [#7 and #5] were unable to get the two clients separated. Staff finally got the two separated after about 30 seconds. Program Director [name] was contacted at this point to let her know the police were called. [Staff #2]			

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	was called to the home to assist as well as Home Manager [name] and [staff #4]. [Client G] ran upstairs and [staff #5] ran after him. Police were at the door when [client G] got upstairs. [Client G] ran back down stairs and [staff #7] was still down stairs. Police stopped [staff #5] from going down stairs to ask him questions. Two officers followed [client G] down stairs and [client G] targeted the two police officers so they handcuffed [client G] and brought him back upstairs. They had [client G] sit in the chair in handcuffs while [staff #5] explained what was going on to the police. [Staff #2] arrived at the home. While [staff #5] was trying to explain why the police were called [client G] continued to get up and resist the police. [Staff #5] and [staff #2] explained to the police that they were able to care for [client G] and had a behavior plan to follow as well as agency approved physical interventions and that [clients E and B] needed the medical attention. Police were getting ready to leave at this point. [Client G] started swinging at staff and biting at staff. [Staff #5] put [client G] in a two arms hold and (client G) bit [staff #5] on the arm and wiggled out of the hold and bit [staff #5] on the leg. [Staff #2] attempted to assist [staff #5] with taking over the hold and the police then took over and			

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	got [client G] in the chair in the living room and held him. [Client G] continued to resist the police. [Staff #2] explained to the police that they could leave and that staff could take care of [client G] that [clients E and B] just needed to be checked out. EMT's (emergency medical technicians) explained that they both [clients E and B] needed to go to the emergency room. [Staff #7] took [client E] to the emergency room and [Home Manager] took [client B] to the emergency room. The police were leaving and (they were) out on the porch. [Client G] got back up and started swinging and biting at staff again. [Staff #2] and [staff #5] put [client G] in a hold once again and the police came back into the home as they must have seen from the living room windows that staff were restraining [client G] again. Police came back into the home and told [staff #2] to get off [client G] and two police officers assisted [staff #5] with the hold and then told [staff #5] to get off [client G] that they would take over. One of the officers told staff, 'This is ridiculous, we can't babysit and this guy shouldn't be living here. We are going to call the big boss.' [Staff #5] asked, 'Who is that?' and one of the police responded, 'The Mayor.' Police informed staff that [client G] would			

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	either have to go to the hospital or that they were taking him to jail. [Staff #2] called PD (Program Director) to report what the police said about either taking him to jail or to the hospital. PD told [staff #2] to tell the police that he could not go to jail that the hospital was the only option. PD called [Area Director] to inform him of the situation and that she would keep him up to date about what was going on. [Client G] continued to resist the police, and police were not allowing staff to assist at this point. The Mayor showed up at the home and came into the home. He told staff that this has happened multiple times that [client G] had gotten into the [name of bar] before, [name of gas station] and that by what he could see going on that the group home was not a good enough facility for him that he needed to be at a different facility to be placed in and that he was going to see to it what he would not be coming back to the group home in [name of city]. [Staff #5] reported that the Mayor stated that 'we would do whatever it took to get him out of this community and it should have happened years ago and enough is enough.' [Client G] continued to target police and they got him in a hold on the ground. Program Director [name] arrived at the group (sic) at that point. [Client G] was on the			

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	ground and police were physically restraining him at this point. Police then got him up off the ground about 30 seconds after PD arrived at the home and assisted him with getting in the chair. The mayor asked [PD] to speak to a supervisor, PD told him that she was the supervisor and he told her that he wanted to talk to her boss. PD [name] called [Area Director] and gave the phone to the Mayor at this point. [Client G] kept trying to get up out of the chair and police kept having him sit back down. [Client G] then got up and moved towards the couch. Police started to hold him and [staff #2] stated he is trying to get to the couch. Police allowed him to move to the couch and [staff #2] got him a pillow and blanket. Program Director [name] gave approval to [staff #2] to give a second PRN medication. Ativan 2mg was given. The Mayor then came back in and told police to call [name] transport that he was being transported to [name of hospital]. [Staff #2] rode in the ambulance with [client G] and PD [name] followed in personal vehicle. [Client G] was taken to [name of hospital] per police and [name of city] Mayor request. [Staff #16] contacted Program Director as she was taking another client home and saw the police at the group home and asked if she needed			

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	to go back once she dropped off the client she was working with. PD [name] told [staff #16] to go back and assist [staff #4] with other clients. [Program Director] contacted Program Nurse [name] to report that [client G] was being taken to [name of hospital] and contacted [Area Director] to report as well. Program Director also contacted [client G's guardian] to report the incident. [Client E's guardian] was contacted to report the incident." On 10/27/14 at 12:54 PM, the Area Director (AD) indicated the police were not called due to client G's behavior but due to client B and E's behavior. The AD indicated the incident occurred during a tornado warning. The AD stated client G was "cycling" and this was the time of year his behaviors increased. The AD indicated the mayor of the city wanted client G moved out of the group home due to being a danger to the community. The AD indicated client G was not going to move. Client G was admitted to the hospital following the incident due to being given two options: jail or the hospital. Client G was discharged from the hospital and returned to the group home. The AD indicated client to client aggression was considered abuse and client to client abuse should be investigated.			

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	On 10/29/14 at 2:14 PM, the Program Director (PD) indicated incidents of client to client abuse should be investigated. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated incidents of client to client abuse should be investigated. 3) On 9/21/14 at 4:08 PM, client G was obsessing over the television and ran up the stairs to get into his roommates' bedrooms to get their electronics. Client G got a fork from the kitchen and tried to stab the TV cord, which was unplugged. Client G tried to stab staff with the fork. Client G was going up the stairs and staff #5 was attempting to block his way. Client G lost his balance and both client G and the staff fell. Client G received a rug burn on his forehead and rib area. Client G was given a PRN. Client G was prompted to take a shower and he did. Staff attempted to take him on a van ride. He refused and started obsessing over the TV again and tried to tear it off the wall. Client G went upstairs and tried to destroy a housemate's CPAP (continuous positive airway pressure) machine. Client G was blocked. Client G knocked his housemate's TV off the stand it broke. Client G also broke the cable box. Client			

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	G ran into another client's bedroom and broken his cable box. Client G was assisted downstairs. A second PRN medication was administered. The facility did not conduct an investigation into the incident to ensure the use of the PRN medications were administered appropriately as well as to investigate how client G sustained rug burns on his forehead and rib area. On 10/31/14 at 12:01 PM, the Program Director (PD) indicated she thought the incident was investigated. The PD indicated the incident should have been investigated. 4) On 8/30/14 at 6:58 PM, client E punched client A in the face. Client A's glasses were broken. There was no documentation of an investigation. On 10/27/14 at 12:54 PM, the AD indicated client to client abuse should be investigated. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated incidents of client to client abuse should be investigated. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated incidents of			

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	client to client abuse should be investigated. 5) On 8/21/14 at 5:00 PM, client B was on his way to a church dinner in the van. Client B was obsessing about dessert since his doctor wanted him to go on a diet. Client B had a seizure. Staff pulled the van over while the other staff attended to client B. Staff called the Home Manager (HM) since client B had been in a seizure for 4 minutes. The HM directed the staff to call 911 since they were out of town and it would take some time for the ambulance to get there. When the ambulance arrived on scene, client B was having trouble breathing. The paramedics attempted to give him oxygen but he was combative. Another group home manager arrived to assist. She was able to get client B calmed down and into the ambulance. Client B was in the emergency room for 3 hours and an EKG (electrocardiogram) was conducted. The hospital sent client B to another hospital to receive care from a cardiologist. Client B's heart rate and blood pressure were elevated. Client B was admitted to the hospital on 8/21/14. There was no documentation an investigation was completed to ensure staff followed client B's plan and appropriate care was given.			

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	On 10/31/14 at 12:01 PM, the Program Director (PD) indicated the incident was not investigated. The PD indicated the incident should have been investigated to ensure the staff provided the appropriate care and implemented client B's risk plan for seizures as written. 6) On 3/2/14 at 8:45 PM, client H and staff #14 went to pick up client D from his relative's house. As client D was putting his items into the van, client H said something (staff did not hear) to client D. The BDDS report, dated 3/3/14, indicated, "[Client D] became upset at what [client H] said and [client D] physically aggressed on [client H]. [Client H] jumped out of the van before staff could separate them." Client H had a small scratch (1/4 inch) under his left eye and basic first aid was administered. The investigation, dated 3/7/14, indicated in the conclusion section, "Evidence supports staff did not intervene appropriately." The Recommendations section indicated, "Retraining of staff that staff will get out of the van and assist [client D] with putting his things in the van to try and prevent any further incidents of this nature in the future." The investigation had conflicting information regarding the date(s) of the investigation. The section for Dates of			

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	Investigation indicated 4/9/14 and 4/10/14. The date completed section indicated the investigation was completed on 3/7/14. On 10/27/14 at 12:54 PM, the AD indicated client to client abuse should be thoroughly investigated. 7) On 1/12/14 at 3:30 PM (clients reported to the Program Director on 1/13/14), clients B, E and H indicated former staff #12 asked them if they wanted to go to the mall. On the way to the mall, staff #12 stopped at former staff #13's house. While at staff #13's house, staff #13 asked clients B, E and H if they wanted to see her gun. Staff #13 showed it to them. Staff #12 and clients B, E and H went to the mall. After leaving the mall, staff #12 took the clients back to staff #13's house. Staff #12 went in but left the clients in the van for 5-10 minutes. Staff #13 came out to the van with staff #12 and showed the clients a "certificate of college." Staff #13 stated to the clients, "This is why I shouldn't be working with you f---tards." Client B reported staff #13 stated, "She was smarter than us." Both staff were suspended. The investigation, dated 1/17/14, indicated staff #12 quit his job after his			

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	shift on 1/12/14. The Conclusion of the investigation indicated, "There is evidence to support that [staff #13] called the clients an inappropriate name while at her house." There was no documentation of the action taken by the facility to address this incident. The investigation did not indicate staff #13 quit prior to corrective actions being implemented. On 10/30/14 at 1:21 PM, the Area Director (AD) indicated in an email, "[Staff #13] quit before any corrective action was done." On 10/27/14 at 12:54 PM, the AD indicated incidents of abuse, neglect and/or mistreatment should be thoroughly investigated. This federal tag relates to complaint #IN00158326. 9-3-2(a)			
W000156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 15 of 31 incident/investigative reports reviewed affecting clients A, B, C, D, E,	W000156	The Program Director was retrained on completing investigations and submitting findings to the	12/09/2014

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	F, G and H, the facility to report the results of investigations to the administrator within 5 working days of the incident. Findings include: A review of the facility's incident/investigative reports was conducted on 10/27/14 at 1:28 PM and indicated the following: 1) On 10/15/14 at 7:30 AM, client F refused to take his lunch box with him to the day program. Client B offered to put the lunch box in the front seat of the van. Staff took the lunch box and put it in between the front seats of the van. Client F was sitting in the front passenger seat of the van. Client F threw his lunch box into the back of the van hitting client B. Client B threw the lunch box back hitting client F in the head. Client B reached up and struck client F on the side of the head multiple times before staff could separate the two. The BPR (Behavior Progress Record) - Narrative Notes, dated 10/15/14, indicated, in part, "Incident(s): Physical assault... [Client F] left his lunch box in walkway so another client tried giving the client his lunchbox. [Client F] refused to take it which made other client		Administrator within 5 working days of the date of the incident. The Area Director will review all investigations to ensure they are submitted timely and any necessary corrective action will be taken as needed at weekly PD/AD meeting.. Responsible Party: Program Director, Area Director	

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	upset so he threw (sic) lunch box at [client F]. [Client F] then hit client and threw lunch box back at client. Client then begin (sic) hitting [client F] in the face multiple times, and calling him an 'old f------ hag.'" The Investigation Summary, dated 10/22/14, indicated, "[Client B] reported that [client F] was grumpy the morning of the incident and [client B] stated he felt like [client F] was 'giving staff a hard time.' [Client B] reported that [client F] didn't want to carry his lunch box out to the van. [Client B] reported he carried [client F's] lunch box for him. [Client B] stated that when he got out to the van he gave staff [client F's] lunch box and they put it in between the two front seat of the van. [Client B] reported that he got in the van and [client F] threw his lunch box at him and 'I got pissed and threw it back.' [Client B] reported he was upset and hit [client F] in the head but couldn't report how many times he hit (him). [Client B] reported that [staff #10 and staff #2] told him to get off [client F] and he did. [Client B] reported he went to day program after that... [Staff #2] reported that [client F] refused to carry his lunch box out to the van. [Staff #2] reported that [client B] carried the lunch box and gave it to her and she put it in between the front seats of the van. [Staff			

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	#2] reported that [staff #10] was sitting in the back seat of the van. [Staff #2] reported that [client F] grabbed his lunch box and threw it into the back seat. [Staff #2] reported that [client B] became upset and yelled a profane name at [client F] and then threw the lunch box back up front. [Staff #2] reported she was verbally redirecting both clients. [Staff #2] reported that the next thing she knew [client B] was hitting [client F] in the side of the head and she was separating the two clients. [Staff #2] reported that the two clients separated and there was no further incident." The Recommendations section indicated, "New seating chart for van to keep [clients F and B] separated. Lunch boxes will be kept in the rear of the van." There was no documentation in the BDDS reports, investigation and BPR Narrative Notes indicating client F sustained bruising on the right side of his face from his forehead to his ear. The Investigation Summary did not include documentation indicating when the results of the investigation were reported to the administrator. The BDDS reports, investigation and BPR Narrative Notes did not address the late guardian notification of the incident. The BDDS reports, investigation and BPR Narrative Notes did not address the initial report to			

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	the Home Manager regarding the incident did not include information of client B hitting client F multiple times causing injuries. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the staff inaccurately reported the incident initially. The HM indicated the staff reported client F refused to carry his lunch box, threw his lunch box at client B, and client B threw the lunch box back at client F. The HM indicated he was not informed of client B hitting client F multiple times. The HM indicated from the report he received there was no reason for him to believe there was an incident of client to client abuse. The HM indicated on 10/20/14 when client F's guardian notified him of the incident, he reviewed the notes and retrained staff on documentation. The HM indicated he did not observe the bruising on client F prior to the guardian observing the injuries due to the HM not being in the home from 10/15/14 to 10/20/14. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the PD and the HM were not given all the information regarding the incident from the staff. The PD indicated from the information they received, a lunch box was thrown. There was no information relayed regarding			

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	client to client abuse. The PD indicated after speaking with client F's guardian on 10/20/14, it was reported client F was hit on the head by client B. The PD indicated she observed client F on 10/20/14 and did not observe the bruising. The PD indicated the Area Director also assessed client F and did not observe bruising. The PD indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 2) On 9/23/14 at 12:45 AM, client G went into the basement of the home, took a television out into the back yard and destroyed it. The BDDS report, dated 9/24/14, indicated, "[Former staff #11] then reported that he was on the porch smoking a cigarette to calm down after the incident and when he went back inside [client G] was gone. [Staff #11] then reported he started making phone calls and got ahold (sic) of [staff #6] and [staff #5] for assistance. Police arrived at the home and talked to [staff #11] about what was going on and staff reported that he was able to get [client G] in the home. [Staff #11] then reported he went inside the home and [client G] was gone. [Staff #11] then reported that the police called the home to report they had found [client G] at [name of gas station] gas station on [name of street] and that an ambulance			

