STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G757		07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00175959. Complaint #IN00175959: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149 and W285. Survey dates: July 7, 8 and 9, 2015. Facility Number: 011817 Provider Number: 15G757 AIM Number: 200940180 These deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 1 of 2 sampled clients (client A), the facility failed to implement its written policy and procedures to prevent abuse of client A during a restraint. The facility failed to develop a written policy and procedure in regard to injuries in restraint to ensure clients were properly restrained and not abused.	W 0149	**W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS** In conjunction with the Plan of Correction for W285, the Area Director (AD), Program Director/QIDP, House Manager, Nurse, and Behaviorist will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals	08/08/2015

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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	Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 7/7/15 at 4:30 PM. The facility's 6/16/15 reportable incident report indicated at 9:15 PM, "[Client A] became agitated and eloped from the front door. Staff followed her to the front yard and attempted an HRC (Human Rights Committee) approved 2 person modified hold. [Client A] took 2 staff to the ground. A third staff member helped by lightly holding [client A's] legs down. One staff person, [staff #4], was observed by the other 2 staff to slap [client A] in the face with an open hand at least twice. Staff also observed [staff #4] pinching [client A's] nose closed and covering [client A's] mouth at the same time. Staff told [staff #4] to stop hurting [client A] and after about 10 more minutes, [client A] calmed and was escorted back to the house. [Client A] was restrained for about 30 minutes total. Upon walking back to the house, [client A] stepped in a hole and twisted her ankle. Staff called house manager and behaviorist to report restraint. Staff also called to report restraint and scratches to [client A's] neck. After shift ended at 10:00pm, staff called house manager and reported the observed abuse. Nurse arrived at 11:00 pm and conducted a whole body skin		served, including during the application of a physical restraint. The Agency Policy/Procedure concerning Abuse, Neglect, and Exploitation states "Unnecessary restraint/confinement is defined as any physical intervention that limits the movement or mobility of an individual that is not outlined in an individual's behavior support plan. Any restraint that is done to prevent serious harm or injury to the individual or others may be necessary in emergency situations. Each instance will be investigated as potential abuse as outlined in section III B of this policy." The QIDP, House Manager, Nurse, and Behaviorist will be retrained on this Standard and on Agency Policy/Procedure to complete a thorough investigation into any injury resulting from the application of a physical restraint, regardless of what is authorized in the Individual's HRC approved BSP concerning authorized physical restraints. In addition, all staff will be retrained on Agency Policy and Reporting Procedures regarding the use of manual restraints and the reporting of injuries resulting from those restraints. Ongoing, the QIDP, House Manager, Nurse, and Behaviorist will monitor any use of physical restraints and monitor the individual promptly afterwards, to rule out injury. If an injury develops, and it is determined to be through the	

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	check of [client A]. Nurse reported scratch (sic) noted to the left and right side (sic) of her neck. Small purple bruise along with scratches noted to upper left arm. [Client A] refused head injury check....House manager called [staff #4] and notified her of her suspension pending investigation of abuse. House manager also contacted [administrative staff #1], Area Director and informed her of the incident. Investigation in progress." The facility's 6/23/15 follow-up report to the 6/16/15 reportable incident report indicated "1. APS (Adult Protective Services), [name of APS staff], was contacted via email on 06/17/2015. 2. Results of the investigation are the allegations of abuse were substantiated. Employee who committed the abuse is being terminated...." The facility's 6/18/15 Investigation Report indicated the behaviorist and the QIDP (Qualified Intellectual Disabilities Professional) conducted the investigation in regard to the allegation of staff to client abuse. The facility's investigation indicated staff and clients were interviewed. The facility's investigation indicated "...[Client A] has a (sic) visible scratch marks on both sides of her neck. Staff member, [staff #2] , reported to the		application of a recently reported physical restraint, the QIDP will immediately notify the Area Director and complete a thorough investigation. The results of this investigation will be forwarded to the Area Director within five business days. Furthermore, the Area Director will monitor all reports of the use of manual restraints to any individual to ensure compliance and evaluation of possible injury. **Will be completed by: 8/8/15** **Persons Responsible: Area Director, Program Director/QIDP, Nurse, and Behaviorist**	

