STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G447	A. BUILDING 00 B. WING	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA CORPORATION OF INDIANA	4114 KNOLLTON RD INDIANAPOLIS, IN46208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for an investigation of complaint #IN00096931. Complaint #IN00096931: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W154 and W157. Unrelated Deficiencies cited. Dates of Survey: 10/12, 10/13, 10/14 and 10/18/11. Facility Number: 000961 Provider Number: 15G447 Aim Number: 100244750 Surveyor: Paula Chika, Medical Surveyor III-Team Leader Brenda Nunan, Public Health Nurse Surveyor, RN (10/13-10/14/11) These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/7/11 by Chris Greeney, Medical Surveyor Supervisor and Ruth Shackelford, Medical Surveyor III.	W0000		
W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on interview and record review for	W0104	CORRECTION: *The Governing body must exercise general*	11/20/2011

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

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	3 of 3 sampled clients (A, B and C) and for 3 additional clients (D, E and F), the governing body failed to exercise general policy and operating direction over the facility to ensure its policy for insect infestation (bed bugs) included preventative measures/corrective actions which would prevent the spread of bed bugs to other parts of the house/clients and/or to prevent others from carrying/spreading the bed bugs once professional treatments started. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 10/13/11 at 11:20 AM. The facility's reportable incident reports indicated the following: -8/26/11 "Knollton group home staff reported to PC (Program Coordinator) [PC #1] that they had found a bug in [client C's] (individual we support) bed. PC immediately contacted [name of exterminator company] to determine what type of bug it was. The [name of exterminator company] technician came to the house and determined the bug was a bed bug. PC [PC #1] began implementation of Adept's operation standard protocol that addresses insect infestations and cleaning and safeguarding		*policy, budget and operating direction over the facility.*Specifically, The agency will incorporate preventative strategies in its insect(bedbug) infestation procedures. PREVENTION: Professional staff will be trained on the agency's updated insect infestation prevention protocols. Additionally, members of the Operations Team will conduct periodic observations of the facility on an ongoing basis to assure preventative measures are implemented per policy Responsible Parties:QDDPD, Support Associates, Operations Team	

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	the home once bed bugs are discovered. [PC #1] also implemented the Occupant Preparation Requirements from [name of exterminator company] which must be completed prior to treatment to exterminate the bugs. [Client C] had recently received some of her clothing and belongings from her mother, [name of mother], who had been living in a halfway house. [Name of client C's mother] reports that her room in the house had bed bugs to the point that she had to move out and she thought that everything had been cleaned prior to her move. It is most probable that the bed bugs were not destroyed in [client C's] belongings that came from her mother's and that is how they were brought into her bed at Knollton. Knollton staff cleaned all clothing and furniture in [client C's] room per the guidelines of the Adept operating standard and the [name of exterminator company] pre-treatment requirements. [Name of exterminator company] is scheduled to return to the home to complete the first treatment for extermination of the bed bugs on Tuesday, 8/30/11 from 12p-3p. PPE (Personal Protection Equipment) gear will be available to staff to use in order to restrict the spread of the bugs. There was (sic) no other bed bugs found in the house."			

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	-8/30/11 "All individuals were relocated to the [name of hotel] in [name of city] on 8/30/11. This was necessary due to the initial pest removal treatment by the exterminator to rid the house of bed bugs. The type of treatment completed was heat treatment and it was not started until late afternoon. The ladies were relocated for the overnight and returned to the group home on 8/31/11. It is believed that the bed bugs were brought into the home via items brought to the group home by one of the individuals returning from a home visit. All items that were brought in were removed from the home, destroyed and replaced with new. Pending the outcome of the initial treatment, staff will insure that all clothing and items are washed, dryed (sic) on high heat and bagged and/or contained per the specifications of the exterminator to limit further exposure and spread of the pest...." Interview with client C on 10/12/11 at 6:08 PM indicated she had problems with bed bugs. Client C indicated the bed bugs came from items she received from her mother and had to spend one month at another group home due to the bed bugs in her room. Interview with staff A on 10/12/11 at 6:15 PM stated the group home had bed bugs in "the whole house." Staff A indicated			