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	was on its way. [Staff #5 and #6] arrived at the home and notified [staff #11] that [staff #5] had notified [Home Manager] who was also on his way to the home. [Home Manager] contacted [staff #6] and instructed her to administer a PRN (as needed), Ativan 2 mg (milligrams), per PRN protocol once she got to the [name of gas station]. [Staff #6] explained to police that [client G] had a PRN medication to assist him when he was agitated. Ambulance arrived on the scene and transported [client G] to the hospital. [Home Manager], [staff #5], [staff #6] all arrived at the hospital and [client G] was released to their care. During the incident [client G] sustained numerous superficial wounds while he was at [name of gas station]. [Staff #11] was suspended pending investigation. Team met on 9/23 and team implemented double staffing during the overnights for two weeks. Team will meet again on 10/7. Nurse, [name], contacted psychiatrist, [name] to discuss the situation and the increase in [client G's] agitation. [Psychiatrist] increased Clozapine (psychotropic medication) from 350 mg daily to 400 mg daily." The investigation, dated 9/30/14, indicated, in part, "Brief summary of the incident: [Client G] eloped from the home and ran to the [name] gas station a			

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	few blocks away and committed property damage. [Staff #11] was supervising at the time of the incident and reportedly did not realize [client G] had eloped. Following the incident, [staff #11] was suspended by the Home Manager [name]... [Staff #5] stated that after [client G] was in bed, he asked [staff #11] what happened and [staff #11], 'acted scared, said he was smoking a cigarette and had headphones on listening to music and cops showed up,' then said he was watching [client G's door] to see if he got up but [client G] must have gone out through the hallway door and down the basement stairs and he didn't see him. [Staff #5] stated that all the blinds were closed when he got to the house so he didn't know how [staff #11] could see in the house except through the high glass section on one of the doors that is the only part not frosted. [Staff #5] reported that through that section you can only see the living room and not into [client G's] bedroom. [Staff #5] stated that he is tall and can't see into [client G's] room through that window. [Staff #5] stated that the alarms were working on all the doors when he was in the home after the incident. [Staff #5] stated that during his shift on 9/22/14, [client G] had behaviors but hadn't tried to elope at any time. [Staff #5] stated that [client G] was in bed when he left at 10pm...".			

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	The investigation indicated, "[Staff #6] stated that she worked in the home on 9/22/14 from 2pm until 12:15am. She stated that she was to be off work at 12am and [staff #11] was to relieve her but she was about 10-15 minutes late and she left at 12:14am or 12:15am... She stated that she went in the room and checked on him at 11:30pm and [client G] was sleeping and then checked on him again right before she left the house and he was asleep and snoring. [Staff #6] stated that no other clients were awake when she left the home and [client G's] roommate [client F] was also asleep. [Staff #6] stated that she left the home after [staff #11] arrived and went home and [staff #11] called her at 12:36am and said '[client G's] gone.' She stated that she asked him what he was talking about and if he had called anyone to report it and [staff #11] said she had tried to 'call everyone and no one would answer.' [Staff #6] stated that she immediately went to the house to help look for [client G] and got there in about 5 minutes and [staff #11] was outside the house by the driveway along the road 'pacing.' [Staff #6] stated she went into the house to look for [client G] and saw the 'mess in the basement' of all the items [client G] had destroyed, and checked around the yard and couldn't find [client G]. She stated			

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	that she found [client G's] pants outside in the backyard. She stated that she had been searching about 6-7 minutes when the police called the house and said [client G] was at [gas station]... [Staff #6] stated that while she was at the hospital, the police talked to her and told her they had received a phone call at 12:22am from a neighbor complaining about someone tearing up a TV in the backyard. They said that they arrived at the house and [staff #11] was on the front porch and they asked him what was going on and [staff #11] replied with 'nothing, at work.' They said that they told [staff #11] they had gotten a call about someone tearing up a TV in the backyard and [staff #11] ran into the house and looked everywhere for [client G] then came back to them and said 'he's gone, can you help?' and they left the house to start looking for [client G]. [Staff #6] stated that the police told her [staff #11] was on the front porch smoking... [Staff #6] stated that when [staff #11] arrived at the house that night to relieve her, he was getting his headphones out of his pocket and untangling them and plugging them into his phone. She stated that she did not see the headphones in his ears but didn't know 'how else he couldn't have heard [client G] tearing stuff up.'" The investigation indicated, "[Staff #11]			

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	stated that his shift started at 12am on 9/23/14. He stated that he arrived at the house at 12am. When asked if he was late, he stated that he wasn't. He stated that [staff #6] was leaving her shift and stayed about 5-10 minutes telling him about [client G's] behaviors he had during her shift. [Staff #11's] time sheet states that he arrived at work at 12am. [Staff #11] stated that [client G] was in bed when he arrived. He stated that [staff #6] said [client G] was asleep and he went and checked and he looked asleep to him. He stated that [client G's] roommate was getting ready for bed and didn't know if he had awakened [client G] during this time. [Staff #11] stated that he was putting some stuff away and [client G] got up and went to use the bathroom and got a drink and [staff #11] told him to go back to bed. He stated that [client G] started laughing, walked back to his bedroom and shoved [staff #11] and then ran out of the back door of the house. [Staff #11] stated that he got [client G] back into the house and into bed. He stated that [client G] just kept laughing then got back up and ran downstairs and started tearing stuff up and pulling things out of the freezer and cabinets. [Staff #11] stated that he didn't want to get hurt and didn't want [client G] to get hurt. He stated that he yelled for [client C], a housemate, to open the			

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	basement door so it would be easier to get [client G] back up the stairs to his bedroom. [Staff #11] stated that [client C] never came to the door. [Staff #11] stated that he got [client G] back into his bed and he laid down. [Staff #11] stated that he called [Home Manager] about 10 times and got no answer. [Staff #11] stated that he then went to the front porch while trying to call [Home Manager] and the police showed up and said they had a complaint of noise in the back yard. [Staff #11] stated that he thought the noise that was reported had been from earlier when he was trying to get [client G] back in (sic) house. [Staff #11] stated that he thought he had locked the basement door earlier after that incident. [Staff #11] stated that he ran in the house and searched for [client G] and couldn't find him and told the police who [client G] was and they left to go look for him. He stated that he found [client G's] clothes in the back yard... When asked about the time he was on the front porch, [staff #11] stated that he was smoking a cigarette and [client G] was in bed after the basement incident. He stated that he was trying to call [Home Manager] from his cell phone and the house phone to report the incident. [Staff #11] stated that he was watching for [client G] to get up through the window of the doors to the house and went to the side porch to			

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	make sure he didn't try to go out his bedroom window... When asked if at any time he had headphones in his ears, [staff #11] stated that he had his 'left headphone in' attached to his cell phone because he was trying to make a call on his cell phone while he used the house phone with his other ear trying to call people. He stated that he also called his girlfriend during this time because she usually brings him some dinner when she gets off work and he wanted to let her know what it wasn't 'safe' to bring him dinner that night due to [client G's] behaviors... When asked why [Home Manager] or [Program Director's] phones did not show any missed calls from him, he stated that he didn't know why they didn't. [Staff #11] stated that he also sent [Home Manager] a text message saying something like 'call me asap (as soon as possible). [Client G] having behaviors...'. When asked if he could show this interviewer the text, he stated that he recently upgraded his iPhone and it wiped out all of his calls and texts and other information and he had to take it to [name of company] to be fixed so he had no information to share." The investigation indicated in the Additional information section, "All alarms on all doors were working when the investigator was at the home on			

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	9/30/14... The police report dated 9/28/14, stated that they received a call from a neighbor at 12:22am on 9/23/14. The officers arrived at the home (at approximately 12:30am based on the incident timeline) and asked [staff #11] what was going on and he replied 'just working.' The police report states that they told [staff #11] they had received a call about someone smashing something in the back of the residence and [staff #11] immediately ran into the residence. The police report states that the officers followed him into the home and [staff #11] then stated 'I need your guys' help, [client G] is out.' The police report states that the officers left the home and began driving around the area in an attempt to locate [client G]. The police report states that a short while later (approximately 10-15 minutes after they were at the home), dispatch advised that there was a man in the [gas station] on [name of street] that was destroying the inside of the store. The report states that when they arrived at the store, they found [client G] in a t-shirt and underwear pulling products off of shelves and throwing them and they restrained him. The report states that he was then transported to [hospital]...". The investigation's Conclusion indicated, "There is evidence to support that [staff			

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	#11] was outside the home on the front porch when [client G] eloped from the home through the basement door and that this supports an allegation of neglect. There is no evidence to support that [staff #11] made phone calls to either of his supervisors and instead contacted his coworkers." On 10/30/14 at 1:26 PM, a review of a Termination Notice, dated 10/1/14, indicated staff #11 was terminated on 10/20/14. The notice indicated, in part, "Indiana MENTOR is terminating [staff #11's] employment due to [staff #11] not following the proper supervision level of a client." On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated he was contacted by staff #5 at 1:00 AM. Staff #5 told the HM staff #5 was on the way to the house due to receiving a call from staff #6 indicating client G had eloped. The HM indicated once the Area Director (AD) was contacted, the AD made the decision to suspend staff #11 at 4:00 AM. Staff #5 was still at the house with staff #11. The HM indicated staff #11 was on the front porch during the incident unaware the incident was taking place. On 10/27/14 at 12:54 PM, the Area Director (AD) indicated staff #11			

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	indicated he arrived to work on time but he was late. Staff #11 reported client G had an incident in the basement and the staff #11 went to smoke a cigarette. The AD indicated a neighbor contacted police due to a disturbance in the backyard. The AD indicated staff #11 indicated he had a headphone in while watching client G through a window while waiting for his girlfriend to bring him dinner. Client G eloped to a gas station. The AD indicated he thought client G went into the basement, got into the food, took the television from the basement and threw it into the neighbor's backyard and went to the gas station. The AD indicated it was his belief staff #11 was not aware of incident until the police showed up. When the police arrived, staff #11 was on the front porch. Staff #11 told the police he was working. Police indicated there was a disturbance. Staff #11 ran into the house, checked the basement and told the police client G was gone. The AD indicated he did not believe staff #11 was aware client G was gone until the police arrived. The AD indicated client G exited the house through the basement door, which had a functioning alarm. The AD indicated the facility has had two overnight staff since the incident. The AD indicated client G caused damage at the gas station. Client G ate a lot of food and then threw it up. The AD indicated			

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	staff #11 was terminated due to neglect. The AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 3) On 8/31/14 at 1:00 PM, client H was upset over his housemate's behavior. Client H reported to staff he punched a hole in the wall. Staff checked client H's hand and put ice on it. Later in the day, client H's hand was discolored and he reported it was sore. Staff took client H to the emergency room. Client H's hand was broken. The investigation, dated 9/6/14, indicated, "[Client H] reported to staff that he had punched the wall because he was upset about roommates (sic) behavior. Staff did not witness [client H] punch the wall... [Client H] reported he was 'mad because [client G] was being a butt.' [Client H] reported that no one saw him punch the wall. [Client H] reported he did tell staff that he punched the wall after he got done." The investigation was not conducted within 5 working days and the results of the investigation were not			

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	reported to the administrator. On 10/27/14 at 12:54 PM, the Area Director (AD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 4) On 8/31/14 at 12:45 PM, client G was climbing on cabinets and writing on his bedroom walls. Staff administered a PRN medication. The investigation, dated 9/6/14, indicated, "Evidence supports staff intervened appropriately." The investigation was not conducted within 5 working days and the results of the investigation were not reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD			

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	indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 5) On 8/31/14 at 12:05 PM, client G was climbing on cabinets. Staff urged him to write it down to communicate to staff. Client G was given a PRN medication. The investigation, dated 9/6/14, indicated, "Evidence supports staff intervened appropriately." The investigation was not conducted within 5 working days and the results of the investigation were not reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 7) On 8/17/14 at 12:32 PM, client G was wanting to watch television and ended up breaking the remote control. The BDDS report, dated 8/18/14, indicated, "He continued by pounding on the TV and [client A] got up and punched [client G]."			

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	The investigation, dated 8/24/14, was not completed timely. There was no documentation the investigation results were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated investigations should be completed within 5 working days and the results of the investigation should be reported to the administrator within 5 working days. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 8) On 8/16/14 at 6:58 PM, client G was obsessing over the television and ran over to the bedroom wall and kicked and hit the wall. Client G kicked out the window and crawled out of it and ran down the sidewalk. Staff #5 was able to calm client G down and returned with him to the home. Client G received a PRN (as needed) medication. The investigation, dated 8/22/14, indicated, "Evidence supports staff intervened appropriately." There was no documentation the results of the investigation were reported to the			

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	administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 9) On 5/12/14 at 8:30 AM, client H was charging at staff and staff was blocking him using agency-approved techniques. Client H walked up to staff and smacked staff across the face before staff could block him. Staff became upset and called 911. Police arrived and talked to client H and left. The investigation, dated 5/14/14, indicated, "[Staff #5] reported he was trying to assist client with getting ready for day program. [Staff #5] reported that '[client H] seemed to be in a bad mood and was cussing at everyone.' [Staff #5] reported that [client H] was refusing to get on the van which was causing everyone else to be late for day program. [Staff #5] reported that when [client H] slapped him he was very upset and he called the police. [Staff #5] reported that			

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	he was not going to press charges against [client H] that he was just upset at the time and that 'I shouldn't have called the police I was just mad when he slapped me across the face.' [Staff #5] reported 'I could have handled it differently.'" There was no documentation the results of the investigation were reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 10) On 4/8/14 at 8:34 PM, the BDDS report, dated 4/9/14, indicated, "HM (Home Manager) called oncall (sic) PD (Program Director) and reported that [client F] locked himself in the bathroom with [client D] and wouldn't (sic) let staff in. When they got in [client D] said [client F] touched him in his groin." The investigation, dated 4/10/14, indicated, "Door knob on bathroom door was changed to a lock that staff can unlock easy (sic) from the outside. Door			

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	chime was put on the bedroom door of [client F's] and roommates (sic) bedroom which leads to the bathroom. Door alarms speakers were placed in the kitchen and living room." There was no documentation the results of the investigation were reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 11) On 3/30/14 at 7:45 PM, client A was upset due to a housemate's behavior. The BDDS report indicated, "He finally snapped when [client G] started having a behavior over the TV and tried to run up (sic) steps. Staff blocked him and when they turned around [client A] was standing there and punched [client G] twice once on the right eye and one time on the lip... [Client G] (sic) eye was a little swollen but is acting normal." The investigation, dated 4/3/14, indicated, "[Client G] was trying to get			

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	upstairs in the home and staff was trying to redirect him to another activity. [Client A] walked up on the situation and became upset and hit [client G] twice before staff could separate the two clients." There was no documentation the investigation results were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 12) On 3/23/14 at 5:00 PM (reported to the Home Manager on 3/25/14), client C reported staff #15 took some of the clients to the park to play basketball. While at the park, a friend of staff #15's asked client C if he "wanted to buy any pot." Client C indicated he told the person no and walked away. Staff #15 continued to spend time with the person until they left the park. Client C indicated he did not report the incident due to not wanting to get anyone into trouble. Staff #15 was suspended.			

