STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	825 MENDLESON DR RICHMOND, IN 47374

(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 the investigation of complaint #IN00148943. Complaint #IN00148943: Substantiated, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W153, W154, W157, W186, W189 and W9999. Unrelated deficiencies cited. Dates of Survey: May 22, 29 and June 6, 2014. Facility Number: 000904 Provider Number: 15G390 AIMS Number: 100233320 Surveyor: Vickie Kolb, RN These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/16/14 by Ruth Shackelford, QIDP.	W000000		
W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview,	W000102	Please see W104 and W122.	07/03/2014

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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NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374	

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	the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sample clients (A, B, C and D) and 4 additional clients (E, F, G and H). The governing body failed: __To prevent the neglect of clients A, B, C, D, E, F and G and the abuse of client D. __To ensure all allegations of abuse for client D were reported immediately to the administrator. __To ensure all allegations of abuse, neglect and injuries of unknown origin were thoroughly investigated for clients A, B, C, D, E, F, G and H. __To ensure clients A, B, C, D, E, F, G and H were provided a home conducive of a calm environment without fear of abuse. __To ensure the privacy of client D's health information. __To ensure the investigation of the neglect for clients A, B, C, D, E, F and G included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty. __To ensure the staff were trained/retrained in regard to reporting abuse/neglect immediately to the administrator, implementing the facility Mandt System (a comprehensive approach to preventing, de-escalating,			

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	and/or intervening when the behavior of an individual that poses a threat of harm to themselves and/or others) in response to client D's behaviors. __To ensure sufficient staff to supervise and implement program plans for clients A, B, F and G. Findings include: 1. The governing body failed to exercise general policy and operating direction over the facility to prevent the neglect of clients A, B, C, D, E, F and G and the abuse of client D, to ensure all allegations of abuse for client D were reported immediately to the administrator, to ensure all allegations of abuse, neglect and injuries of unknown origin were thoroughly investigated for clients A, B, C, D, E, F, G and H and to ensure clients A, B, C, D, E, F, G and H were provided a home conducive of a calm environment and did not have to live with fear of abuse from staff and or peers within their own home. The governing body failed to ensure client D's health information was maintained in regard to HIPAA laws, to ensure the investigation of the neglect for clients A, B, C, D, E, F and G included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while			

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	on duty and to ensure the staff were trained/retrained in regard to reporting abuse/neglect immediately to the administrator, implementing the facility Mandt System in response to client D's behaviors and to ensure the privacy of client D's personal health information. Please see W104. 2. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients A, B, C, D, E, F, G and H. The governing body failed to prevent the neglect of clients A, B, C, D, E, F and G and to prevent the abuse of client D, to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the facility would be monitored to ensure no reoccurrence of the neglect in regard to staff sleeping while on duty for clients A, B, C, D, E, F and G. The governing body failed to ensure all allegations of abuse, neglect and injuries of unknown origin were thoroughly investigated for clients A, B, C, D, E, F, G and H and to ensure all staff were trained/retrained in regard to abuse/neglect, the facility Mandt System and in the protection of client D's personal health information. Please see W122. This federal tag relates to complaint			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	825 MENDLESON DR RICHMOND, IN 47374

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	#IN00148943. 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 record review and interview for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the governing body failed to exercise general policy and operating direction over the facility: __To prevent the neglect of clients A, B, C, D, E, F and G and the abuse of client D. __To ensure all allegations of abuse for client D were reported immediately to the administrator. __To ensure all allegations of abuse, neglect and injuries of unknown origin were thoroughly investigated for clients A, B, C, D, E, F, G and H. __To ensure clients A, B, C, D, E, F, G and H were provided a home conducive of a calm environment and did not have to live with fear of abuse from staff and or peers within their own home. __To ensure the privacy of client D's health information. __To ensure the investigation of the	W000104	Please see W112, W149, W153, W154, W157, W186, and W189	07/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/06/2014
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	neglect for clients A, B, C, D, E, F and G included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty. __To ensure the staff were trained/retrained in regard to reporting abuse/neglect immediately to the administrator, implementing the facility Mandt System (a comprehensive approach to preventing, de-escalating, and/or intervening when the behavior of an individual that poses a threat of harm to themselves and/or others) in response to client D's behaviors. __To ensure sufficient staff to supervise and implement the client ' s program plans for clients A, B, F and G. Findings include: 1. The governing body failed to ensure the confidentiality of client D's protected medical information. Please see W112. 2. The governing body failed to exercise general policy and operating direction over the facility to prevent the neglect of clients A, B, C, D, E, F and G and the abuse of client D. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse for client			

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	D were reported immediately to the administrator, to ensure all allegations of abuse, neglect and injuries of unknown origin were thoroughly investigated for clients A, B, C, D, E, F, G and H, to ensure clients A, B, C, D, E, F, G and H were provided a home conducive of a calm environment without fear of abuse within their own home. The governing body failed to ensure the staff were trained/retrained in regard to reporting abuse/neglect immediately to the administrator for client D. The governing body failed to exercise general policy and operating direction over the facility to ensure the investigation of the neglect for clients A, B, C, D, E, F and G included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty. The governing body failed to ensure the privacy of client D's health information, to implement the facility Mandt System in response to client D's behaviors and to ensure client D's personal health information was protected. Please see W149. 3. The governing body failed to ensure all incidents of abuse were reported immediately to the administrator for client D. Please see W153.			

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	4. The governing body failed to ensure all allegations of abuse/neglect, client to client abuse and injuries of unknown origin were thoroughly investigated for clients A, B, C, D, E, F, G and H. Please see W154. 5. The governing body failed to ensure the investigation of neglect of clients A, B, C, D, E, F and G included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty. Please see W157. 6. The governing body failed to ensure sufficient staff to supervise and implement the clients' program plans for clients A, B, F and G. Please see W186. 7. The governing body failed to ensure the staff were trained/retrained in regard to reporting abuse/neglect immediately to the administrator, implementing the facility Mandt System in response to client D's behaviors and to ensure the privacy of client D's personal health information. Please see W189. This federal tag relates to complaint #IN00148943. 9-3-1(a)			

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W000112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. Based on record review and interview for 1 of 4 sampled clients (D), the facility failed to ensure the confidentiality of the client's protected medical information. Findings include: The facility's reportable and investigative records were reviewed on 5/22/14 at 2 PM. The 10/11/13 investigative summary of the allegations of abuse made by client D on 10/7/13 indicated staff #9 had violated HIPAA (Health Insurance Portability and Accountability Act) laws in disclosing client D's protected health information to staff #9's family member. The records indicated staff #9's mother had called HR (Human Resources) on 10/8/13 "communicating to HR specific details about [client D's] diagnoses and protected health information." During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM: __The RD indicated staff #9's mother had	W000112	**Correctiveactionforresident(s)foundtohavebeenaffected** Staff #9 was terminatedfrom employment with AWS on 10-16-13 after the allegations of consumer abuseand violation of HIPAA were substantiated per an AWS investigation. All staff are trained on HIPAA and confidentialityof consumer records at new hire orientation and also annually at Staff AnnualTraining (SAT). All group home staffwill also be retrained by the Regional Director (RD) on HIPAA and consumerconfidentiality at staff trainings to be held on 7-2-14 and 7-3-14. AWS will continue to train all agency staffon HIPAA and confidentiality of consumer records at orientation and annually atSAT. **Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasurestaken** All residentscould be affected andcorrective action willaddress the needsof all clients. **Measuresorsystemicchangesfacilityputinplacetoensurenorecurrence** All group home staffwill be retrained by the RD on HIPAA and	07/03/2014

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	called the HR department and relayed personal information about client D that was told to her by her daughter (staff #9). __The RD indicated clients' personal heath information was not to be disclosed to the general public and all staff were to be retrained in regard to the protection of the client's personal health information. 9-3-1(a)		confidentiality of consumer records atstaff meetings to be held on 7-2-14 and 7-3-14. Any current group home staff not attending oneof these meetings will be removed from the schedule until they receive thistraining from the RD or a designated representative. The RD will sign off on these trainings andwill give copies to Human Resources (HR) to be placed in each employee's HRfile. Staff will also continue tobe trained on HIPAA and confidentiality of consumer records at new hireorientation and SAT. **Howcorrectiveactionswillbemonitoredtoensurenorecurrence** Staff will continue to be trained on HIPAA andconfidentiality of consumer records at new hire orientation and SAT. According to AWS policy, no staff can workwithout attending new hire orientation and also annual SAT training. The HR department, the RD, and the Group HomeManager (GHM) monitor the expirations list weekly which includes mandatoryannual SAT training to ensure complete compliance.	
W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and	W000122	Pleasesee W149, W153, W154, W157, W186, and W189	07/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2014

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	for 4 additional clients (E, F, G and H). The facility failed: __To implement their abuse/neglect policy to prevent the neglect of clients A, B, C, D, E, F and G and to prevent the abuse of client D. __To ensure the investigation of the neglect included a specific plan of corrective oversight to include how the facility would be monitored to ensure no reoccurrence of the neglect in regard to staff sleeping while on duty for clients A, B, C, D, E, F and G. __To ensure all allegations of abuse, neglect and injuries of unknown origin were thoroughly investigated for clients A, B, C, D, E, F, G and H. __To ensure the staff were trained/retrained in regard to reporting abuse/neglect immediately to the administrator, maintaining the privacy of the clients' health information and to implement the facility Mandt System (a comprehensive approach to preventing, de-escalating and/or intervening when the behavior of an individual poses a threat of harm to themselves and/or others) in response to client D's behaviors. __To ensure sufficient staff to supervise and implement client A's, B's, F's and G's program plans. Findings include:			

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	1. The facility failed to implement their abuse/neglect policy to prevent the neglect of clients A, B, C, D, E, F and G in regard to staff sleeping while on duty, to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty. The facility failed to ensure all allegations of abuse for client D were reported immediately to the administrator and all allegations of abuse, neglect and injuries of unknown origin were thoroughly investigated for clients A, B, C, D, E, F, G and H. The facility failed to ensure clients A, B, C, D, E, F, G and H were provided a home conducive of a calm environment without fear of abuse and to ensure the privacy of client D's personal health information. The facility failed to ensure sufficient staff to supervise and implement client A's, B's, F's and G's program plans. Please see W149. 2. The facility failed to ensure all incidents of abuse were reported immediately to the administrator for client D. Please see W153. 3. The facility failed to ensure all allegations of abuse/neglect, client to client abuse and injuries of unknown			

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	origin were thoroughly investigated for clients A, B, C, D, E, F, G and H. Please see W154. 4. The facility failed to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty for all clients A, B, C, D, E, F and G. Please see W157. 5. The facility failed to ensure sufficient staff to supervise the clients and implement the clients' program plans for clients A, B, F and G. Please see W186. 6. The facility failed to ensure the staff were trained/retrained in regard to reporting abuse/neglect immediately to the administrator, to implement the facility Mandt System and to ensure the privacy of client D's personal health information. Please see W189. This federal tag relates to complaint #IN00148943. 9-3-2(a)			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS			

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	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observations, record review and interview for 4 of 4 sampled clients (A, B, C and D) and 4 additional clients (E, F, G and H), the facility failed to implement written policy and procedures: __To ensure all allegations of abuse for client D were reported immediately to the administrator. __To ensure all allegations of abuse, neglect and injuries of unknown origin were thoroughly investigated for clients A, B, C, D, E, F, G and H. __To ensure clients A, B, C, D, E, F, G and H were provided a home conducive of a calm environment and did not have to live with fear of abuse from staff and or peers within their own home. __To ensure the privacy of client D's health information. __To ensure the investigation of the neglect for clients A, B, C, D, E, F and G included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty. __All staff were trained/retrained in regard to reporting abuse/neglect immediately to the administrator, maintaining the privacy of the clients' health information and to implement the	W000149	**Corrective action for resident(s) found to have been affected** The RD will retrainall group home staff at staff meetings on 7-2-14 and 7-3-14 on the AWSAbuse/Neglect Policy as well as the Incident Reporting Policy. This will include what is abuse/neglect, whatincidents are reportable, and the mandate for immediate reporting to the QIDP. The RD will pass out Incident Report cards thatprovide a reminder of what incidents are reportable. Also the RD will place a reminder of whatincidents are reportable on the Staff Communication Board in the medication room. The RD retrainedQIDPs and the GHM on necessary components of investigations on 6-23-14. This included conducting thorough interviewsof all relevant individuals, immediate reporting, and ensuring that allconsumers feel safe in their home. Anyconcerns with clients feeling unsafe in their home will be addressed and followed up on. All staff aretrained on HIPAA and confidentiality of consumer records at new hireorientation and also annually at SAT. All group home staff will also be retrained by the RD on HIPAA andconsumer confidentiality at staff trainings to be held on 7-2-14 and7-3-14. AWS will	07/03/2014

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	facility Mandt System (a comprehensive approach to preventing, de-escalating and/or intervening when the behavior of an individual poses a threat of harm to themselves and/or others) in response to client D's behaviors. __To ensure sufficient staff to supervise and implement client A's, B's, F's and G's program plans. Findings include: The facility's reportable and investigative records were reviewed on 5/22/14 at 2 PM. 1. The BDDS (Bureau of Developmental Disabilities Services) reports indicated: __On 10/6/13 at 7:30 AM client D came out of her bedroom to take morning medications and client E said something mean to client D. Client D responded by sticking her tongue out at client E. Client E then slapped client D on each arm and client D responded by slapping client E in each arm and punching client D in the stomach. The report indicated client D was assigned 1:1 (one staff to one client) supervision during waking hours to reduce the number of negative encounters with peers. __On 10/7/13 at 8 AM "When LPN [name of LPN] went to talk to [client D] about how she broke her glasses over the		continue to train allagency staff on HIPAA and confidentiality of consumer records at orientationand annually at SAT. There will besufficient staff present during all meal times to ensure that clients areproperly supervised and to facilitate active treatment. AWS will continue to mandate that all AWS employees who work overnight shifts log in via computer or call in their time every hour. Management staff, including QIDPs and GHM will conduct random visits, no less than monthly, to ensure staff are awake and appropriately supervising clients. **How facility will identify other residents potentially affected and what measures taken** All consumers couldpotentially be affected and corrective action plans will address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** The RD will retrainall group home staff at staff meetings on 7-2-14 and 7-3-14 on the AWS Abuse/Neglect Policy as well as the Incident Reporting Policy. This will include what is abuse/neglect, what incidents are reportable and the mandate for immediate reporting to theQIDP. The RD will pass out Incident Report cards that provide a reminder of what incidents are reportable. Also the RD will place a reminder of what incidents are reportable on the Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/06/2014
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	weekend [client D] told [name of LPN] that a staff pushed her down on her bed and held her down. [Client D] did not say which staff, only said staff. LPN contacted director. All staff who worked over the weekend were suspended while an investigation was initiated. [Client D] was interviewed by Director of HR (Human Resources). [Client D] reported that [staff #8 and #9] had pushed her down on Saturday and held her pinned to the bed." __The follow up BDDS report dated 10/12/13 indicated "AWS teaches basic Mandt (a comprehensive approach to preventing, de-escalating, and/or intervening when the behavior of an individual poses a threat of harm to themselves and/or others) to all staff and intermediate Mandt to staff working in situations where HRC (Human Rights Committee) approved restraints may be necessary. Staff working with [client D] were trained in intermediate Mandt. Staff were retrained on appropriate behavioral interventions and [client D's] specific BSP (Behavior Support Plan) on 10/10/13. Best accounts of the situation from staff and [client D] herself was it was only a few seconds that [client D] was actually held down. It was also found out that the situation did not occur on [client D's] bed but in (sic) the floor of the living room at approximately 4:30		Communication Board in the medication room. Any current group home staff not attending one of these meetings will be removed from the schedule until theyreceive this training from the RD or a designated representative. The RD will sign off on these trainings and will give copies to HR to be placed in each employee's HR file. All group home staff will be retrained by the RD on HIPAA and confidentiality of consumer records atstaff meetings to be held on 7-2-14 and 7-3-14. Any current group home staff not attending one of these meetings will be removed from the schedule until they receive this training from the RD or adesignated representative. The RD will sign off on these trainings and will give copies to Human Resources (HR) to be placed in each employee's HR file. Staff will also continue to be trained on HIPAA and confidentiality of consumer records at new hire orientation and SAT. The RD retrained all QIDPs and the GHM on necessary components of investigations. This included conducting thorough interviews of all relevant individuals, immediate reporting, and ensuring that all consumers feel safe in their home. Any concerns with clients feeling unsafe in their home will be addressed and followed up on by the QIDP conducting the investigation. The RD signed off	