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	House Manager, [staff #1], that she witnessed [staff #4] slap [client A] in the face three times. Staff member, [staff #3], reported to the (sic) [staff #1] that she witnessed [staff #4] slap [client A] one time in the face. [Client A] reports that the scratch marks on her neck came from [staff #4] grabbing her on the throat because 'I was going to spit on her again.'" The facility's 6/18/15 investigative report indicated "...DSP (Direct Support Professional), [staff #2] reported that around 8pm in the evening the mood of the house changed. [Staff #4] was 'getting on' to [client A] for her being rude to he (sic) roommate, [client C]. [Client A] retreated to her room and slammed the door. DSP, [staff #3], reported the same events happening. From there, both staff report she took (client A) took a few minutes in her room, then grabbed her notebook and went to the dining room table. Neither [staff #3] nor [staff #2] saw anything, but both reported the sound of a chair falling or slamming down. [Staff #2] stated that [staff #4] 'went in there to confront her behavior,' and [staff #3] states that '[staff #4] yelled at her (client A).' Around 8:30pm [client A] got up and eloped out the front door to (sic) end of the driveway near the mailbox in the grassy area.			

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	[Staff #4] went out the front door after her first, them [staff #2] and finally [staff #3] went out initially to help. [Staff #4] grabbed [client A] by the left arm and [staff #2] on the right. They attempted a two person hold. [Client A] took staff [staff #2] and [staff #4] to the ground and [staff #3] joined to try and hold the legs as recently approved in her 5/5/2015 sitting or lying face up restraint (approved by HRC). [Staff #2] and [staff #3] both report that [client A] was kicking, spitting, biting, at [staff #4], but not them. [Staff #2] stated that she saw [staff #4] slap [client A] 2 times, maybe 3 times in the face, and pinching her nose. [Staff #3] reported witnessing her (staff #4) slap [client A] only once...." The facility's 6/18/15 investigation indicated staff #4 denied slapping and/or pinching client A's nose. The facility's investigation indicated staff #4 admitted to placing her hand on client A's forehead to stop the client from banging her head and using a bite release technique. The facility's 6/18/15 investigation indicated client A was interviewed. Client A's undated witness statement indicated "...[Client A] reports [staff #4] came in yelling at her and that is why she eloped. She recalls that [staff #4] said 'take her down' to [staff #2] and [staff #4] got to her first. [Staff #4] grabbed her by			

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	the next (sic) and took her down to the ground hard and she hit her head. [Client A's] story of the restraint is much different because she says after that is when [staff #2] got there to assist (so [staff #2] would not have been able to see the grabbing of the throat). However, [client A] says they were on the ground, and [staff #3] came to assist by holding her legs. [Client A] admits to spitting and verbal aggression toward [staff #4] but denies biting. [Client A] reports that [staff #4] slapped her 2 maybe 3 times in the face...." The facility's 6/18/15 investigative report indicated "III. Conclusion Based on Facts: "DSPs [staff #4], [staff #3] and [staff #2] were not following BSP protocol. [Client A's] BSP states if she is already agitated or showing aggression that she should be monitored for safety. There is also additional elopement protocol that [client A] should be restrained at the door when agitated, so she is not able to get out into the community and further hurt herself or put herself in a dangerous situation. In this situation, [client A] should have been directed to the back door and allowed to go in the back yard to cool down where she is safe within the fenced yard. Per all staff report (sic) they were not in the same room as her when she writing in her			

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	notebook in the dining room. All staff heard the commotion with the chair and when [staff #4] approached [client A] she eloped out the door before staff was able to restrain her...[Staff #4] admits to being on the left side of [client A] during the restraint, and [client A] has bruising on lower and upper arm (left side). [Staff #4] admits to placing her hand (palm) on [client A's] forehead in order to keep her from banging her head on the ground. This is not approved in [client A's] plan. [Staff #4] also stated that she attempted bite release technique by rubbing [client A's] upper lip. However, there was no report by [staff #4] or other staff that [client A] actually bit anyone or that her bite would need physical interaction in order to release. [Staff #4] admits to placing her hands on [client A's] face two separate times during the restraint, which were unnecessary or may be considered harmful. Both other staff involved in the hold report that [staff #4] slapped [client A] in the face. Both staff [staff #2] and [staff #3] witnessed at least one slap, up to as many as three times. [Client A] also reports that during the struggle to the ground that [staff #4] grabbed her by throat, leaving two scratches. Due to the fact that staff, [staff #4], self reported she put her hands on [client A's] face (without it being approved in BSP) on two separate occasions, the potential for			