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	The investigation, dated 4/2/14, indicated client C recanted his allegation. Client C indicated the person he met at the park did not have marijuana and did not ask him to buy any. The investigation's Conclusion indicated, "There is no evidence to support that [staff #15] was interacting inappropriately around any of the clients." The investigation was not signed by the investigator. There was no documentation indicating the results of the investigation were reported the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 13) On 3/2/14 at 8:45 PM, client H and staff #14 went to pick up client D from his relative's house. As client D was putting his items into the van, client H said something (staff did not hear) to client D. The BDDS report, dated 3/3/14, indicated, "[Client D] became upset at what [client H] said and [client D] physically aggressed on [client H].			

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	[Client H] jumped out of the van before staff could separate them." Client H had a small scratch (1/4 inch) under his left eye and basic first aid was administered. The investigation, dated 3/7/14, indicated in the conclusion section, "Evidence supports staff did not intervene appropriately." The Recommendations section indicated, "Retraining of staff that staff will get out of the van and assist [client D] with putting his things in the van to try and prevent any further incidents of this nature in the future." The investigation had conflicting information regarding the date(s) of the investigation. The section for Dates of Investigation indicated 4/9/14 and 4/10/14. The date completed section indicated the investigation was completed on 3/7/14. There was no documentation the results of the investigation were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident.			

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	14) On 2/13/14 at 6:30 PM, client G asked for a snack right after dinner. Staff redirected client G to take a shower. After his shower, client G saw an empty soda can on the living room table. Client G ran over and stuck his finger into the opening, cutting his finger. Staff #5 attempted to get the can. Client G swung at staff and missed. Client G swung again and then body slammed into staff #5. Staff #5 and client G fell to the floor. Staff #5 and client G hit their heads together during the fall. Client G received a cut about his r ight eye and staff could not get it to stop bleeding. Staff #5 contacted the nurse who instructed staff to take client G to the emergency room. The emergency room indicated client G had a minor concussion and they glued the cut. On the way out of the emergency room, client G "attacked" the soda machine and attempted to "attack" staff. A PRN (as needed) medication was administered after client G arrived home due to continued aggression toward staff. The investigation, dated 2/18/14, indicated, "Evidence supports that staff followed [client G's] BSP (behavior support plan) and PRN protocol when PRN Ativan 2mg was administered to [client G]." There was no documentation			

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	the results of the investigation were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 15) On 1/12/14 at 3:30 PM (clients reported to the Program Director on 1/13/14), clients B, E and H indicated former staff #12 asked them if they wanted to go to the mall. On the way to the mall, staff #12 stopped at former staff #13's house. While at staff #13's house, staff #13 asked clients B, E and H if they wanted to see her gun. Staff #13 showed it to them. Staff #12 and clients B, E and H went to the mall. After leaving the mall, staff #12 took the clients back to staff #13's house. Staff #12 went in but left the clients in the van for 5-10 minutes. Staff #13 came out to the van with staff #12 and showed the clients a "certificate of college." Staff #13 stated to the clients, "This is why I shouldn't be working with you f---tards." Client B reported staff #13 stated, "She was			

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	smarter than us." Both staff were suspended. The investigation, dated 1/17/14, indicated staff #12 quit his job after his shift on 1/12/14. The Conclusion of the investigation indicated, "There is evidence to support that [staff #13] called the clients an inappropriate name while at her house." There was no documentation of the action taken by the facility to address this incident. The investigation did not indicate staff #13 quit prior to corrective actions being implemented. There was no documentation the results of the investigation were reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. This federal tag relates to complaints #IN00157027 and #IN00158326. 9-3-2(a)			

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W000157	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 20 of 31 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed to implement effective corrective actions to address abuse, neglect and/or exploitation at the group home. Findings include: A review of the facility's incident/investigative reports was conducted on 10/27/14 at 1:28 PM and indicated the following: 1) On 10/15/14 at 7:30 AM, client F refused to take his lunch box with him to the day program. Client B offered to put the lunch box in the front seat of the van. Staff took the lunch box and put it in between the front seats of the van. Client F was sitting in the front passenger seat of the van. Client F threw his lunch box into the back of the van hitting client B. Client B threw the lunch box back hitting client F in the head. Client B reached up and struck client F on the side of the head multiple times before staff could separate	W000157	The Program Director was retrained on notification of guardians, conducting IDT meeting's and revision of clients plans as needed to ensure client safety. Program Director will conduct client IDT's meetings as needed on an ongoing basis but at least on a yearly basis. Area Director will monitor to ensure IDT's are completed at least annually and any necessary corrective action will be taken as needed. Program Director and Area Director will review incidents, investigations, and follow up needed at weekly meetings to ensure that recommendations based on the results of the investigations have been addressed. Program Director and Area Director will meet weekly to review corrective actions and results of investigations. Monitoring form will be completed weekly to ensure facility compliance. Responsible Party: Program Director, Area Director	12/09/2014

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	the two. The BPR (Behavior Progress Record) - Narrative Notes, dated 10/15/14, indicated, in part, "Incident(s): Physical assault... [Client F] left his lunch box in walkway so another client tried giving the client his lunchbox. [Client F] refused to take it which made other client upset so he threw (sic) lunch box at [client F]. [Client F] then hit client and threw lunch box back at client. Client then begin (sic) hitting [client F] in the face multiple times, and calling him an 'old f------ hag.'" The Investigation Summary, dated 10/22/14, indicated, "[Client B] reported that [client F] was grumpy the morning of the incident and [client B] stated he felt like [client F] was 'giving staff a hard time.' [Client B] reported that [client F] didn't want to carry his lunch box out to the van. [Client B] reported he carried [client F's] lunch box for him. [Client B] stated that when he got out to the van he gave staff [client F's] lunch box and they put it in between the two front seat of the van. [Client B] reported that he got in the van and [client F] threw his lunch box at him and 'I got pissed and threw it back.' [Client B] reported he was upset and hit [client F] in the head but couldn't report how many times he hit (him).			

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	[Client B] reported that [staff #10 and staff #2] told him to get off [client F] and he did. [Client B] reported he went to day program after that... [Staff #2] reported that [client F] refused to carry his lunch box out to the van. [Staff #2] reported that [client B] carried the lunch box and gave it to her and she put it in between the front seats of the van. [Staff #2] reported that [staff #10] was sitting in the back seat of the van. [Staff #2] reported that [client F] grabbed his lunch box and threw it into the back seat. [Staff #2] reported that [client B] became upset and yelled a profane name at [client F] and then threw the lunch box back up front. [Staff #2] reported she was verbally redirecting both clients. [Staff #2] reported that the next thing she knew [client B] was hitting [client F] in the side of the head and she was separating the two clients. [Staff #2] reported that the two clients separated and there was no further incident." The Recommendations section indicated, "New seating chart for van to keep [clients F and B] separated. Lunch boxes will be kept in the rear of the van." There was no documentation in the BDDS reports, investigation and BPR Narrative Notes indicating client F sustained bruising on the right side of his face from his forehead to his ear. The			

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	Investigation Summary did not include documentation indicating when the results of the investigation were reported to the administrator. The BDDS reports, investigation and BPR Narrative Notes did not address the late guardian notification of the incident. The BDDS reports, investigation and BPR Narrative Notes did not address the initial report to the Home Manager regarding the incident did not include information of client B hitting client F multiple times causing injuries. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the staff inaccurately reported the incident initially. The HM indicated the staff reported client F refused to carry his lunch box, threw his lunch box at client B, and client B threw the lunch box back at client F. The HM indicated he was not informed of client B hitting client F multiple times. The HM indicated from the report he received there was no reason for him to believe there was an incident of client to client abuse. The HM indicated on 10/20/14 when client F's guardian notified him of the incident, he reviewed the notes and retrained staff on documentation. The HM indicated he did not observe the bruising on client F prior to the guardian observing the injuries due to the HM not being in the			

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	home from 10/15/14 to 10/20/14. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the PD and the HM were not given all the information regarding the incident from the staff. The PD indicated from the information they received, a lunch box was thrown. There was no information relayed regarding client to client abuse. The PD indicated after speaking with client F's guardian on 10/20/14, it was reported client F was hit on the head by client B. The PD indicated she observed client F on 10/20/14 and did not observe the bruising. The PD indicated the Area Director also assessed client F and did not observe bruising. The PD indicated the guardian should have been notified within 24 hours of the incident. The PD indicated client to client aggression was considered abuse. The PD indicated the facility should prevent abuse. The PD indicated the facility had a policy and procedure prohibiting abuse. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours. The PD indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 2) On 10/7/14 at 6:55 PM, the BDDS report, dated 10/8/14, indicated, "On 10/7 at approximately 6:45 pm the tornado			

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	sirens sounded in [name of city]. Clients and staff, [staff #5 and #7] followed the tornado protocol and all clients and staff went into the basement of the group home. While in the basement [client G] started obsessing over the freezer and started swinging at staff. Staff used agency approved PIA (Physical Intervention Alternatives) blocking techniques to block [client G]. [Client G] then started charging at staff and staff [#5] used agency approved PIA blocking and one arm restraint. [Staff #7] called Program Director [name] for approval of PRN (as needed) Ativan 2mg (milligrams) at approximately 6:55 pm. [Client G] continued to swing at staff and other clients in the basement. [Client B] became upset at this point and targeted [client G]. [Staff #5] had [client G] in a hold and [client B] charged at [client G] and grabbed [client G's] neck. [Staff #5] verbally redirected [client B] to release [client G's] neck and to remove himself from around [client G]. [Staff #5] released [client G] from the hold to physically get in between the two clients and then [client B] released [client G's] neck and then punched [client G] in the face two times while staff was trying to keep them separated. [Client G] then started charging at staff again and agency approved two arm hold was implemented at this time.			

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	[Client E] told [client B], 'That was f------ uncalled for you didn't need to choke him.' [Client B] responded and said, "Shut the f--- up fa----' and charged at [client E]. [Client B] swung and made contact with [client E] and staff, [staff #7] attempted to get in between the two clients. [Client B] bit [client E] on the back and [client E] punched [client B] in the eye causing laceration to his eye. [Client G] had been released from his hold at this point. Police were called to assist as staff [#7 and #5] were unable to get the two clients separated. Staff finally got the two separated after about 30 seconds. Program Director [name] was contacted at this point to let her know the police were called. [Staff #2] was called to the home to assist as well as Home Manager [name] and [staff #4]. [Client G] ran upstairs and [staff #5] ran after him. Police were at the door when [client G] got upstairs. [Client G] ran back down stairs and [staff #7] was still down stairs. Police stopped [staff #5] from going down stairs to ask him questions. Two officers followed [client G] down stairs and [client G] targeted the two police officers so they handcuffed [client G] and brought him back upstairs. They had [client G] sit in the chair in handcuffs while [staff #5] explained what			

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	was going on to the police. [Staff #2] arrived at the home. While [staff #5] was trying to explain why the police were called [client G] continued to get up and resist the police. [Staff #5] and [staff #2] explained to the police that they were able to care for [client G] and had a behavior plan to follow as well as agency approved physical interventions and that [clients E and B] needed the medical attention. Police were getting ready to leave at this point. [Client G] started swinging at staff and biting at staff. [Staff #5] put [client G] in a two arms hold and (client G) bit [staff #5] on the arm and wiggled out of the hold and bit [staff #5] on the leg. [Staff #2] attempted to assist [staff #5] with taking over the hold and the police then took over and got [client G] in the chair in the living room and held him. [Client G] continued to resist the police. [Staff #2] explained to the police that they could leave and that staff could take care of [client G] that [clients E and B] just needed to be checked out. EMT's (emergency medical technicians) explained that they both [clients E and B] needed to go to the emergency room. [Staff #7] took [client E] to the emergency room and [Home Manager] took [client B] to the emergency room. The police were leaving and (they were)			

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	out on the porch. [Client G] got back up and started swinging and biting at staff again. [Staff #2] and [staff #5] put [client G] in a hold once again and the police came back into the home as they must have seen from the living room windows that staff were restraining [client G] again. Police came back into the home and told [staff #2] to get off [client G] and two police officers assisted [staff #5] with the hold and then told [staff #5] to get off [client G] that they would take over. One of the officers told staff, 'This is ridiculous, we can't babysit and this guy shouldn't be living here. We are going to call the big boss.' [Staff #5] asked, 'Who is that?' and one of the police responded, 'The Mayor.' Police informed staff that [client G] would either have to go to the hospital or that they were taking him to jail. [Staff #2] called PD (Program Director) to report what the police said about either taking him to jail or to the hospital. PD told [staff #2] to tell the police that he could not go to jail that the hospital was the only option. PD called [Area Director] to inform him of the situation and that she would keep him up to date about what was going on. [Client G] continued to resist the police, and police were not allowing staff to assist at this point. The Mayor showed up at the home and			

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	came into the home. He told staff that this has happened multiple times that [client G] had gotten into the [name of bar] before, [name of gas station] and that by what he could see going on that the group home was not a good enough facility for him that he needed to be at a different facility to be placed in and that he was going to see to it that he would not be coming back to the group home in [name of city]. [Staff #5] reported that the Mayor stated that 'we would do whatever it took to get him out of this community and it should have happened years ago and enough is enough.' [Client G] continued to target police and they got him in a hold on the ground. Program Director [name] arrived at the group (sic) at that point. [Client G] was on the ground and police were physically restraining him at this point. Police then got him up off the ground about 30 seconds after PD arrived at the home and assisted him with getting in the chair. The mayor asked [PD] to speak to a supervisor, PD told him that she was the supervisor and he told her that he wanted to talk to her boss. PD [name] called [Area Director] and gave the phone to the Mayor at this point. [Client G] kept trying to get up out of the chair and police kept having him sit back down. [Client G] then got up and moved towards the couch. Police started to hold			

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	him and [staff #2] stated he is trying to get to the couch. Police allowed him to move to the couch and [staff #2] got him a pillow and blanket. Program Director [name] gave approval to [staff #2] to give a second PRN medication. Ativan 2mg was given. The Mayor then came back in and told police to call [name] transport that he was being transported to [name of hospital]. [Staff #2] rode in the ambulance with [client G] and PD [name] followed in personal vehicle. [Client G] was taken to [name of hospital] per police and [name of city] Mayor request. [Staff #16] contacted Program Director as she was taking another client home and saw the police at the group home and asked if she needed to go back once she dropped off the client she was working with. PD [name] told [staff #16] to go back and assist [staff #4] with other clients. [Program Director] contacted Program Nurse [name] to report that [client G] was being taken to [name of hospital] and contacted [Area Director] to report as well. Program Director also contacted [client G's guardian] to report the incident. [Client E's guardian] was contacted to report the incident." On 10/27/14 at 12:54 PM, the Area Director (AD) indicated the police were			

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	not called due to client G's behavior but due to client B and E's behavior. The AD indicated the incident occurred during a tornado warning. The AD stated client G was "cycling" and this was the time of year his behaviors increased. The AD indicated the mayor of the city wanted client G moved out of the group home due to being a danger to the community. The AD indicated client G was not going to move. Client G was admitted to the hospital following the incident due to being given two options: jail or the hospital. Client G was discharged from the hospital and returned to the group home. The AD indicated the facility ordered client G a weighted blanket to assist with calming him. The AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The AD indicated client to client abuse should be investigated. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. The PD indicated incidents of client to client abuse should be investigated. On			