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	PM on 10/5/13 by staff [staff #8]. [Staff #8] has been suspended pending the outcome of the investigation. [Staff #8's] employment with AWS will be terminated based on the investigation which has substantiated consumer abuse. Staff were retrained on 10/10/13 on appropriate behavioral interventions, [client D's] BSP, client rights, professional conduct and the AWS Abuse/Neglect Policy. Staff working in [client D's] home will be mandated to retake intermediate Mandt at the next available course offering." A written statement from staff #10 dated 10/6/13 indicated "I was in kitchen giving breakfast when staff called for help. I contacted team lead and manager requesting that they come to the house. [Client D] was throwing a tantrum in her room. She was throwing things, kicking things, hitting things. She had bitten staff and drew blood. All other clients (A, B, C, E, F, G and H) were asked to stay away and to return to their rooms. Staff did not leave [client D] unattended. Her behaviors caused other housemates to escalate to crisis point. Two housemates were emotionally distraught and began to cry. Staff attempted to offer comfort. [Client D's] behaviors did not end until manager told staff how to handle the situation. Nurse was contacted. All other		on these trainings and gave copies to HR to be placed in each employee's HR file. Each client will also be asked about their home and living environment in their quarterly meetings. This will be documented on the meeting notesand saved in their main chart in the office. There will be sufficient staff present during all meal times to ensure that clients are properly supervised and to facilitate active treatment. The GHM and the RD will monitor the schedule submitted by the GH Supervisor (GHS) to ensure sufficient staff are scheduled at all meal times. AWS will continue to mandate that all AWS employees who work overnight shifts log in via computer or call in their time every hour. Management staff, including QIDPs and the GHM, will conduct random visits, no less than monthly, to ensure staff are awake and appropriatelysupervising clients. The first visit will occur at 4:00am on 6-30-14 and will be conducted by the RD, GHM, and QIDPs. Management staff will record their visits and observations on the Manager Observations Log as well as recording Manager In-Home time on the Provide time entry program. **How corrective actions will be monitored to ensure no recurrence** The RD will monitor the Provide time entry system as well as the Manager Observation	

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	clients are reacting to [client D] with fear and anger. Roommate [client C] was afraid to enter their (client C's and D's) shared room. [Client D] was placed in 1 on 1 (one staff to one client) with manager and then team lead. Staff is at a loss and I personally do not know how to deal with [client D]." The facility's records did not indicate client C's fear of client D was addressed and/or investigated. A written statement from staff #7 dated 10/7/13 indicated "On arrival Sat (Saturday) AM 10-5-2013 [client D] was and had been having behaviors which involved kicking, hitting and biting both herself and staff. The other clients were getting their hair cut and she (client D) was upset that she was not allowed to go. The behaviors continued on during the day but seemed to me (staff #7) to be initiated each time by the attitude of her one-on-one person toward her. She (the staff) was speaking to her in a disrespectful manner and yelling at her as if she were a small child. When [client D] would get angry or even do something as simple as sneeze and then hold on to the back of the chair she was near, she (the staff) would criticize her in a very disrespectful and demeaning manner which would further escalate [client D] and would result in more behaviors. This		Log monthly to ensure random home visits are being conducted at least monthly. The RD will meet with the Group Home Management team which includes the GHM, the QIDPs and the RN at least twice per month to discuss concerns and appropriate home visits and on the spot training opportunities. The GHM and RD will monitor the staff schedule presented by the GHS and the Provide time entry system weekly to ensure appropriate staff are scheduled to facilitate active treatment and appropriate supervision. The RD will review 100% of incident reports for each QIDP until the QIDP is proficient in writing and submitting incident reports. After the QIDP is proficient in writing and submitting incident reports, the RD will place documentation in the QIDPs employee file and continue to review incident reports randomly. Staff will continue to be trained in HIPAA and confidentiality of consumer records at new hire orientation and SAT. According to AWS policy, no staff can work without attending new hire orientation and also annual SAT training. The HR department, the RD, and the Group Home Manager (GHM) monitor the expirations list weekly which includes mandatory annual SAT training to ensure complete compliance.	

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	continued on throughout the afternoon. The clients were going out for dinner and [client D] was upset and crying that she was not allowed to go. [Client D] had more kicking behaviors and broke the mirror on the door in her room. During this time [staff #8] was very condescending to her and not directly to her but so that I'm sure she could hear, called her (client D) 'a little heffer (sic)' and continued calling her that throughout the day. After getting the rest of the ladies on the van, I (staff #7) walked over to close the storm door which had been propped open. I heard [staff #8] yelling at her (client D) and walked in to see if I could help. I witnessed [staff #8] holding her (client D's) head down over the arm of the sofa then grab the back of her (client D's) shirt and pull her down to the ground. I walked back outside to get [staff #9] who was already in the driver's seat. It was then that [staff #8] came out and said 'Can't I get a little help in here?' [Client D] was going down the hallway kicking walls and hitting doors and biting herself. She went into her room and I went back out to the van and we left for dinner. On arrival back home [client D] was still agitated and was yelled at by [staff #8] to 'go to your room.' She went to her room but started kicking and hitting her door. [Staff #8] had called the [RM (Residential Manager)] earlier and			

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	she came to the house while we were out for dinner. She (client D) continued kicking and hitting her door and throwing things in her room. This went on for about 20 minutes. Her roommate, [client C] was crying and saying she didn't want to sleep in the room with her. It was causing behaviors from another client. [Client B] who pushed [client E] and she (client E) fell. In the mean time, [RM] was called and [staff #8] was instructed to call 911. I was instructed by [staff #8] to go outside and watch for the police which I did. When they arrived, I showed the first officer to her (client D's) bedroom. At that point [staff #9] had the door open and she (client D) was sitting on her bed crying. The officer talked to her (client D) and decided to take her to [name of hospital]. They arrived home a few hours later. When I arrived on Sun (Sunday) AM 10/6/13 [RM] informed me I would be one-on-one with [client D] as there had been further behaviors in the morning with one staff being bitten in the forearm. I was given instructions on what to do during the day and had no problems or behaviors from [client D] the whole day. After dinner [client D] had an episode of vomiting.... When she went in to take her evening meds she coughed and [staff #8] was very rude to her telling her to cover her mouth she didn't want her germs all over her.... [Client D] asked			

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AWS	825 MENDLESON DR RICHMOND, IN 47374

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	if she should get ready for her shower and was told by [staff #8] 'You don't need a shower. Just get your pajamas on and go to bed'." A written statement from staff #9 dated 10/8/13 indicated "when [client H] went to give her (client D) a hug she (client D) bit her (client H) on the right arm but only got her jacket.... She (client D) was upset and stomping around. She wasn't watching where her feet were and fell.... [Client D] was mad and was kicking, hitting and yelling. She bit herself and ended up bloodying her lip. She proceeded to whipe (sic) blood all over a chair and a wall after staff told her not to.... Around 4 PM staff started getting all of the other clients ready to go out to dinner with the other two houses. As another staff and I were getting the other clients on the van and about to leave [client D] went off and escalated again. [RM] was called and on her way. Staff left her (client D) in the living room and was in the laundry room and right outside the (sic) door to make sure she (client D) was safe because she was throwing things, hitting and kicking. I went with another staff and the other clients out to dinner. When we came back [client D] started again and was taken to the hospital in an ambulance and the police were called after she (client D) had been			

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	violent for 12 hours. Sunday (10/6/13) morning I (staff #9) came in to pass meds. I let everyone sleep in due to the eventful day they had on Saturday. I woke [client D] up at 7 AM and asked her to please wash her hair then come get her meds before getting dressed or eating and explained that I let everyone sleep in but that we need to get meds done quickly. She (client D) did not come out of her room until 7:30 AM and when I asked her to come get her meds she decided to become verbally aggressive and get into a fight with [client E]. She (client D) tried to slam the med office door in [client E's] face to hurt her and procided (sic) to strike [client E] multiple times before I (staff #9) could get in between them. [Client D] proceed (sic) to bite me breaking skin. I had the only other staff there put in a call to [RM]. She (the RM) arrived 15 min (minutes) later. While the call was being place (sic) I physically assisted [client D] to her bedroom and shut the door.... I held the door shut until [RM] arrived because she kept trying to attack people. I went and helped calm down the other 7 clients and then [name of staff] arrived." A written statement from staff #10 dated 10/8/13 indicated on 10/5/13 "She [client D] exchanged a few words with staff and became distraught. Housemate attempted			

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	to offer comfort with a hug and [client D] bit housemate on the shoulder. I went to staff to tell her what had happened and she came out and raised her voice to [client D]. This furthered [client D's] behaviors and she began to bite herself. Staff left to med office. [Client D] followed and more words were exchanged. [Client D] was told she could not get her hair cut. She became more upset. I had to give showers and do not know what happened. When I went into the living room to get the next client, [client D] was on the floor between the couch and chairs. She told me she fell and I told staff she needed first-aid and went to give showers. [Client D] worked herself into a fit and had to stay home. I was told to stay behind with her. As staff and clients were leaving [client D] fell again in the doorway, right beside the fire door. She was bleeding again and moved to the leather chair. She wanted to talk to the manager and I asked if I could give her first-aid before I gave her the phone. She agreed and when I came back with gloves, her glasses had been broken. I removed them and placed them on the desk. She calmed down for the most part and I left after everyone came back. I came back in that night at ten to find team lead was still there. I was updated and told to check on [client D] periodically. She slept through the night			

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	when she woke up the next morning she seemed fine. I was doing breakfast and showers again. Then staff called for me to call manager and I did. [Client D] had bitten staff. She was carried to her room and we held the door shut. Manager and team lead were called and both came in. [Client D] bit manager. I had to finish breakfast and showers so I do not really know what happened." The investigative records indicated a termination letter from staff #9 dated 10/8/13. The letter indicated "I (staff #9) cannot speak for everyone in the organization but for me personally I cannot continue to provide good quality care in an environment where I do not feel safe for the clients or myself. I must resign my position with AWS as a Direct Support Personnel. My last day of employment will be October 22, 2013. After reading the above if you would like to discuss possible changes we could make to provide a safer environment for clients and staff so as I may continue with my position as a Direct Support Personnel. I am willing to do so at any time." The 10/11/13 investigative summary of the allegations of abuse made by client D that staff pushed her and held her down indicated:			

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	__The allegations of abuse were substantiated and client D was pushed, held down and restricted to her bedroom "for approximately 10 minutes" by staff #8 and #9. __Staff #7 "witnessed staff #8 hold [client D's] head down on the couch, pulled her to the ground by her T-shirt and held her on the ground. [Staff #7] then left the home with other consumers leaving [client D] alone with [staff #8]. [Staff #7] did not report the abuse until questioned by LPN on 10/7/13. She then disclosed information to LPN and HR during interview." __Staff #7's, #8's and #9's employment was terminated. __Staff #9 violated HIPAA (Health Insurance Portability and Accountability Act) laws in disclosing client D's protected health information. Staff #9's mother had called HR on 10/8/13 "communicating to HR specific details about [client D's] diagnoses and protected health information." __"All staff working in this home will be retrained on consumer rights, abuse neglect policy and professional conduct. All staff working in this home will be retrained on Intermediate Mandt to reemphasize appropriate consumer interactions...." The investigative record indicated an			

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	interview with client D. The investigative record indicated no interviews from client D's housemates (clients A, B, C, E, F, G and H) in regard to the events that happened on 10/6/13 and 10/7/13. Review of facility staff training dated 10/10/13 via email on 6/4/14 at 10:11 AM indicated staff #10 was not provided training in regard to consumer rights, abuse neglect policy, professional conduct and implementation of the Mandt System after the incidents in October 2013 with client D. The facility records indicated the facility failed to ensure the staff reported abuse immediately to the administrator, to ensure client D was not abused, to ensure clients A, B, C, D, E, F, G and H were provided a calm environment without fear of abuse within their home and to ensure client D's health information was maintained in regard to HIPAA laws. The facility investigative records did not indicate the facility addressed client C's fear of client D as reported in the written statement from staff #10. During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM: __The RD indicated all allegations of abuse/neglect were to be reported			

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	immediately to the administrator and thoroughly investigated. __The RD indicated all staff were retrained in the Mandt System, consumer rights, abuse neglect policy and professional conduct. __The RD indicated no documentation of training for staff #10 in regard to the retraining of consumer rights, abuse neglect policy and professional conduct. The RD stated "She (staff #10) was at the training but we can't find any documentation of it." __The RD indicated staff #9's mother had called the HR department and relayed personal information about client D that was told to her by her daughter (staff #9). __The RD indicated clients' personal heath information was not to be disclosed to the general public and all staff were to be retrained in regard to the HIPAA (Health Insurance Portability and Accountability Act laws.) __The RD stated staff #10's date of hire was 9/16/13 and the staff was "fairly new when all this happened." __The RD indicated staff #7, #8, #9, #10, the previous house manager and the RM were no longer employed with the facility. __The RD indicated the facility had not addressed client C's fear of client D that was documented in staff #10's written statement of 10/6/13.			

