

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408
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W 0000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: March 28, 29, 30, 31, April 1, 4 and 5, 2016</p> <p>Facility Number: 000744 Provider Number: 15G220 AIM Number: 100234860</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/8/16.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body</p>	W 0102	<p>W 102 GOVERNING BODY AND MANAGEMENT(CONDITION) Corrective action for resident(s) found to have been affected New screens are in windows, windows have been cleaned, entire outside of house was power washed. Staff will be</p>	05/05/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>failed to ensure: 1) the windows in the group home had screens, 2) the outside trim and siding of the kitchen window above the sink was cleaned after staff poured grease out the window and 3) the Qualified Intellectual Disabilities Professional (QIDP) was monitored and supervised to ensure the QIDP integrated, coordinated and monitored the clients' Individual Support Plans. The governing body failed to implement its policies and procedures to prevent client to client abuse, ensure corrective actions were implemented to address medication/treatment errors, ensure staff implemented client #4's risk plan for falls, ensure client #4's risk plan for falls indicated the parameters of his one on one supervision, and ensure client #4 had a plan to address his extended length of time in the shower. The governing body failed to ensure client #4 and #5's privacy while each was engaged in personal care. The governing body failed to ensure client #4's Individual Support Plan (ISP) was revised to reflect the dentist's recommendations to brush his teeth three times a day and the parameters of client #4's medical one on one supervision plan were defined. The governing body failed to ensure client #4's risk plan for falls was implemented as written.</p> <p>Findings include:</p>		<p>trained on structural house maintenance. QIDP and staff will be trained on Individual Support Plans, including integration, coordination and monitoring the ISP to ensure client's needs are being met(including changes made by medical professionals) and goals are being tracked. QIDP will be trained on new client admission policy, including completing Comprehensive Functional Assessment(CFA) within 30 days of admission. QIDP and staff will be trained on policy and prevention of client to client abuse. QIDP and staff will be trained in client rights, with a focus on privacy. QIDP will be trained on corrective action following medication errors. Staff and QIDP will be trained on policies and procedures to follow risk plans. Moreover, staff will be re-trained on all client's risk plans. Nursing staff will define and clarify a medical one on one supervision plan for one client. Nursing staff will train all staff on this plan. QIDP and staff will be trained on active treatment programing. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence</p>	

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	<p>1) Please refer to W104. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the windows in the group home had screens, 2) the outside trim and siding of the kitchen window above the sink was cleaned after staff poured grease out the window and 3) the Qualified Intellectual Disabilities Professional (QIDP) was monitored and supervised to ensure the QIDP integrated, coordinated and monitored the clients' Individual Support Plans. The governing body failed to monitor the QIDP as evidenced by the QIDP failing to: a) conduct regular reviews of client #4 and #5's progress toward completing their program plans, b) ensure staff documented the implementation of client #1, #3, #4, #5 and #6's program plans, c) ensure client #4 and #5's privacy while each was engaged in personal care, d) client #2, #4 and #5's comprehensive functional assessments (CFA) were completed within 30 days after admission, e) prepare client #5's individual program plan (IPP) within 30 days after admission to the group home, f) ensure client #4 had a plan to address prolonged periods of time in the shower, client #4 had a plan for staff to assist him with flossing daily and</p>		<p>Repairs and cleaning will be completed. Staff and QIDP training will occur. Nursing staff will clarify medical supervision plan and train staff on implementation. QIDP will develop an active treatment schedule to reflect client's medical supervision plan and train all staff How corrective actions will be monitored to ensure no recurrence The QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>client #5 had a plan addressing respecting others' privacy while they were in the restroom, g) revise client #4's Individual Support Plan (ISP) to reflect the dentist's recommendations to brush his teeth three times a day and define the parameters of client #4's medical one on one supervision plan, h) ensure staff implemented client #4's risk plan for falls as written, i) develop an active treatment schedule for client #4 to participate in during the day program hours (8:00 AM to 4:00 PM), j) ensure client #4 had a plan to reduce the use of his psychotropic medications, k) ensure client #4 received recommended dental treatment in a timely manner, l) ensure client #5 had a plan to wear his glasses, m) ensure evacuation drills were held under varied conditions at the routine supervision level, and n) ensure clients #1, #2 and #3 were involved with preparing their eggs for breakfast.</p> <p>2) Please refer to W122. For 4 of 6 clients living in the group home (#1, #4, #5 and #6) and two additional former clients (#7 and #8), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse and ensure corrective actions were implemented to address medication/treatment errors. The</p>			

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W 0104 Bldg. 00	<p>facility failed to ensure client #4 and #5's privacy while each was engaged in personal care. The facility failed to ensure client #4 had a plan to address prolonged periods of time in the shower. The facility failed to ensure client #4's risk plan for falls was implemented as written.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the windows in the group home had screens, 2) the outside trim and siding of the kitchen window above the sink was cleaned after staff poured grease out the window and 3) the Qualified Intellectual Disabilities Professional (QIDP) was monitored and supervised to ensure the QIDP integrated,</p>	W 0104	<p>W104 GOVERNING BODY Corrective action for resident(s) found to have been affected New screens are in windows, windows have been cleaned. Entire house has been power washed. Staff will be trained on structural house maintenance. QIDP and staff will be trained on Individual Support Plans, including integration, coordination and monitoring the ISP to ensure client's needs are being met (including changes made by medical professionals) and goals</p>	05/05/2016			

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	coordinated and monitored the clients' Individual Support Plans. The governing body failed to monitor the QIDP as evidenced by the QIDP failing to: a) conduct regular reviews of client #4 and #5's progress toward completing their program plans, b) ensure staff documented the implementation of client #1, #3, #4, #5 and #6's program plans, c) ensure client #4 and #5's privacy while each was engaged in personal care, d) client #2, #4 and #5's comprehensive functional assessments (CFA) were completed within 30 days after admission, e) prepare client #5's individual program plan (IPP) within 30 days after admission to the group home, f) ensure client #4 had a plan to address prolonged periods of time in the shower, client #4 had a plan for staff to assist him with flossing daily and client #5 had a plan addressing respecting others' privacy while they were in the restroom, g) revise client #4's Individual Support Plan (ISP) to reflect the dentist's recommendations to brush his teeth three times a day and define the parameters of client #4's medical one on one supervision plan, h) ensure staff implemented client #4's risk plan for falls as written, i) develop an active treatment schedule for client #4 to participate in during the day program hours (8:00 AM to 4:00 PM), j) ensure client #4 had a plan to reduce the use of		are being tracked. QIDP will be trained on new client admission policy, including completing Comprehensive Functional Assessment(CFA) within 30 days of admission. QIDP and staff will be trained on policy and prevention of client to client abuse. QIDP and staff will be trained in client rights, with a focus on privacy. QIDP will be trained on corrective action following medication errors. Staff and QIDP will be trained on policies and procedures to follow risk plans. Moreover, staff will be re-trained on all client's risk plans. Nursing staff will define and clarify a medical one on one supervision plan for one client. Nursing staff will train all staff on this plan. QIDP and staff will be trained on active treatment programming. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Repairs and cleaning will be completed. Staff and QIDP training will occur. Nursing staff will clarify medical supervision plan and train staff on implementation. QIDP will develop an active treatment schedule to reflect client's medical supervision plan. How	