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	10/31/14 at 12:01 PM, the PD indicated an investigation was conducted and the facility should have given the surveyor the investigation to review. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The HM indicated incidents of client to client abuse should be investigated. 3) On 9/23/14 at 12:45 AM, client G went into the basement of the home, took a television out into the back yard and destroyed it. The BDDS report, dated 9/24/14, indicated, "[Former staff #11] then reported that he was on the porch smoking a cigarette to calm down after the incident and when he went back inside [client G] was gone. [Staff #11] then reported he started making phone calls and got ahold (sic) of [staff #6] and [staff #5] for assistance. Police arrived at the home and talked to [staff #11] about what was going on and staff reported that he was able to get [client G] in the home. [Staff #11] then reported he went inside the home and [client G] was gone. [Staff #11] then reported that the police called the home to report they had found [client G] at [name of gas station] gas station on			

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	[name of street] and that an ambulance was on its way. [Staff #5 and #6] arrived at the home and notified [staff #11] that [staff #5] had notified [Home Manager] who was also on his way to the home. [Home Manager] contacted [staff #6] and instructed her to administer a PRN (as needed), Ativan 2 mg (milligrams), per PRN protocol once she got to the [name of gas station]. [Staff #6] explained to police that [client G] had a PRN medication to assist him when he was agitated. Ambulance arrived on the scene and transported [client G] to the hospital. [Home Manager], [staff #5], [staff #6] all arrived at the hospital and [client G] was released to their care. During the incident [client G] sustained numerous superficial wounds while he was at [name of gas station]. [Staff #11] was suspended pending investigation. Team met on 9/23 and team implemented double staffing during the overnights for two weeks. Team will meet again on 10/7. Nurse, [name], contacted psychiatrist, [name] to discuss the situation and the increase in [client G's] agitation. [Psychiatrist] increased Clozapine (psychotropic medication) from 350 mg daily to 400 mg daily." The investigation, dated 9/30/14, indicated, in part, "Brief summary of the incident: [Client G] eloped from the			

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	home and ran to the [name] gas station a few blocks away and committed property damage. [Staff #11] was supervising at the time of the incident and reportedly did not realize [client G] had eloped. Following the incident, [staff #11] was suspended by the Home Manager [name]... [Staff #5] stated that after [client G] was in bed, he asked [staff #11] what happened and [staff #11], 'acted scared, said he was smoking a cigarette and had headphones on listening to music and cops showed up,' then said he was watching [client G's door] to see if he got up but [client G] must have gone out through the hallway door and down the basement stairs and he didn't see him. [Staff #5] stated that all the blinds were closed when he got to the house so he didn't know how [staff #11] could see in the house except through the high glass section on one of the doors that is the only part not frosted. [Staff #5] reported that through that section you can only see the living room and not into [client G's] bedroom. [Staff #5] stated that he is tall and can't see into [client G's] room through that window. [Staff #5] stated that the alarms were working on all the doors when he was in the home after the incident. [Staff #5] stated that during his shift on 9/22/14, [client G] had behaviors but hadn't tried to elope at any time. [Staff #5] stated that [client G] was in			

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	bed when he left at 10pm...". The investigation indicated, "[Staff #6] stated that she worked in the home on 9/22/14 from 2pm until 12:15am. She stated that she was to be off work at 12am and [staff #11] was to relieve her but she was about 10-15 minutes late and she left at 12:14am or 12:15am... She stated that she went in the room and checked on him at 11:30pm and [client G] was sleeping and then checked on him again right before she left the house and he was asleep and snoring. [Staff #6] stated that no other clients were awake when she left the home and [client G's] roommate [client F] was also asleep. [Staff #6] stated that she left the home after [staff #11] arrived and went home and [staff #11] called her at 12:36am and said '[client G's] gone.' She stated that she asked him what he was talking about and if he had called anyone to report it and [staff #11] said she had tried to 'call everyone and no one would answer.' [Staff #6] stated that she immediately went to the house to help look for [client G] and got there in about 5 minutes and [staff #11] was outside the house by the driveway along the road 'pacing.' [Staff #6] stated she went into the house to look for [client G] and saw the 'mess in the basement' of all the items [client G] had destroyed, and checked around the yard			

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	and couldn't find [client G]. She stated that she found [client G's] pants outside in the backyard. She stated that she had been searching about 6-7 minutes when the police called the house and said [client G] was at [gas station]... [Staff #6] stated that while she was at the hospital, the police talked to her and told her they had received a phone call at 12:22am from a neighbor complaining about someone tearing up a TV in the backyard. They said that they arrived at the house and [staff #11] was on the front porch and they asked him what was going on and [staff #11] replied with 'nothing, at work.' They said that they told [staff #11] they had gotten a call about someone tearing up a TV in the backyard and [staff #11] ran into the house and looked everywhere for [client G] then came back to them and said 'he's gone, can you help?' and they left the house to start looking for [client G]. [Staff #6] stated that the police told her [staff #11] was on the front porch smoking... [Staff #6] stated that when [staff #11] arrived at the house that night to relieve her, he was getting his headphones out of his pocket and untangling them and plugging them into his phone. She stated that she did not see the headphones in his ears but didn't know 'how else he couldn't have heard [client G] tearing stuff up.'"			

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	The investigation indicated, "[Staff #11] stated that his shift started at 12am on 9/23/14. He stated that he arrived at the house at 12am. When asked if he was late, he stated that he wasn't. He stated that [staff #6] was leaving her shift and stayed about 5-10 minutes telling him about [client G's] behaviors he had during her shift. [Staff #11's] time sheet states that he arrived at work at 12am. [Staff #11] stated that [client G] was in bed when he arrived. He stated that [staff #6] said [client G] was asleep and he went and checked and he looked asleep to him. He stated that [client G's] roommate was getting ready for bed and didn't know if he had awakened [client G] during this time. [Staff #11] stated that he was putting some stuff away and [client G] got up and went to use the bathroom and got a drink and [staff #11] told him to go back to bed. He stated that [client G] started laughing, walked back to his bedroom and shoved [staff #11] and then ran out of the back door of the house. [Staff #11] stated that he got [client G] back into the house and into bed. He stated that [client G] just kept laughing then got back up and ran downstairs and started tearing stuff up and pulling things out of the freezer and cabinets. [Staff #11] stated that he didn't want to get hurt and didn't want [client G] to get hurt. He stated that he yelled			

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	for [client C], a housemate, to open the basement door so it would be easier to get [client G] back up the stairs to his bedroom. [Staff #11] stated that [client C] never came to the door. [Staff #11] stated that he got [client G] back into his bed and he laid down. [Staff #11] stated that he called [Home Manager] about 10 times and got no answer. [Staff #11] stated that he then went to the front porch while trying to call [Home Manager] and the police showed up and said they had a complaint of noise in the back yard. [Staff #11] stated that he thought the noise that was reported had been from earlier when he was trying to get [client G] back in (sic) house. [Staff #11] stated that he thought he had locked the basement door earlier after that incident. [Staff #11] stated that he ran in the house and searched for [client G] and couldn't find him and told the police who [client G] was and they left to go look for him. He stated that he found [client G's] clothes in the back yard... When asked about the time he was on the front porch, [staff #11] stated that he was smoking a cigarette and [client G] was in bed after the basement incident. He stated that he was trying to call [Home Manager] from his cell phone and the house phone to report the incident. [Staff #11] stated that he was watching for [client G] to get up through the window of the doors to			

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	the house and went to the side porch to make sure he didn't try to go out his bedroom window... When asked if at any time he had headphones in his ears, [staff #11] stated that he had his 'left headphone in' attached to his cell phone because he was trying to make a call on his cell phone while he used the house phone with his other ear trying to call people. He stated that he also called his girlfriend during this time because she usually brings him some dinner when she gets off work and he wanted to let her know what it wasn't 'safe' to bring him dinner that night due to [client G's] behaviors... When asked why [Home Manager] or [Program Director's] phones did not show any missed calls from him, he stated that he didn't know why they didn't. [Staff #11] stated that he also sent [Home Manager] a text message saying something like 'call me asap (as soon as possible). [Client G] having behaviors...'. When asked if he could show this interviewer the text, he stated that he recently upgraded his iPhone and it wiped out all of his calls and texts and other information and he had to take it to [name of company] to be fixed so he had no information to share." The investigation indicated in the Additional information section, "All alarms on all doors were working when			

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	the investigator was at the home on 9/30/14... The police report dated 9/28/14, stated that they received a call from a neighbor at 12:22am on 9/23/14. The officers arrived at the home (at approximately 12:30am based on the incident timeline) and asked [staff #11] what was going on and he replied 'just working.' The police report states that they told [staff #11] they had received a call about someone smashing something in the back of the residence and [staff #11] immediately ran into the residence. The police report states that the officers followed him into the home and [staff #11] then stated 'I need your guys' help, [client G] is out.' The police report states that the officers left the home and began driving around the area in an attempt to locate [client G]. The police report states that a short while later (approximately 10-15 minutes after they were at the home), dispatch advised that there was a man in the [gas station] on [name of street] that was destroying the inside of the store. The report states that when they arrived at the store, they found [client G] in a t-shirt and underwear pulling products off of shelves and throwing them and they restrained him. The report states that he was then transported to [hospital]...". The investigation's Conclusion indicated,			

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	"There is evidence to support that [staff #11] was outside the home on the front porch when [client G] eloped from the home through the basement door and that this supports an allegation of neglect. There is no evidence to support that [staff #11] made phone calls to either of his supervisors and instead contacted his coworkers." On 10/30/14 at 1:26 PM, a review of a Termination Notice, dated 10/1/14, indicated staff #11 was terminated on 10/20/14. The notice indicated, in part, "Indiana MENTOR is terminating [staff #11's] employment due to [staff #11] not following the proper supervision level of a client." On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated he was contacted by staff #5 at 1:00 AM. Staff #5 told the HM staff #5 was on the way to the house due to receiving a call from staff #6 indicating client G had eloped. The HM indicated once the Area Director (AD) was contacted, the AD made the decision to suspend staff #11 at 4:00 AM. Staff #5 was still at the house with staff #11. The HM indicated staff #11 was on the front porch during the incident unaware the incident was taking place. On 10/27/14 at 12:54 PM, the Area			

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	Director (AD) indicated staff #11 indicated he arrived to work on time but he was late. Staff #11 reported client G had an incident in the basement and the staff #11 went to smoke a cigarette. The AD indicated a neighbor contacted police due to a disturbance in the backyard. The AD indicated staff #11 indicated he had a headphone in while watching client G through a window while waiting for his girlfriend to bring him dinner. Client G eloped to a gas station. The AD indicated he thought client G went into the basement, got into the food, took the television from the basement and threw it into the neighbor's backyard and went to the gas station. The AD indicated it was his belief staff #11 was not aware of incident until the police showed up. When the police arrived, staff #11 was on the front porch. Staff #11 told the police he was working. Police indicated there was a disturbance. Staff #11 ran into the house, checked the basement and told the police client G was gone. The AD indicated he did not believe staff #11 was aware client G was gone until the police arrived. The AD indicated client G exited the house through the basement door, which had a functioning alarm. The AD indicated the facility has had two overnight staff since the incident. The AD indicated client G caused damage at the gas station. Client G ate a lot of food			

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	and then threw it up. The AD indicated staff #11 was terminated due to neglect. 4) On 9/21/14 at 4:08 PM, client G was obsessing over the television and ran up the stairs to get into his roommates' bedrooms to get their electronics. Client G got a fork from the kitchen and tried to stab the TV cord, which was unplugged. Client G tried to stab staff with the fork. Client G was going up the stairs and staff #5 was attempting to block his way. Client G lost his balance and both client G and the staff fell. Client G received a rug burn on his forehead and rib area. Client G was given a PRN. Client G was prompted to take a shower and he did. Staff attempted to take him on a van ride. He refused and started obsessing over the TV again and tried to tear it off the wall. Client G went upstairs and tried to destroy a housemate's CPAP (continuous positive airway pressure) machine. Client G was blocked. Client G knocked his housemate's TV off the stand it broke. Client G also broke the cable box. Client G ran into another client's bedroom and broke his cable box. Client G was assisted downstairs. A second PRN medication was administered. The facility did not conduct an investigation into the incident to ensure the PRN medications were administered			

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	appropriately as well as to investigate how client G sustained rug burns on his forehead and rib area. On 10/31/14 at 12:01 PM, the Program Director (PD) indicated she thought the incident was investigated. The PD indicated the incident should have been investigated. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the timeframe for reporting incidents to BDDS was 24 hours. 5) On 8/31/14 at 1:00 PM, client H was upset over his housemate's behavior. Client H reported to staff he punched a hole in the wall. Staff checked client H's hand and put ice on it. Later in the day, client H's hand was discolored and he reported it was sore. Staff took client H to the emergency room. Client H's hand was broken. The investigation, dated 9/6/14, indicated, "[Client H] reported to staff that he had punched the wall because he was upset about roommates (sic) behavior. Staff did not witness [client H] punch the wall... [Client H] reported he			

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	was 'mad because [client G] was being a butt.' [Client H] reported that no one saw him punch the wall. [Client H] reported he did tell staff that he punched the wall after he got done." The investigation was not conducted within 5 working days and the results of the investigation were not reported to the administrator. On 10/27/14 at 12:54 PM, the Area Director (AD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 6) On 8/31/14 at 12:45 PM, client G was climbing on cabinets and writing on his bedroom walls. Staff administered a PRN medication. The investigation, dated 9/6/14, indicated, "Evidence supports staff intervened appropriately." The investigation was not conducted within 5 working days and the results of the investigation were not reported to the administrator.			

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	On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 7) On 8/31/14 at 12:05 PM, client G was climbing on cabinets. Staff urged him to write it down to communicate to staff. Client G was given a PRN medication. The investigation, dated 9/6/14, indicated, "Evidence supports staff intervened appropriately." The investigation was not conducted within 5 working days and the results of the investigation were not reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The PD indicated investigations should be completed within 5 working days. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations			

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	should be reported to the administrator within 5 working days of the incident. The AD indicated investigations should be completed within 5 working days. 8) On 8/30/14 at 6:58 PM, client E punched client A in the face. Client A's glasses were broken. There was no documentation of an investigation. On 10/27/14 at 12:54 PM, the AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The AD indicated client to client abuse should be investigated. The AD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. The PD indicated incidents of client to client abuse should be investigated. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client			

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	aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The HM indicated incidents of client to client abuse should be investigated. The HM indicated the timeframe for reporting incidents to BDDS was 24 hours. 9) On 8/21/14 at 5:00 PM, client B was on his way to a church dinner in the van. Client B was obsessing about dessert since his doctor wanted him to go on a diet. Client B had a seizure. Staff pulled the van over while the other staff attended to client B. Staff called the Home Manager (HM) since client B had been in a seizure for 4 minutes. The HM directed the staff to call 911 since they were out of town and it would take some time for the ambulance to get there. When the ambulance arrived on scene, client B was having trouble breathing. The paramedics attempted to give him oxygen but he was combative. Another group home manager arrived to assist. She was able to get client B calmed down and into the ambulance. Client B was in the emergency room for 3 hours and an EKG (electrocardiogram) was conducted. The hospital sent client B to another hospital to receive care from a cardiologist. Client B's heart rate and blood pressure were elevated. Client B			

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	was admitted to the hospital on 8/21/14. There was no documentation an investigation was completed to ensure staff followed client B's plan and appropriate care was given. On 10/31/14 at 12:01 PM, the Program Director (PD) indicated the incident was not investigated. The PD indicated the incident should have been investigated to ensure the staff provided the appropriate care and implemented client B's risk plan for seizures as written. 10) On 8/17/14 at 12:32 PM, client G was wanting to watch television and ended up breaking the remote control. The BDDS report, dated 8/18/14, indicated, "He continued by pounding on the TV and [client A] got up and punched [client G]." The investigation, dated 8/24/14, was not completed timely. There was no documentation the investigation results were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated investigations should be completed within 5 working days and the results of the investigation should be reported to the administrator within 5 working days.			