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	2. The 2/11/14 BDDS report indicated on 2/6/14 at 7:30 AM client H was taken to the day program on the group home van "as usual. When she (client H) arrived to the day program she refused to get off the van, saying that her knee was hurting. Residential and day program staff assisted [client H] into the building and she was assessed by the residential nurse. The nurse asked that [client H] be taken to the hospital to have an x-ray of her knee. The result showed no sign of injury. __The 2/10/14 BDDS report indicated on 2/9/14 at 9 PM "[Client H] refused to get off the van taking her to day program on 2/6/14. She stated her leg was hurting. There were no known incidents which may have caused her injury and staff report that she was fine prior to this complaint. The residential nurse examined [client H] and she was taken to the hospital for an x-ray. The results showed no sign of injury. [Client H] continued to refuse to walk and on 2/9/14 was refusing all other daily activities as well such as eating, showering, and using the restroom. Her support staff notified the Behavior Specialist of [client H's] non-typical behaviors of non-compliance and verbal aggression. [Client H's] team decided she should go to the local emergency room to determine if any			

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	reason could be found for her drastic change in behavior." The labs and x-rays came back normal "however was diagnosed with a torn ligament in her left leg ad a leg immobilizer was ordered. This QDDP (Qualified Developmental Disability Professional) has started the unknown injury investigation. [Client H's] team agrees that an inpatient admission should be sought because in her current state it is extremely difficult for the group home staff to take care of her needs." __The investigative records indicated written statements from 5 group home staff and one day program staff. The statements indicated the staff were to answer one question, "Have you witnessed anything that might have caused [client H] to injure her leg?" The statement from staff #6 dated 2/10/14 indicated "I have not witnessed anything. [Client H] did tell me she fell while doing meals on wheels." The statement from staff #3 dated 2/10/14 indicated, "I have no idea what happened. She (client H) was fine until Thursday morning when she was getting off the van, she sat down and wouldn't get back up, saying her knee was hurting."			

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	The statement from staff #2 dated 2/10/14 indicated "No, I have been off on sick. I came back today." The statement from staff #10 dated 2/10/14 indicated "No." The statement from staff #5 dated 2/10/14 indicated "No, I have not." The statement from day program staff #1 dated 2/10/14 indicated "No, she [client H] did not fall when she was with me doing meals on wheels." The facility records indicated no further statements and/or interviews with staff. The facility records indicated no client interviews. The facility records did not indicate a thorough investigation was conducted. The 5/7/14 BDDS report indicated on 5/6/14 at 8 PM "[Client H] was discharged from the [name of nursing facility (NF)] at 3 PM on 5/6/14 where she has been a resident since 2/27/14. [Client H's] guardian transported her from the NF to her group home where she had been a resident for 8 years. When [client H] arrived to her home she refused to move from the seated walker she was sitting in. She became combative with staff, refused to ambulate or eat her evening meal. Because [client H] is a non			

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	insulin dependent diabetic and takes oral medications and is on a special diet, nurse advised staff to call ambulance to have [client H] taken to the [name of hospital] for evaluation. While at the ER it was discovered that client has a left hip fracture and a urinary tract infection and she was admitted to the hospital. She is scheduled to have surgery the afternoon of 5/7/14. AWS was advised by the NF that [client H] had fallen 5/5/14 while still admitted at the NF but their assessment was negative for injury." The facility records indicated the facility had conducted an investigation in regard to client H's hip fracture. __The investigative summary indicated "Verbal report from [name of NF] to AWS RN that [client H] had fallen on 5/5/14 and NF had not completed a hip x-ray.... [Client H] fell on 5/5/14 while a patient at NF. [Client H] did not move from the spot her guardian place (sic) her while in AWS services. [Client H] was transported via ambulance to [name of hospital] where it was discovered she had a broken hip. [Client H] did not fall nor have the opportunity to be hurt while in AWS services. AWS staff did the correct procedure by calling the ambulance and having [client H] seen at the ER." __The investigative records indicated one written statement from staff #2, "[Client			

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	H] was brought in by her guardian [name of guardian and name of guardian's mother] and [client H] refused to get off the seat of her walker so they pushed her to her room on the walker and [client H] refused to move from the seat for bathroom, eating, getting pajamas on the entire evening. Nurse and supervisor were contacted and nurse came and evaluated [client H] and she was sent to the hospital by ambulance." __The investigative records indicated no staff interviews, no client interviews, no interviews with the staff at the NF and no interview with the client's guardian. The facility records did not indicate a thorough investigation was conducted. Client H's hospital records were reviewed on 5/29/14 at 9 AM. Client H's physician's note dated 2/11/14 at 5:39 PM indicated client H was "evaluated by myself (the physician) 2 days ago, with a history of a fall which occurred on February 3, 2014. Subsequent x-rays were unremarkable. She presented at that time with refusal to get up and not eating and a personality change. She had an unremarkable workup here at that time.... She saw her doctor yesterday and was given Hydrocodone (for pain). She has			

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	returned today with the staff saying that they are unable to provide the care she needs that she still will not get up and will not walk and will not eat. She is making unusual noises, as if she might be in pain somewhere.... She [client H] has also developed an early sacral decubitus (pressure sore) since she was here. I have asked for repeat x-rays of the left leg from the hip to foot. She is recommended for admission and further evaluation." Client H's physician's note dated 2/13/14 at 10:30 PM indicated client H had a "lateral tibial plateau fracture (a bone fracture or break of the shinbone called the tibial plateau and affecting the knee joint) with 2 mm (millimeters) of depression of the posterior lateral tibial plateaus, as well as a joint effusion (increased fluid around the joint).... Addendum: She [client H] is very galled (reddened, irritated and painful skin area caused from friction of skin rubbing together) around the peri (genital) area probably from her incontinence. We will anchor a Foley (internal catheter) to help with incontinence. Get some			

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	barrier cream on the skin, good hygiene and see if we can get her skin healing up." Client H's record was reviewed on 5/29/14 at 2 PM. Client H's February 2014 nursing notes indicated (not all inclusive): __2/6/14 "Called PCP (Primary Care Physician) for a left knee x-ray for left knee edema (swelling)/pain. PCP did not want to see client." __2/7/14 "Received results from medical records. Left knee no fracture or dislocation...." __2/10/14 "Staff contacted this nurse with c/o (complaint of) that [client H] would still not walk and has became incontinent of B/B (bowel and bladder) and is refusing to do anything for herself. This nurse instructed staff to transport her (client H) to the ER for eval (evaluation) for change in condition. At ER Dr. (doctor) stated that he thought she had a torn ligament to left leg. Released to home and to f/u (follow up) with PCP." __2/11/14 "...[client H] was not eating or drinking and that she refused to help staff with transporting her, rest-rooming her and she now had a sore on her buttocks from not letting staff clean her after soiling herself." __2/12/14 "[Name of doctor] did not have admitting rights at [name of			

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	hospital] so for us to go ahead and take [client H] to the ER again for the leg c/o, chance of becoming dehydrated. Staff and this nurse took [client H] to the ER. Many labs and tests were performed. It was found that [client H] had a Tibial Plateau fracture on the left leg. No floor would admit her so [name of doctor] spoke with [name of doctor] and agreed to admit her to the psych floor." Interview with staff #2 on 5/22/14 at 5:10 PM indicated staff #2 worked the afternoon client H returned to the group home. Staff #2 stated client H returned "around 3:30 PM." Staff #2 indicated client H's guardian transported client H in her truck from the NF (nursing facility) to the GH (group home). When asked how did client H get out of the truck, staff #2 stated, "It took all three of us (client H's guardian, the guardian's mother and staff #2) to get her (client H] out of the truck. We had to lift her." Staff #2 indicated client H's guardian owned a large 4 door cab truck. "She [client H] fought us. We sat her down on the seat of her walker and [name of guardian] pushed her (client H) into the house and down the hall to her bedroom." Staff #2 indicated client H was rolled into the house via her rolling walker. Staff #2 stated, "She [client H] wouldn't stand, eat or go to the bathroom for us. We put a table in her room and we			

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	got her to eat a little bit of applesauce, but that was it. She wouldn't put her pajamas on. We couldn't take care of her, so we were told to take her to the hospital. Staff #2 indicated client H was returned to the facility for 4 1/2 hours prior to being returned to the hospital." During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM, the RD: __Indicated the facility RN had spoken with someone at the NF in regard to client H and the facility RN was told client H had fallen 5/5/14 while at the NF and stated "But they checked her out and didn't find anything wrong." The RD indicated no documentation of the interview with the NF. __When asked how client H was transported from the NF back to the group home, the RD indicated via a large truck that belonged to client H's guardian. The RD indicated client H's guardian and the guardian's mother returned client H to the group home from the NF. The RD stated, "Yeah, we wondered too how she was able to get her up and down in that truck without any problem." The RD indicated no interview with client H's guardian had been conducted. __Indicated no need to continue with the investigation after being told client H had fallen on 5/5/14.			

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	3. The 8/17/13 BDDS report indicated on 8/17/13 at 1 PM the clients from the group home (clients A, B, C, D, E, F, G and H) were loading the facility van after a picnic in the park when client D refused to put her seat belt on. Client D began to yell and curse at the staff while kicking and hitting "everything around her.... Staff made the decision to make the attempt to get the consumers of (sic) the van in order to protect them." The report indicated clients A and E were kicked by client D. __The 8/17/13 statement from staff #8 indicated client D had "kicked several of them (the other clients on the van). She (client D) clawed and scratched the staff. She kept yelling and cussing at both staff and clients. Other clients were all removed to the picnic table for their safety. [Client D] kept up the kicking, hitting and biting for another 1/2 hour. Staff contacted team leader and QMRP (Qualified Mental Retardation Professional) for advice. Whole van was exposed to unsafe conditions and staff could not get her to stop long enough to get them home. Other clients were hurt when another client acted out and bruised one's shoulder and got another client in a head lock. It took both staff to try to handle the situation and also keep other clients safe. All clients were sitting on			

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	picnic table crying. Two clients told staff they were afraid." __The 8/17/13 statement from staff #9 indicated "Several of the clients were extremely upset and frightened, they were crying and physically shaken. She [client D] continued to attack staff and refuse to cooperate. After staff tried contacting all possible options of people to come get [client D] to no avail, staff attempted to put clients on van and keep [client D] separated but she again physically attacked staff and the van had to be pulled over after less than two hundred feet of driving. Staff in another van from another house showed up on the scene and talked to [client D] but she still ended up having to be removed and taken to another house for her fellow housemates' protection." __The facility investigative records indic ated two staff statements and one client interview. The records indicated no other interviews. The facility records did not indicate a thorough investigation. · __The investigative report/summary dated 8/19/13 indicated as corrective actions the staff were to continue to follow client D's BSP. The report indicated "Based upon the evidence obtained during the course of the investigation there is a preponderance of the evidence to substantiate abuse against [client D]. This decision is based upon			

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	the staff witness statements as well as the victim statements. · __The facility records did not indicate the facility had addressed the fear and intimidation by the clients. · · During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM, the RD indicated the investigation was conducted as a peer to peer abuse in regard to client D who had kicked clients A and E. The RD stated all clients "should be interviewed during an investigation." The RD indicated no investigation in regard to the fear and intimidation caused by client D's behaviors. · · 4. The 5/18/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 5/18/14 at 7 AM staff #3 arrived at the group home and "found [staff #10] sleeping. [Staff #3] called and notified supervisor. Supervisor came to the home to begin an internal investigation and to suspend the staff who was accused of sleeping." The report indicated staff #10 "resigned on the spot to keep from being part of the investigation. All consumers (clients A, B, C, D, E, F and G) were checked on and all were sleeping with no issues." · · The investigative summary dated			

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	5/23/14 indicated "Allegation that third shift staff (#10) was sleeping when morning staff (#3) came on shift at 7 AM." Summary of evidence indicated "This investigator (the QIDP (Qualified Intellectual Disabilities Professional) looked at Provide (a computer program) time entries on 5/18/14. [Staff #10] did not enter her time in Provide during the shift from 2 AM onward. Per procedure, overnight staff are to enter their time every hour. This does not prove she was asleep during that time, but it could have helped show she wasn't sleeping if time had been entered as required at 4 AM, 5 AM and 6 AM." The investigative records indicated a statement from the staff that alleged the client neglect and a statement from the supervisor. The facility records indicated no client interviews and/or interviews to ensure no history of staff sleeping in the group home while on duty. The facility records did not indicate a thorough investigation was conducted. · · The plan of corrective action indicated "Allegation of neglect due to sleeping substantiated. When GH (group home) supervisor, who was working at a house across the street, heard of the allegation, she immediately went to suspend [staff #10]. [Staff #10] refused to cooperate with the investigation and			

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	resigned on the spot." The investigative record indicated no specific plan of corrective oversight and/or how the facility would be monitored to prevent the neglect from reoccurrence. The facility records indicated no documentation of administrative and/or supervisory staff observations and/or monitoring. · · During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM: · __When the RD was asked how the facility monitored the staff to ensure staff were not sleeping while on duty and the clients were not being neglected, the RD stated, "We do drop in visits and the staff are to make an entry in Provide once an hour." · __The RD stated the "drop in visits" made by supervisory staff were not documented. · __The RD indicated the hourly entries made by the staff in Provide was not conclusive evidence the staff were not sleeping while on duty. · __The RD indicated the facility did not develop and/or implement a plan of protective oversight to monitor the staff in the group home to ensure no further neglect due to staff sleeping while on duty for clients living in the group home (clients A, B, C, D, E, F and G).			