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	<p>his psychotropic medications, k) ensure client #4 received recommended dental treatment in a timely manner, l) ensure client #5 had a plan to wear his glasses, m) ensure evacuation drills were held under varied conditions at the routine supervision level, and n) ensure clients #1, #2 and #3 were involved with preparing their eggs for breakfast. The governing body failed to implement its policies and procedures to prevent client to client abuse, ensure corrective actions were implemented to address medication/treatment errors, ensure staff implemented client #4's risk plan for falls, ensure client #4's risk plan for falls indicated the parameters of his one on one supervision, and ensure client #4 had a plan to address his extended length of time in the shower. The governing body failed to ensure client #4 and #5's privacy while each was engaged in personal care.</p> <p>Findings include:</p> <p>1) On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the group home. During the observation, the kitchen window above the sink was open and there was no screen on the window. During the observation, there were two windows in the living room open with no screens in the windows. There were no screens in the open windows to keep</p>		<p>corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>insects, animals and debris from entering the group home. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated she asked maintenance to replace the screens in the windows at the group home. The QIDP indicated she was told by maintenance screens were not required for the windows. The QIDP indicated the group home needed to have screens on the windows.</p> <p>2) On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the group home. During the observation, the outside trim and siding below the kitchen window (above the kitchen sink) were discolored and stained. This area was visible from the sidewalk leading to the front door of the group home. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 3/28/16 at 4:23 PM, the Assistant Group Home Director (AGHD) indicated the stain on the kitchen window trim and siding below the window was from a staff pouring grease out of the window. The AGHD indicated the issue was addressed with the staff. The AGHD indicated the area needed to be cleaned.</p> <p>On 3/31/16 at 1:28 PM, the QIDP indicated the area below the kitchen</p>						

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	<p>window had previously been discolored and stained from staff dumping grease out of the window. The QIDP indicated the area was cleaned up by maintenance. The QIDP stated, "maybe someone was doing it again." The QIDP indicated the staff needed to stop pouring grease out of the window. The QIDP indicated the area needed to be cleaned.</p> <p>3) Please refer to W149. For 18 of 19 incident/investigative reports reviewed affecting clients #1, #4, #5, #6, former client #7 and former client #8, the facility neglected to implement its policies and procedures to prevent client to client abuse, ensure corrective actions were implemented to address medication/treatment errors and ensure staff implemented client #4's risk plan for falls, ensure client #4's risk plan for falls indicated the parameters of his one on one supervision, and ensure client #4 had a plan to address his extended length of time in the shower.</p> <p>4) Please refer to W157. For 5 of 19 incident reports reviewed affecting clients #1, #4, #5 and #6, the facility failed to implement appropriate corrective actions to address medication/treatment errors.</p> <p>5) Please refer to W159. The governing</p>						

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	body failed to monitor the QIDP to ensure: 1) regular reviews of client #4 and #5's progress toward completing their program plans were conducted, 2) staff documented the implementation of client #1, #3, #4, #5 and #6's program plans, 3) client #4 and #5's privacy while each was engaged in personal care, 4) client #2, #4 and #5's comprehensive functional assessments (CFA) were completed within 30 days after admission, 5) client #5's individual program plan (IPP) was prepared within 30 days after admission to the group home, 6) client #4 had a plan to address prolonged periods of time in the shower, client #4 had a plan for staff to assist him with flossing daily and client #5 had a plan addressing respecting others' privacy while they were in the restroom, 7) client #4's Individual Support Plan (ISP) was revised to reflect the dentist's recommendations to brush his teeth three times a day and define the parameters of client #4's medical one on one supervision plan, 8) staff implemented client #4's risk plan for falls as written, 9) an active treatment schedule for client #4 was developed to participate in activities during the day program hours (8:00 AM to 4:00 PM), 10) client #4 had a plan to reduce the use of his psychotropic medications, 11) client #4 received recommended dental treatment in a timely manner, 12) client			

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W 0122 Bldg. 00	<p>#5 had a plan to wear his glasses, 13) evacuation drills were held under varied conditions at the routine supervision level, and 14) clients #1, #2 and #3 were involved with preparing their eggs for breakfast.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review for 4 of 6 clients living in the group home (#1, #4, #5 and #6) and two additional former clients (#7 and #8), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse, ensure corrective actions were implemented to address medication/treatment errors, ensure staff implemented client #4's risk plan for falls, ensure client #4's risk plan for falls indicated the parameters of his one on one supervision, and ensure client #4 had a plan to address his extended length of time in the shower. The facility failed to ensure client #4 and #5's privacy while</p>	W 0122	<p>W 122 CLIENT PROTECTIONS(CONDITIONS) Corrective action for resident(s) found to have been affected QIDP and staff will be trained on policy and prevention of client to client abuse. QIDP and staff will be trained in client rights, with a focus on privacy. QIDP will be trained on corrective action following medication errors. Staff and QIDP will be trained on policies and procedures to follow risk plans. Moreover, staff will be re-trained on all client's risk plans. Nursing staff will define and clarify a medical one on one supervision plan for one client. Nursing staff will train all staff on this plan. QIDP and staff will be trained on active treatment programing. How facility will identify other</p>	05/05/2016

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	<p>each was engaged in personal care.</p> <p>Findings include:</p> <p>1) Please refer to W130. For 2 of 3 clients in the sample (#4 and #5), the facility failed to ensure the clients' privacy while each was engaged in personal care.</p> <p>2) Please refer to W149. For 18 of 19 incident/investigative reports reviewed affecting clients #1, #4, #5, #6, former client #7 and former client #8, the facility neglected to implement its policies and procedures to prevent client to client abuse, ensure corrective actions were implemented to address medication/treatment errors, ensure staff implemented client #4's risk plan for falls, ensure client #4's risk plan for falls indicated the parameters of his one on one supervision, and ensure client #4 had a plan to address his extended length of time in the shower.</p> <p>3) Please refer to W157. For 5 of 19 incident reports reviewed affecting clients #1, #4, #5 and #6, the facility failed to implement appropriate corrective actions to address medication/treatment errors.</p> <p>9-3-2(a)</p>		<p>residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff will be trained.</p> <p>How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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W 0130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 2 of 3 clients in the sample (#4 and #5), the facility failed to ensure the clients' privacy while each was engaged in personal care.</p> <p>Findings include:</p> <p>On 3/29/16 from 6:05 AM to 7:54 AM, an observation was conducted at the group home. At 6:51 AM, client #5 entered the bathroom where client #4 was taking a shower. Client #5 urinated in the toilet and left the restroom in under 1 minute. Staff #3 was sitting in a chair in the hallway leading to the restroom. Staff #3 did not intervene/prompt client #5 to use a different bathroom (there were three additional bathrooms at the group home, all on a different floor).</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients needed to have privacy during personal care.</p>	W 0130	<p>W130 PROTECTIONS OF CLIENTS RIGHTS Corrective action for resident(s) found to have been affected QIDP and staff will be trained on client rights, with a focus on privacy. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Training will be conducted.</p> <p>How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will</p>	05/05/2016

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W 0149 Bldg. 00	<p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 18 of 19 incident/investigative reports reviewed affecting clients #1, #4, #5, #6, former client #7 and former client #8, the facility neglected to implement its policies and procedures to prevent client to client abuse, ensure corrective actions were implemented to address medication/treatment errors and ensure staff implemented client #4's risk plan for falls, ensure client #4's risk plan for falls indicated the parameters of his one on one supervision, and ensure client #4 had a plan to address his extended length of time in the shower.</p> <p>Findings include:</p> <p>On 3/28/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 5/10/15 at 6:45 PM, former client #7 got upset when staff reminded him of</p>	W 0149	<p>provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p>W149 STAFF TREATMENT OF CLIENTS Corrective action for resident(s) found to have been affected QIDP and staff will be trained on Prevention of Abuse and Neglect and Client Rights, focusing on privacy How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff will be trained. How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training.</p>	05/05/2016

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	<p>portion sizes during dinner. Client #7 ripped up a sign in the group home. Client #1 got upset at client #7 and yelled at him. Client #1 kicked client #7's right leg. Client #7 punched client #1 three times on the back. The 5/11/15 Bureau of Developmental Disabilities Services incident report indicated, "The fight lasted less than 30 seconds, and neither staff could have predicted the incident was going to happen...." Neither client was injured.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>2) On 6/4/15 at 6:50 AM, former client #7 observed client #1 getting clothes from the laundry room. Client #7 informed staff client #1 took his shirt. Staff checked the shirt and it was client #1's size. Client #7 looked all around the area for his shirt. Client #7 attempted to take the shirt from client #1. Client #1 kicked client #7 on the buttocks. Client #7 hit client #1 on the back with an open palm. Neither client was injured.</p>		The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.				