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	the group home had undergone 3 treatments thus far. Staff A stated "They replaced the mattresses where the bed bugs were at, but they have spread through house." Staff A stated she last saw a bed bug in the medication room on 10/11/11 that was "brownish in color with a flat top." Interview with staff B on 10/12/11 at 6:35 PM stated the group home had bed bugs "for over a month." Staff B indicated he saw a bed bug yesterday when passing the 5:00 PM medications. Staff B stated the facility had a company come in and "spray the whole house." Staff B indicated the bed bugs started in client C's bedroom. Staff B indicated client C complained something was biting her and that is when they discovered the bed bugs. Interview with staff C on 10/12/11 at 6:46 PM indicated the facility had bed bugs. Staff C indicated the facility was in the process of treating the bed bugs. When asked which clients' mattresses had been changed, staff C stated only clients A and C as the bed bugs were in their bedrooms. The facility's policy and procedures were reviewed on 10/13/11 at 11:51 AM. The facility's 5/24/11 policy entitled Emergency, Disaster, Evacuation Plans and Responses indicated the policy			

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	included a section entitled "Emergency plan for insect infestation (bed bugs)." The 5/24/11 policy indicated "...bed bugs (Cimex lectularius) are brown to reddish-brown, oval shaped, flattened and about 3/16 to 1/5 inch long. Their flat shapes enables them to readily hide in cracks and crevices. Newly hatched bugs are nearly colorless. Nymphs can immediately begin to feed. They require a blood meal in order to mold. The adult's life span may encompass 12-18 months. Three or more generations can occur each year. Bed bugs hide in dark, protected sites...B. Check mattresses, box springs and bed frame, as well as crack and crevices that the bed bugs may hide in during the day or when digesting a blood meal....." The 5/24/11 bed bug policy indicated the facility would treat the affected areas. The policy indicated "....2. Frequently vacuum the mattresses and premises, wash bedding and clothing in hot water and dry on high heat for 30 minutes,...3. Use a stiff brush to scrub the mattress seams and box springs to dislodge bed bugs and their eggs. 4. After the mattress and box springs are scrubbed and vacuumed, put each in a zippered mattress encasement. Leave the cover in place for a year...7. Insecticide treatments will be completed by a professional exterminator using currently excepted bed bug removal practices. Be			

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	prepared to vacate the property a minimum of 2 hours after arrival of the service technician." The facility's 5/24/11 policy did not specifically indicate what the facility would do to prevent the spread of bed bugs to others while undergoing professional treatments to eliminate the bed bugs. Interview with administrative staff #3 on 10/13/11 at 1:05 PM and at 2:55 PM indicated client C went to another group home for 2 to 3 weeks due to bed bugs in her bedroom. Administrative staff #3 indicated the bed bugs were brought into the group home from some items the client's mother had gave the client. Administrative staff #3 indicated the group home had been treated for the bed bugs and client A and C's mattresses and box springs were replaced as they were roommates and in the room with the bed bugs. Administrative staff #3 indicated the clients' mattresses/box springs had been covered with plastic to prevent the bed bugs from returning. Administrative staff #3 indicated clients C, D, E and F's mattresses had not been covered. Administrative staff #3 indicated the pest control company had completed a third and final spray last week. When asked when bed bugs were last seen, administrative staff #3 stated "about a month ago." The administrative staff			

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	indicated one had been found/seen on a sink in the bathroom. Administrative staff #3 indicated facility staff had not reported seeing any bed bugs recently. Administrative staff #3 indicated facility staff should report any bed bugs so the facility could inform the pest control company so they would come back out. When asked if the facility was checking for bed bugs at night, administrative staff did not know. Administrative staff #3 indicated the facility staff had used PPE gear when the bugs were first found in the home to prevent the spread of the bed bugs. Interview with administrative staff #2 and #3 on 10/14/11 at 9:30 AM indicated the last treatment had been completed. Administrative staff #2 indicated facility staff should have reported seeing a bed bug this week. Administrative staff #2 stated it was an "operational decision" to only purchase mattress covers for clients A and C. Administrative staff #2 indicated he did not have any input into the decision. Administrative staff #2 indicated the facility's policy for bed bug infestation did not specifically include any preventative/corrective measures the facility would implement/take to prevent the spread of bed bugs to other parts of the house/clients, and/or others except to be professionally treated.			