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	these allegations of further abuse to be true is high. IV. Actions: DSP, [staff #4], be terminated for allegations of abuse (verbal and physical) are substantiated....Staff members, [staff #3] and [staff #2] will be retrained on [client A's] BSP protocol for elopement and physical restraints. They will also be retrained on Abuse, Neglect, and exploitation, policy B-02." Staff #4's personnel record was reviewed on 7/8/15 at 2:00 PM. Staff #4's 6/17/15 Employee Counseling Report indicated staff #4 was suspended on 6/17/15 for an allegation of physical abuse. The facility's inservice training records were reviewed on 7/8/15 at 4:04 PM. The facility's 6/24/15 Statement Of Inservice Training For Employees indicated staff #2 and #3 were retrained on 6/24/15. Interview with client A on 7/8/15 at 11:02 AM stated the facility staff treated her "good except one staff. She yelled at me and choked me." Client A indicated the staff who yelled at her and choked her was staff #4. Client A indicated facility staff would restrain her when she attempted to elope from the group home. Client A indicated staff #4 no longer worked at the group home.			

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	Interview with staff #1 on 7/7/15 at 4:41 PM indicated staff #4 was terminated for abuse on 6/22/15. Staff #1 indicated facility staff was retrained in regard to abuse, neglect, client A's BSP and restraints on 6/24/15. The facility's policy and procedures were reviewed on 7/7/15 at 5:22 PM. The facility's 2/23/15 policy entitled Policy and Procedure Concerning Abuse, Neglect and Exploitation indicated "Dungarvin believes that each individual has the right to be free from mental, emotional; and physical abuse in his/her daily life...Abuse, neglect or exploitation of the individuals' served is strictly prohibited in any Dungarvin service delivery setting...." The 2/23/15 policy indicated physical abuse was defined "...as any act which contains a violation of the assault, prostitution or criminal sexual conduct statutes including intentionally touching another person in a rude, insolent or angry manner, willful infliction of injury, unnecessary restraint/confinement...Unnecessary restraint/confinement is defined as any physical intervention that limits the movement or mobility of an individual that is not outlined in an individual's behavior support plan...." The facility's policy and procedure indicated			

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	"...Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonable (sic) be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonable (sic) be expected to produce mental or emotional distress, including communicating with words or actions in a individual's presence with intent to cause fear of retaliation, fear of confinement or restraint,...cause a (sic) individual to react in a negative manner...." 2. The facility's reportable incident reports and/or investigations were reviewed on 7/7/15 at 4:30 PM. The facility's reportable incident reports indicated the following (not all inclusive): -4/3/15 "[Client A] became agitated while watching a movie with staff and housemates. Staff monitored as she removed herself to the back common area and then to the dining area, then walked through the laundry room and into the garage. She started kicking the van and then threw a long florescent light bulb at staff. She attempted to open the garage door, but staff blocker (sic) her access to the opener. [Client A] hit staff. while (sic) attempting an HRC (Human Rights Committee) approved 2 person hold,			

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	[client A] hit, kicked and spit on staff. Staff achieved the HRC approved 2 person hold while [client A] continued to bite ad spit on staff. She calmed after several minutes and staff released her. [Client A] immediately began kicking staff again and again staff utilized the HRC approved 2 person hold (sic)... [Client A] refused PRN (as needed behavioral medication) and kept saying she wants to go to jail. Staff noted some bruising and scrapes on both [client A's] arms from the restraint. [Client A] self treated her injuries. Staff will continue to follow protocol and monitor [client A's] health and safety...." -4/29/15 "[Client A] was transported home from her incarceration and arrived home at 2:40. She was bonded out after being charged with level 6 felony of battery of a public official. [Client A] and behaviorist were discussing changes in her BSP (Behavior Support Plan) and her guardian's request to change the plan for [client A's] mother's upcoming visit. The guardian said to have staff supervision throughout the mother's visit. [Client A] became upset and started throwing boxes of gloves at behaviorist and staff. [Client A] quickly escalated to throwing punches. She rolled an office chair violently to the office door and unlocked and opened the door and			

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	attempted to elope. Behaviorist and staff placed [client A] in a 2 person hold at 2:55. The restraint lasted 13 minutes. Once released [client A] laid on the floor for 30 to 40 minutes. [Client A] refused her 4 pm meds (medications). [Client A] ate dinner and did proper clean up. [Client A] then sat in the back room bathroom, staff checked on [client A] after 10 minutes. [Client A] yelled 'leave me the f... alone, stop following me.' (sic) at staff, staff reminded her that they was (sic) just ensuring that she was safe. [Client A] then came out of the bathroom then grabbed a permanent marker and began writing on herself and on the wall in the back common area, staff offered her paper to write on, [client A] threw the marker and began punching the wall. [Client A] then ran out of the back door and stood on the patio. Staff followed and [client A] began yelling, 'leave me the f...alone b....!!' [Client A] then ran to the fence and began punching and kicking it. [Client A] began opening the fence door, staff attempted to redirect [client A], but she continued. At 7:19pm staff put [client A] in a 2 person hold. The hold lasted 6 minutes...An emergency IDT meeting was held prior to her release from jail to modify her BSP so as to prevent further police involvement when [client A] becomes agitated. The BSP has been updated and			