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	<p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>3) On 7/10/15 at 1:00 PM at the facility-operated day program, client #1 insisted on helping staff with a peer's walker. Client #1's grabbed the peer's hand and would not let go. The peer reached out and pinched client #1. Client #1 hit the peer on the head two times with a Frisbee. Client #1 pinched the peer's right forearm. Neither client was injured.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>4) On 7/28/15 through 7/31/15 at 6:30 AM, the 8/3/15 BDDS report indicated, "...staff failed to transcribe medication orders properly resulting in incorrect administration of medication as ordered for [client #1]. Physician's order was to discontinue Atorvastatin 10 mg (milligrams) and Lisinopril 2.5 mg on 07/27/2015. However, these meds were</p>						

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	<p>passed after being discontinued. On 08/02/2015, this med error was discovered while switching out the MARs (Medication Administration Records) and MIS (Medication Information Sheets) for the month." The BDDS report indicated, "Staff will be disciplined as per Stone Belt's med error policy."</p> <p>There was no documentation the staff received disciplinary action as indicated in the BDDS report.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated the staff should have received disciplinary action as indicated.</p> <p>5) On 8/19/15 at 2:00 PM at the facility-operated day program, client #1 slapped a peer's face when the peer attempted to take his stuffed monkey.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>6) On 8/31/15 at 8:00 AM, client #1 asked client #5 to roll up the window due to being cold. Client #5 did not roll up the window. The staff rolled up the</p>			

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	<p>driver's side window. Client #1 asked client #5 to roll up his window. Clients #1 and #5 yelled at each other. Client #1 slapped client #5's right cheek. Client #5 punched client #1's face near his nose. Neither client was injured.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>7) On 10/2/15 at 2:20 PM at the facility-operated day program, client #5 was in the cafeteria with a peer. The peer grabbed client #5's face with both hands and kissed him on the mouth. Client #5 said, "Get away from me [name of peer]!" Client #5 attempted to hit the peer. The peer grabbed client #5's nipples through his shirt with both hands. Client #5 screamed.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>8) On 11/2/15 at 7:30 AM, former client #8 told client #1 he could not take a toy</p>			

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	<p>phone with him to the day program. Client #1 attempted to hit client #8. Client #8 slapped client #1's face. Neither client was injured.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>9) On 11/16/15 at 10:50 AM at the facility-operated day program, client #1 sat next to a peer who moved her arm close to client #1. Client #1 yelled at the peer to not touch him and client #1 hit the peer's forearm with his forearm. The peer was not injured.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>10) On 11/19/15 at 1:20 PM at the facility-operated day program, client #1 slapped a peer's right hand a couple of times while in a vehicle. Staff changed client #1's seating position. Client #1 slapped another peer with the back of his hand on the peer's face. The peer hit in</p>						

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	<p>the face had redness under his eyes and a shallow cut on the bridge of his nose. The other peer was not injured.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>11) On 11/20/15 at 4:05 PM at the facility-operated day program, client #6's peer alleged client #6 hit her on the arm. The incident was not witnessed and client #6's peer did not have injuries.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>12) On 12/29/15 at 11:54 AM at the facility-operated day program, client #1 stomped on a peer's foot without warning and stated, "Gotcha!" after stomping on the peer's foot. The peer was not injured.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated</p>						

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	<p>the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>13) On 1/5/16 at 8:00 AM, client #5 did not receive Chlorhexidine mouth wash. The 1/10/16 BDDS report indicated, "However, this mouth rinse was not given because staff didn't know it was stocked in the home. On 01/09/2016 while passing AM meds, this med error was found when staff discovered a note stating he did not receive his mouth wash. Pager notified; there was no adverse effect to [client #5] due to this med error. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>There was no documentation the staff was disciplined.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated the staff should have received disciplinary action as indicated.</p> <p>14) On 1/11/16 at 6:30 AM, staff discovered while passing medications to client #4 that he did not have any glucose test strips. Client #4's blood sugar was to be tested every morning. Client #4's blood sugar was not tested. The 1/12/16 BDDS report indicated, "Director SGL (Supervised Group Living) will insure that training will be conducted for House Manager and Day Aide (sic) to make</p>			

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	<p>certain supplies and medications are in the home."</p> <p>There was no documentation the Home Manager and Day Aid received training.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated the corrective actions indicated in the BDDS report should be implemented as written.</p> <p>15) On 2/3/16 at 7:00 AM, client #5 did not receive Flomax as ordered. The 2/4/16 BDDS report indicated, "The House Manager, [name], was told the orders by the nurse on 02/02/2016, and was instructed to copy them onto the Medication Administration Record (MAR). House Manager did not transcribe the orders into the MAR resulting in the error the following morning." The 2/4/16 Medication Error Report (MER) indicated in the Document Action Taken section, "Verbal discussion/training."</p> <p>There was no documentation the House Manager received training as indicated.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated the corrective actions indicated in the MER should be implemented as written.</p>						

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	<p>16) On 2/11/16 at 7:00 AM, the 2/12/16 BDDS report indicated, in part, "...staff failed to follow Risk Plan for [client #6]. Physician's order is for [client #6's] blood pressure to be taken three times a week: Monday, Thursday, and Saturday mornings; however staff did not take [client #6's] blood pressure... Staff will be disciplined as per Stone Belt's med error policy." The 2/12/16 MER was blank in the Document action taken section.</p> <p>There was no documentation the staff received disciplinary action as indicated in the BDDS report.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated the corrective actions indicated in the BDDS report should be implemented as written.</p> <p>17) a) On 3/12/16 at 10:00 AM, client #4 was taking a shower. Staff #6 heard someone faintly yelling from the downstairs bathroom. When staff #6 entered the downstairs bathroom, client #4 was side-lying halfway in and out of the shower with the door open and the water was running. Client #4 indicated he fell and could not get up. Staff #6 called staff #5 for assistance. Staff #5 and #6 assisted client #4 his feet. The 3/12/16 Stone Belt ARC, Inc. Incident</p>						

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	<p>Report indicated, "...[staff #5] assisted me (staff #6) in lifting and stabilizing [client #4] by holding him under his outstretched arms. We placed dry towels on the wet ground and lead (sic) [client #4] to the safety bar adjacent to the toilet and he grasped firmly while supporting his own weight free from staff assistance. [Staff #5] went upstairs to grab [client #4's] blood sugar kit as I started towards [client #4's] door to retrieve a Depend when I heard [client #4] begin to fall again. I turned and saw that he fell slowly. First, he fell back to the support of the wall and his knees then buckled and he slid onto his left hip then to his buttocks. When he finished moving he was in a seated position against the wall with knees bent, legs draped to his left side... We then examined [client #4] and found some redness and tenderness on his left side. He feet were also red. [Client #4's] fasting blood sugar was 114 and [client #4] responded to everything spoken and asked of him, but was unable to complete unless frequently prompted...."</p> <p>b) On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the group home. At 5:22 PM, client #4 indicated he needed to take a shower after he exited the restroom. Client #4 went downstairs and got into the shower. At</p>			