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W0149	9-3-1(a) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 3 sampled clients (A) and for 1 additional client (D), the facility failed to implement its policy and procedures in regard to reporting all allegations of abuse, injuries of unknown origin immediately to the administrator. The facility failed to implement its policy and procedures to conduct through investigation in regard to incident of unknown origin. Findings include: The facility's policy and procedures were reviewed on 10/13/11 at 11:51 AM. The facility's 9/14/07 policy entitled Abuse, Neglect, Exploitation indicated "Adept employees actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, local, state and federal guidelines." The 9/14/07 policy indicated "...3. Any employee who	W0149	CORRECTION: *The facility must develop and implement written policies and procedures that prohibit mistreatment, abuse or neglect of the client.* Specifically, a report was submitted to Divisionof Disability and Rehabilitation Services regarding client A's injury of unknown origin,after the reporting error was discovered during a review of documentation and facility staff were retrained regarding reporting requirements. Specifically for Client D,supervisory staff was also retrained regarding the need to draw conclusions in investigations based solely on the evidence gathered during the investigation. Additionally,staff A was suspended on 10/18/11 when, through investigation, additional allegations indicated suspected abuse. These allegations have been substantiated and Staff A's employment will be terminated. PREVENTION: Operations Team members will review all facility documentation on an ongoing basis to assure all incidents are reported as required and the Operations Team will review all facility investigations to assure conclusions match the gathered	11/20/2011

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	suspects an individual is the victim of abuse, neglect or exploitation will immediately notify the Program Director (PD) Director of Operations and Director of Quality Assurance who will then begin the investigation process. The Executive Director and the Regional Director will also be notified...." The facility's 9/14/07 policy indicated allegations of abuse, neglect and incidents of injuries of unknown origin would be investigated. 1. The facility failed to ensure facility staff immediately reported an injury of unknown origin to the administrator regarding client A. Please see W153. 2. The facility failed to conduct a thorough investigation involving client D's injury of unknown origin and in regard to an allegation of abuse involving client G. Please see W154. This federal tag relates to complaint #IN00096931. 9-3-2(a)		evidence. Additionally the Executive Director and Human Resources Director will conduct a Peer Review of all investigations conducted by the Operations Team to assure conclusions match the gathered evidence and that all relevant evidence is collected. Responsible Parties: QDDPD, Support Associates, Operations Team, Executive Director, HR Director	
W0153	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.			

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	Based on interview and record review for 1 of 9 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to immediately report an injury of unknown origin to the administrator for client A. Findings include: Client A's record was reviewed on 10/13/2011 at 1:40 p.m. A "Program Plan Progress Note" dated 10/05/2011 indicated, "...Writer discovered a bruise on right leg between knee and ankle. Appears to be the size of a half silver dollar. Purplish blue...." The facility's reportable incident reports were reviewed on 10/13/2011 at 11:20 p.m. The facility's reportable incident reports from 7/11 to 10/11 indicated there was no documentation to indicate an injury of unknown origin for client A had been immediately reported to administrator. During an interview on 10/14/2011 at 10:00 a.m.,, the QDDP (Qualified Developmental Disabilities Professional) indicated she was not aware of client A's injury of unknown origin until 10/13/2011. She indicated the injury should have been immediately reported to the administrator.	W0153	CORRECTION: *The facility mustensure that all allegations of mistreatment, neglect or abuse, as well asinjuries of unknown source are reported immediately to the administrator or toother officials in accordance with state law through established procedures.* Specifically,a report was made to the Division of Disability and Rehabilitation Services andAdult Protective Services regarding client A's injury of unknown origin, afterthe reporting error was discovered during a review of documentation and facilitystaff were retrained regarding reporting requirements. PREVENTION: The facility will send copies of internal incident reportsto the administrator via electronic fax upon completion, to assure theoperations team has the ability to report incidents to state agencies asrequired in a timely manner. Members of the operations team will compareinternal incident reports to the agency's incident tracking log to assureincidents are reported as required. Responsible Parties: QDDPD, Support Associates, Operations Team	11/20/2011