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	· · The facility policies were reviewed on 5/22/14 at 2 PM. The revised "Group Home Abuse and Neglect" policy dated 8/08 indicate "AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse." · The policy indicated definitions of (not all inclusive): "Physical abuse is any action that could lead to bodily harm, including corporal punishment, like spanking or hitting or pinching. Verbal abuse is speaking, writing or gesturing in a derogatory manner to a client or in proximity of a client. Neglect includes failure to provide appropriate care, food, medical care or supervision." The policy indicated "If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this immediately to their supervisor and the AWS Residential Director. The supervisor is responsible for reporting the incident to all appropriate entities. These include, but are not limited to: Bureau of Developmental Disability Services, Adult/Child Protective Services, and client representatives. Client representatives include Guardian, family members, Health Care Representatives,			

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	and Power of Attorneys. If the situation affects more than one person, all necessary representatives will be notified." The revised facility policy "Incident Reporting and Investigation Policy - Indiana" dated 6/13/13 indicated all alleged, suspected and/or actual allegations of abuse/neglect and all injuries of unknown origin were to be investigated. "The investigator conducts interviews and collects written statements from all relevant individuals." This federal tag relates to complaint #IN00148943. 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 1 of 1 allegation of abuse for client D, the facility failed to ensure all incidents of abuse were reported immediately to the administrator. Findings include:	W000153	**Correctiveactionforresident(s)foundtohavebeenaffected** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on the AWSAbuse/Neglect Policy as well as the Incident Reporting Policy. This will include what is abuse/neglect, whatincidents	07/03/2014

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	825 MENDLESON DR RICHMOND, IN 47374

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	The facility's reportable and investigative records were reviewed on 5/22/14 at 2 PM. The BDDS (Bureau of Developmental Disabilities Services) report dated 10/7/13 indicated on 10/7/13 at 8 AM indicated "When LPN [name of LPN] went to talk to [client D] about how she broke her glasses over the weekend [client D] told [name of LPN] that a staff pushed her down on her bed and held her down. [Client D] did not say which staff, only said staff. LPN contacted director. All staff who worked over the weekend were suspended while an investigation was initiated. [Client D] was interviewed by Director of HR (Human Resources). [Client D] reported that [staff #8 and #9] had pushed her down on Saturday and held her pinned to the bed." A written statement from staff #7 dated 10/7/13 indicated "On arrival Sat (Saturday) AM 10-5-2013 [client D] was and had been having behaviors which involved kicking, hitting and biting both herself and staff. The other clients were getting their hair cut and she (client D) was upset that she was not allowed to go. The behaviors continued on during the day but seemed to me (staff #7) to be initiated each time by the attitude of her one-on-one person toward her (staff #8).		are reportable, and the mandate for immediate reporting to theQIDP. The RD will pass out IncidentReport cards that provide a reminder of what incidents are reportable. Also the RD will place a reminder of whatincidents are reportable on the Staff Communication Board in the medicationroom. RD retrained allQIDPs and the GHM on necessary components of investigations. This included conducting thorough interviewsof all relevant individuals, immediate reporting, and ensuring that allconsumers feel safe in their home. Anyconcerns with clients feeling unsafe in their home will be addressed andfollowed up on. **Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasurestaken** All residentsare affected and correctiveaction will address theneeds of all clients. **Measuresorsystemicchangesfacilityputinplacetoensurenorecurrence** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on the AWSAbuse/Neglect Policy as well as the Incident Reporting Policy. This will include what is abuse/neglect, whatincidents are reportable and the mandate for immediate reporting to theQIDP. The RD will pass out IncidentReport cards that provide a reminder of what incidents are reportable. Also the RD will place a reminder of	

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	She (staff #8) was speaking to her in a disrespectful manner and yelling at her as if she were a small child. When [client D] would get angry or even do something as simple as sneeze and then hold on to the back of the chair she was near, she (the staff) would criticize her in a very disrespectful and demeaning manner which would further escalate [client D] and would result in more behaviors. This continued on throughout the afternoon. The clients were going out for dinner and [client D] was upset and crying that she was not allowed to go. [Client D] had more kicking behaviors and broke the mirror on the door in her room. During this time [staff #8] was very condescending to her and not directly to her but so that I'm sure she could hear, called her (client D) 'a little heffer (sic)' and continued calling her that throughout the day. After getting the rest of the ladies on the van, I (staff #7) walked over to close the storm door which had been propped open. I heard [staff #8] yelling at her (client D) and walked in to see if I could help. I witnessed [staff #8] holding her (client D's) head down over the arm of the sofa then grab the back of her (client D's) shirt and pull her down to the ground. I walked back outside to get [staff #9] who was already in the driver's seat. It was then that [staff #8] came out and said 'Can't I get a little help in here?'		whatincidents are reportable on the Staff Communication Board in the medicationroom. Any current group home staff not attendingone of these meetings will be removed from the schedule until they receive thistraining from the RD or a designated representative. The RD will sign off on these trainings andwill give copies to HR to be placed in each employee's HR file. The RD retrained allQIDPs and the GHM on necessary components of investigations. This included conducting thorough interviewsof all relevant individuals, immediate reporting, and ensuring that allconsumers feel safe in their home. Anyconcerns with clients feeling unsafe in their home will be addressed andfollowed up on by the QIDP conducting the investigation. The RD signed off onthese trainings and will give copies to HR to be placed in each employee's HRfile. Each client will also be askedabout their home and living environment in their quarterly meetings. This will be documented on the meeting notesand saved in their main chart in the office. **Howcorrectiveactionswillbemonitoredtoensurenorecurrence** Incidents are to bereported to the RD immediately. The RDwill write an email to document the date and time notified to be included withthe investigation packet. Theinvestigation packet is then sent to the RD for original signature. The	

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	[Client D] was going down the hallway kicking walls and hitting doors and biting herself. She went into her room and I went back out to the van and we left for dinner. On arrival back home [client D] was still agitated and was yelled at by [staff #8] to 'go to your room'. She went to her room but started kicking and hitting her door. [Staff #8] had called the [RM (Residential Manager)] earlier and she came to the house while we were out for dinner. She (client D) continued kicking and hitting her door and throwing things in her room. This went on for about 20 minutes. Her roommate, [client C] was crying and saying she didn't want to sleep in the room with her. It was causing behaviors from another client. [Client B] who pushed [client E] and she (client E) fell. In the mean time, [RM] was called and [staff #8] was instructed to call 911. I was instructed by [staff #8] to go outside and watch for the police which I did. When they arrived, I showed the first officer to her (client D's) bedroom. At that point [staff #9] had the door open and she (client D) was sitting on her bed crying. The officer talked to her (client D) and decided to take her to [name of hospital]. They arrived home a few hours later. When I arrived on Sun (Sunday) AM 10/6/13 [RM] informed me I would be one-on-one with [client D] as there had been further behaviors in the		RD sends the original investigationpacket to the Vice President for original signature. The Vice President sends the originalinvestigation packet to the Director of Compliance for original signature. Once all signatures are obtained, theDirector of Compliance scans the investigation packet to the RD to file. The RD will review100% of incident reports for each QIDP until the QIDP is proficient in writingand submitting incident reports. After aQIDP is proficient in writing and submitting incident reports, the RDwill place documentation in the QIDPs employee file and continue to reviewincident reports randomly.	

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	morning with one staff being bitten in the forearm. I was given instructions on what to do during the day and had no problems or behaviors from [client D] the whole day. After dinner [client D] had an episode of vomiting.... When she went in to take her evening meds she coughed and [staff #8] was very rude to her telling her to cover her mouth she didn't want her germs all over her.... [Client D] asked if she should get ready for her shower and was told by [staff #8] 'You don't need a shower. Just get your pajamas on and go to bed'." A written statement from staff #9 dated 10/8/13 indicated "when [client H] went to give her (client D) a hug she (client D) bit her (client H) on the right arm but only got her jacket.... She (client D) was upset and stomping around. She wasn't watching where her feet were and fell.... [Client D] was mad and was kicking, hitting and yelling. She bit herself and ended up bloodying her lip. She proceeded to whipe (sic) blood all over a chair and a wall after staff told her not to.... Around 4 PM staff started getting all of the other clients ready to go out to dinner with the other two houses. As another staff and I were getting the other clients on the van and about to leave [client D] went off and escalated again. [RM] was called and on her way. Staff			

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	left her (client D) in the living room and was in the laundry room and right outside the (sic) door to make sure she (client D) was safe because she was throwing things, hitting and kicking. I went with another staff and the other clients out to dinner. When we came back [client D] started again and was taken to the hospital in an ambulance and the police were called after she (client D) had been violent for 12 hours. Sunday (10/6/13) morning I (staff #9) came in to pass meds. I let everyone sleep in due to the eventful day they had on Saturday. I woke [client D] up at 7 AM and asked her to please wash her hair then come get her meds before getting dressed or eating and explained that I let everyone sleep in but that we need to get meds done quickly. She (client D) did not come out of her room until 7:30 AM and when I asked her to come get her meds she decided to become verbally aggressive and get into a fight with [client E]. She (client D) tried to slam the med office door in [client E's] face to hurt her and procided (sic) to strike [client E] multiple times before I (staff #9) could get in between them. [Client D] proceed (sic) to bite me breaking skin. I had the only other staff there put in a call to [RM]. She (the RM) arrived 15 min (minutes) later. While the call was being place (sic) I physically assisted [client D] to her			

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	bedroom and shut the door.... I held the door shut until [RM] arrived because she kept trying to attack people. I went and helped calm down the other 7 clients and then [name of staff] arrived." A written statement from staff #10 dated 10/8/13 indicated on 10/5/13 "She [client D] exchanged a few words with staff and became distraught. Housemate attempted to offer comfort with a hug and [client D] bit housemate on the shoulder. I went to staff to tell her what had happened and she came out and raised her voice to [client D]. This furthered [client D's] behaviors and she began to bite herself. Staff left to med office. [Client D] followed and more words were exchanged. [Client D] was told she could not get her hair cut. She became more upset. I had to give showers and do not know what happened. When I went into the living room to get the next client, [client D] was on the floor between the couch and chairs. She told me she fell and I told staff she needed first-aid and went to give showers. [Client D] worked herself into a fit and had to stay home. I was told to stay behind with her. As staff and clients were leaving [client D] fell again in the doorway, right beside the fire door. She was bleeding again and moved to the leather chair. She wanted to talk to the manager and I asked if I could give			

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	her first-aid before I gave her the phone. She agreed and when I came back with gloves, her glasses had been broken. I removed them and placed them on the desk. She calmed down for the most part and I left after everyone came back. I came back in that night at ten to find team lead was still there. I was updated and told to check on [client D] periodically. She slept through the night when she woke up the next morning she seemed fine. I was doing breakfast and showers again. Then staff called for me to call manager and I did. [Client D] had bitten staff. She was carried to her room and we held the door shut. Manager and team lead were called and both came in. [Client D] bit manager." The investigative report indicated staff #7 "witnessed staff #8 hold [client D's] head down on the couch, pulled her to the ground by her T-shirt and held her on the ground. [Staff #7] then left the home with other consumers leaving [client D] alone with [staff #8]. [Staff #7] did not report the abuse until questioned by LPN on 10/7/13. Telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM indicated abuse was to be reported immediately to the administrator.			

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	This federal tag relates to complaint #IN00148943. 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 1 of 1 allegation of abuse for client D, for 8 of 16 incidents of client to client abuse for clients A, B, D, E, F and H, for 5 of 5 injuries of unknown origin for clients B, C, F and H and for 1 of 1 allegation of neglect for clients A, B, C, D, E, F and G, the facility failed to ensure all allegations of abuse/neglect, client to client abuse and injuries of unknown origin were thoroughly investigated. Findings include: The facility's reportable and investigative records were reviewed on 5/22/14 at 2 PM. 1. The 2/11/14 BDDS report indicated on 2/6/14 at 7:30 AM client H was taken to the day program on the group home van "as usual. When she (client H) arrived to the day program she refused to get off the	W000154	**Corrective action for resident(s) found to have beenaffected** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on the AWSAbuse/Neglect Policy as well as the Incident Reporting Policy. This will include what is abuse/neglect, whatincidents are reportable, reporting of any statements of fear, and the mandatefor immediate reporting to the QIDP. TheRD will pass out Incident Report cards that provide a reminder of whatincidents are reportable. Also the RDwill place a reminder of what incidents are reportable on the StaffCommunication Board in the medication room. RD retrained allQIDPs and the GHM on necessary components of investigations. This included conducting thorough interviewsof all relevant individuals, immediate reporting, and ensuring that allconsumers feel safe in their home. Anyreports of with clients feeling unsafe in their home will be	07/03/2014

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	van, saying that her knee was hurting. Residential and day program staff assisted [client H] into the building and she was assessed by the residential nurse. The nurse asked that [client H] be taken to the hospital to have an x-ray of her knee. The result showed no sign of injury." The 2/10/14 BDDS report indicated on 2/9/14 at 9 PM "[Client H] refused to get off the van taking her to day program on 2/6/14. She stated her leg was hurting. There were no known incidents which may have caused her injury and staff report that she was fine prior to this complaint. The residential nurse examined [client H] and she was taken to the hospital for an x-ray. The results showed no sign of injury. [Client H] continued to refuse to walk and on 2/9/14 was refusing all other daily activities as well such as eating, showering, and using the restroom. Her support staff notified the Behavior Specialist of [client H's] non-typical behaviors of non-compliance and verbal aggression. [Client H's] team decided she should go to the local emergency room to determine if any reason could be found for her drastic change in behavior. The labs and x-rays came back normal however was diagnosed with a torn ligament in her left leg and a leg immobilizer was ordered.		addressed andfollowed up on. AWS will continue tomandate that all AWS employees who work overnight shifts log in via computer orcall in their time every hour. Management staff, including QIDPs and the GHM, will conduct randomvisits, no less than monthly, to ensure staff are awake and appropriatelysupervising clients. **How facility will identify other residents potentiallyaffected and what measures taken** All residentsare affected and correctiveaction will address theneeds of all clients. **Measures or systemic changes facility put in place toensure no recurrence** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on the AWSAbuse/Neglect Policy as well as the Incident Reporting Policy. This will include what is abuse/neglect, whatincidents are reportable, reporting statements of fear, and the mandate for immediatereporting to the QIDP. The RD will passout Incident Report cards that provide a reminder of what incidents arereportable. Also the RD will place areminder of what incidents are reportable on the Staff Communication Board inthe medication room. Any current grouphome staff not attending one of these meetings will be removed from theschedule until they receive this training from the RD or a	

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	This QDDP (Qualified Developmental Disability Professional) has started the unknown injury investigation. [Client H's] team agrees that an inpatient admission should be sought because in her current state it is extremely difficult for the group home staff to take care of her needs." Client H's hospital records were reviewed on 5/29/14 at 9 AM. Client H's physician's note dated 2/11/14 at 5:39 PM indicated client H was "evaluated by myself (the physician) 2 days ago, with a history of a fall which occurred on February 3, 2014. Subsequent x-rays were unremarkable. She presented at that time with refusal to get up and not eating and a personality change. She had an unremarkable workup here at that time.... She saw her doctor yesterday and was given Hydrocodone (for pain). She has returned today with the staff saying that they are unable to provide the care she needs that she still will not get up and will not walk and will not eat. She is making unusual noises, as if she might be in pain somewhere.... She [client H] has also developed an early sacral decubitus (pressure		designatedrepresentative. The RD will sign off onthese trainings and will give copies to HR to be placed in each employee's HRfile. The RD retrained allQIDPs and the GHM on necessary components of investigations. This included conducting thorough interviewsof all relevant individuals, immediate reporting, and ensuring that allconsumers feel safe in their home. Anyreports of clients feeling unsafe in their home will be addressed and followedup on by the QIDP conducting the investigation. The RD signed off on thesetrainings and will give copies to HR to be placed in each employee's HRfile. Each client will also be askedabout their home and living environment in their quarterly meetings. This will be documented on the meeting notesand saved in their main chart in the office. AWS will continue tomandate that all AWS employees who work overnight shifts log in via computer orcall in their time every hour. Management staff, including QIDPs and the GHM, will conduct randomvisits, no less than monthly, to ensure staff are awake and appropriatelysupervising clients. The first visitwill occur at 4:00am on 6-30-14 and will be conducted by the RD, GHM, andQIDPs. Management staff will recordtheir visits and observations on the Manager Observations Log as well asrecording Manager In-Home time on the Provide time entry	

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	sore) since she was here. I have asked for repeat x-rays of the left leg from the hip to foot. She is recommended for admission and further evaluation." Client H's physician's note dated 2/13/14 at 10:30 PM indicated client H had a "lateral tibial plateau fracture (a bone fracture or break of the shinbone called the tibial plateau and affecting the knee joint) with 2 mm (millimeters) of depression of the posterior lateral tibial plateau, as well as a joint effusion (increased fluid around the joint).... Addendum: She [client H] is very galled (reddened, irritated and painful skin area caused from friction of skin rubbing together) around the peri (genital) area probably from her incontinence. We will anchor a Foley (internal catheter) to help with incontinence. Get some barrier cream on the skin, good hygiene and see if we can get her skin healing up." The investigative records indicated written statements from 5 group home staff and one day program staff. The statements indicated the staff were to answer one question, "Have you		program. **How corrective actions will be monitored to ensure norecurrence** Incidents are to bereported to the RD immediately. The RDwill write an email to document the date and time notified to be included withthe investigation packet. The investigationpacket is then sent to the RD for original signature. The RD sends the original investigationpacket to the Vice President for original signature. The Vice President sends the originalinvestigation packet to the Director of Compliance for original signature. Once all signatures are obtained, theDirector of Compliance scans the investigation packet to the RD to file. The RD will review100% of incident reports for each QIDP until the QIDP is proficient in writingand submitting incident reports. After aQIDP is proficient in writing and submitting incident reports, the RDwill place documentation in the QIDPsemployee file and continue to review incident reports randomly. The RD will monitorthe Provide time entry system as well as the Manager Observation Log monthly toensure random home visits are being conducted at least monthly. The RD will meet with the Group HomeManagement team which includes the GHM, the QIDPs and the RN at least twice permonth to discuss concerns and appropriate visits.	