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	staff have been trained in new protocol." Client A's 4/3/15 and/or 4/29/15 reportable incident reports and/or investigations indicated the facility did not investigate client A's injuries due to the use of the above mentioned manual restraints/incidents. Client A's record was reviewed on 7/8/15 at 4:00 PM. Client A's 4/8/15 Individual Support Plan (ISP) and/or record indicated client A's interdisciplinary team (IDT) did not address and/or review the above mentioned incidents involving client A being injured when restrained to ensure sufficient safeguards were in place to prevent potential injuries. The facility's policy and procedures were reviewed on 7/7/15 at 5:22 PM and on 7/8/15 at 2:00 PM. The facility's 2/23/15 policy entitled Policy and Procedure Concerning Abuse, Neglect and Exploitation and the facility's 11/17/14 policy entitled Policy and Procedure Concerning Reporting and Documentation Of Incidents and General Events indicated the facility did not have a specific policy which addressed how the facility would deal with injuries in restraint. Interview with staff #1 on 7/7/15 at 4:41			

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	PM indicated when asked how client A received the 4/29/15 injuries to her arm, staff #1 stated "from restraint or from her (client A) injuring herself." Staff #1 then called the facility's behaviorist and stated the behaviorist indicated "it was from the restraint." Staff #1 indicated no investigation was completed in regard to client A's injury from the restraint. Interview with client A on 7/8/15 at 11:02 AM indicated facility staff would restrain client A when she attempted to elope from the group home. When asked if client A had been hurt when restrained, client A stated "No. I bruise easy though." Client A stated she had been "yelled at and choked " by staff #4 who no longer worked at the group home. Interview with the behaviorist on 7/8/15 at 2:15 PM indicated client A had been injured due to staff restraining the client. When asked how the facility looked at restraints, the behaviorist stated "We have a meeting afterwards to look at behavior. How could the situation be handled differently." The behaviorist stated "We expect to see bruising on arms and legs due to fighting in restraint. It is not uncommon for her to have injuries." The behaviorist indicated the facility's nurse would come to the group home and assess the client for any injuries when			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

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	restrained. The behaviorist stated the IDT "Does not look at restraint injury." The behaviorist indicated she was not sure the facility had a policy which addressed clients being injured when restrained. This federal tag relates to complaint #IN00175959. 9-3-2(a)			
W 0285 Bldg. 00	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. Based on interview and record review for 1 of 2 sampled clients (A), the facility failed to review behavioral incidents which resulted with a client being injured while restrained to ensure the restraints were properly implemented and/or sufficient safeguards were put in place to prevent injury. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 7/7/15 at 4:30 PM. The facility's reportable incident reports indicated the	W 0285	**W 285 483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR** In conjunction with the Plan of Correction for W149, the Area Director (AD), Program Director/QIDP, House Manager, Nurse, and Behaviorist will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, including reviewing all incidents in which application of a physical restraint resulted in injury. The	08/08/2015

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	following (not all inclusive): -4/3/15 "[Client A] became agitated while watching a movie with staff and housemates. Staff monitored as she removed herself to the back common area and then to the dining area, then walked through the laundry room and into the garage. She started kicking the van and then threw a long florescent light bulb at staff. She attempted to open the garage door, but staff blocker (sic) her access to the opener. [Client A] hit staff. while (sic) attempting an HRC (Human Rights Committee) approved 2 person hold, [client A] hit, kicked and spit on staff. Staff achieved the HRC approved 2 person hold while [client A] continued to bite and spit on staff. She calmed after several minutes and staff released her. [Client A] immediately began kicking staff again and again staff utilized the HRC approved 2 person hold (sic)... [Client A] refused PRN (as needed behavioral medication) and kept saying she wants to go to jail. Staff noted some bruising and scrapes on both [client A's] arms from the restraint. [Client A] self treated her injuries. Staff will continue to follow protocol and monitor [client A's] health and safety...." -4/29/15 "[Client A] was transported home from her incarceration and arrived		Agency Policy/Procedure concerning Abuse, Neglect, and Exploitation states "Unnecessary restraint/confinement is defined as any physical intervention that limits the movement or mobility of an individual that is not outlined in an individual's behavior support plan. Any restraint that is done to prevent serious harm or injury to the individual or others may be necessary in emergency situations. Each instance will be investigated as potential abuse as outlined in section III B of this policy." The QIDP, House Manager, Nurse, and Behaviorist will be retrained on this Standard and on Agency Policy/Procedure to complete a thorough investigation into any injury resulting from the application of a physical restraint, regardless of what is authorized in the Individual's HRC approved BSP concerning authorized physical restraints. In addition, all staff will be retrained on Agency Policy and Reporting Procedures regarding the use of manual restraints and the reporting of injuries resulting from those restraints. Ongoing, the QIDP, House Manager, Nurse, and Behaviorist will monitor any use of physical restraints and monitor the individual promptly	