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	During an interview on 10/14/2011 at 9:30 a.m., Administrative staff #2 indicated he was notified of the bruise documented on a progress note, dated 10/05/2011 on 10/13/2011. Administrative staff #2 indicated facility staff should have reported client A's injury of unknown origin to the administrator when found on 10/5/11. 9-3-2(a)			
W0154	The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 2 of 8 allegations of abuse, neglect and/or injuries injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation in regard to an injury of unknown origin for client D as the investigation did not actually determine how the client received the injuries of unknown origin, and in regard to an allegation of staff to client abuse involving client G. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 10/13/2011 at 11:20 a.m. An	W0154	CORRECTION: *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically for Client D, supervisory staff was retrained regarding the need to draw conclusions in investigations based solely on the evidence gathered during the investigation. Additionally, staff A was suspended on 10/18/11 when, through investigation, additional allegations indicated suspected abuse. These allegations have been substantiated and Staff A's employment will be terminated. PREVENTION: The Operations Team will review all facility investigations to assure conclusions match the gathered evidence. Additionally the Executive Director and Human	11/20/2011

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	Indiana Division of Disability and Rehabilitative Services report, dated, 07/18/2011 at 7:50 a.m., indicated, "...While assisting [client D] with her morning shower, staff noted a 4 in (inch) diameter (SIC) which was red in the middle and black around the edges. Supervisory staff and the nurse on call were notified per protocol...The Program coordinator has initiated an investigation the origin of the injury...." An Indiana Division of Disability and Rehabilitative Services Incident Follow Up Report, dated 08/01/2011 indicated, "...The bruise on the left side of [client D's] abdomen healed without complications. Through investigation, the team determined that although no one actually saw [client D] sustain the injury, she most likely received the bruise as a result of bumping into something as she transferred in or our (SIC) of her wheelchair. Through ongoing assessment, the interdisciplinary team has determined [client D] rushes when transferring to and from her wheelchair which sometimes results in injury. The manifestation of her self-injurious behavior is addressed in [client D's] Behavior Support Plan...." A "STAFF INTERVIEW - INJURY OF UNKNOWN ORIGIN" form dated 7/18/2011 at 7:00 a.m., indicated staff did		Resources Director will conduct a Peer Review of all investigations conducted by the Operations Team to assure conclusions match the gathered evidence and that all relevant evidence is collected. Responsible Parties: QDDPD, Support Associates, Operations Team	

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	not see client D "falling, walking or running into any objects in or outside of the home," and did not indicate "self-injurious behavior within the past 24 hours." A "STAFF INTERVIEW - INJURY OF UNKNOWN ORIGIN" form, dated 7/18/2011, no time recorded, indicated staff did not see client D "falling, walking or running into any objects in or outside of the home," and did not indicate "self-injurious behavior within the past 24 hours." A "STAFF INTERVIEW - INJURY OF UNKNOWN ORIGIN" form, dated 7/18/2011 at 10:00 p.m., indicated staff did not see client D "falling, walking or running into any objects in or outside of the home," and did not indicate "self-injurious behavior within the past 24 hours." A "STAFF CONSUMER INJURY OF UNKNOWN ORIGIN CONFIDENTIAL WITNESS STATEMENT FORM" dated 7/19/2011 at 4:30 p.m., indicated the client interviewed did not see client D "WALK/RUN OR HIT ANY OBJECTS IN OR OUTSIDE THE HOME," and did not indicate "SELF IN INJURIOUS BEHAVIORS WITHIN THE PAST 48 HOURS."			

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	A "STAFF CONSUMER INJURY OF UNKNOWN ORIGIN CONFIDENTIAL WITNESS STATEMENT FORM" dated 7/19/2011, no time recorded, indicated the client interviewed did not see client D "WALK/RUN OR HIT ANY OBJECTS IN OR OUTSIDE THE HOME," and did not indicate "SELF IN INJURIOUS BEHAVIORS WITHIN THE PAST 48 HOURS." A "CONSUMER INTERVIEW - INJURY OF UNKNOWN ORIGIN CONFIDENTIAL WITNESS STATEMENT FORM" dated 7/23/2011 at 2:15 p.m., indicated the client interviewed did not see client D "falling, walking or running into any objects in or outside of the home," and did not indicate "anything to hurt him/herself within the past 24 hours." A "CONSUMER INTERVIEW INJURY OF UNKNOWN ORIGIN CONFIDENTIAL WITNESS STATEMENT FORM" dated 7/23/2011 at 2:20 p.m. indicated the client interviewed did not see client D "falling, walking or running into any objects in or outside of the home," and did not indicate "anything to hurt him/herself within the past 24 hours."			