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	witnessed anything that might have caused [client H] to injure her leg?" The statement from staff #6 dated 2/10/14 indicated "I have not witnessed anything. [Client H] did tell me she fell while doing meals on wheels." The statement from staff #3 dated 2/10/14 indicated, "I have no idea what happened. She (client H) was fine until Thursday morning when she was getting off the van she sat down and wouldn't get back up, saying her knee was hurting." The statement from staff #2 dated 2/10/14 indicated "No, I have been off on sick. I came back today." The statement from staff #10 dated 2/10/14 indicated "No." The statement from staff #5 dated 2/10/14 indicated "No, I have not." The statement from day program staff #1 dated 2/10/14 indicated "No, she [client H] did not fall when she was with me doing meals on wheels." The facility records indicated no further statements/interviews with staff. The facility records indicated no client interviews. The facility records did not indicate a thorough investigation was			

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NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374	

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	conducted. The 5/7/14 BDDS report indicated on 5/6/14 at 8 PM "[Client H] was discharged from the [name of nursing facility (NF)] at 3 PM on 5/6/14 where she has been a resident since 2/27/14. [Client H's] guardian transported her from the NF to her group home where she had been a resident for 8 years. When [client H] arrived to her home she refused to move from the seated walker she was sitting in. She became combative with staff, refused to ambulate or eat her evening meal. Because [client H] is a non insulin dependent diabetic and takes oral medications and is on a special diet, nurse advised staff to call ambulance to have [client H] taken to the [name of hospital] for evaluation. While at the ER it was discovered that client has a left hip fracture and a urinary tract infection and she was admitted to the hospital. She is scheduled to have surgery the afternoon of 5/7/14. AWS was advised by the NF that [client H] had fallen 5/5/14 while still admitted at the NF but their assessment was negative for injury." The facility records indicated the facility had conducted an investigation in regard to client H's hip fracture. The investigative records indicated "Verbal report from [name of NF] to AWS RN			

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	that [client H] had fallen on 5/5/14 and NF had not completed a hip x-ray.... [Client H] fell on 5/5/14 while a patient at NF. [Client H] did not move from the spot her guardian place (sic) her while in AWS services. [Client H] was transported via ambulance to [name of hospital] where it was discovered she had a broken hip. [Client H] did not fall nor have the opportunity to be hurt while in AWS services. AWS staff did the correct procedure by calling the ambulance and having [client H] seen at the ER." The investigative records indicated a written statement from staff #2. The statement indicated "[Client H] was brought in by her guardian [name of guardian and name of guardian's mother] and [client H] refused to get off the seat of her walker so they pushed her to her room on the walker and [client H] refused to move from the seat for bathroom, eating, getting pajamas on the entire evening. Nurse and supervisor were contacted and nurse came and evaluated [client H] and she was sent to the hospital by ambulance." The investigative records indicated no staff interviews, no client interviews, no interviews with the staff at the NF and no interview with the client's guardian. The facility records did not indicate a			

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	thorough investigation was conducted. During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM, the RD: __Indicated the facility RN had spoken with someone at the NF in regard to client H and the facility RN was told client H had fallen 5/5/14 while at the NF and stated "But they checked her out and didn't find anything wrong." The RD indicated no documentation of the interview with the NF. __When asked how client H was transported from the NF back to the group home, the RD indicated via a large truck that belonged to client H's guardian. The RD indicated client H's guardian and the guardian's mother returned client H to the group home from the NF. The RD stated, "Yeah, we wondered too how she was able to get her up and down in that truck without any problem." The RD indicated no interview with client H's guardian had been conducted. 2. The 7/29/13 BDDS report indicated on 7/29/13 at 1:30 AM "In the middle of the night staff were alerted into [client B's] room by [client B] yelling. When staff arrived to her room they found her lying on the floor next to her bed. Due to a lack of witness it remains unclear how exactly [client B] fell out of her bed. There were			

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	no apparent injuries and at the time [client B] was not complaining of any pain. As the day progressed [client B] began to complain of back pain. At that time the group home nurse scheduled an appointment to have [client B] assessed. It should be noted there are still no outward injuries as a result of this fall and that staff complete 30 minute bed checks throughout the night of each room." The 8/2/13 follow up BDDS report of the incident of 7/29/13 indicated "[Client B] continues to be a little slow and stiff getting up in the morning but is showing improvement each day. As the day goes on [client B] does not complain of back pain, only when first getting up in the morning. Following another fall incident on 7/30 [client B] was seen in the emergency room and no injuries were found. She has an appointment with her primary care physician schedules for August 6th at 9 AM for follow up." The facility investigative records indicated no investigation in regard to the incident of 7/29/13 when client B was found on the floor and/or in regard to falls. During a telephone interview with the RD (Regional Director) on 6/4/14 at 3			

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	PM, the RD indicated no investigation in regard to the incident of 7/29/13 in regard to client B being found on the floor and/or in regard to client B's falls. 3. The 8/17/13 BDDS report indicated on 8/17/13 at 1 PM the clients from the group home (clients A, B, C, D, E, F, G and H) were loading the facility van after a picnic in the park when client D refused to put her seat belt on. Client D began to yell and curse at the staff while kicking and hitting "everything around her.... Staff made the decision to make the attempt to get the consumers of (sic) the van in order to protect them." The report indicated client E was kicked in the thigh. __The 8/17/13 statement from staff #8 indicated client D had "kicked several of them (the other clients on the van). She (client D) clawed and scratched the staff. She kept yelling and cussing at both staff and clients. Other clients were all removed to picnic table for their safety. [Client D] kept up the kicking, hitting and biting for another 1/2 hour. Staff contacted team leader and QMRP (Qualified Mental Retardation Professional) for advice. Whole van was exposed to unsafe conditions and staff could not get her to stop long enough to get them home. Other clients were hurt when another client acted out and bruised one's shoulder and got another client in a			

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	head lock. It took both staff to try to handle the situation and also keep other clients safe. All clients were sitting on picnic table crying. Two clients told staff they were afraid." __The 8/17/13 statement from staff #9 indicated "Several of the clients were extremely upset and frightened, they were crying and physically shaken. She [client D] continued to attack staff and refuse to cooperate. After staff tried contacting all possible options of people to come get [client D] to no avail, staff attempted to put clients on van and keep [client D] separated but she again physically attacked staff and the van had to be pulled over after less than two hundred feet of driving. Staff in another van from another house showed up on the scene and talked to [client D] but she still ended up having to be removed and taken to another house for her fellow housemates' protection." __The facility investigative records indicated two staff statements and an interview with client E in regard to the peer to peer abuse. The records indicated no other interviews. The facility records did not indicate a thorough investigation was conducted. The facility records indicated no investigation in regard to the staff statements of the clients being afraid of client D and/or the "unsafe conditions" alleged by the staff.			

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	During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM, the RD indicated no investigation in regard to the staff statements of unsafe client conditions and client fears documented in the staff written statements dated 8/17/13. 4. The 5/18/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 5/18/14 at 7 AM staff #3 arrived at the group home and "found [staff #10] sleeping. [Staff #3] called and notified supervisor. Supervisor came to the home to begin an internal investigation and to suspend the staff who was accused of sleeping." The report indicated staff #10 "resigned on the spot to keep from being part of the investigation. All consumers (clients A, B, C, D, E, F and G) were checked on and all were sleeping with no issues." __The investigative records indicated a statement from the staff that alleged the client neglect and a statement from the supervisor. The facility records indicated no client interviews and/or interviews to ensure no history of staff sleeping in the group home while on duty. The facility records did not indicate a thorough investigation was conducted. The 9/5/13 BDDS report indicated on			

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	9/5/13 at 2 PM a peer hit client F in the right side of her face and knocked client F's glasses off her face. __The investigative records indicated an interview with one staff. The investigative records indicated no client interviews. The facility records did not indicate a thorough investigation was conducted. The 10/6/13 BDDS report indicated on 10/6/13 at 7:30 AM client D came out of her bedroom to take her morning medications and stuck her tongue out at client E. Client E then slapped and punched client D and client D slapped and punched client E in return. __The investigative records indicated three staff statements and no client interviews. The facility records did not indicate a thorough investigation was conducted. The 10/7/13 BDDS report indicated on 10/7/13 at 8 AM "When LPN [name of LPN] went to talk to [client D] about how she broke her glasses over the weekend [client D] told [name of LPN] that a staff pushed her down on her bed and held her down.... [Client D] reported that [staff #8 and #9] had pushed her down on Saturday and held her pinned to the bed." __The investigative records indicated			

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	staff statements and interview with client D. The facility records indicated no further client interviews. The facility records did not indicate a thorough investigation was conducted. The 10/7/13 BDDS report indicated on 10/5/13 at 9 AM client H was bitten by client D while trying to give client D a hug. __The investigative records indicated no client interviews. The facility records did not indicate a thorough investigation was conducted. The 10/25/13 investigative records indicated on 10/25/13 at 7 PM client H reported to the staff client D had "hit her in the stomach. She was crying but she had no marks or bruises." __The investigative records indicated no client interviews. The facility records did not indicate a thorough investigation was conducted. The 2/4/14 BDDS report indicated on 2/4/14 at 10:30 AM while at the day program client F hit client A and another peer in the middle of their backs. __The investigative records indicated two staff statements and no client interviews. The facility records did not indicate a thorough investigation was conducted.			

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NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374	

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	The 2/12/14 BDDS report indicated on 2/12/14 at 7:45 AM indicated client E was "agitated" that morning before leaving for the workshop and "grabbed a steak knife and threatened staff and herself with the knife." Client D started to cry and client E "struck the housemate [client D] twice on her upper right shoulder/chest area with an open hand. As staff moved the housemates (clients A, B, C, D, F, G and H) to a safer location, [client E] barricaded herself in her room with the knife. Staff was not able to retrieve the steak knife from [client E] and 911 was contacted. [Client E] was transported to [name of hospital]." __The investigative records indicated when the police arrived client E threw the knife down the hallway. The investigative records indicated interviews with client E and F. The records indicated no interviews with clients A, B, C, D, G and H in regard to the incident of 2/12/14. The facility records did not indicate a thorough investigation was conducted. The 3/7/14 BDDS report indicated on 3/7/14 at 2:30 PM client B was hit on the top of her left hand by a peer while at the day program. __The investigative records indicated one staff written statement. The investigative			

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	record indicate no client interviews. The facility records did not indicate a thorough investigation was conducted. The 5/10/14 BDDS report indicated on 5/10/14 at 9:30 AM staff noticed a bruise "about 2 inches by 2 inches on the front of her (client F's) right leg halfway between her knee and ankle. [Client F] did not know how the bruise happened." __The investigative records indicated no client interviews in regard to client F's injury. The facility records did not indicate a thorough investigation was conducted. The 5/10/14 BDDS report indicated on 5/10/14 at 11 AM staff noticed client C's index finger on her right hand to be swollen and bruised at the knuckle. The report indicated client C did not know how she injured her hand. __The investigative records indicated no client interviews in regard to client C's injury. The facility records did not indicate a thorough investigation was conducted. The 5/18/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 5/18/14 at 7 AM staff #3 arrived at the group home and "found [staff #10] sleeping. [Staff #3] called and notified supervisor. Supervisor came to			

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NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374	

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	the home to begin an internal investigation and to suspend the staff who was accused of sleeping." The report indicated staff #10 "resigned on the spot to keep from being part of the investigation. All consumers (clients A, B, C, D, E, F and G) were checked on and all were sleeping with no issues." __The investigative records indicated a statement from the staff that alleged the client neglect and a statement from the supervisor. The facility records indicated no client interviews and/or interviews to ensure no history of staff sleeping in the group home while on duty. The facility records did not indicate a thorough investigation was conducted. During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM, the RD Indicated all allegations of abuse/neglect were to be thoroughly investigated and were to include client interviews. This federal tag relates to complaint #IN00148943. 9-3-2(a)			
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate			

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	corrective action must be taken. Based on interview and record review for 1 of 1 allegation of neglect reviewed, the facility failed to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty for all clients living at the group home (clients A, B, C, D, E, F and G). Findings include: The facility's reportable and investigative records were reviewed on 5/22/14 at 2 PM. The 5/18/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 5/18/14 at 7 AM staff #3 arrived at the group home and "found [staff #10] sleeping. [Staff #3] called and notified supervisor. Supervisor came to the home to begin an internal investigation and to suspend the staff who was accused of sleeping." The report indicated staff #10 "resigned on the spot to keep from being part of the investigation. All consumers (clients A, B, C, D, E, F and G) were checked on and all were sleeping with no issues." The investigative summary dated 5/23/14	W000157	**Corrective action for resident(s) found to have beenaffected** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on the AWSAbuse/Neglect Policy which includes sleeping while on duty. AWS will continue tomandate that all AWS employees who work overnight shifts log in via computer orcall in their time every hour. Management staff, including QIDPs and GHM will conduct random visits, noless than monthly, to ensure staff are awake and appropriately supervisingclients. **How facility will identify other residents potentiallyaffected and what measures taken** All residents areaffected and corrective action will address the needs of all clients. **Measures or systemic changes facility put in place toensure no recurrence** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on the AWSAbuse/Neglect Policy as which includes sleeping while on duty. Any current group home staff not attending oneof these meetings will be removed from the schedule until they receive thistraining from the RD or a designated representative. The RD will sign off on these trainings andwill give copies to HR to be	07/03/2014