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	<p>5:52 PM, the Assistant Group Home Director (AGHD) indicated client #4 had been spending as much as two hours at a time in the shower. At 6:10 PM at the end of the observation, client #4 was still in the shower.</p> <p>On 3/29/16 from 6:05 AM to 7:54 AM, an observation was conducted at the group home. At 6:05 AM, client #4 was in the shower. At 6:51 AM, client #4 was still in the shower. Staff #3 stated to client #4, "Are you ready to come out?" At 7:00 AM, staff #3 came upstairs and indicated to the HM that client #4 was out of the shower and in his room getting dressed.</p> <p>On 3/29/16 at 6:11 AM, the Home Manager (HM) indicated client #4 took long showers. The HM indicated the staff at the group home was not monitoring client #4's showers until he had a fall in the shower (3/12/16). The HM indicated the staff was not aware he was taking long showers. The HM indicated client #4 typically just stands in the shower. The HM indicated the staff encourage client #4 to take faster showers. The HM indicated after client #4 was incontinent, the staff encourage client #4 to just wash his private areas. The HM stated client #4's morning shower was "always" the longest. The</p>			

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	<p>HM indicated client #4, at times, took 3-5 showers a day due to incontinence. The HM indicated the staff use a timer starting at 20 minutes and then 10 minute intervals after that to try to get client #4 to get out of the shower until he finished with his shower. The HM stated, "can't tell him to turn off the water."</p> <p>On 3/29/16 at 6:22 AM, staff #3 informed the HM that client #4 had been in the shower since 5:20 AM.</p> <p>On 3/29/16 at 6:22 AM, staff #3 indicated she started the timer at 20 minutes and then 10 minute intervals after that. Staff #3 indicated when the timer went off, she prompted client #4 to get out of the shower.</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. There was no documentation in client #4's record addressing his extended periods of time in the shower. There was no documentation addressing his showers in his 1/29/16 Individual Support Plan or his 12/11/15 Transitional Behavior Support Plan.</p> <p>On 3/31/16 at 4:27 PM, the AGHD indicated client #4 needed a written plan to address his extended periods of time in the shower.</p>						

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	<p>On 4/1/16 at 10:38 AM, the Behavior Clinician (BC) indicated client #4's interdisciplinary team (IDT) discussed the use of a timer to address client #4's extended showers. The BC indicated the IDT discussed waking client #4 up in the morning earlier as to not interfere with the other clients' routines. The BC indicated the staff was attempting different strategies, like the use of a timer, but there was no plan addressing his extended showers. The BC indicated client #4 needed a plan to address showering.</p> <p>c) On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the group home. At 5:12 PM, client #4 exited the living room holding his buttocks as he entered the half bathroom adjacent to the front door of the group home. At 5:22 PM, client #4 exited the restroom and called out for staff #6. Staff #6 did not respond. Client #4 indicated, to no one in particular, he needed to take a shower. At 5:23 PM, client #4 started to go downstairs to the basement to take a shower. The surveyor informed the Assistant Group Home Director (AGHD) client #4 was going down the stairs to the basement without staff assistance. The AGHD went to assist client #4 down the stairs. At 6:05</p>			

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	<p>PM, staff #6 came upstairs while client #4 was in the shower. Staff #6 entered the kitchen briefly and then went to the office area of the group home. At 6:10 PM, staff #6 returned downstairs to a chair in the hallway with an electronic device while client #4 was still in the shower. During client #4's shower, staff #6 was located in the hallway of the basement. The bathroom was located several feet away. The basement bathroom was separated from the hallway by the laundry room. Staff #6 was not in a location to be able to provide stand by assistance while client #4 was in the shower.</p> <p>On 3/29/16 from 6:05 AM to 7:54 AM, an observation was conducted at the group home. At 6:05 AM, client #4 was in the shower in the basement. At 6:22 AM, staff #3 informed the Home Manager client #4 had been in the shower since 5:20 AM. Staff #3 was in the hallway in the basement on the outside of the laundry room. At 6:51 AM, client #4 was in the shower. Staff #3 was in the basement hallway. At 7:00 AM, staff #3 entered the kitchen area of the group home and indicated client #4 was in his room getting dressed.</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client</p>			

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	#4's 3/25/16 Nursing Consultation indicated, "This writer (nurse) attended IDT (interdisciplinary team) meeting regarding client to discuss current medical concerns and how these concerns effect services provided at this time. This writer, and writer's supervisor, [Nurse Manager], recommend one on one for this client at this time based on current medical condition, and risk for injury from fall, etc. IDT in agreeance at this time. Client set to see PCP (primary care physician) on 3/30/16. This writer will be accompanying client to that appt (appointment) and presenting the rapid decline and possibility that client may need skilled care for a period of time until his condition is stabilized." Client #4's 3/16/16 risk plan for falls indicated, in part, "Client has trouble with visual depth perception and a diagnosis of diabetes. In 2003 client had a fall secondary to hypoglycemia (low blood sugar) resulting in fracture. Client has a history of two falls in the last few years without injury due to trouble with depth perception. Client fell on 3/12/16 in the shower. He was found lying on the floor. Staff assisted him to a standing position and client slid down to the floor again. Xrays (sic) were taken on 3/14/16 and no evidence of fracture was found... Staff must provide stand by assist during showers. [Client #4] is not safe to			

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	<p>shower alone...."</p> <p>Client #4's risk plan did not define stand by assist in the plan. Client #4's plan did not indicate the parameters/responsibilities of the staff when client #4 was taking a shower. Client #4's plan did not address whether or not client #4 required staff's assistance when using the stairs to the basement where his bedroom and bathroom were located. The plan did not indicate the level of supervision client #4 required when not taking a shower (line of sight supervision or within arm's length). There was no documentation in client #4's record of the IDT meeting on 3/25/16 referred to by the nurse in her Nursing Consultation note.</p> <p>On 3/31/16 at 1:15 PM, the RN indicated the IDT discussed staff being with him at all times due to his medical issues. The RN indicated the IDT was concerned about him falling. The RN indicated client #4 needed to be supervised at all times. The RN indicated the group home administration indicated they would provide client #4 a one on one (1:1) when possible (when there was sufficient staff to do so). The RN stated, 'he needs 1:1 staff.' The RN indicated client #4's plan needed to indicate the level of supervision client #4 required.</p>			

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	<p>On 3/31/16 at 1:27 PM, the QIDP indicated nursing services decided client #4 needed one on one staffing due to the risk of injury during a fall. The QIDP indicated there was no specific written instructions to staff indicating his supervision level. The QIDP indicated at the group home, client #4 was receiving 15 minute checks from 4:00 PM to 8:00 AM and one on one staffing from 8:00 AM to 4:00 PM. The QIDP indicated client #4 should have a staff with him at all times when he was in the shower.</p> <p>d) On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the group home. At 5:12 PM, client #4 exited the living room holding his buttocks as he entered the half bathroom adjacent to the front door of the group home. At 5:22 PM, client #4 exited the restroom and called out for staff #6. Staff #6 did not respond. Client #4 indicated, to no one in particular, he needed to take a shower. At 5:23 PM, client #4 started to go downstairs to the basement to take a shower. The surveyor informed the Assistant Group Home Director (AGHD) client #4 was going down the stairs to the basement without staff assistance. The AGHD went to assist client #4 down the stairs. At 6:05 PM, staff #6 came upstairs while client</p>						