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	15G447	A. BUILDING 00 B. WING	10/18/2011

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	The facility's undated "Final Report" (investigation summary) indicated, "...EVIDENCE SUBSTANTIATES THAT CONSUMER (client D) DID CAUSE INJURY TO HIMSELF (SIC) OR OTHERS AS A RESULT OF HER BEHAVIOR...." The facility's investigation did not specifically indicate what kind of self-injurious behavior client D demonstrated to cause the injuries as facility staff indicated client D did not demonstrate any self-injurious behavior. During an interview on 10/14/2011 at 10:00 a.m., Administrative staff #2 stated, he could, "only speculate" the injury was due to self-injurious behavior because client D "engaged in self injurious behaviors." Administrative staff #2 indicated he did not consider self transferring from the wheel chair to be self injurious behavior. He stated "poor wording" was used on the incident report. 2. The facility's reportable incident reports and/or investigations were reviewed on 10/13/11 at 11:20 AM. The facility's 9/14/11 reportable incident report indicated "A co-worker reported to the Program Coordinator that staff [staff A] was observed hitting [client G]. [Client G] was not injured but told the PC that she had been 'roughed up'."			

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	The facility's 9/21/11 Investigation Summary indicated facility staff and clients were interviewed. The 9/21/11 investigation indicated client G was interviewed 2 different times. Client G's 9/15/11 witness statement indicated client G indicated client D had attempted to hit her and they were arguing back and forth. Client G's 9/15/11 witness statements indicated client G did not substantiate staff A hit her. Client G's witness statement indicated the client stated clients D and E hit her when client E was not mentioned by staff. Client G's witness statement indicated she could not name the staff who worked with her that evening as she stated a name of a staff person who did not have that name in her group home. The facility's 9/21/11 investigation indicated the staff person who reported the alleged incident "...she observed [staff A] come out of the medication room and hit [client G] several times while attempting to redirect her...." The 9/21/11 investigation indicated client G was having a behavioral incident with client D where staff alleged client G hit client D. The investigation indicated staff C attempted to intervene and client G scratched the staff person. The investigation indicated "[Staff C]...said that when she went into the medication			

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	room to get a band aid for herself, [staff A] (Support Associate/alleged perpetrator) came out of the medication room approached [client G] from behind and hit her with an open hand several times while saying 'I told you to stop.' [Staff C] said [staff B]...was in the living room at the time...." The facility's 9/21/11 investigation indicated staff A and B indicated staff A did not hit client B. The facility's investigation indicated staff A indicated she had placed her hand on client G's forearm and asked the client to stop throwing client D's items. The investigation indicated staff A "...described her action as gentle and not restraining...." The facility's investigation indicated staff C indicated staff A had placed her hand on client G's forearm, and did not indicate staff A had hit client G. The facility's investigation also indicated staff A and B indicated client G did not hit client D. The facility's 4/21/11 "Conclusions:" section of the investigation indicated "1. The evidence does not substantiate that [staff A]...hit [client G] (consumer/alleged victim) on the evening of Wednesday, 9/14/11. 2. The evidence does not substantiate that [staff A's] actions resulted in [client G] experiencing injury or mental anguish. 3. Based on demonstrative and testimonial evidence,			

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	[staff C] had a partially obscured view of the alleged incident and most likely misunderstood what she believed she observed." The facility's 4/21/11 investigation did not specifically indicate staff C stated her view was "partially obscured." The facility's 4/21/11 investigation did not indicate the facility re-interviewed staff in regard to their conflicting statements to ensure the alleged abuse did not occur. Confidential interview M stated staff A "slapped" client G in the back of the head "several times." Confidential interview M stated client G's head moved "forward" when the client was slapped in the back of the head. Confidential interview M indicated client G had a stroke a couple of years ago and would get confused. Interview with administrative staff #3 on 10/13/11 at 1:05 PM indicated she did not know of any conflicts between staff at the group home. Administrative staff #3 stated client G "got a waiver" and was moved to a supportive living group home. Interview with administrative staff #2 on 10/14/11 at 9:30 AM indicated the facility did not substantiate staff A hit client G even though staff C indicated it happened. Administrative staff #2 indicated client G			