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	indicated "Allegation that third shift staff (#10) was sleeping when morning staff (#3) came on shift at 7 AM." Summary of evidence indicated "This investigator (the QIDP (Qualified Intellectual Disabilities Professional) looked at Provide (a computer program) time entries on 5/18/14. [Staff #10] did not enter her time in Provide during the shift from 2 AM onward. Per procedure, overnight staff are to enter their time every hour. This does not prove she was asleep during that time, but it could have helped show she wasn't sleeping if time had been entered as required at 4 AM, 5 AM and 6 AM." The investigative records indicated a statement from the staff that alleged the client neglect and a statement from the supervisor. The facility records indicated no client interviews and/or interviews to ensure no history of staff sleeping in the group home while on duty. The plan of corrective action indicated "Allegation of neglect due to sleeping substantiated. When GH (group home) supervisor, who was working at a house across the street, heard of the allegation, she immediately went to suspend [staff #10]. [Staff #10] refused to cooperate with the investigation and resigned on the spot." The investigative record indicated no specific plan of corrective oversight and/or how the facility would be		placed in each employee's HR file. AWS will continue tomandate that all AWS employees who work overnight shifts log in via computer orcall in their time every hour. Management staff, including QIDPs and the GHM, will conduct randomvisits, no less than monthly, to ensure staff are awake and appropriatelysupervising clients. The first visitwill occur at 4:00am on 6-30-14 and will be conducted by the RD, GHM, andQIDPs. Management staff will recordtheir visits and observations on the Manager Observations Log as well asrecording Manager In-Home time on the Provide time entry program. **How corrective actions will be monitored to ensure norecurrence** The RD will monitorthe Provide time entry system as well as the Manager Observation Log monthly toensure random home visits are being conducted at least monthly. The RD will meet with the Group HomeManagement team which includes the GHM, the QIDPs and the RN at least twice permonth to discuss concerns and appropriate visits.	

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	monitored to prevent the neglect from reoccurrence. The facility records indicated no documentation of administrative and/or supervisory staff observations and/or monitoring. During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM: __When the RD was asked how the facility monitored the staff to ensure staff were not sleeping while on duty and the clients were not being neglected, the RD stated, "We do drop in visits and the staff are to make an entry in Provide once an hour." __The RD indicated no documentation of the "drop in visits." __The RD indicated the facility did not develop and/or implement a plan of protective oversight to monitor the staff in the group home to ensure no further neglect due to staff sleeping while on duty for clients living in the group home (clients A, B, C, D, E, F and G). This federal tag relates to complaint #IN00148943. 9-3-2(a)			
W000186	483.430(d)(1-2) DIRECT CARE STAFF			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	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 living unit. Based on observations, record review and interview for 2 of 4 sample clients (A and B) and 2 additional clients (F and G), the facility failed to ensure sufficient staff to supervise the clients and to implement the clients' program plans. Findings include: Observations were conducted at the group home on 5/22/14 between 3:45 PM and 6:30 PM. During this observation period there were seven clients (clients A, B, C, D, E, F and G) and two staff (staff #1 and staff #2). A crock-pot meat, broccoli, mashed potatoes and a peanut butter dessert were prepared for the evening meal. __At 4 PM staff #1 was in the kitchen starting the evening meal. __From 4 PM until 4:40 PM, staff #2 was in the rear of the home preparing the evening medications. __From 4 PM until 5:30 PM, client G sat in the living room without activity, the television on, but not actively watching it.	W000186	**Corrective action for resident(s) found to have beenaffected** There will besufficient staff present during all meal times to ensure that clients areproperly supervised and to facilitate active treatment. The GH Dieticianwill be present, observing a meal, and providing on the spot training on7-1-14. Any staff not in attendance willbe trained by the RD on 7-2-14 and 7-3-14. **How facility will identify other residents potentiallyaffected and what measures taken** All residents areaffected and corrective action will address the needs of all clients. **Measures or systemic changes facility put in place toensure no recurrence** There will besufficient staff present during all meal times to ensure all clients areproperly supervised and to facilitate active treatment. All consumers diningplans will be reviewed by the RN and the dietician. Should revisions be made staff will betrained on the updates. All consumers BSPswill be reviewed by the QIDP. Shouldrevisions be	07/03/2014

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	__At 5:30 PM client G walked out to the dining room and stood watching the meal preparation. Staff #1 took the meat from the crock pot and placed some scraps of meat and fat onto a paper towel near the crock pot. Staff #1 then took the plate of meat to the kitchen island and began cutting the meat with a pair of scissors. Client G walked over the sink area and eyed the meat scraps on the counter near the crackpot. Client G looked around to see if staff #1 was watching her, which she wasn't. Client G reached for the scraps of meat on the paper towel and saw this surveyor watching her. Client G turned and walked away, past the stove where there were two pots, one with broccoli and one with mashed potatoes. Client G stood looking over the food on the stove and then went to her seat at the dining room table. __At 5:50 PM staff #2 returned from the back of the house. The table was set with the dishes and utensils and clients A, B, C, D, E, F and G were sitting at the dining room table. Staff #1 cut up slices of bread and placed a serving on client A's, F's and G's plate while staff #2 began serving the crock pot meat. Staff #1 then began serving the mashed potatoes and then the broccoli. As soon as food was placed on clients A's, B's, F's and G's plates the clients began eating while the staff were still serving the meal to the		made staff will be trained on the updates. The GH Dieticianwill be observing a meal and providing on the spot training on 7-1-14. Any current group home staff not inattendance will be trained by the RD on 7-2-14 and 7-3-14. Any current group home staff not attendingone of these meetings will be removed from the schedule until they receive thistraining from the RD or a designated representative. At least one memberof the GH Management team will be present until 7pm at least 1 night per weekto provide oversight and on the spot training for staff. Each QIDP will be present at least 4 hoursper week in the home to provide documentation review and on the spottraining. **How corrective actions will be monitored to ensure norecurrence** The GHM and RD willmonitor the staff schedule presented by the GHS and the Provide time entrysystem weekly to ensure appropriate staff are scheduled to facilitate activetreatment and appropriate supervision. The RD will monitorthe Provide time entry system to ensure Management staff are present at leastone night per week until 7pm and the QIDPs are present in the home at least 4hours per week.	

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	other clients. __At 6:02 PM staff #1 sat down at the table beside clients C and D. __At 6:05 PM staff #2 sat down beside client F. Client F had already eaten a large part of her meal. Client F was not provided 1:1 supervision throughout her evening meal. __At 6:05 PM client G had eaten all of her meal except for her dessert. Client G ate at a fast pace and overloaded her utensil with large bites. __At 6:11 PM client G was finished with her meal and drank down her liquids. Client G got up from the table, took her dishes to the sink and saw the scraps of meat on the paper towel. Client G turned her back to the staff and looked over her shoulder to see if the staff were watching her. Client G then grabbed the meat scraps off of the paper towel and put them in her mouth and ate them. Staff #1 and staff #2 were sitting at the dining room table and unaware of what client G had just done. __At 6:12 PM client B had finished her meal. Client B did not have 1:1 staff supervision while eating her meal. Client B ate at a fast pace and took large bites while eating. __At 6:15 PM client A had finished her meal. Client A ate at a fast pace, used her fingers and took large bites while she ate her meal. Client A was not provided 1:1			

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	supervision while eating her meal. Client A's record was reviewed on 5/29/14 at 12 PM. Client A's revised dining plan dated 9/18/13 indicated client A was at "moderate" risk for choking and at risk for aspiration. Client A's dining plan indicated (not all inclusive): "FOOD TEXTURE: It is appropriate for staff to cut food into 1/4" (inch) to 1/2" pieces due to her tendency to grab foods and put them into her mouth. She does not always chew her food well. EATING/DRINKING STRATEGIES: She is to have 1:1 supervision during meal times. Staff need to encourage her to alternate food/liquid." Client B's record was reviewed on 5/29/14 at 1 PM. Client B's revised dining plan dated 9/18/13 indicated client B was at risk for choking and aspiration. Client B's dining plan indicated (not all inclusive): "EATING/DRINKING STRATEGIES: 1:1 supervision is required Small sips/bites Must be alert and sitting upright (90 degrees if possible)." Client F's record was reviewed on 5/29/14 at 3 PM. Client F's revised dining			

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	plan dated 10/1/13 indicated client F was at risk for choking and aspiration. Client F's dining plan indicated (not all inclusive): "EATING/DRINKING STRATEGIES: 1:1 supervision is required for eating and drinking Prompt to take small bites/sips, slowing rate, alternating consistencies and to use extra swallows." Client G's record was reviewed on 5/29/14 at 3:30 PM. Client G's revised dining plan dated 10/1/13 indicated (not all inclusive): "EATING/DRINKING STRATEGIES: [Client G] is supervised while eating. Staff need to prompt [client G] to slow pace of eating at times. [Client G] is to use smaller utensils during meals to prevent overloading." Client G's revised BSP dated 9/22/13 indicated client G had a targeted behavior of "Dangerous Eating: Consuming uncooked food, eating out of the trash, putting large quantities of food into her mouth, eating out of 'community' containers." The BSP indicated "Dangerous eating was added as a targeted behavior as [client G] will consume uncooked items or retrieve garbage from the trash to eat. Recently			

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	she was redirected from eating food out of the sink. Staff reports [client G] has eaten uncooked meat out of the pan on the stove and directly from the refrigerator before they could intervene. [Client G] has a long history of attempting to eat out of the trash and has needed redirection not to do so. However, this behavior has increased and she does not often respond to verbal redirection when this occurs. [Client G] also has a tendency to cram large amounts of food into her mouth when she is eating during unscheduled at times. For example, staff has found her dipping her hand into a cottage cheese container and peanut butter jar and eating as well as consuming handfuls of crackers, cereal, and/or bread. [Client G] will rarely leave the kitchen upon returning home from the workshop during the weekdays and needs constant supervision to keep her safe.... REACTIVE STRATEGIES/SPECIFIC INTERVENTIONS: COOKING: When cooking staff need to be next to the stove at all times to help block [client G] from grabbing food. She is less likely to attempt to grab something off of the stove if a staff member is right there. This will require two staff present in the kitchen when cooking - one to assist peers with cooking and the other staff to help observe and redirect [client G]. If [client G] has managed to consume raw			

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	food items or come extremely close to injuring herself by attempting to reach into a hot stove then staff should consider letting third shift staff cook the meat they need to use for the following meal and letting clients assist with warming it up as [client G] could become very sick eating raw meat and/or chicken. Please note, before doing this staff should ask QMRP or house manager for permission." The facility failed to provide sufficient staff to supervise client G during and after the meal preparation and to provide clients A, B and F with 1:1 staff supervision to be able to implement the clients' dining plans. During interview with staff #2 on 5/22/14 at 5:30 PM, staff #2 stated, "We have gone through a major staffing change." Staff #2 indicated staff #1 had worked with the clients for three weeks and filled in when she could. Staff #2 stated, "The only regular staff in the home now is myself (staff #2), (staff #3) that works the night shift and [staff #4] that works weekends. Staff #2 stated, "A lot of staff come and go just to fill in." During interview with staff #1 and staff #2 on 5/22/14 at 6:30 PM, staff #2 stated, "We have to watch [client G] like a			

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	hawk. She's always hovering over the stove or sinks looking for something to eat." Staff #1 and #2 indicated they did not see client G eat the scrap of meat on the counter near the crock-pot. Staff #1 stated, "Oh no, did she eat that. I didn't think anything about it when I put that there." Staff #2 stated, "Yeah, we have to have one person just to keep an eye on her when we're fixing the meal. There is just so much commotion going on and it's hard to watch her with just two of us." During telephone interview with the RD (Regional Director) on 6/6/14 at 10:45 AM indicated a ratio of 2 staff to eight clients. The RD indicated the staff were to follow the clients' dining plans as written. The RD stated "we're trying to get a third staff for the evening shift while the clients are awake." When the RD was asked how the staff were to supervise client G while the evening meal is being prepared with one staff in the kitchen and one staff in the back of the home giving medications. The RD stated, "Well usually she (client G) sits in the living room while the meal is being prepared and it's generally not a problem." When asked what the staff were to do if client G came to the kitchen with only one staff present, the RD stated, "They would have to stop what they were doing and escort her back to			

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	the living room and get her (client G) involved in another activity before returning to the kitchen to finish the evening meal." This federal tag relates to complaint #IN00148943. 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 1 of 4 sample clients (D), the facility failed to ensure the staff were trained/retrained in regard to: __Reporting abuse/neglect immediately to the administrator. __Implementing the Mandt System (a comprehensive approach to preventing, de-escalating, and/or intervening when the behavior of an individual that poses a threat of harm to themselves and/or others) in response to client D's behaviors. __Ensure client D's personal health information was protected.	W000189	**Corrective action for resident(s) found to have beenaffected** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on the AWSAbuse/Neglect Policy as well as the Incident Reporting Policy. This will include what is abuse/neglect, whatincidents are reportable, and the mandate for immediate reporting to the QIDP. The RD will pass out Incident Report cardsthat provide a reminder of what incidents are reportable. Also the RD will place a reminder of whatincidents are reportable on the Staff Communication Board in the medicationroom. All staff aretrained on HIPAA and	07/03/2014

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	Findings include: The facility's reportable and investigative records were reviewed on 5/22/14 at 2 PM. The BDDS (Bureau of Developmental Disabilities Services) reports indicated: __On 10/6/13 at 7:30 AM client D came out of her bedroom to take morning medications and client E said something mean to client D. Client D responded by sticking her tongue out at client E. Client E then slapped client D on each arm and client D responded by slapping client E in each arm and punching client D in the stomach. The report indicated client D was assigned 1:1 (one staff to one client) supervision during waking hours to reduce the number of negative encounters with peers. __On 10/7/13 at 8 AM "When LPN [name of LPN] went to talk to [client D] about how she broke her glasses over the weekend [client D] told [name of LPN] that a staff pushed her down on her bed and held her down. [Client D] did not say which staff, only said staff. LPN contacted director. All staff who worked over the weekend were suspended while an investigation was initiated. [Client D] was interviewed by Director of HR (Human Resources). [Client D] reported that [staff #8 and #9] had pushed her		confidentiality of consumer records at orientation andalso annually at Staff Annual Training (SAT). All group home staff will also be retrained by the Regional Director(RD) on HIPAA and consumer confidentiality at staff trainings to be held on7-2-14 and 7-3-14. AWS will continue totrain all agency staff on HIPAA and confidentiality of consumer records atorientation and annually at SAT. **How facility will identify other residents potentiallyaffected and what measures taken** All residentsare affected and correctiveaction will address theneeds of all clients. **Measures or systemic changes facility put in place toensure no recurrence** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on the AWSAbuse/Neglect Policy as well as the Incident Reporting Policy. Any current group home staff not attendingone of these meetings will be removed from the schedule until they receive thistraining from the RD or a designated representative. The RD will sign off on these trainings andwill give copies to HR to be placed in each employee's HR file. All group home staff will be retrained by theRD on HIPAA and confidentiality of consumer records at staff meetings to beheld on 7-2-14 and 7-3-14. Any currentgroup home	