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	home at 2:40. She was bonded out after being charged with level 6 felony of battery of a public official. [Client A] and behaviorist were discussing changes in her BSP (Behavior Support Plan) and her guardian's request to change the plan for [client A's] mother's upcoming visit. The guardian said to have staff supervision throughout the mother's visit. [Client A] became upset and started throwing boxes of gloves at behaviorist and staff. [Client A] quickly escalated to throwing punches. She rolled an office chair violently to the office door and unlocked and opened the door and attempted to elope. Behaviorist and staff placed [client A] in a 2 person hold at 2:55. The restraint lasted 13 minutes. Once released [client A] laid on the floor for 30 to 40 minutes. [Client A] refused her 4 pm meds (medications). [Client A] ate dinner and did proper clean up. [Client A] then sat in the back room bathroom, staff checked on [client A] after 10 minutes. [Client A] yelled 'leave me the f... alone, stop following me.' (sic) at staff, staff reminded her that they was (sic) just ensuring that she was safe. [Client A] then came out of the bathroom then grabbed a permanent marker and began writing on herself and on the wall in the back common area, staff offered her paper to write on, [client A] threw the marker and began punching the wall.		afterwards, to rule out injury. If an injury develops, and it is determined to be through the application of a recently reported physical restraint, the QIDP will immediately notify the Area Director and complete a thorough investigation. The results of this investigation will be forwarded to the Area Director within five business days. Furthermore, the Area Director will monitor all reports of the use of manual restraints to any individual to ensure compliance and evaluation of possible injury. **Will be completed by: 8/8/15** **Persons Responsible: Area Director, Program Director/QIDP, Nurse, and Behaviorist**	

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	[Client A] then ran out of the back door and stood on the patio. Staff followed and [client A] began yelling, 'leave me the f...alone b....!!' [Client A] then ran to the fence and began punching and kicking it. [Client A] began opening the fence door, staff attempted to redirect [client A], but she continued. At 7:19pm staff put [client A] in a 2 person hold. The hold lasted 6 minutes...An emergency IDT meeting was held prior to her release from jail to modify her BSP so as to prevent further police involvement when [client A] becomes agitated. The BSP has been updated and staff have been trained in new protocol." Client A's 4/3/15 and/or 4/29/15 reportable incident reports and/or investigations indicated the facility did not investigate client A's injuries due to the use of the above mentioned manual restraints/incidents. Client A's record was reviewed on 7/8/15 at 4:00 PM. Client A's 4/8/15 Individual Support Plan (ISP) and/or record indicated client A's IDT did not address and/or review the above mentioned incidents involving client A being injured when restrained to ensure sufficient safeguards were in place to prevent potential injuries.			

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	Interview with staff #1 on 7/7/15 at 4:41 PM indicated when asked how client A received the 4/29/15 injuries to her arm, staff #1 stated "from restraint or from her (client A) injuring herself." Staff #1 then called the facility's behaviorist and stated the behaviorist indicated "it was from the restraint." Staff #1 indicated no investigation was completed in regard to client A's injury from the restraint. Interview with the behaviorist on 7/18/15 at 2:15 PM indicated client A had been injured due to staff restraining the client. When asked how the facility looked at restraints, the behaviorist stated "We have a meeting afterwards to look at behavior. How could the situation be handled differently." The behaviorist stated "We expect to see bruising on arms and legs due to fighting in restraint. It is not uncommon for her to have injuries." The behaviorist indicated the facility's nurse would come to the group home and assess the client for any injuries when restrained. The behaviorist stated the IDT "Does not look at restraint injury." The behaviorist indicated she was not sure the facility had a policy which addressed clients being injured when restrained. This federal tag relates to complaint #IN00175959.			

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