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	On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 11) On 8/16/14 at 6:58 PM, client G was obsessing over the television and ran over to the bedroom wall and kicked and hit the wall. Client G kicked out the window and crawled out of it and ran down the sidewalk. Staff #5 was able to calm client G down and returned with him to the home. Client G received a PRN (as needed) medication. The investigation, dated 8/22/14, indicated, "Evidence supports staff intervened appropriately." There was no documentation the results of the investigation were reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator			

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	within 5 working days of the incident. The AD indicated the timeframe for reporting incidents to BDDS was 24 hours. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the timeframe for reporting incidents to BDDS was 24 hours. 12) On 5/12/14 at 8:30 AM, client H was charging at staff and staff was blocking him using agency-approved techniques. Client H walked up to staff and smacked staff across the face before staff could block him. Staff became upset and called 911. Police arrived and talked to client H and left. The investigation, dated 5/14/14, indicated, "[Staff #5] reported he was trying to assist client with getting ready for day program. [Staff #5] reported that '[client H] seemed to be in a bad mood and was cussing at everyone.' [Staff #5] reported that [client H] was refusing to get on the van which was causing everyone else to be late for day program. [Staff #5] reported that when [client H] slapped him he was very upset and he called the police. [Staff #5] reported that he was not going to press charges against [client H] that he was just upset at the time and that 'I shouldn't have called the			

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	police I was just mad when he slapped me across the face.' [Staff #5] reported 'I could have handled it differently.'" There was no documentation the results of the investigation were reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 13) On 4/8/14 at 8:34 PM, the BDDS report, dated 4/9/14, indicated, "HM (Home Manager) called oncall (sic) PD (Program Director) and reported that [client F] locked himself in the bathroom with [client D] and wouldn't (sic) let staff in. When they got in [client D] said [client F] touched him in his groin." The investigation, dated 4/10/14, indicated, "Door knob on bathroom door was changed to a lock that staff can unlock easy (sic) from the outside. Door chime was put on the bedroom door of [client F's] and roommates (sic) bedroom which leads to the bathroom. Door			

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	alarms speakers were placed in the kitchen and living room." There was no documentation the results of the investigation were reported to the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 14) On 3/30/14 at 7:45 PM, client A was upset due to a housemate's behavior. The BDDS report indicated, "He finally snapped when [client G] started having a behavior over the TV and tried to run up (sic) steps. Staff blocked him and when they turned around [client A] was standing there and punched [client G] twice once on the right eye and one time on the lip... [Client G] (sic) eye was a little swollen but is acting normal." The investigation, dated 4/3/14, indicated, "[Client G] was trying to get upstairs in the home and staff was trying to redirect him to another activity. [Client A] walked up on the situation and			

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	became upset and hit [client G] twice before staff could separate the two clients." There was no documentation the investigation results were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse.			

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	15) On 3/23/14 at 5:00 PM (reported to the Home Manager on 3/25/14), client C reported staff #15 took some of the clients to the park to play basketball. While at the park, a friend of staff #15's asked client C if he "wanted to buy any pot." Client C indicated he told the person no and walked away. Staff #15 continued to spend time with the person until they left the park. Client C indicated he did not report the incident due to not wanting to get anyone into trouble. Staff #15 was suspended. The investigation, dated 4/2/14 (not completed within 5 working days), indicated client C recanted his allegation. Client C indicated the person he met at the park did not have marijuana and did not ask him to buy any. The investigation's Conclusion indicated, "There is no evidence to support that [staff #15] was interacting inappropriately around any of the clients." The investigation was not signed by the investigator. There was no documentation indicating the results of the investigation were reported the administrator. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of			

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	the incident. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 16) On 3/2/14 at 8:45 PM, client H and staff #14 went to pick up client D from his relative's house. As client D was putting his items into the van, client H said something (staff did not hear) to client D. The BDDS report, dated 3/3/14, indicated, "[Client D] became upset at what [client H] said and [client D] physically aggressed on [client H]. [Client H] jumped out of the van before staff could separate them." Client H had a small scratch (1/4 inch) under his left eye and basic first aid was administered. The investigation, dated 3/7/14, indicated in the conclusion section, "Evidence supports staff did not intervene appropriately." The Recommendations section indicated, "Retraining of staff that staff will get out of the van and assist [client D] with putting his things in the van to try and prevent any further incidents of this nature in the future." The investigation had conflicting information regarding the date(s) of the investigation. The section for Dates of Investigation indicated 4/9/14 and			

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	4/10/14. The date completed section indicated the investigation was completed on 3/7/14. There was no documentation the results of the investigation were reported to the administrator. On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. The AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. The AD indicated client to client abuse should be thoroughly investigated. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. 17) On 2/13/14 at 6:30 PM, client G asked for a snack right after dinner. Staff			

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	redirected client G to take a shower. After his shower, client G saw an empty soda can on the living room table. Client G ran over and stuck his finger into the opening, cutting his finger. Staff #5 attempted to get the can. Client G swung at staff and missed. Client G swung again and then body slammed into staff #5. Staff #5 and client G fell to the floor. Staff #5 and client G hit their heads together during the fall. Client G received a cut about his right eye and staff could not get it to stop bleeding. Staff #5 contacted the nurse who instructed staff to take client G to the emergency room. The emergency room indicated client G had a minor concussion and they glued the cut. On the way out of the emergency room, client G "attacked" the soda machine and attempted to "attack" staff. A PRN (as needed) medication was administered after client G arrived home due to continued aggression toward staff. The investigation, dated 2/18/14, indicated, "Evidence supports that staff followed [client G's] BSP (behavior support plan) and PRN protocol when PRN Ativan 2mg was administered to [client G]." There was no documentation the results of the investigation were reported to the administrator.			

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	On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 18) On 1/12/14 at 3:30 PM (clients reported to the Program Director on 1/13/14), clients B, E and H indicated former staff #12 asked them if they wanted to go to the mall. On the way to the mall, staff #12 stopped at former staff #13's house. While at staff #13's house, staff #13 asked clients B, E and H if they wanted to see her gun. Staff #13 showed it to them. Staff #12 and clients B, E and H went to the mall. After leaving the mall, staff #12 took the clients back to staff #13's house. Staff #12 went in but left the clients in the van for 5-10 minutes. Staff #13 came out to the van with staff #12 and showed the clients a "certificate of college." Staff #13 stated to the clients, "This is why I shouldn't be working with you f---tards." Client B reported staff #13 stated, "She was smarter than us." Both staff were suspended.			

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	The investigation, dated 1/17/14, indicated staff #12 quit his job after his shift on 1/12/14. The Conclusion of the investigation indicated, "There is evidence to support that [staff #13] called the clients an inappropriate name while at her house." There was no documentation of the action taken by the facility to address this incident. The investigation did not indicate staff #13 quit prior to corrective actions being implemented. There was no documentation the results of the investigation were reported to the administrator within 5 working days of the incident. On 10/30/14 at 1:21 PM, the Area Director indicated in an email, "[Staff #13] quit before any corrective action was done." On 10/27/14 at 12:54 PM, the AD indicated the results of investigations should be reported to the administrator within 5 working days of the incident. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the results of investigations should be reported to the administrator within 5 working days of the incident. 19) On 1/8/14 at 6:30 PM, clients A and E hit each other. Client A's glasses were			

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	broken during the incident. Client A sustained a small bruise on his forehead. On 10/27/14 at 12:54 PM, the AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. 20) On 11/24/13 at 12:40 PM, client G urinated on his blankets. Client G attempted to get his soiled blankets. Staff redirected client G. Client G attempted to hit staff. Client A punched client G in the side of the head and face on the left side. Client G was not injured. On 10/27/14 at 12:54 PM, the AD indicated client to client aggression was			

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	considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse. This federal tag relates to complaints #IN00157027 and #IN00158326. 9-3-2(a)			
W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential			

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	living unit. Based on observation, record review and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to provide sufficient staffing to manage and supervise the clients in accordance with their individual program plans. Findings include: A review of the facility's incident/investigative reports was conducted on 10/27/14 at 1:28 PM and indicated the following: 1) On 10/15/14 at 7:30 AM, client F refused to take his lunch box with him to the day program. Client B offered to put the lunch box in the front seat of the van. Staff took the lunch box and put it in between the front seats of the van. Client F was sitting in the front passenger seat of the van. Client F threw his lunch box into the back of the van hitting client B. Client B threw the lunch box back hitting client F in the head. Client B reached up and struck client F on the side of the head multiple times before staff could separate the two. The BPR (Behavior Progress Record) - Narrative Notes, dated 10/15/14, indicated, in part, "Incident(s): Physical	W000186	Staff training was completed on 11/06/14 to address the staffing needs of the clients and staff location and presence when clients are present in the home. Home Manager will complete bi-weekly schedules. Program Director will review the bi-weekly schedule to ensure appropriate staffing levels are maintained and staffed accordingly. In home observations will be completed by administrative staff at least weekly for 30 days and then monthly thereafter. Staff training will be completed on review of daily schedule and notification of Home Manager, Program Director, or Area Director if scheduled staff is not present for their shift. Responsible Party: Home Manager, Program Director, Area Director.	12/09/2014

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	assault... [Client F] left his lunch box in walkway so another client tried giving the client his lunchbox. [Client F] refused to take it which made other client upset so he threw (sic) lunch box at [client F]. [Client F] then hit client and threw lunch box back at client. Client then begin (sic) hitting [client F] in the face multiple times, and calling him an 'old f------ hag.'" The Investigation Summary, dated 10/22/14, indicated, "[Client B] reported that [client F] was grumpy the morning of the incident and [client B] stated he felt like [client F] was 'giving staff a hard time.' [Client B] reported that [client F] didn't want to carry his lunch box out to the van. [Client B] reported he carried [client F's] lunch box for him. [Client B] stated that when he got out to the van he gave staff [client F's] lunch box and they put it in between the two front seat of the van. [Client B] reported that he got in the van and [client F] threw his lunch box at him and 'I got pissed and threw it back.' [Client B] reported he was upset and hit [client F] in the head but couldn't report how many times he hit (him). [Client B] reported that [staff #10 and staff #2] told him to get off [client F] and he did. [Client B] reported he went to day program after that... [Staff #2] reported that [client F] refused to carry			

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	his lunch box out to the van. [Staff #2] reported that [client B] carried the lunch box and gave it to her and she put it in between the front seats of the van. [Staff #2] reported that [staff #10] was sitting in the back seat of the van. [Staff #2] reported that [client F] grabbed his lunch box and threw it into the back seat. [Staff #2] reported that [client B] became upset and yelled a profane name at [client F] and then threw the lunch box back up front. [Staff #2] reported she was verbally redirecting both clients. [Staff #2] reported that the next thing she knew [client B] was hitting [client F] in the side of the head and she was separating the two clients. [Staff #2] reported that the two clients separated and there was no further incident." The Recommendations section indicated, "New seating chart for van to keep [clients F and B] separated. Lunch boxes will be kept in the rear of the van." 2) On 10/7/14 at 6:55 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 10/8/14, indicated, "On 10/7 at approximately 6:45 pm the tornado sirens sounded in [name of city]. Clients and staff, [staff #5 and #7] followed the tornado protocol and all clients and staff went into the basement of the group home. While in the basement [client G] started obsessing			

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	over the freezer and started swinging at staff. Staff used agency approved PIA (Physical Intervention Alternatives) blocking techniques to block [client G]. [Client G] then started charging at staff and staff [#5] used agency approved PIA blocking and one arm restraint. [Staff #7] called Program Director [name] for approval of PRN (as needed) Ativan 2mg (milligrams) at approximately 6:55 pm. [Client G] continued to swing at staff and other clients in the basement. [Client B] became upset at this point and targeted [client G]. [Staff #5] had [client G] in a hold and [client B] charged at [client G] and grabbed [client G's] neck. [Staff #5] verbally redirected [client B] to release [client G's] neck and to remove himself from around [client G]. [Staff #5] released [client G] from the hold to physically get in between the two clients and then [client B] released [client G's] neck and then punched [client G] in the face two times while staff was trying to keep them separated. [Client G] then started charging at staff again and agency approved two arm hold was implemented at this time. [Client E] told [client B], 'That was f------ uncalled for you didn't need to choke him.' [Client B] responded and said, "Shut the f--- up fa----' and charged at [client E]. [Client B] swung and made			

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	contact with [client E] and staff, [staff #7] attempted to get in between the two clients. [Client B] bit [client E] on the back and [client E] punched [client B] in the eye causing laceration to his eye. [Client G] had been released from his hold at this point. Police were called to assist as staff [#7 and #5] were unable to get the two clients separated. Staff finally got the two separated after about 30 seconds. Program Director [name] was contacted at this point to let her know the police were called. [Staff #2] was called to the home to assist as well as Home Manager [name] and [staff #4]. [Client G] ran upstairs and [staff #5] ran after him. Police were at the door when [client G] got upstairs. [Client G] ran back down stairs and [staff #7] was still down stairs. Police stopped [staff #5] from going down stairs to ask him questions. Two officers followed [client G] down stairs and [client G] targeted the two police officers so they handcuffed [client G] and brought him back upstairs. They had [client G] sit in the chair in handcuffs while [staff #5] explained what was going on to the police. [Staff #2] arrived at the home. While [staff #5] was trying to explain why the police were called [client G] continued to get up and resist the police. [Staff #5] and [staff #2] explained to the police that they were			

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	able to care for [client G] and had a behavior plan to follow as well as agency approved physical interventions and that [clients E and B] needed the medical attention. Police were getting ready to leave at this point. [Client G] started swinging at staff and biting at staff. [Staff #5] put [client G] in a two arms hold and (client G) bit [staff #5] on the arm and wiggled out of the hold and bit [staff #5] on the leg. [Staff #2] attempted to assist [staff #5] with taking over the hold and the police then took over and got [client G] in the chair in the living room and held him. [Client G] continued to resist the police. [Staff #2] explained to the police that they could leave and that staff could take care of [client G] that [clients E and B] just needed to be checked out. EMT's (emergency medical technicians) explained that they both [clients E and B] needed to go to the emergency room. [Staff #7] took [client E] to the emergency room and [Home Manager] took [client B] to the emergency room. The police were leaving and (they were) out on the porch. [Client G] got back up and started swinging and biting at staff again. [Staff #2] and [staff #5] put [client G] in a hold once again and the police came back into the home as they must have seen from the living room windows			