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	down on Saturday and held her pinned to the bed." __The follow up BDDS report dated 10/12/13 indicated "AWS teaches basic Mandt to all staff and intermediate Mandt to staff working in situation where HRC (Human Rights Committee) approved restraints may be necessary. Staff working with [client D] were trained in intermediate Mandt. Staff were retrained on appropriate behavioral interventions and [client D's] specific BSP (Behavior Support Plan) on 10/10/13. Best accounts of the situation from staff and [client D] herself was it was only a few seconds that [client D] was actually held down. It was also found out that the situation did not occur on [client D's] bed but in (sic) the floor of the living room at approximately 4:30 PM on 10/5/13 by staff [staff #8]. [Staff #8] has been suspended pending the outcome of the investigation. [Staff #8's] employment with AWS will be terminated based on the investigation which has substantiated consumer abuse. Staff were retrained on 10/10/13 on appropriate behavioral interventions, [client D's] BSP, client rights, professional conduct and the AWS Abuse/Neglect Policy. Staff working in [client D's] home will be mandated to retake intermediate Mandt at the next available course offering."		staff not attending one of these meetings will be removed from theschedule until they receive this training from the RD or a designatedrepresentative. The RD will sign off onthese trainings and will give copies to Human Resources (HR) to be placed ineach employee's HR file. Staffwill also continue to be trained on HIPAA and confidentiality of consumerrecords at new hire orientation and SAT. **How corrective actions will be monitored to ensure norecurrence** Staff will continue to be trained on the Abuse NeglectPolicy, HIPAA and confidentiality of consumer records at new hire orientationand SAT. According to AWS policy, nostaff can work without attending new hire orientation and also annual SATtraining. The HR department, the RD, andthe Group Home Manager (GHM) monitor the expirations list weekly which includesmandatory annual SAT training to ensure complete compliance.	

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	A written statement from staff #10 dated 10/6/13 indicated "I was in kitchen giving breakfast when staff called for help. I contacted team lead and manager requesting that they come to the house. [Client D] was throwing a tantrum in her room. She was throwing things, kicking things and hitting things. She had bitten staff and drew blood. All other clients (A, B, C, E, F, G and H) were asked to stay away and to return to their rooms. Staff did not leave [client D] unattended. Her behaviors caused other housemates to escalate to crisis point. Two housemates were emotionally distraught and began to cry. Staff attempted to offer comfort. [Client D's] behaviors did not end until manager told staff how to handle the situation. Nurse was contacted. All other clients are reacting to [client D] with fear and anger. Roommate [client C] was afraid to enter their (client C's and D's) shared room. [Client D] was placed in 1 on 1 (one staff to one client) with manager and then team lead. Staff is at a loss and I personally do not know how to deal with [client D]." A written statement from staff #7 dated 10/7/13 indicated "On arrival Sat (Saturday) AM 10-5-2013 [client D] was and had been having behaviors which involved kicking, hitting and biting both herself and staff. The other clients were			

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	getting their hair cut and she (client D) was upset that she was not allowed to go. The behaviors continued on during the day but seemed to me (staff #7) to be initiated each time by the attitude of her one-on-one person toward her. She (the staff) was speaking to her in a disrespectful manner and yelling at her as if she were a small child. When [client D] would get angry or even do something as simple as sneeze and then hold on to the back of the chair she was near, she (the staff) would criticize her in a very disrespectful and demeaning manner which would further escalate [client D] and would result in more behaviors. This continued on throughout the afternoon. The clients were going out for dinner and [client D] was upset and crying that she was not allowed to go. [Client D] had more kicking behaviors and broke the mirror on the door in her room. During this time [staff #8] was very condescending to her and not directly to her but so that I'm sure she could hear, called her (client D) 'a little heffer (sic)' and continued calling her that throughout the day. After getting the rest of the ladies on the van, I (staff #7) walked over to close the storm door which had been propped open. I heard [staff #8] yelling at her (client D) and walked in to see if I could help. I witnessed [staff #8] holding her (client D's) head down over the arm			

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	of the sofa then grab the back of her (client D's) shirt and pull her down to the ground. I walked back outside to get [staff #9] who was already in the driver ' s seat. It was then that [staff #8] came out and said 'Can't I get a little help in here?' [Client D] was going down the hallway kicking walls and hitting doors and biting herself. She went into her room and I went back out to the van and we left for dinner. In arrival back home [client D] was still agitated and was yelled at by [staff #8] to 'go to your room.' She went to her room but started kicking and hitting her door. [Staff #8] had called the [RM (Residential Manager)] earlier and she came to the house while we were out for dinner. She (client D) continued kicking and hitting her door and throwing things in her room. This went on for about 20 minutes. Her roommate, [client C] was crying and saying she didn't want to sleep in the room with her. It was causing behaviors from another client. [Client B] who pushed [client E] and she (client E) fell. In the mean time, [RM] was called and [staff #8] was instructed to call 911. I was instructed by [staff #8] to go outside and watch for the police which I did. When they arrived, I showed the first officer to her (client D's) bedroom. At that point [staff #9] had the door open and she was sitting on her bed crying. The officer talked to her (client			

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	D) and decided to take her to [name of hospital]. They arrived home a few hours later. When I arrived on Sun (Sunday) AM 10/6/13 [RM] informed me I would be one-on-one with [client D] as there had been further behaviors in the morning with one staff being bitten in the forearm. I was given instructions on what to do during the day and had no problems or behaviors from [client D] the whole day. After dinner [client D] had an episode of vomiting.... When she went in to take her evening meds she coughed and [staff #8] was very rude to her telling her to cover her mouth she didn't want her germs all over her.... [Client D] asked if she should get ready for her shower and was told by [staff #8] 'You don't need a shower. Just get your pajamas on and go to bed'." A written statement from staff #9 dated 10/8/13 indicated "when [client H] went to give her (client D) a hug she (client D) bit her (client H) on the right arm but only got her jacket.... She (client D) was upset and stomping around. She wasn't watching where her feet were and fell.... [Client D] was mad and was kicking, hitting and yelling. She bit herself and ended up bloodying her lip. She proceeded to whipe (sic) blood all over a chair and a wall after staff told her not to.... Around 4 PM staff started getting all			

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	of the other clients ready to go out to dinner with the other two houses. As another staff and I were getting the other clients on the van and about to leave [client D] went off and escalated again. [RM] was called and on her way. Staff left her (client D) in the living room and was in the laundry room and right outside the (sic) door to make sure she (client D) was safe because she was throwing things, hitting and kicking. I went with another staff and the other clients out to dinner. When we came back [client D] started again and was taken to the hospital in an ambulance and the police were called after she (client D) had been violent for 12 hours. Sunday (10/6/13) morning I (staff #9) came in to pass meds. I let everyone sleep in due to the eventful day they had on Saturday. I woke [client D] up at 7 AM and asked her to please wash her hair then come get her meds before getting dressed or eating and explained that I let everyone sleep in but that we need to get meds done quickly. She (client D) did not come out of her room until 7:30 AM and when I asked her to come get her meds she decided to become verbally aggressive and get into a fight with [client E]. She (client D) tried to slam the med office door in [client E's] face to hurt her and procided (sic) to strike [client E] multiple times before I (staff #9) could get in			

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	between them. [Client D] proceed (sic) to bite me breaking skin. I had the only other staff there put in a call to [RM]. She (the RM) arrived 15 min (minutes) later. While the call was being place (sic) I physically assisted [client D] to her bedroom and shut the door.... I held the door shut until [RM] arrived because she kept trying to attack people. I went and helped calm down the other 7 clients and then [name of staff] arrived." A written statement from staff #10 dated 10/8/13 indicated on 10/5/13 "She [client D] exchanged a few words with staff and became distraught. Housemate attempted to offer comfort with a hug and [client D] bit housemate on the shoulder. I went to staff to tell her what had happened and she came out and raised her voice to [client D]. This furthered [client D's] behaviors and she began to bite herself. Staff left to med office. [Client D] followed and more words were exchanged. [Client D] was told she could not get her hair cut. She became more upset. I had to give showers and do not know what happened. When I went into the living room to get the next client, [client D] was on the floor between the couch and chairs. She told me she fell and I told staff she needed first-aid and went to give showers. [Client D] worked herself into a fit and had to stay home. I			

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	was told to stay behind with her. As staff and clients were leaving [client D] fell again in the doorway, right beside the fire door. She was bleeding again and moved to the leather chair. She wanted to talk to the manager and I asked if I could give her first-aid before I gave her the phone. She agreed and when I came back with gloves, her glasses had been broken. I removed them and placed them on the desk. She calmed down for the most part and I left after everyone came back. I came back in that night at ten to find team lead was still there. I was updated and told to check on [client D] periodically. She slept through the night when she woke up the next morning she seemed fine. I was doing breakfast and showers again. Then staff called for me to call manager and I did. [Client D] had bitten staff. She was carried to her room and we held the door shut. Manager and team lead were called and both came in. [Client D] bit manager. I had to finish breakfast and showers so I do not really know what happened." The investigative records indicated a termination letter from staff #9 dated 10/8/13. The letter indicated "I (staff #9) cannot speak for everyone in the organization but for me personally I cannot continue to provide good quality care in an environment where I do not			

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	feel safe for the clients or myself. I must resign my position with AWS as a Direct Support Personnel. My last day of employment will be October 22, 2013. After reading the above if you would like to discuss possible changes we could make to provide a safer environment for clients and staff so as I may continue with my position as a Direct Support Personnel. I am willing to do so at any time." The 10/11/13 investigative summary of the allegations of abuse made by client D that staff pushed her and held her down indicated: __The allegations of abuse were substantiated and client D was pushed, held down and restricted to her bedroom "for approximately 10 minutes" by staff #8 and #9. __Staff #7 "witnessed staff #8 hold [client D's] head down on the couch, pulled her to the ground by her T-shirt and held her on the ground. [Staff #7] then left the home with other consumers leaving [client D] alone with [staff #8]. [Staff #7] did not report the abuse until questioned by LPN on 10/7/13. She then disclosed information to LPN and HR during interview." __Staff #7's, #8's and #9's employment was terminated. __Staff #9 violated HIPAA laws in			

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NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374	

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	disclosing client D's protected health information. Staff #9's mother had called HR on 10/8/13 "communicating to HR specific details about [client D's] diagnoses and protected health information." __"All staff working in this home will be retrained on consumer rights, abuse neglect policy and professional conduct. All staff working in this home will be retrained on Intermediate Mandt to reemphasize appropriate consumer interactions...." Review of facility staff training dated 10/10/13 via email on 6/4/14 at 10:11 AM indicated staff #10 was not provided training in regard to consumer rights, abuse neglect policy, professional conduct and implementation of the Mandt System on 10/10/13. The facility failed to ensure staff #7, #8, #9 and #10 were sufficiently trained in regard to reporting abuse/neglect immediately to the administrator, to implementing the Mandt System in response to client D's extreme behaviors and to ensure client D's personal and health information was protected. During a telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM:			

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NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374	

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	__The RD indicated all staff were to be trained/retrained in the facility policy of abuse/neglect, the Mandt System and protecting clients' personal heath information. __The RD indicated staff #9's mother had called the HR department and relayed personal information about client D that was told to her by her daughter (staff #9). __The RD indicated staff #7's, #8's and #9's employment had been terminated. __The RD indicated no documentation of training could be provided for staff #10 in regard to the retraining of consumer rights, abuse neglect policy and professional conduct that was provided on 10/10/13. The RD stated "She (staff #10) was at the training provided in October, but we can't find any documentation of it." The RD indicated staff #10 resigned from her position on 5/18/14. This federal tag relates to complaint #IN00148943. 9-3-3(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			

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	treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 3 of 4 sample clients (A, B and C) and 2 additional clients (F and G), the facility failed to ensure the staff implemented client A's, B's and C's program plans when formal and informal training opportunities existed, to follow client A's, B's and F's dining plans and to implement client G's BSP (Behavior Support Plan). Findings include: Observations were conducted at the group home on 5/22/14 between 3:45 PM and 6:30 PM. During this observation period a crock-pot meat, broccoli, mashed potatoes and a peanut butter dessert were prepared for the evening meal. At 4 PM staff #1 was in the kitchen starting the evening meal while staff #2 began the evening medication pass. From 4 PM until 5:30 PM: __Client A was prompted to go to the bathroom once and was asked if she wanted to hold a sock. Client A walked around the kitchen/dining room area holding her hands together, non verbal and not involved in any activities.	W000249	**Corrective action for resident(s) found to have beenaffected** There will besufficient staff present during all meal times to ensure that clients areproperly supervised and to facilitate active treatment. The GH Dieticianwill be present, observing a meal, and providing on the spot training on7-1-14. This will include dining plans,meal preparation. The QIDP will bepresent providing ideas and suggestions for active treatment during pre mealactivities. **How facility will identify other residents potentiallyaffected and what measures taken** All residents areaffected and corrective action will address the needs of all clients. **Measures or systemic changes facility put in place toensure no recurrence** There will besufficient staff present during all meal times to ensure all clients areproperly supervised and to facilitate active treatment. All consumers diningplans will be copied and placed in a binder in the kitchen, easily reachablefor staff during meal times. Diningplans will be reviewed by the RN and the dietician. Should revisions be made staff will betrained on the updates.	07/03/2014