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	<p>#4 was in the shower. Staff #6 entered the kitchen briefly and then went to the office area of the group home. At 6:10 PM, staff #6 returned downstairs to a chair in the hallway with an electronic device while client #4 was still in the shower. During client #4's shower, staff #6 was located in the hallway of the basement. The bathroom was located several feet away. The basement bathroom was separated from the hallway by the laundry room. Staff #6 was not in a location to be able to provide stand by assistance while client #4 was in the shower.</p> <p>On 3/29/16 from 6:05 AM to 7:54 AM, an observation was conducted at the group home. At 6:05 AM, client #4 was in the shower in the basement. At 6:22 AM, staff #3 informed the Home Manager client #4 had been in the shower since 5:20 AM. Staff #3 was in the hallway in the basement on the outside of the laundry room. At 6:51 AM, client #4 was in the shower. Staff #3 was in the basement hallway. At 7:00 AM, staff #3 entered the kitchen area of the group home and indicated client #4 was in his room getting dressed. Staff #3 was not in a location to be able to provide stand by assistance while client #4 was in the shower.</p>			

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	<p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4's 3/16/16 risk plan for falls indicated, in part, "Client has trouble with visual depth perception and a diagnosis of diabetes. In 2003 client had a fall secondary to hypoglycemia (low blood sugar) resulting in fracture. Client has a history of two falls in the last few years without injury due to trouble with depth perception. Client fell on 3/12/16 in the shower. He was found lying on the floor. Staff assisted him to a standing position and client slid down to the floor again. Xrays (sic) were taken on 3/14/16 and no evidence of fracture was found... Staff must provide stand by assist during showers. [Client #4] is not safe to shower alone...."</p> <p>On 3/31/16 at 1:15 PM, the Registered Nurse (RN) indicated client #4's risk plan for falls should be implemented as written. The RN indicated the staff needed to be right outside the shower door. The RN indicated client #4 should not be left in the shower by himself. The RN indicated the staff should not be sitting in a chair in the hallway. The RN stated, "the staff should know to not leave him in the shower."</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional</p>			

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	<p>(QIDP) indicated the staff should be standing by the shower door. The QIDP indicated the staff sitting in a chair in the hallway did not meet the stand by assist portion of his risk plan. The QIDP indicated the risk plan should be implemented as written. The QIDP stated client #4 "should always have a staff with him in the shower."</p> <p>On 4/1/16 at 10:38 AM, the Behavior Clinician (BC) indicated the risk plan for falls indicated the staff should be close enough to client #4 in order to assist him. The BC indicated staff sitting in a chair in the hallway two rooms away was not stand by assistance.</p> <p>18) On 3/22/16 at 4:10 PM while in the group home van, client #1 pushed client #6 causing client #6's head to make contact with the window. Client #6 had a red mark on the right side of his face in between his eye and ear.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure in place prohibiting abuse of the clients.</p> <p>On 3/28/16 at 3:12 PM, a review of the facility's policy titled, Incident</p>			

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W 0157 Bldg. 00	<p>Investigation/Review Protocol, dated 5/14/13, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law...."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate</p>				

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	<p>corrective action must be taken.</p> <p>Based on record review and interview for 5 of 19 incident reports reviewed affecting clients #1, #4, #5 and #6, the facility failed to implement appropriate corrective actions to address medication/treatment errors.</p> <p>Findings include:</p> <p>On 3/28/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 7/28/15 through 7/31/15 at 6:30 AM, the 8/3/15 BDDS report indicated, "...staff failed to transcribe medication orders properly resulting in incorrect administration of medication as ordered for [client #1]. Physician's order was to discontinue Atorvastatin 10 mg (milligrams) and Lisinopril 2.5 mg on 07/27/2015. However, these meds were passed after being discontinued. On 08/02/2015, this med error was discovered while switching out the MARs (Medication Administration Records) and MIS (Medication Information Sheets) for the month." The BDDS report indicated, "Staff will be disciplined as per Stone Belt's med error policy."</p>	W 0157	<p>W157 STAFF TREATMENT OF CLIENTS Corrective action for resident(s) found to have been affected QIDP and staff will be trained on medication administration policy and procedure, including policy and procedure and implementation of corrective actions for medication errors. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff training. How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	05/05/2016			

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	<p>There was no documentation the staff received disciplinary action as indicated in the BDDS report.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff should have received disciplinary action as indicated.</p> <p>2) On 1/5/16 at 8:00 AM, client #5 did not receive Chlorhexidine mouth wash. The 1/10/16 BDDS report indicated, "However, this mouth rinse was not given because staff didn't know it was stocked in the home. On 01/09/2016 while passing AM meds, this med error was found when staff discovered a note stating he did not receive his mouth wash. Pager notified; there was no adverse effect to [client #5] due to this med error. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>There was no documentation the staff was disciplined.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated the staff should have received disciplinary action as indicated.</p> <p>3) On 1/11/16 at 6:30 AM, staff discovered while passing medications to client #4 that he did not have any glucose test strips. Client #4's blood sugar was to</p>			

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	<p>be tested every morning. Client #4's blood sugar was not tested. The 1/12/16 BDDS report indicated, "Director SGL (Supervised Group Living) will insure that training will be conducted for House Manager and Day Aide (sic) to make certain supplies and medications are in the home."</p> <p>There was no documentation the Home Manager and Day Aid received training.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated the corrective actions indicated in the BDDS report should be implemented as written.</p> <p>4) On 2/3/16 at 7:00 AM, client #5 did not receive Flomax as ordered. The 2/4/16 BDDS report indicated, "The House Manager, [name], was told the orders by the nurse on 02/02/2016, and was instructed to copy them onto the Medication Administration Record (MAR). House Manager did not transcribe the orders into the MAR resulting in the error the following morning." The 2/4/16 Medication Error Report (MER) indicated in the Document Action Taken section, "Verbal discussion/training."</p> <p>There was no documentation the House Manager received training as indicated.</p>			

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	<p>On 3/31/16 at 1:27 PM, the QIDP indicated the corrective actions indicated in the MER should be implemented as written.</p> <p>5) On 2/11/16 at 7:00 AM, the 2/12/16 BDDS report indicated, in part, "...staff failed to follow Risk Plan for [client #6]. Physician's order is for [client #6's] blood pressure to be taken three times a week: Monday, Thursday, and Saturday mornings; however staff did not take [client #6's] blood pressure... Staff will be disciplined as per Stone Belt's med error policy." The 2/12/16 MER was blank in the Document action taken section.</p> <p>There was no documentation the staff received disciplinary action as indicated in the BDDS report.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated the corrective actions indicated in the BDDS report should be implemented as written.</p> <p>9-3-2(a)</p>			