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	that staff were restraining [client G] again. Police came back into the home and told [staff #2] to get off [client G] and two police officers assisted [staff #5] with the hold and then told [staff #5] to get off [client G] that they would take over. One of the officers told staff, 'This is ridiculous, we can't babysit and this guy shouldn't be living here. We are going to call the big boss.' [Staff #5] asked, 'Who is that?' and one of the police responded, 'The Mayor.' Police informed staff that [client G] would either have to go to the hospital or that they were taking him to jail. [Staff #2] called PD (Program Director) to report what the police said about either taking him to jail or to the hospital. PD told [staff #2] to tell the police that he could not go to jail that the hospital was the only option. PD called [Area Director] to inform him of the situation and that she would keep him up to date about what was going on. [Client G] continued to resist the police, and police were not allowing staff to assist at this point. The Mayor showed up at the home and came into the home. He told staff that this has happened multiple times that [client G] had gotten into the [name of bar] before, [name of gas station] and that by what he could see going on that the group home was not a good enough			

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	facility for him that he needed to be at a different facility to be placed in and that he was going to see to it that he would not be coming back to the group home in [name of city]. [Staff #5] reported that the Mayor stated that 'we would do whatever it took to get him out of this community and it should have happened years ago and enough is enough.' [Client G] continued to target police and they got him in a hold on the ground. Program Director [name] arrived at the group (sic) at that point. [Client G] was on the ground and police were physically restraining him at this point. Police then got him up off the ground about 30 seconds after PD arrived at the home and assisted him with getting in the chair. The mayor asked [PD] to speak to a supervisor, PD told him that she was the supervisor and he told her that he wanted to talk to her boss. PD [name] called [Area Director] and gave the phone to the Mayor at this point. [Client G] kept trying to get up out of the chair and police kept having him sit back down. [Client G] then got up and moved towards the couch. Police started to hold him and [staff #2] stated he is trying to get to the couch. Police allowed him to move to the couch and [staff #2] got him a pillow and blanket. Program Director [name] gave approval to [staff #2] to give a second PRN medication. Ativan 2mg			

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	was given. The Mayor then came back in and told police to call [name] transport that he was being transported to [name of hospital]. [Staff #2] rode in the ambulance with [client G] and PD [name] followed in personal vehicle. [Client G] was taken to [name of hospital] per police and [name of city] Mayor request. [Staff #16] contacted Program Director as she was taking another client home and saw the police at the group home and asked if she needed to go back once she dropped off the client she was working with. PD [name] told [staff #16] to go back and assist [staff #4] with other clients. [Program Director] contacted Program Nurse [name] to report that [client G] was being taken to [name of hospital] and contacted [Area Director] to report as well. Program Director also contacted [client G's guardian] to report the incident. [Client E's guardian] was contacted to report the incident." 3) On 9/23/14 at 12:45 AM, client G went into the basement of the home, took a television out into the back yard and destroyed it. The BDDS report, dated 9/24/14, indicated, "[Former staff #11] then reported that he was on the porch smoking a cigarette to calm down after the incident and when he went back			

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	inside [client G] was gone. [Staff #11] then reported he started making phone calls and got ahold (sic) of [staff #6] and [staff #5] for assistance. Police arrived at the home and talked to [staff #11] about what was going on and staff reported that he was able to get [client G] in the home. [Staff #11] then reported he went inside the home and [client G] was gone. [Staff #11] then reported that the police called the home to report they had found [client G] at [name of gas station] gas station on [name of street] and that an ambulance was on its way. [Staff #5 and #6] arrived at the home and notified [staff #11] that [staff #5] had notified [Home Manager] who was also on his way to the home. [Home Manager] contacted [staff #6] and instructed her to administer a PRN (as needed), Ativan 2 mg (milligrams), per PRN protocol once she got to the [name of gas station]. [Staff #6] explained to police that [client G] had a PRN medication to assist him when he was agitated. Ambulance arrived on the scene and transported [client G] to the hospital. [Home Manager], [staff #5], [staff #6] all arrived at the hospital and [client G] was released to their care. During the incident [client G] sustained numerous superficial wounds while he was at [name of gas station]. [Staff #11] was suspended pending investigation. Team met on 9/23 and team implemented			

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	double staffing during the overnights for two weeks. Team will meet again on 10/7. Nurse, [name], contacted psychiatrist, [name] to discuss the situation and the increase in [client G's] agitation. [Psychiatrist] increased Clozapine (psychotropic medication) from 350 mg daily to 400 mg daily." The investigation, dated 9/30/14, indicated, in part, "Brief summary of the incident: [Client G] eloped from the home and ran to the [name] gas station a few blocks away and committed property damage. [Staff #11] was supervising at the time of the incident and reportedly did not realize [client G] had eloped. Following the incident, [staff #11] was suspended by the Home Manager [name]... [Staff #5] stated that after [client G] was in bed, he asked [staff #11] what happened and [staff #11], 'acted scared, said he was smoking a cigarette and had headphones on listening to music and cops showed up,' then said he was watching [client G's door] to see if he got up but [client G] must have gone out through the hallway door and down the basement stairs and he didn't see him. [Staff #5] stated that all the blinds were closed when he got to the house so he didn't know how [staff #11] could see in the house except through the high glass section on one of the doors that is the			

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	only part not frosted. [Staff #5] reported that through that section you can only see the living room and not into [client G's] bedroom. [Staff #5] stated that he is tall and can't see into [client G's] room through that window. [Staff #5] stated that the alarms were working on all the doors when he was in the home after the incident. [Staff #5] stated that during his shift on 9/22/14, [client G] had behaviors but hadn't tried to elope at any time. [Staff #5] stated that [client G] was in bed when he left at 10pm...". The investigation indicated, "[Staff #6] stated that she worked in the home on 9/22/14 from 2pm until 12:15am. She stated that she was to be off work at 12am and [staff #11] was to relieve her but she was about 10-15 minutes late and she left at 12:14am or 12:15am... She stated that she went in the room and checked on him at 11:30pm and [client G] was sleeping and then checked on him again right before she left the house and he was asleep and snoring. [Staff #6] stated that no other clients were awake when she left the home and [client G's] roommate [client F] was also asleep. [Staff #6] stated that she left the home after [staff #11] arrived and went home and [staff #11] called her at 12:36am and said '[client G's] gone.' She stated that she asked him what he was talking about			

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	and if he had called anyone to report it and [staff #11] said she had tried to 'call everyone and no one would answer.' [Staff #6] stated that she immediately went to the house to help look for [client G] and got there in about 5 minutes and [staff #11] was outside the house by the driveway along the road 'pacing.' [Staff #6] stated she went into the house to look for [client G] and saw the 'mess in the basement' of all the items [client G] had destroyed, and checked around the yard and couldn't find [client G]. She stated that she found [client G's] pants outside in the backyard. She stated that she had been searching about 6-7 minutes when the police called the house and said [client G] was at [gas station]... [Staff #6] stated that while she was at the hospital, the police talked to her and told her they had received a phone call at 12:22am from a neighbor complaining about someone tearing up a TV in the backyard. They said that they arrived at the house and [staff #11] was on the front porch and they asked him what was going on and [staff #11] replied with 'nothing, at work.' They said that they told [staff #11] they had gotten a call about someone tearing up a TV in the backyard and [staff #11] ran into the house and looked everywhere for [client G] then came back to them and said 'he's gone, can you help?' and they left the house to			

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	start looking for [client G]. [Staff #6] stated that the police told her [staff #11] was on the front porch smoking... [Staff #6] stated that when [staff #11] arrived at the house that night to relieve her, he was getting his headphones out of his pocket and untangling them and plugging them into his phone. She stated that she did not see the headphones in his ears but didn't know 'how else he couldn't have heard [client G] tearing stuff up.'" The investigation indicated, "[Staff #11] stated that his shift started at 12am on 9/23/14. He stated that he arrived at the house at 12am. When asked if he was late, he stated that he wasn't. He stated that [staff #6] was leaving her shift and stayed about 5-10 minutes telling him about [client G's] behaviors he had during her shift. [Staff #11's] time sheet states that he arrived at work at 12am. [Staff #11] stated that [client G] was in bed when he arrived. He stated that [staff #6] said [client G] was asleep and he went and checked and he looked asleep to him. He stated that [client G's] roommate was getting ready for bed and didn't know if he had awakened [client G] during this time. [Staff #11] stated that he was putting some stuff away and [client G] got up and went to use the bathroom and got a drink and [staff #11] told him to go back to bed. He stated that			

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	[client G] started laughing, walked back to his bedroom and shoved [staff #11] and then ran out of the back door of the house. [Staff #11] stated that he got [client G] back into the house and into bed. He stated that [client G] just kept laughing then got back up and ran downstairs and started tearing stuff up and pulling things out of the freezer and cabinets. [Staff #11] stated that he didn't want to get hurt and didn't want [client G] to get hurt. He stated that he yelled for [client C], a housemate, to open the basement door so it would be easier to get [client G] back up the stairs to his bedroom. [Staff #11] stated that [client C] never came to the door. [Staff #11] stated that he got [client G] back into his bed and he laid down. [Staff #11] stated that he called [Home Manager] about 10 times and got no answer. [Staff #11] stated that he then went to the front porch while trying to call [Home Manager] and the police showed up and said they had a complaint of noise in the back yard. [Staff #11] stated that he thought the noise that was reported had been from earlier when he was trying to get [client G] back in (sic) house. [Staff #11] stated that he thought he had locked the basement door earlier after that incident. [Staff #11] stated that he ran in the house and searched for [client G] and couldn't find him and told the police who [client			

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	G] was and they left to go look for him. He stated that he found [client G's] clothes in the back yard... When asked about the time he was on the front porch, [staff #11] stated that he was smoking a cigarette and [client G] was in bed after the basement incident. He stated that he was trying to call [Home Manager] from his cell phone and the house phone to report the incident. [Staff #11] stated that he was watching for [client G] to get up through the window of the doors to the house and went to the side porch to make sure he didn't try to go out his bedroom window... When asked if at any time he had headphones in his ears, [staff #11] stated that he had his 'left headphone in' attached to his cell phone because he was trying to make a call on his cell phone while he used the house phone with his other ear trying to call people. He stated that he also called his girlfriend during this time because she usually brings him some dinner when she gets off work and he wanted to let her know what it wasn't 'safe' to bring him dinner that night due to [client G's] behaviors... When asked why [Home Manager] or [Program Director's] phones did not show any missed calls from him, he stated that he didn't know why they didn't. [Staff #11] stated that he also sent [Home Manager] a text message saying something like 'call me asap (as soon as			

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	possible). [Client G] having behaviors...'. When asked if he could show this interviewer the text, he stated that he recently upgraded his iPhone and it wiped out all of his calls and texts and other information and he had to take it to [name of company] to be fixed so he had no information to share." The investigation indicated in the Additional information section, "All alarms on all doors were working when the investigator was at the home on 9/30/14... The police report dated 9/28/14, stated that they received a call from a neighbor at 12:22am on 9/23/14. The officers arrived at the home (at approximately 12:30am based on the incident timeline) and asked [staff #11] what was going on and he replied 'just working.' The police report states that they told [staff #11] they had received a call about someone smashing something in the back of the residence and [staff #11] immediately ran into the residence. The police report states that the officers followed him into the home and [staff #11] then stated 'I need your guys' help, [client G] is out.' The police report states that the officers left the home and began driving around the area in an attempt to locate [client G]. The police report states that a short while later (approximately 10-15 minutes after they were at the			

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	home), dispatch advised that there was a man in the [gas station] on [name of street] that was destroying the inside of the store. The report states that when they arrived at the store, they found [client G] in a t-shirt and underwear pulling products off of shelves and throwing them and they restrained him. The report states that he was then transported to [hospital]...". The investigation's Conclusion indicated, "There is evidence to support that [staff #11] was outside the home on the front porch when [client G] eloped from the home through the basement door and that this supports an allegation of neglect. There is no evidence to support that [staff #11] made phone calls to either of his supervisors and instead contacted his coworkers." On 10/30/14 at 1:26 PM, a review of a Termination Notice, dated 10/1/14, indicated staff #11 was terminated on 10/20/14. The notice indicated, in part, "Indiana MENTOR is terminating [staff #11's] employment due to [staff #11] not following the proper supervision level of a client." 4) On 9/21/14 at 4:08 PM, client G was obsessing over the television and ran up the stairs to get into his roommates'			

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	bedrooms to get their electronics. Client G got a fork from the kitchen and tried to stab the TV cord, which was unplugged. Client G tried to stab staff with the fork. Client G was going up the stairs and staff #5 was attempting to block his way. Client G lost his balance and both client G and the staff fell. Client G received a rug burn on his forehead and rib area. Client G was given a PRN. Client G was prompted to take a shower and he did. Staff attempted to take him on a van ride. He refused and started obsessing over the TV again and tried to tear it off the wall. Client G went upstairs and tried to destroy a housemate's CPAP (continuous positive airway pressure) machine. Client G was blocked. Client G knocked his housemate's TV off the stand it broke. Client G also broke the cable box. Client G ran into another client's bedroom and broke his cable box. Client G was assisted downstairs. A second PRN medication was administered. 5) On 8/31/14 at 1:00 PM, client H was upset over his housemate's behavior. Client H reported to staff he punched a hole in the wall. Staff checked client H's hand and put ice on it. Later in the day, client H's hand was discolored and he reported it was sore. Staff took client H to the emergency room. Client H's hand was broken.			

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	The investigation, dated 9/6/14, indicated, "[Client H] reported to staff that he had punched the wall because he was upset about roommates (sic) behavior. Staff did not witness [client H] punch the wall... [Client H] reported he was 'mad because [client G] was being a butt.' [Client H] reported that no one saw him punch the wall. [Client H] reported he did tell staff that he punched the wall after he got done." The investigation was not conducted within 5 working days and the results of the investigation were not reported to the administrator. 6) On 8/30/14 at 6:58 PM, client E punched client A in the face. Client A's glasses were broken. 7) On 8/17/14 at 12:32 PM, client G was wanting to watch television and ended up breaking the remote control. The BDDS report, dated 8/18/14, indicated, "He continued by pounding on the TV and [client A] got up and punched [client G]." 8) On 4/8/14 at 8:34 PM, the BDDS report, dated 4/9/14, indicated, "HM (Home Manager) called oncall (sic) PD (Program Director) and reported that [client F] locked himself in the bathroom with [client D] and wouldn't (sic) let staff in. When they got in [client D] said			

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	[client F] touched him in his groin." The investigation, dated 4/10/14, indicated, "Door knob on bathroom door was changed to a lock that staff can unlock easy (sic) from the outside. Door chime was put on the bedroom door of [client F's] and roommates (sic) bedroom which leads to the bathroom. Door alarms speakers were placed in the kitchen and living room." 9) On 3/30/14 at 7:45 PM, client A was upset due to a housemate's behavior. The BDDS report indicated, "He finally snapped when [client G] started having a behavior over the TV and tried to run up (sic) steps. Staff blocked him and when they turned around [client A] was standing there and punched [client G] twice once on the right eye and one time on the lip... [Client G] (sic) eye was a little swollen but is acting normal." The investigation, dated 4/3/14, indicated, "[Client G] was trying to get upstairs in the home and staff was trying to redirect him to another activity. [Client A] walked up on the situation and became upset and hit [client G] twice before staff could separate the two clients." 10) On 3/2/14 at 8:45 PM, client H and			

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	staff #14 went to pick up client D from his relative's house. As client D was putting his items into the van, client H said something (staff did not hear) to client D. The BDDS report, dated 3/3/14, indicated, "[Client D] became upset at what [client H] said and [client D] physically aggressed on [client H]. [Client H] jumped out of the van before staff could separate them." Client H had a small scratch (1/4 inch) under his left eye and basic first aid was administered. The investigation, dated 3/7/14, indicated in the conclusion section, "Evidence supports staff did not intervene appropriately." The Recommendations section indicated, "Retraining of staff that staff will get out of the van and assist [client D] with putting his things in the van to try and prevent any further incidents of this nature in the future." 11) On 2/13/14 at 6:30 PM, client G asked for a snack right after dinner. Staff redirected client G to take a shower. After his shower, client G saw an empty soda can on the living room table. Client G ran over and stuck his finger into the opening, cutting his finger. Staff #5 attempted to get the can. Client G swung at staff and missed. Client G swung again and then body slammed into staff #5. Staff #5 and client G fell to the floor.			