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	was interviewed 2 times and did not substantiate the abuse. Administrative staff #2 indicated the other staff who witnessed the incident did not indicate the abuse occurred. This federal tag relates to complaint #IN00096931. 9-3-2(a)			
W0157	If the alleged violation is verified, appropriate corrective action must be taken. Based on 1 of 9 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to put in place corrective measures to address/monitor an incident of staff to client abuse where there were conflicting statements involving client G. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 10/13/11 at 11:20 AM. The facility's 9/14/11 reportable incident report indicated "A co-worker reported to the Program Coordinator that staff [staff A] was observed hitting [client G]. [Client G] was not injured but told the PC that she had been 'roughed up'."	W0157	CORRECTION: *If the alleged violation is verified, appropriate action must be taken.* Specifically, due to additional substantiated allegations, Staff A is currently suspended and termination of employment has been approved. PREVENTION: When investigations result in conflicting evidence, the facility will develop a plan to implement protective measures including but not limited to an increased supervisory presence, counseling and retraining and weekly follow-up with potentially affected clients. Members of the Operations Team will follow-up with facility supervisory staff to oversee the implementation protective measures are in place. Responsible Parties: QDDPD, Support Associates, Operations Team	11/20/2011

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	The facility's 9/21/11 Investigation Summary indicated facility staff and clients were interviewed. The facility's 9/21/11 Investigation Summary indicated facility staff and clients were interviewed. The 9/21/11 investigation indicated client G was interviewed 2 different times. Client G's 9/15/11 witness statement indicated client G indicated client D had attempted to hit her and they were arguing back and forth. Client G's 9/15/11 witness statements indicated client G did not substantiate staff A hit her. Client G's witness statement indicated the client stated clients D and E hit her when client E was not mentioned by staff. Client G's witness statement indicated she could not name the staff who worked with her that evening as she stated a name of a staff person who did not have that name in her group home. The facility's investigation indicated the staff person who reported the alleged incident "...she observed [staff A] come out of the medication room and hit [client G] several times while attempting to redirect her...." The 9/21/11 investigation indicated client G was having a behavioral incident with another client. The investigation indicated staff C attempted to intervene and client G scratched the staff person. The investigation indicated "[Staff C]...said			

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	that when she went into the medication room to get a band aid for herself, [staff A] (Support Associate/alleged perpetrator) came out of the medication room approached [client G] from behind and hit her with an open hand several times while saying 'I told you to stop.' [Staff C] said [staff B]...was in the living room at the time...." The facility's 9/21/11 investigation indicated staff A and B indicated staff A did not hit client B. The facility's investigation indicated staff A indicated she had placed her hand on client G's forearm and asked the client to stop throwing client D's items. The investigation indicated staff A "...described her action as gentle and not restraining...." The facility's investigation indicated staff C indicated staff A had placed her hand on client G's forearm, and did not indicate staff A had hit client G. The facility's 4/21/11 "Conclusions:" section of the investigation indicated "1. The evidence does not substantiate that [staff A]...hit [client G] (consumer/alleged victim) on the evening of Wednesday, 9/14/11. 2. The evidence does not substantiate that [staff A's] actions resulted in [client G] experiencing injury or mental anguish. 3. Based on demonstrative and testimonial evidence, [staff C] had a partially obscured view of the alleged incident and most likely			

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	misunderstood what she believed she observed." The facility's 4/21/11 investigation did not include any additional corrective measures on how the facility would monitor staff A and/or staff at the group home, as their was conflicting evidence given during the investigation, to ensure clients would not be abused. Confidential interview M stated staff A "slapped" client G in the back of the head "several times." Confidential interview M stated client G's head moved "forward" when the client was slapped in the back of the head. Confidential interview M indicated client G had a stroke a couple of years ago and would get confused. Interview with administrative staff #3 on 10/13/11 at 1:05 PM indicated she did not know of any conflicts between staff at the group home. Administrative staff #3 stated client G "got a waiver" and was moved to a supportive living group home. Interview with administrative staff #2 on 10/14/11 at 9:30 AM indicated the facility did not substantiate staff A hit client G even though staff C indicated it happened. Administrative staff #2 indicated client G was interviewed 3 times and did not substantiate the abuse. Administrative			

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	staff #2 indicated the other staff who witnessed the incident did not indicate the abuse occurred. This federal tag relates to complaint #IN00096931. 9-3-2(a)			