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W 0159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' individual program plans. The QIDP failed to: 1) conduct regular reviews of client #4 and #5's progress toward completing their program plans, 2) ensure staff documented the implementation of client #1, #3, #4, #5 and #6's program plans, 3) ensure client #4 and #5's privacy while each was engaged in personal care, 4) client #2, #4 and #5's comprehensive functional assessments (CFA) were completed within 30 days after admission, 5) prepare client #5's individual program plan (IPP) within 30 days after admission to the group home, 6) ensure client #4 had a plan to address prolonged periods of time in the shower, client #4 had a plan for staff to assist him with flossing daily and client #5 had a plan addressing respecting others' privacy while they were in the restroom, 7) revise client #4's Individual Support Plan (ISP) to reflect the dentist's recommendations to brush	W 0159	W159 QIDP Corrective action for resident(s) found to have been affected QIDP job description will be reviewed. QIDP will be trained on developing Individual Support Plans, including integration, coordination and monitoring the ISP to ensure client's needs are being met (including changes made by medical professionals) and goals are being tracked. QIDP will be trained on new client admission policy, including completing Comprehensive Functional Assessment (CFA) within 30 days of admission. QIDP and staff will be trained on policy and prevention of client to client abuse. QIDP and staff will be trained in client rights, with a focus on privacy. QIDP will be trained on corrective action following medication errors. Staff and QIDP will be trained on policies and procedures to follow risk plans. Moreover, staff will be re-trained on all client's risk plans. Nursing staff will define and clarify a medical one on one supervision plan for one client. Nursing staff will train all staff on this plan. QIDP and staff will be trained on active treatment programing. How facility will	05/05/2016
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	<p>his teeth three times a day and define the parameters of client #4's medical one on one supervision plan, 8) ensure staff implemented client #4's risk plan for falls as written, 9) develop an active treatment schedule for client #4 to participate in during the day program hours (8:00 AM to 4:00 PM), 10) ensure client #4 had a plan to reduce the use of his psychotropic medications, 11) ensure client #4 received recommended dental treatment in a timely manner, 12) ensure client #5 had a plan to wear his glasses, 13) ensure evacuation drills were held under varied conditions at the routine supervision level, and 14) ensure clients #1, #2 and #3 were involved with preparing their eggs for breakfast.</p> <p>Findings include:</p> <p>1) On 3/31/16 at 2:18 PM, a focused review of client #1's record was conducted. Client #1's Individual Support Plans (ISP) were dated 2/3/14 and 2/29/16 for the past 12 months. There was no documentation in client #1's record of monthly or quarterly reviews of his training objectives since January 2015.</p> <p>On 3/31/16 at 2:18 PM, a focused review of client #3's record was conducted. Client #3's ISP was dated 7/12/13. There</p>		<p>identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP will be trained and monitored by Director to follow through with all aspects of job. Monitoring will occur during the oversight meeting. How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>was no documentation in client #3's record of monthly or quarterly reviews of his training objectives since January 2015.</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4 was admitted to the group home on 12/30/15. There was no documentation the QIDP reviewed client #4's progress toward meeting his 1/29/16 Individual Support Plan (ISP) training objectives. There was no documentation in client #4's record of training objectives being implemented.</p> <p>On 3/31/16 at 10:55 AM, a review of client #5's record was conducted. Client #5 was admitted to the group home on 8/17/15 (he transferred to the group home from another Stone Belt group home). There was no documentation the QIDP reviewed client #5's progress toward meeting his 7/9/15 Individual Support Plan (ISP) training objectives. There was no documentation in client #5's record of training objectives being implemented. The most recent quarterly review was conducted on 7/5/15 covering client #5's training objectives in April, May and June 2015 while client #5 was living in another group home. There was no documentation the QIDP reviewed, revised, updated or deleted client #5's</p>			

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	<p>program plans since his admission to the group home on 8/17/15. A 1/15/16 SGL (Supervised Group Living) Quarterly Review Form did not include documentation in the monthly, quarterly average, achieved and continue or update sections of the form. The form was blank.</p> <p>On 3/31/16 at 2:15 PM, a focused review of client #6's record was conducted. Client #6's ISP was dated 5/14/15. There was no documentation in client #6's record of monthly or quarterly reviews of his training objectives since January 2015.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated she did not have documentation the clients' training objectives were implemented. The QIDP indicated the previous coordinator indicated he did not know where the documentation was located and could not locate it. The QIDP indicated this affected clients #1, #3 and #6. The QIDP indicated she did not have documentation of regular reviews of client #4 and #5's program plans. The QIDP indicated the clients' training objectives should be reviewed quarterly.</p> <p>2) On 3/31/16 at 2:18 PM, a focused review of client #1's record was</p>			

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	<p>conducted. There was no documentation in client #1's record of staff documenting the implementation of his programs plans since March 2015. Client #1's ISP were dated 2/3/14 and 2/29/16 for the past 12 months.</p> <p>On 3/31/16 at 2:18 PM, a focused review of client #3's record was conducted. Client #3's ISP was dated 7/12/13. There was no documentation in client #3's record of staff documenting the implementation of his programs plans since March 2015.</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4 was admitted to the group home on 12/30/15. There was no documentation client #4's 1/29/16 ISP was implemented. There was no documentation in his record of the staff implementing his goals and objectives.</p> <p>On 3/31/16 at 10:55 AM, a review of client #5's record was conducted. Client #5 was admitted to the group home on 8/17/15. There was no documentation client #5's 7/9/15 ISP was implemented. There was no documentation in his record of the staff implementing his goals and objectives.</p> <p>On 3/31/16 at 2:15 PM, a focused review</p>						

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	<p>of client #6's record was conducted. Client #6's ISP was dated 5/14/15. There was no documentation in client #6's record of staff documenting the implementation of his programs plans since March 2015.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated she did not have documentation the clients' training objectives were implemented. The QIDP indicated the clients' program plans should be implemented and documented.</p> <p>3) Please refer to W130. For 2 of 3 clients in the sample (#4 and #5), the QIDP failed to ensure the clients' privacy while each was engaged in personal care.</p> <p>4) Please refer to W210. For 3 of 3 clients in the sample (#2, #4 and #5) who were admitted to the group home since March 2015, the QIDP failed to ensure the clients' comprehensive functional assessments (CFA) were completed within 30 days after admission.</p> <p>5) Please refer to W226. For 1 of 3 clients in the sample (#5) who was admitted to the group home on 8/17/15, the QIDP failed to prepare an individual program plan (IPP) within 30 days after admission to the group home.</p>						

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	<p>6) Please refer to W227. For 2 of 3 clients in the sample (#4 and #5), the QIDP failed to ensure: 1) client #4 had a plan to address prolonged periods of time in the shower, 2) client #4 had a plan for staff to assist him with flossing daily and 3) client #5 had a plan addressing respecting others' privacy while they were in the restroom.</p> <p>7) Please refer to W240. For 1 of 3 clients in the sample (#4), the QIDP failed to describe relevant interventions to support the client toward independence by failing to: 1) revise client #4's Individual Support Plan (ISP) to reflect the dentist's recommendations to brush his teeth three times a day and 2) define the parameters of client #4's medical one on one supervision plan.</p> <p>8) Please refer to W249. For 1 of 3 clients in the sample (#4), the QIDP failed to ensure staff implemented client #4's risk plan for falls as written.</p> <p>9) Please refer to W250. For 1 of 1 client in the sample (#4) who did not attend the facility-operated day program, the QIDP failed to develop an active treatment schedule for client #4 to participate in during the day program hours (8:00 AM to 4:00 PM).</p>			

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	<p>10) Please refer to W312. For 1 of 1 client (#4) in the sample with psychotropic medications, the QIDP failed to ensure his program plan included a plan to reduce the use of his psychotropic medications.</p> <p>11) Please refer to W356. For 1 of 3 clients in the sample (#4), the QIDP failed to ensure client #4 received recommended dental treatment in a timely manner.</p> <p>12) Please refer to W436. For 1 of 3 clients in the sample with adaptive equipment (#5), the QIDP failed to ensure client #5 had a plan to wear his glasses.</p> <p>13) Please refer to W441. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to ensure evacuation drills were held under varied conditions at the routine supervision level.</p> <p>14) Please refer to W488. For 1 of 3 clients in the sample (#2) and 2 additional clients (#1 and #3), the QIDP failed to ensure the clients were involved with preparing their eggs for breakfast.</p> <p>9-3-3(a)</p>			