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	Staff #5 and client G hit their heads together during the fall. Client G received a cut about his right eye and staff could not get it to stop bleeding. Staff #5 contacted the nurse who instructed staff to take client G to the emergency room. The emergency room indicated client G had a minor concussion and they glued the cut. On the way out of the emergency room, client G "attacked" the soda machine and attempted to "attack' staff. A PRN (as needed) medication was administered after client G arrived home due to continued aggression toward staff. 12) On 1/8/14 at 6:30 PM, clients A and E hit each other. Client A's glasses were broken during the incident. Client A sustained a small bruise on his forehead. 13) On 11/24/13 at 12:40 PM, client G urinated on his blankets. Client G attempted to get his soiled blankets. Staff redirected client G. Client G attempted to hit staff. Client A punched client G in the side of the head and face on the left side. Client G was not injured. A review of client A's record was conducted on 10/28/14 at 11:54 AM. Client A's Individualized Support Plan (ISP), dated 3/21/14, indicated he needed 24 hour supervision. Client A's Behavior			

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	Support Plan (BSP), dated 3/1/14, indicated he had the following targeted behaviors: vacating, physical aggression, inappropriate social behavior, property destruction, resistance to instruction and self injurious behavior. A review of client B's ISP and BSP was conducted on 10/30/14 at 10:36 AM. Client B's ISP, dated 7/24/14, indicated he needed 24 hour supervision. Client B's BSP, dated 10/24/14, indicated he had the following targeted behaviors: type 1 and 2 resistance, physical assault, and temper outbursts. A review of client C's record was conducted on 10/28/14 at 11:23 AM. Client C's ISP, dated 8/22/14, indicated he needed 24 hour supervision. A review of client D's ISP was conducted on 10/30/14 at 10:39 AM. Client D's ISP, dated 1/31/14, indicated he needed 24 hour supervision. A review of client E's ISP and BSP was conducted on 10/30/14 at 10:41 AM. Client E's ISP, dated 3/14/14, indicated he needed 24 hour supervision. Client E's BSP, dated 4/1/14, indicated he had the following targeted behaviors: type 1 and 2 resistance, physical assault, property misuse/destruction, verbal abuse			

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	and suicidal talk. A review of client F's record was conducted on 10/29/14 at 12:08 PM. Client F's ISP, dated 5/2/14, indicated he needed 24 hour supervision. Client F's BSP, dated 4/1/14, indicated he had the following targeted behaviors: type 1 and 2 resistance, physical aggression, verbal aggression, invading others' space and inappropriate sexual behavior. A review of client G's record was conducted on 10/29/14 at 12:25 PM. Client G's ISP, dated 5/2/14, indicated he needed 24 hour supervision. Client G's BSP, dated 10/23/14, indicated he had the following targeted behaviors: physical aggression, property destruction, self injurious behavior, inappropriate nudity, food/drink stealing, elopement and obsessing. A review of client H's ISP and BSP was conducted on 10/30/14 at 10:47 AM. Client H's ISP, dated 3/24/14, indicated he needed 24 hour supervision. Client H's BSP, dated 4/1/14, indicated he had the following targeted behaviors: verbal abuse, inappropriate social behavior, runs/wanders away, obsessing about food, property destruction, physical assault, inappropriate sexual behavior and manipulative behavior.			

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	Observations were conducted at the group home on 10/27/14 from 3:57 PM to 6:13 PM and 10/28/14 from 6:16 AM to 7:32 AM. During the observations, there was a minimal amount of food at the group home. The group home had the food for the items on the menu for 10/27/14 and 10/28/14. The cabinets in the kitchen contained a few canned goods. The refrigerator contained a partial gallon of milk and a vegetable tray. After the clients packed their lunches on 10/28/14, there was no fresh fruit left at the group home. Confidential interview #1 (CI #1) indicated two weekends ago there was no food in the group home on Friday and Saturday. CI #1 indicated the Program Director (PD) brought groceries to the group home on Sunday after the staff called the PD to report there was not enough food. Confidential interview #2 (CI #2) indicated there were numerous times the group home did not have enough food to provide the items from the menu due to a lack of staff. CI #2 indicated the Area Director told the staff to take all the clients to the store but leave some of them in the van while the other staff shopped. CI #2 indicated it took over an			

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	hour, at times 2 hours, to shop for groceries. CI #2 indicated two weekends ago the group home did not have any food. CI #2 indicated both the PD and Home Manager (HM) were contacted with no response from either of them. CI #2 indicated the group home had to order pizza. CI #2 indicated the PD did respond and went shopping on Sunday for groceries. CI #2 indicated the issue was related to the facility not having enough staff to go shopping. CI #2 stated, "It's not that the home isn't willing to buy food just difficult to get to the store to shop due to a lack of staffing." CI #2 indicated there was not enough food to follow the menu for the clients' snacks. CI #2 indicated the main items on the menu were being purchased but not snacks and breakfast items like cereal. CI #2 indicated the clients pack bologna or lunch meat for their lunches. CI #2 indicated the lunch meat was not healthy for the clients. CI #2 indicated the Home Manager (HM) did not assist with staffing the home by working shifts. CI #2 indicated the clients missed their individual outings, with the exception of client H, recently due to a lack of staff. CI #2 indicated banking did not involve the clients going into the bank due to a lack of staff. CI #2 indicated the management staff were not in the home to see what was going on with staffing			

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	and the clients' behaviors to assess if there was enough staff. CI #2 indicated client F had not been attending church due to a lack of staff. Client A's guardian indicated on 10/29/14 at 10:42 AM the group home had a lot of staff turnover and the staff did not seem to know what to do. The guardian indicated the group home did not have enough staff. The guardian indicated client A did not get to go to church on a regular basis due to the lack of staff. Client F's guardian indicated on 10/28/14 at 1:59 PM there was a lack of staffing at the group home. The guardian indicated client F had been missing church due to the lack of staff. She indicated three staff quit last week. The guardian indicated there was insufficient staff to keep her brother from getting hit by another client. The guardian indicated the PD and HM were not working in the home to ensure there was enough staff to take client F to church. The guardian indicated there was not enough staff in order to go to the grocery store to ensure the group home had food. Client F's guardian indicated the group home did not have enough food for meals. The guardian indicated when she was there on 10/20/14 she read the menu. The clients were to have sub sandwiches but client F had a bologna			

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	sandwich instead. The guardian indicated there were times when the group home ran out of food due to not having enough staff to go to the store. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated two staff were sufficient to implement the clients' program plans. The PD indicated the group home had sufficient staff to staff the house with pulling staff from other locations. The PD indicated she did not regularly work direct care at the group home. The PD indicated the clients were not routinely getting to go on their weekly one on one outings due to short staffing at the house. The PD indicated the clients had not missed many of their outings but some had missed their outings. The PD indicated the reports of not having enough food in the home due to the lack of staff were not accurate. The PD indicated the staff working at the group home did not know the staffing levels for the home. The PD indicated client G did not need two staff to stay with him while he was at the group home. The PD indicated client G did need two staff to supervise him in the community. The PD indicated she went there two weekends ago to take the clients to church. When she arrived, the staff reported there was not enough food. The PD indicated she went to the store to get			

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	some groceries for chicken pot pie. The PD stated the ingredients were already there, the staff needed to "think outside the box." The PD indicated staff #3 ordered pizza two Saturdays ago. The PD indicated she was there the next day and there was food in the house although the supply was low. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the group home should have at least 2 staff during the day shift (7:00 AM to 3:00 PM), 3 staff on the evening shift (3:00 PM to 11:00 PM), and 2 staff during the night shift (11:00 PM to 7:00 AM). The HM indicated most of the time there were three staff on each shift but occasionally there were 2 staff working at the group home. The HM indicated the group home attempted to have four staff during the evening shift on Mondays, Wednesdays and Fridays. The HM indicated two staff were sufficient to implement the clients' program plans. The HM initially stated when asked if the group home had sufficient staff, "Right now, no." The HM indicated there was not enough staff assigned to the group home to fill the open staffing positions. The HM indicated during the last pay period, he worked 11 hours of direct care at the group home. The HM indicated the clients were not getting to participate in			

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	their weekly one on one outings. The HM indicated staff #5 went grocery shopping every Tuesday and several times throughout the week. The HM indicated he was aware of one time when the food supply was low after client G destroyed food from the freezer. The HM indicated the food was replaced the next day. This federal tag relates to complaint #IN00158326. 9-3-3(a)			
W000189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 2 of 4 clients in the sample (C and G) and one additional client (B), the facility failed to ensure staff received training to enable the staff to perform their duties effectively, efficiently and competently. Findings include: A review of the client-specific staff training documentation, not dated, was conducted on 10/30/14 at 11:53 AM and	W000189	Staff in the home were re-trained on all client's current ISP, Behavior Support Plans, RMAP's, and Goals on 11/6/14, 11/10/14, and 11/20/14. In home observations will be completed by administrative staff at least weekly for 30 days and then monthly thereafter. Responsible Party: Home Manager, Program Director, and Area Director.	12/09/2014

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	indicated the following: -Client B's most recent Individualized Support Plan (ISP), dated 7/24/14, was reviewed on 10/30/14 at 10:36 AM. There was no documentation staff #1, #2, #3, #4, #5, #6 and #8 received training on client B's ISP. Client B's most recent Behavior Support Plan (BSP), dated 10/24/14, was reviewed on 10/30/14 at 12:19 PM. There was no documentation staff #1, #2, #3, #4, #5, #6, #7, #8 and #9 received training on client B's BSP. -Client C: Client C's most recent ISP, dated 8/22/14, was reviewed on 10/30/14 at 10:36 AM. There was no documentation staff #1, #2, #3, #4, #5, #6 and #8 received training on client C's updated ISP. -Client G: Client G's most recent BSP, dated 10/23/14, was reviewed on 10/29/14 at 12:25 PM. There was no documentation staff #1, #2, #3, #4, #5, #6, #7, #8 and #9 received training on client G's BSP. Confidential Interview #2 (CI #2) indicated the staff had not received training on the clients' current program plans. CI #2 indicated the clients' Behavior Support Plans had not been updated in awhile or if they had, the staff			

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	did not receive training on them. On 10/29/14 at 10:42 AM, client A's guardian stated the staff at the group home "don't seem to know what to do." The guardian indicated she did not think the staff had received training on the clients' plans. On 10/31/14 at 12:01 PM, the Program Director (PD) indicated the staff were trained on the clients' plans on 10/23/14. The PD indicated she was going to submit the documentation for review. On 10/31/14 at 4:05 PM, the PD indicated she was unable to send the documentation to verify the staff received training on the clients' plans. The PD indicated the staff should be training on the clients' current plans. This federal tag relates to complaints #IN00157027 and #IN00158326. 9-3-3(a)			
W000198	483.440(b)(1) ADMISSIONS, TRANSFERS, DISCHARGE Clients who are admitted by the facility must be in need of and receiving active treatment services. Based on observation, record review and interview for 1 of 4 clients in the sample	W000198	Program Director has contacted BDDS Service Coordinator about Level of Care for waiver services.	12/09/2014

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	(C), the facility failed to ensure client C was in need of and received active treatment services. Findings include: Observations were conducted at the group home on 10/27/14 from 3:57 PM to 6:13 PM and 10/28/14 from 6:16 AM to 7:32 AM. During the evening observation at 4:59 PM, client C was using his cellphone to play a poker video game. At 5:04 PM, client C rode his skateboard to a local church for dinner. Client C stopped at each intersection and waited for the staff and peers to catch up. Client C's pedestrian safety skills were appropriate. During the morning observation at 6:44 AM, client C prepared his medication and took it with staff observing. Client C signed his Medication Administration Record. Client C knew the name of his medication and the purpose of his medication. An observation was conducted at the workshop client C attended on 10/28/14 from 9:00 AM to 10:00 AM. During the observation, client C was on-task using an air-compressed machine to punch holes in medical tubing. Client C stayed on-task during the observation.		Team met to discuss client's plan and no changes to his plan are needed at this time. The Program Director will continue to monitor. Responsible Party: Program Director, and Area Director	

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	A review of client C's record was conducted on 10/28/14 at 11:23 AM. Client C's Individualized Support Plan (ISP), dated 8/22/14, indicated client C was an emancipated adult. The ISP indicated the following: "Assessment of dining skills: Independent. Assessment of food and liquid intake: Independent. Assessment of food Service skills: Independent. Willingness to wear glasses: Independent. Assessment of ability to care for glasses: Independent. List any information that has changed to include success in past goals: [Client C] is aware of what time his medications are to be taken. [Client C] comes to the med room independently." Client C did not have a Behavior Support Plan or psychotropic medication. Client C's ISP indicated, "Assessment of verbal communication skills: Independent. Assessment of non-verbal communication skills: Independent. Assessment of receptive language skills: Independent. Can he/she make sense of various environments: Yes. Assessment of fine motor skills that he/she cannot do: N/A. Assessment of fine motor skills that he/she can do: Independent. Assessment of gross motor skills that he/she can do: Independent. Assessment of gross motor skills he/she cannot do: N/A. Assessment of his/her ability to ambulate: Independent. Assessment of			

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	his/her ability to care for adaptive equipment: Independent. Assessment of how he problem solves: Requires minimal assistance. Assessment of how he follows directions: [Client C] is capable of following 6 or more step directions. Assessment of ability to mix hot water safely: Independent. Assessment of ability to evacuate during a fire drill: Independent. Assessment of ability to perform household tasks: Requires verbal prompting at times. Assessment of ability/limitations to care for personal hygiene: Requires verbal prompting at times. Assessment of ability/limitations to groom self: Independent. Assessment of ability/limitations in food preparation: Requires assistance at times. Assessment of financial skills/limitations: Requires assistance at times. Assessment of pedestrian skills: Independent. Assessment of ability to provide informed consent: Requires assistance at times. List who helps provide informed consent when he/she is unable to: Mother and Interdisciplinary Team. Assessment of leisure skills: Independent." Client C's ISP indicated he had the following training objectives: Client C will increase his independence with his financial skills (fill out and turn in invoices for work completed); brush teeth			