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	__Client B sat in the living room in a recliner. The television was on but the client was not actively watching it. Throughout this time period client B sat talking to herself. __Client C sat in the living room in a recliner. The television was on but the client was not actively watching it. Client C sat with her eyes closed most of the time. __Client G sat in the living room without activity, the television on, but not actively watching it. At 5:30 PM client G walked out to the dining room and stood watching the meal preparation. Staff #1 took the meat from the crock pot and placed some scraps of meat and fat onto a paper towel near the crock pot. Staff #1 then took the plate of meat to the kitchen island and began cutting the meat with a pair of scissors. Client G walked over to the sink area and eyed the meat scraps on the counter near the crock-pot. Client G looked around to see if staff was watching her, which she wasn't. Client G reached for the scraps of meat on the paper towel and saw this surveyor watching her. Client G turned and walked toward the stove where there were two pots, one with broccoli and one with mashed potatoes. Client G stood looking over the food on the stove and then went to her seat at the dining room table and sat down.		All consumersBSPs will be reviewed by the QIDP. Should revisions be made staff will be trained on the updates. Also the QIDP will review pre meal activitiesfor active treatment and review individual consumer schedules. Should revisions be made staff will betrained on the updates. The GH Dieticianwill be observing a meal and providing on the spot training on 7-1-14. Any current group home staff not inattendance will be trained by the RD on 7-2-14 and 7-3-14. Any current group home staff not attendingone of these meetings will be removed from the schedule until they receive thistraining from the RD or a designated representative. At least one memberof the GH Management team will be present until 7pm at least 1 night per weekto provide oversight and on the spot training for staff. Each QIDP will be present at least 4 hoursper week in the home to provide documentation review and on the spottraining. **How corrective actions will be monitored to ensure norecurrence** The GHM and RD willmonitor the staff schedule presented by the GHS and the Provide time entrysystem weekly to ensure appropriate staff are scheduled to facilitate activetreatment and appropriate supervision. The RD will monitorthe Provide time entry system to ensure at least one member of the managementis present	

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	__At 5:50 PM staff #2 returned from the back of the house. The table was set with the dishes and utensils and clients A, B, C, D, E, F and G were sitting at the dining room table for their evening meal. Staff #1 cut up slices of bread and placed a serving on client A's, F's and G's plates while staff #2 began serving the crock pot meat. Staff #1 then began serving the mashed potatoes and then the broccoli. As soon as food was placed on clients A's, B's, F's and G's plates the clients began eating while the staff were still serving the meal to the other clients. __At 6:02 PM staff #1 sat down at the table beside clients C and D. __At 6:05 PM staff #2 sat down beside client F. Client F had already eaten a large part of her meal. Client F was not provided 1:1 supervision throughout her evening meal. __At 6:05 PM client G had eaten all of her meal except for her dessert. Client G ate at a fast pace and overloaded her utensil with large bites. __At 6:11 PM client G was finished with her meal and drank down her liquids. Client G got up from the table, took her dishes to the sink and saw the scraps of meat on the paper towel. Client G turned her back to the staff and looked over her shoulder to see if the staff were watching her. Client G then grabbed the meat scraps off of the paper towel and put		at least one night per week until 7pm and the QIDPs are present inthe home at least 4 hours per week. The RD will visitthe home at least monthly to ensure compliance with staff schedule, diningplans are copied and present in the kitchen, and active treatment ispresent. This visit will be documentedon the Manager Observation Log as well as in the Provide time entryprogram.	

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	them in her mouth and ate them. Staff #1 and staff #2 were sitting at the dining room table and unaware of what client G had just done. __At 6:12 PM client B had finished her meal. Client B did not have 1:1 staff supervision while eating her meal. Client B ate at a fast pace and took large bites while eating. __At 6:15 PM client A had finished her meal. Client A ate at a fast pace, used her fingers and took large bites while she ate her meal. Client A was not provided 1:1 supervision while eating her meal. During this observation period the staff did not provide clients A, B, C, F or G with formal/informal training when opportunity was available, the staff did not directly supervise clients A, B and G while eating their evening meal, the staff did not prompt clients A, B and F throughout the meal to take small bites, lay their utensils down and/or to slow their pace of eating. The staff did not directly supervise client G to prevent her from eating the scraps of food. Client A's record was reviewed on 5/29/14 at 12 PM. Client A's revised dining plan dated 9/18/13 indicated client A was at "moderate" risk for choking and at risk for aspiration. Client A's dining plan indicated (not all inclusive):			

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	"FOOD TEXTURE: It is appropriate for staff to cut food into 1/4" (inch) to 1/2" pieces due to her tendency to grab foods and put them into her mouth. She does not always chew her food well. EATING/DRINKING STRATEGIES: She is to have 1:1 supervision during meal times. Staff need to encourage her to alternate food/liquid." Client A's 10/1/13 ISP indicated client A had the following objectives: __To brush her teeth. __To identify her medications. __To eat at a slower pace. __To participate in an activity of her choice for 15 minutes. __To identify the cold water knob in order to become more independent with water regulation. __To make of one dinner item. __With prompting from staff, client A will sort the different coins. __To complete one step of cleaning her room. __To learn table manners. The ADL (Adult Daily Living) Reference Sheet indicated the following training steps: "1. Staff will sit next to the consumer for the meal. 2. Staff will verify that she has the correct adaptive ware for the meal.			

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	3. Staff will verify that her meal is mechanical soft. 4. Staff will remind consumer to only place a small amount of food item on her utensil. 5. Staff assist her with verbal cues to place her utensil down after she places the food into her mouth. 6. Staff will also make sure that she is completely chewing her food up and swallowing before taking another bite. 7. Staff will ask her to take a drink with each bite as well. 8. Staff will praise consumer for all attempts." Client A's ISP indicated "[Client A] is a choking risk due to eating large bites, eating too quickly, and not chewing thoroughly. She requires 1:1 monitoring during lunchtime to prevent these issues." Client B's record was reviewed on 5/29/14 at 1 PM. Client B's revised dining plan dated 9/18/13 indicated client B was at risk for choking and aspiration. Client B's dining plan indicated (not all inclusive): "EATING/DRINKING STRATEGIES: 1:1 supervision is required Small sips/bites Must be alert and sitting upright (90 degrees if possible)."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	825 MENDLESON DR RICHMOND, IN 47374

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	Client B's 10/1/13 ISP indicated client B had the following objectives: __To eat at a safer pace by placing her utensils down between bites and taking a drink between bites. __To help clean up after dinner. __To be able to identify different coins. __To be able to complete the basic steps to cleaning her room. __To be able to regulate the water temperature. __To be able to choose and participate in a leisure activity. Client B's ISP indicated "[Client B] is at a high risk for choking due to history, medication, and eating too fast. Food must be cut HAND OVER HAND prior to her eating. Needs constant prompting to slow down. Staff are to be sitting next to [client B] while she is eating to prompt her and ensure safety." Client C's record was reviewed on 5/29/14 at 1:30 PM. Client C's 10/1/13 ISP indicated client C had the following objectives: __To brush her teeth. __To name her medications. __To be able to regulate the water temperature. __To assist with the clean up after dinner. __To choose a leisure activity of her own.			

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AWS	825 MENDLESON DR RICHMOND, IN 47374

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	__To identify money. __To increase her memory skills. __To complete the basic steps to cleaning her room. Client F's record was reviewed on 5/29/14 at 3 PM. Client F's revised dining plan dated 10/1/13 indicated client F was at risk for choking and aspiration. Client F's dining plan indicated (not all inclusive): "EATING/DRINKING STRATEGIES: 1:1 supervision is required for eating and drinking Prompt to take small bites/sips, slowing rate, alternating consistencies and to use extra swallows." Client F's 10/1/13 ISP indicated client F had the following objectives: __To brush her teeth. __To repeat the names of her medications. __To be able to regulate the water temperature. __To participate in a leisure activity of her choice. __To identify different coins. __To assist with the preparation of one dinner item. Client G's record was reviewed on 5/29/14 at 3:30 PM. Client G's revised dining plan dated 10/1/13 indicated (not			

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AWS	825 MENDLESON DR RICHMOND, IN 47374

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	all inclusive): "EATING/DRINKING STRATEGIES: [Client G] is supervised while eating. Staff need to prompt [client G] to slow pace of eating at times. [Client G] is to use smaller utensils during meals to prevent overloading." Client G's 10/1/13 ISP indicated client G had the following objectives: __To be able to regulate the water temperature. __To place her utensil down between bites of food and take a drink of liquid. __To clean her gums and swab her moth with mouthwash. __To identify different coins. __To assist with the preparation of one dinner item. __To participate in a leisure activity of her choice. __To increase her social skills by repeating three simple words after staff. __To repeat the names of her medications. Client G's revised BSP dated 9/22/13 indicated client G had a targeted behavior of "Dangerous Eating: Consuming uncooked food, eating out of the trash, putting large quantities of food into her mouth, eating out of 'community' containers." The BSP indicated			

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	"Dangerous eating was added as a targeted behavior as [client G] will consume uncooked items or retrieve garbage from the trash to eat. Recently she was redirected from eating food out of the sink. Staff reports [client G] has eaten uncooked meat out of the pan on the stove and directly from the refrigerator before they could intervene. [Client G] has a long history of attempting to eat out of the trash and has needed redirection not to do so. However, this behavior has increased and she does not often respond to verbal redirection when this occurs. [Client G] also has a tendency to cram large amounts of food into her mouth when she is eating during unscheduled at times. For example, staff has found her dipping her hand into a cottage cheese container and peanut butter jar and eating as well as consuming handfuls of crackers, cereal, and/or bread. [Client G] will rarely leave the kitchen upon returning home from the workshop during the weekdays and needs constant supervision to keep her safe.... REACTIVE STRATEGIES/SPECIFIC INTERVENTIONS: COOKING: When cooking staff need to be next to the stove at all times to help block [client G] from grabbing food. She is less likely to attempt to grab something off of the stove if a staff member is right there. This will require two staff present in the			

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	kitchen when cooking - one to assist peers with cooking and the other staff to help observe and redirect [client G]. If [client G] has managed to consume raw food items or come extremely close to injuring herself by attempting to reach into a hot stove then staff should consider letting third shift staff cook the meat they need to use for the following meal and letting clients assist with warming it up as [client G] could become very sick eating raw meat and/or chicken. Please note, before doing this staff should ask QMRP or house manager for permission." During interview with staff #1 and staff #2 on 5/22/14 at 6:30 PM, staff #2 stated, "We have to watch [client G] like a hawk. She's always hovering over the stove or sinks looking for something to eat." Staff #1 and #2 indicated they did not see client G eat the scraps of meat on the counter near the crock-pot. Staff #1 stated, "Oh no, did she eat that. I didn't think anything about it when I put that there." Staff #2 stated, "Yeah, we have to have one person just to keep an eye on her when we're fixing the meal. There is just so much commotion going on and it's hard to watch her with just two of us." During a telephone interview with the RD (Regional Director) on 6/4/14 at 3			

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	PM, the RD indicated the staff were to implement the clients ' program plans and were to offer the clients training and/or leisure time activity whenever possible. This federal tag relates to complaint #IN00148943. 9-3-4(a)			
W000455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 4 of 4 sample clients (A, B, C and D) and 3 additional clients (E, F and G), the facility failed to ensure the clients washed their hands prior to eating their evening meal. Findings include: Observations were conducted at the group home on 5/22/14 between 3:45 PM and 6:30 PM. During this observation period a crock-pot meat, broccoli, mashed potatoes and a peanut butter dessert were prepared for the evening meal. By 5:50 PM the table was set with the dishes and utensils and the clients	W000455	**Corrective action for resident(s) found to have beenaffected** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on UniversalPrecautions and proper hand washing. Any current group home staff not attending oneof these meetings will be removed from the schedule until they receive thistraining from the RD or a designated representative. **How facility will identify other residents potentiallyaffected and what measures taken** All consumers couldpotentially be affected and corrective action plans will address the needs ofall clients. **Measures or systemic changes facility put in place toensure no**	07/03/2014

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	were prompted to come to the dining room for the evening meal. The staff did not prompt clients A, B, C, D, E, F and G to wash their hands prior to eating their evening meal. During telephone interview with the RD (Regional Director) on 6/6/14 at 10:45 AM indicated the staff were to prompt the clients to wash their hands prior to every meal. 9-3-7(a)		**recurrence** All group home staffwill be retrained by the RD on universal precautions and proper hand washing atstaff meetings to be held on 7-2-14 and 7-3-14. Any current group home staff not attending one of these meetings will beremoved from the schedule until they receive this training from the RD or adesignated representative. The RD willsign off on these trainings and will give copies to Human Resources (HR) to beplaced in each employee's HR file. Staffwill also continue to be trained on universal precautions and proper handwashing at new hire orientation and SAT. At least one memberof the GH Management team will be present until 7pm at least 1 night per weekto provide oversight and on the spot training for staff. Each QIDP will be present at least 4 hoursper week in the home to provide oversight and on the spot training. **How corrective actions will be monitored to ensure norecurrence** Staff will continue to be trained on universal precautionsand proper hand washing at new hire orientation and SAT. According to AWS policy, no staff can workwithout attending new hire orientation and also annual SAT training. The HR department, the RD, and the Group HomeManager monitor the expirations list weekly which includes mandatory annual SATtraining to ensure complete	

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			compliance. At least one memberof the GH Management team will be present until 7pm at least 1 night per weekto monitor appropriate hand washing.	
W009999				
	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met. 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division. 11. An emergency intervention for the individual resulting from: a. a physical symptom. b. a medical or psychiatric condition. c. any other event. This state rule was not met as evidenced by: Based on record review and interview for 1 of 4 sample clients (D), the facility	W009999	**Corrective action for resident(s) found to have beenaffected** RD will retrain allgroup home staff at staff meetings on 7-2-14 and 7-3-14 on the IncidentReporting Policy. This will include whatincidents are reportable and the mandate for immediate reporting to theQIDP. The RD will pass out IncidentReport cards that provide a reminder of what incidents are reportable. Also the RD will place a reminder of what incidentsare reportable on the Staff Communication Board in the medication room. **How facility will identify other residents potentiallyaffected and what measures taken** All residentsare affected and correctiveaction will address theneeds of all clients. **Measures or systemic changes facility put in place toensure no recurrence** The RD will retrainall group home staff at staff meetings on 7-2-14 and 7-3-14 on the AWS Incident Reporting Policy whichincludes what incidents are reportable. Any current group home staff not attending one	07/03/2014

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	failed to notify the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law regarding an incident requiring emergency services. Findings include: The facility's records were reviewed on 5/22/14 at 2 PM. The Report of Injury for client D dated 3/13/14 indicated client D "bit herself, hit the staff, the walls and anything in sight." The report indicated client D sustained injuries on both wrists. The report of injury indicated staff called 911. The facility records did not indicate the incident requiring emergency response was reported to BDDS. Telephone interview with the RD (Regional Director) on 6/4/14 at 3 PM indicated no knowledge of the incident of 3/13/14. The RD stated, "BDDS should have been notified." 9-3-1(a)		of these meetings will beremoved from the schedule until they receive this training from the RD or adesignated representative. The RD willsign off on these trainings and will give copies to HR to be placed in eachemployee's HR file. Staff willalso continue to be trained on incident reporting at new hire orientation and annuallyat SAT. **How corrective actions will be monitored to ensure norecurrence** Staff will continue to be trained on the Incident ReportingPolicy at new hire orientation and SAT. According to AWS policy, no staff can work without attending new hireorientation and also annual SAT training. The HR department, the RD, and the Group Home Manager (GHM) monitor theexpirations list weekly which includes mandatory annual SAT training to ensurecomplete compliance.	