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W 0210 Bldg. 00	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 3 of 3 clients in the sample (#2, #4 and #5) who were admitted to the group home since March 2015, the facility failed to ensure the clients' comprehensive functional assessments (CFA) were completed within 30 days after admission.</p> <p>Findings include:</p> <p>On 3/31/16 at 12:17 PM, a review of client #2's record was conducted. Client #2 was admitted to the facility on 2/25/16. There was no documentation in client #2's record indicating a CFA was completed since his admission to the group home.</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4 was admitted to the group home on 12/30/15. There was no documentation in client #4's record indicating a CFA was completed since his admission to the group home.</p>	W 0210	<p>W210 INDIVIDUAL PROGRAM PLAN Corrective action for resident(s) found to have been affected QIDP will be trained on new client admission policy, including completing Comprehensive Functional Assessment(CFA) within 30 days of admission. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP will be trained and monitored by Director. How corrective actions will be monitored to ensure no recurrence The QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will</p>	05/05/2016

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W 0226	<p>On 3/31/16 at 10:55 AM, a review of client #5's record was conducted. Client #5 was admitted to the group home on 8/17/15 from another Stone Belt group home. There was no documentation in client #5's record indicating his CFA was reviewed or revised since his admission to the group home. Client #5's 9/18/15 SGL (Supervised Group Living) Support Team notes indicated, in part, "Coordinator completing Program Assessment (CFA)." There was no documentation in client #5's record the Coordinator completed a new (or reviewed and revised) client #5's CFA since his admission to the group home.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (called Coordinator) indicated client #5's CFA should have been reviewed and revised since his admission to the group home. The Coordinator indicated client #2 and #4's CFAs were completed however the CFA was not in their electronic records for review. The Coordinator did not provide client #2 and #4's CFAs for review during the survey.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p>		provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.				

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Bldg. 00	<p>Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 1 of 3 clients in the sample (#5) who was admitted to the group home on 8/17/15, the facility failed to prepare an individual program plan (IPP) within 30 days after admission to the group home.</p> <p>Findings include:</p> <p>On 3/31/16 at 10:55 AM, a review of client #5's record was conducted. Client #5 was admitted to the group home on 8/17/15 from another Stone Belt group home. There was no documentation in client #5's record indicating his IPP was reviewed or revised since his admission to the group home. Client #5's 9/18/15 SGL (Supervised Group Living) Support Team notes indicated, in part, "Coordinator revisiting [client #5's] IHPs (individual habilitation plan - IPP)." There was no documentation in client #5's record the Coordinator completed a new (or reviewed and revised) client #5's IPP since his admission to the group home.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (called Coordinator) indicated client #5's IPP should have been re-done as</p>	W 0226	<p>W226 INDIVIDUAL PROGRAM PLAN Corrective action for resident(s) found to have been affected QIDP will be trained on policy and procedure about developing and implementing an Individual Program Plan(IPP) Director will monitor client records to ensure documentation is timely and accurate. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP will be trained and monitored. How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	05/05/2016
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W 0227 Bldg. 00	<p>indicated by the previous Coordinator in the SGL Support Team notes.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 2 of 3 clients in the sample (#4 and #5), the facility failed to ensure: 1) client #4 had a plan to address prolonged periods of time in the shower, 2) client #4 had a plan for staff to assist him with flossing daily and 3) client #5 had a plan addressing respecting others' privacy while they were in the restroom.</p> <p>Findings include:</p> <p>1) On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the group home. At 5:22 PM, client #4 indicated he needed to take a shower after he exited the restroom. Client #4 went downstairs and got into the shower. At 5:52 PM, the Assistant Group Home Director (AGHD) indicated client #4 had been spending as much as two hours at a time in the shower. At 6:10 PM at the</p>	W 0227	<p>W227 INDIVIDUAL PROGRAM PLAN Corrective action for resident(s) found to have been affected QIDP will be trained on policy and procedure about developing and implementing an Individual Program Plan(IPP) Director will monitor client records to ensure documentation is timely and accurate. Moreover, QIDP will implement specific objectives in the IPP to meet client needs. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP will be trained and monitored for quality and implementation of goals. How corrective actions will be monitored to ensure no recurrenceThe QIDP is</p>	05/05/2016	

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	<p>end of the observation, client #4 was still in the shower.</p> <p>On 3/29/16 from 6:05 AM to 7:54 AM, an observation was conducted at the group home. At 6:05 AM, client #4 was in the shower. At 6:51 AM, client #4 was still in the shower. Staff #3 stated to client #4, "Are you ready to come out?" At 7:00 AM, staff #3 came upstairs and indicated to the HM that client #4 was out of the shower and in his room getting dressed.</p> <p>On 3/29/16 at 6:11 AM, the Home Manager (HM) indicated client #4 took long showers. The HM indicated the staff at the group home was not monitoring client #4's showers until he had a fall in the shower (3/12/16). The HM indicated the staff was not aware he was taking long showers. The HM indicated client #4 typically just stands in the shower. The HM indicated the staff encourage client #4 to take faster showers. The HM indicated after client #4 was incontinent, the staff encourage client #4 to just wash his private areas. The HM stated client #4's morning shower was "always" the longest. The HM indicated client #4, at times, took 3-5 showers a day due to incontinence. The HM indicated the staff use a timer starting at 20 minutes and then 10 minute</p>		<p>supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>intervals after that to try to get client #4 to get out of the shower until he finished with his shower. The HM stated, "can't tell him to turn off the water."</p> <p>On 3/29/16 at 6:22 AM, staff #3 informed the HM that client #4 had been in the shower since 5:20 AM.</p> <p>On 3/29/16 at 6:22 AM, staff #3 indicated she started the timer at 20 minutes and then 10 minute intervals after that. Staff #3 indicated when the timer went off, she prompted client #4 to get out of the shower.</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. There was no documentation in client #4's record addressing his extended periods of time in the shower. There was no documentation addressing his showers in his 1/29/16 Individual Support Plan or his 12/11/15 Transitional Behavior Support Plan.</p> <p>On 3/31/16 at 4:27 PM, the AGHD indicated client #4 needed a written plan to address his extended periods of time in the shower.</p> <p>On 4/1/16 at 10:38 AM, the Behavior Clinician (BC) indicated client #4's interdisciplinary team (IDT) discussed</p>			

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	<p>the use of a timer to address client #4's extended showers. The BC indicated the IDT discussed waking client #4 up in the morning earlier as to not interfere with the other clients' routines. The BC indicated the staff was attempting different strategies, like the use of a timer, but there was no plan addressing his extended showers. The BC indicated client #4 needed a plan to address showering.</p> <p>2) On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4's 2/10/16 Stone Belt Outside Services Report (Dental) indicated, in part, "6 month dental check up/Stone Belt intake visit." The dental report indicated, "Are there any decayed teeth? Yes... Is there evidence of improper brushing? Yes... Please list future treatments (if needed): Patient has multiple areas of decay. 4, 15, (and) 14 will need RCT (root canal treatment) to save teeth. #9 also has decay (and) #22... Additional Comments: Please help patient to use flossers...."</p> <p>There was no documentation in client #4's record indicating client #4 had a plan for staff to assist him to floss his teeth.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408		
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	<p>(QIDP) indicated client #4 did not have a plan for staff to assist him with flossing his teeth. The QIDP indicated client #4 needed a plan.</p> <p>3) On 3/29/16 from 6:05 AM to 7:54 AM, an observation was conducted at the group home. At 6:51 AM, client #5 entered the bathroom where client #4 was taking a shower. Staff #3 was sitting in a chair in the hallway leading to the restroom. Staff #3 did not intervene/prompt client #5 to use a different bathroom (there were three additional bathrooms at the group home, all on a different floor).</p> <p>On 3/31/16 at 10:55 AM, a review of client #5's record was conducted. There was no documentation of a plan in his 7/9/15 Individual Support Plan and Behavior Support Plan addressing giving others' privacy while they used the bathroom.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated this was an on-going issue with client #5. The QIDP indicated client #5 needed to have a plan to address respecting others' privacy when they were in the bathroom.</p> <p>9-3-4(a)</p>				