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	twice a day; pick a meal to cook, go shopping for the ingredients and cook the meal; participate in his alone time of up to 6 hours each week by notifying staff of his destination and being back by the agreed upon time; prepare meds correctly and check them before meds are administered; and use key to unlock the basement door. Client C's Vocational Profile Summary, dated 5/2/14, indicated client C works full time at a sheltered workshop, Monday through Friday, 8:00 AM to 4:00 PM. The summary indicated client C had "good communication skills" and "good with time awareness." The summary indicated, "very productive, very important position at work." Client C's Camelot Behavioral Checklist, dated 5/2/14, indicated client C was independent in the following areas: eating behaviors, dressing and undressing, toilet use, cares for own health (sought help for injury or illness, stayed on special diet if necessary, performed simple first aid on self, took own medication, and got prescriptions filled), knowledge of self (knew full name, names of family members, his age, address and telephone number), bathing, hair care, grooming, physical development (stands alone, balance on tip			

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	toes, balance on one foot, balance on one foot with arms crossed), walking, posture, body movements (with the exception of doing a chin up on a bar), hand movements, sensory development (discriminated colors, forms, sizes, tastes, sounds, smells, temperature, weight and textures), home duties (sweeping with broom, used a dust pan, emptied trash, make his bed, mop the floors, dust the furniture, cleaned windows and mirrors, cleaned walls, tub, sink and toilet, changed linens regularly, used a vacuum, cleaned stove and refrigerator, and simple home repairs), clothing care (hang up clothes, put clothes away, folded clothes, dried clothes, washed clothes, ironed clothes, select water temperature, and used bleach), cooking (cleared and wiped the table, dry dishes, put dishes away, washed dishes, set table, prepared foods requiring no mixing, select proper pans for cooking, stored and refrigerated foods, baked food, boiled food, prepared food for mixing, fried food, grilled food, prepared a complete meal, and sautéed food), yard care (sweep, shovel snow, raked leaves, pulled weeds, watered the lawn, and mowed the lawn), operation of appliances (toaster, clothes dryer, washing machine, iron, vacuum, coffee pot, electric range, garbage disposal, can opener, coin operated washing machine and dryer and dishwasher), vocational			

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	behavior (knew his supervisor, asked for help when needed, understood and followed directions, arrived to work on time, stayed at work for required period, worked without supervision, responded well to criticism, use lunch facilities, responded appropriately to supervisor, started work without prompting, responded to co-workers appropriately, productive, operated time clock, handled tools safely, responded to job interview, requested more work when needed, took care of tools, and responded appropriately to customers), jobs skills (sort, fold, stack, janitorial work, yard work, packing jobs, stapling jobs, tying jobs, assembled by screwing parts, inserted and sealed jobs, painted, operated machinery and use a commercial dishwasher), economic behavior (bought toiletry items, knew food prices, bought groceries, knew clothing sizes, bought own clothes, and bought a variety of foods), money handling (knew equivalents, counted change, planned for specific purchases, made bank deposits, budgeted money, opened savings account, cash checks, and made savings withdrawals), independent travel (walked safely to destination, rode bike safely to destination, rode bus, and rode in taxi), travel skills (understood directions - right/left/up/down, recognized police as a source of help,			

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	read addresses, responded to traffic lights and signs, found and used public toilets, read common signs, knew location of local landmarks, asked for and followed directions, knew North, South, East and West, and read maps), numerical skills (counted to 100 by 1's, counted to 100 by 10's, wrote numbers to 100, read numbers to 100, counted to 100 by 5's, understood greater, less and equal, read number words to 100, added with carrying, and multiplication), time (knew days of week, dates of month, read a calendar, seasons, holidays, could tell time and scheduled events by time), communication skills (selected an object if named, followed simple instructions, listened when other spoke, followed ordinal instructions, followed numerical instructions and followed conditional instructions), expressive language (spoke in phrases, asked questions, used nouns in speech, used verbs in speech, pitch of voice was appropriate, spoke in sentences, voice quality, resonance was appropriate, imitated new words, rate and rhythm of speech was appropriate, intensity of speech was appropriate, described situations and events, articulated well, used pronouns in speech, used prepositions in speech, used adjectives and adverbs in speech), reading (could get information from pictures and packages, knew alphabet, recognized			

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	safety words, recognized functional words, remembered what he read, read books, alphabetized, read packages, and read newspapers), writing (copied, traced, traced letters, spelled names, copied letters, spelled common words, printed or wrote notes and messages, wrote letters, and used dictionary), use of telephone (answered phone, dialed number, took messages, placed call from private phone, found number in alphabetically list, found emergency numbers, and found number in yellow pages), spectator events (watched TV, listened to radio, played records or tapes, went to athletic events, went to movies, plays or concerts, and read magazines and newspapers), participation in social events (joined on-going activities, initiated own leisure time, did arts and crafts, played cards and table games, danced, played board games, swam, played team sports, jogged, and bowled), interaction with others (expressed emotion, greeted appropriately, looked at person while speaking, maintained appropriate social distance, engaged in conversation, apologized appropriately, waited while others spoke, and introduced self to others), responsibility (followed smoking rules, understood and respected private property, and knew and followed the law), response to emergencies (cleaned up debris from small accidents, could call			

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	the police and fire department, could activate the fire alarm, and could call doctor), security (identified own belongings, returned borrowed items and used lock and key). On 10/27/14 at 5:37 PM, client C indicated he wanted to move out of the group home. Client C stated he could do everything "independently." Client C indicated he had 6 hours of unsupervised time each week and had not had any issues during his free time. Client C indicated he liked to visit his girlfriend, ride his skateboard and bike and get away from the group home during his alone time. Client C indicated he always returned to the group home on time. Client C indicated he was able to take his medications independently. Client C indicated he could cook, shop, launder his clothes, read and write and complete all tasks independently. Client C indicated he had a high school diploma. Client C indicated he did not engage in the incidents at the group home. Client C indicated he walked away anytime an incident started to not get involved. Client C indicated he was ready to move into an apartment in a waiver setting. On 10/28/14 at 9:07 AM, the Director of client C's workshop stated, "Absolutely ready to move out. He's great, no			

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	behaviors, no issues, works the hardest job here." The Director indicated client C was a quick learner when there were new jobs. The Director indicated client C wanted more free time with his living situation. The Director indicated client C arrived to work on time, stayed on task and returned from breaks on time. On 10/28/14 at 9:09 AM, a workshop supervisor (WS) stated client C was not involved in the "drama" at the workshop. The WS indicated client C was helpful to others, staff and clients. The WS stated, "He's a great kid." The WS indicated client C was independent while at the workshop. The WS stated, "I wish we had more like him." The WS indicated client C had no behaviors, stayed on task and returns from breaks on time. On 10/28/14 at 9:22 AM, client C's workshop supervisor (WS) indicated client C assists her with fixing the machines in the room. Client C stays on task. He's very independent. The WS stated, "He's ready for waiver." Client C did not engage in the "drama" at the workshop. On 10/28/14 at 6:32 AM, group home staff #3 stated client C was "great, very responsible." Staff #3 stated, "He would be great in waiver." Staff #3 indicated			

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	client C did not have any behaviors. He controlled his own money and took his own medications. Staff #3 indicated client C cooked his own breakfast on the weekends. Client C did his own laundry without prompting from staff. Staff #3 again stated, "Very independent." On 10/27/14 at 6:06 PM, the Home Manager (HM) indicated client C had 6 hours per week of alone time in the community. There have been no issues during the time client C was away from the group home. Client C checked in when he was supposed to and was where he was supposed to be on time. On 10/28/14 at 11:30 AM, the HM indicated client C was independent with his laundry and cooking. The HM indicated client C fixed the lawnmower when it was not running right. The HM indicated client C did not engage in the behavioral incidents at the group home. The HM indicated client C paid his bills and liability. Client C has a poker table to play with staff and his peers. The HM indicated client C used his alone time to ride his bike and spend time with his girlfriend. On 10/28/14 at 11:30 AM, the Program Director (PD) stated client C had a "strong desire" to move out of the group			

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	home. The PD indicated client C could do his own laundry. He was safe while cooking. Client C fixed the lawnmower and cut the grass at his group home and another group home. Client C stayed out of the incidents at the group home. The PD indicated client C had 6 hours of unsupervised time per week and there had been no issues during his alone time. The PD indicated client C was meeting his training objectives. On 10/28/14 at 11:35 AM, the Area Director (AD) stated client C was "very high functioning" and "responsible." On 10/29/14 at 1:44 PM, the group home's Registered Nurse (RN) indicated client C would benefit from moving out of the group home. The RN indicated client C was his own guardian. The RN stated, "I think he would be a wonderful candidate (for waiver services)." 9-3-4(a)			
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the			

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	achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 3 of 4 clients in the sample (A, B and G) and one additional client (E), the facility failed to ensure staff implemented the clients' program plans as written. Findings include: 1) An observation was conducted at the group home on 10/28/14 from 6:16 AM to 7:32 AM. At 6:30 AM, client A received his medications from staff #3. Staff #3 prompted client A to name three medications but did not ask or inform client A of the purpose of the medications. At 6:34 AM, client B received his medications from staff #3. Client B identified one medication, Lexapro, but was not prompted to identify the purpose of the medication. Client B was not prompted to identify his other medications (13 other medications administered) and their purpose. A review of client A's record, including his Individualized Support Plan (ISP), was conducted on 10/28/14 at 11:54 AM. Client A's 3/21/14 ISP indicated he had a training objective to be implemented daily at each medication pass to state the names and purpose of all his medications.	W000249	Staff in the home were re-trained on all client's current ISP, Behavior Support Plans, RMAP's, and Goals on 11/6/14, 11/10/14, and 11/20/14. Staff in the home was re-trained on goal implementation, ensure the basement door is kept locked and clients are implementing goal, client's medication objectives, financial objectives, and client banking process on 11/06/14. Medication observation will be completed by Administrative staff at five days a week for two weeks, then at least twice a week for two weeks and then random thereafter. In home observations will be completed by administrative staff at least weekly for 30 days and then monthly thereafter. The Program Director will continue to monitor this completion on an ongoing basis. Responsible Party: Home Manager, Program Director, and Area Director.	12/09/2014

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	A review of client B's ISP was conducted on 10/28/14 at 11:38 AM. Client B's ISP indicated he had a training objective to review his medication cards indicating what medications he was prescribed and identify the purpose of each medication. On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated the clients' medication administration training objectives should be implemented as written at each medication pass. On 10/29/14 at 2:14 PM, the Program Director (PD) indicated the clients' medication administration training objectives should be implemented as written at each medication pass. 2) An observation was conducted at the group home on 10/27/14 from 3:57 PM to 6:13 PM. During the observation, the door adjacent to the kitchen leading to the basement area of the group home was unlocked. On 10/29/14 at 12:25 PM, a review of client G's record was conducted. Client G's 6/6/14 ISP indicated, in part, "Due to [client G's] elopement and property destruction behavior basement door from kitchen has been locked. HRC (Human Rights Committee) approval has been			

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	obtained." On 10/29/14 at 2:14 PM, the HM indicated client G had a plan to lock the basement door. The HM indicated the basement door should have been locked during the evening observation. On 10/29/14 at 2:14 PM, the PD indicated client G had a plan to lock the basement door. The HM indicated the basement door should have been locked during the evening observation. 3) Confidential Interview #2 (CI #2) indicated the clients did not get to do their own banking. The CI indicated when the clients went to the bank, staff go through the drive through window. The CI indicated this occurred every time the clients went to the bank. The CI stated, "Clients are not going in and not learning anything." A review of client G's record was conducted on 10/29/14 at 12:25 PM. Client G's 6/6/14 Individualized Support Plan (ISP) indicated, "Increase financial skills through a formal goal: Weekly, [client G] will withdraw money from his bank account." A review of client E's ISP was conducted on 10/30/14 at 10:36 AM. Client E's			

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	3/14/14 ISP indicated, "Increase financial skills and independence through a formal goal: Bimonthly, [client E] will deposit 35% of his paycheck at minimum into his personal savings account." On 10/29/14 at 2:14 PM, the Home Manager (HM) indicated since he had worked at the group home banking consisted of the clients using the drive through window. The HM indicated this was the way the facility conducted banking when he started and he did not change how banking was being conducted. The HM stated the clients were "not learning anything." 9-3-4(a)			
W000263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on observation, interview and record review for 1 of 4 clients in the sample (C), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure restrictions in the group home were implemented with written informed consent of client C.	W000263	The Program Director was retrained on process of getting clients and guardians approvals prior to HRC approval, on 11/24/2014 The Program Director will continue to monitor the HRC process for all clients on an ongoing basis. HRC committee will ensure that clients and/or guardians have been notified	12/09/2014

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	Findings include: Observations were conducted at the group home on 10/27/14 from 3:57 PM to 6:13 PM and 10/28/14 from 6:16 AM to 7:32 AM. During the observations, all exit doors sounded an alarm when opened. The basement door was locked during the morning observation on 10/28/14. The knives were locked up during the observations. On 10/28/14 at 11:23 AM, client C's record was reviewed. Client C's Individual Support Plan (ISP), dated 8/22/14 indicated he was an emancipated adult. There was no documentation in client C's record and the facility did not provide documentation indicating client C gave his written informed consent for the restrictions (basement door locked, door alarms and sharps locked) in the group home. On 10/31/14 at 12:01 PM, the Program Director (PD) indicated the facility should have obtained client C's written informed consent. The PD indicated she attempted to email the consent form to the surveyor on 10/30/14 however the consent form was not received. 9-3-4(a)		prior to signing off on HRC approvals. Program Director and Area Director will meet weekly to review request for HRC and approvals of HRC. Responsible Party: Program Director, Area Director	

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W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 7 of 8 clients living in the group home who packed their lunches (A, B, C, D, E, F and H), the facility failed to ensure the clients packed a nourishing, well-balanced diet. Findings include: An observation was conducted at the group home on 10/28/14 from 6:16 AM to 7:32 AM. At 7:16 AM, clients A, B, C, D, E, F and H were prompted to pack their lunches. Client A, B, C, D, E, F and H's lunches did not contain vegetables. On 10/28/14 at 7:16 AM, a review of the Fall 2014 lunch menu for 10/28/14 indicated the following was to be served: 1/2 Kaiser roll with 2 ounces of chicken, 1/2 cup of cooked vegetables, and 1 - 100 calorie canned fruit. On 10/28/14 at 7:16 AM, the Program Director (PD) indicated the clients' lunches should include a vegetable for lunch. The PD stated, in regard to the	W000460	Staff in the home were re-trained on all client's current ISP which include nutritional information on 11/06/2014. Staff were trained on menu planning, grocery shopping, food substitution, and food supply checklist. The Program Director will continue to monitor this completion on an ongoing basis. Food Supply and Meal observations will be completed weekly for 30 days and then randomly thereafter. Responsible Party: Home Manager, Program Director, and Area Director.	12/09/2014

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	clients' lunches including vegetables, "If that's what the menu says." On 10/29/14 at 2:14 PM, the PD indicated the clients' lunches were missing vegetables per the menu. The PD indicated there was a vegetable tray in the refrigerator and she should have ensured the clients were prompted to pack a vegetable. On 10/29/14 at 2:14 PM, the Home Manager indicated the staff should have ensured the clients packed a vegetable in their lunches. This federal tag relates to complaint #IN00158326. 9-3-8(a)			