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W 0240 Bldg. 00	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#4), the facility failed to describe relevant interventions to support the client toward independence by failing to:</p> <p>1) revise client #4's Individual Support Plan (ISP) to reflect the dentist's recommendations to brush his teeth three times a day and 2) define the parameters of client #4's medical one on one supervision plan.</p> <p>Findings include:</p> <p>1) On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4's 2/10/16 Stone Belt Outside Services Report (Dental) indicated, in part, "6 month dental check up/Stone Belt intake visit." The dental report indicated, "Are there any decayed teeth? Yes... Is there evidence of improper brushing? Yes... Please list future treatments (if needed): Patient has multiple areas of decay. 4, 15, (and) 14 will need RCT (root canal treatment) to save teeth. #9 also has decay (and) #22... The back of the Outside Services Report indicated, "We</p>	W 0240	<p>W 240 INDIVIDUAL PROGRAM PLAN Corrective action for resident(s) found to have been affected QIDP will be trained on policy and procedure about developing and implementing an Individual Program Plan(IPP) Director will monitor client records to ensure documentation is timely and accurate. Moreover, QIDP will implement specific objectives in the IPP to meet client needs, including medical supervision plan. Nursing staff will train QIDP and staff on client's medical supervision plan, risk plans.</p> <p>How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP will be trained and monitored for quality, implementation of goals and integration of doctor's orders and active treatment schedule for a client with high medical needs. QIDP and staff will be trained on risk plans and medical supervision plan. How corrective actions will be monitored to ensure no</p>	05/05/2016

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	<p>are recommending 4, 14 (and) 15 have RCT with BU (build up) & (and) crowns to save teeth. He has deep decay. #9 has an existing crown with decay around margins. He needs a new crown. These services are not covered by his dental insurance. Please check if he has help available to save teeth. If not 4, 14 (and) 15 will need to be extracted." The Outside Services Report indicated, "He also needs to brush 3x (three times) per day."</p> <p>Client #4's 1/29/16 ISP indicated he had a program plan to practice his oral hygiene by brushing his teeth twice daily. Client #4's ISP was not updated or revised to reflect the 2/10/16 dental recommendations to brush his teeth three times a day.</p> <p>On 3/31/16 at 1:15 PM, the Registered Nurse (RN) indicated client #4's ISP should have been updated to reflect the dental recommendations.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4's ISP should have been updated to reflect the dental recommendations.</p> <p>2) On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the</p>		<p>recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>group home. At 5:12 PM, client #4 exited the living room holding his buttocks as he entered the half bathroom adjacent to the front door of the group home. At 5:22 PM, client #4 exited the restroom and called out for staff #6. Staff #6 did not respond. Client #4 indicated, to no one in particular, he needed to take a shower. At 5:23 PM, client #4 started to go downstairs to the basement to take a shower. The surveyor informed the Assistant Group Home Director (AGHD) client #4 was going down the stairs to the basement without staff assistance. The AGHD went to assist client #4 down the stairs. At 6:05 PM, staff #6 came upstairs while client #4 was in the shower. Staff #6 entered the kitchen briefly and then went to the office area of the group home. At 6:10 PM, staff #6 returned downstairs to a chair in the hallway with an electronic device while client #4 was still in the shower. During client #4's shower, staff #6 was located in the hallway of the basement. The bathroom was located several feet away. The basement bathroom was separated from the hallway by the laundry room. Staff #6 was not in a location to be able to provide stand by assistance while client #4 was in the shower.</p> <p>On 3/29/16 from 6:05 AM to 7:54 AM,</p>			

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	<p>an observation was conducted at the group home. At 6:05 AM, client #4 was in the shower in the basement. At 6:22 AM, staff #3 informed the Home Manager client #4 had been in the shower since 5:20 AM. Staff #3 was in the hallway in the basement on the outside of the laundry room. At 6:51 AM, client #4 was in the shower. Staff #3 was in the basement hallway. At 7:00 AM, staff #3 entered the kitchen area of the group home and indicated client #4 was in his room getting dressed.</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4's 3/25/16 Nursing Consultation indicated, "This writer (nurse) attended IDT (interdisciplinary team) meeting regarding client to discuss current medical concerns and how these concerns effect services provided at this time. This writer, and writer's supervisor, [Nurse Manager], recommend one on one for this client at this time based on current medical condition, and risk for injury from fall, etc. IDT in agreeance at this time. Client set to see PCP (primary care physician) on 3/30/16. This writer will be accompanying client to that appt (appointment) and presenting the rapid decline and possibility that client may need skilled care for a period of time until his condition is stabilized." Client</p>			

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	<p>#4's 3/16/16 risk plan for falls indicated, in part, "Client has trouble with visual depth perception and a diagnosis of diabetes. In 2003 client had a fall secondary to hypoglycemia (low blood sugar) resulting in fracture. Client has a history of two falls in the last few years without injury due to trouble with depth perception. Client fell on 3/12/16 in the shower. He was found lying on the floor. Staff assisted him to a standing position and client slid down to the floor again. Xrays (sic) were taken on 3/14/16 and no evidence of fracture was found... Staff must provide stand by assist during showers. [Client #4] is not safe to shower alone...."</p> <p>Client #4's risk plan did not define stand by assist in the plan. Client #4's plan did not indicate the parameters/responsibilities of the staff when client #4 was taking a shower. Client #4's plan did not address whether or not client #4 required staff's assistance when using the stairs to the basement where his bedroom and bathroom were located. The plan did not indicate the level of supervision client #4 required when not taking a shower (line of sight supervision or within arm's length). There was no documentation in client #4's record of the IDT meeting on 3/25/16 referred to by the nurse in her</p>			

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	<p>Nursing Consultation note.</p> <p>On 3/31/16 at 1:15 PM, the RN indicated the IDT discussed staff being with him at all times due to his medical issues. The RN indicated the IDT was concerned about him falling. The RN indicated client #4 needed to be supervised at all times. The RN indicated the group home administration indicated they would provide client #4 a one on one (1:1) when possible (when there was sufficient staff to do so). The RN stated, "he needs 1:1 staff." The RN indicated client #4's plan needed to indicate the level of supervision client #4 required.</p> <p>On 3/31/16 at 1:27 PM, the QIDP indicated nursing services decided client #4 needed one on one staffing due to the risk of injury during a fall. The QIDP indicated there were no specific written instructions to staff indicating his supervision level. The QIDP indicated at the group home, client #4 was receiving 15 minute checks from 4:00 PM to 8:00 AM and one on one staffing from 8:00 AM to 4:00 PM. The QIDP indicated client #4 should have a staff with him at all times when he was in the shower.</p> <p>9-3-4(a)</p>			
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W 0249 Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure staff implemented client #4's risk plan for falls as written.</p> <p>Findings include:</p> <p>On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the group home. At 5:12 PM, client #4 exited the living room holding his buttocks as he entered the half bathroom adjacent to the front door of the group home. At 5:22 PM, client #4 exited the restroom and called out for staff #6. Staff #6 did not respond. Client #4 indicated, to no one in particular, he needed to take a shower. At 5:23 PM, client #4 started to go downstairs to the basement to take a shower. The surveyor informed the Assistant Group Home Director (AGHD) client #4 was going down the stairs to the basement without staff assistance. The AGHD went to assist client #4 down the</p>	W 0249	<p>W249 PROGRAM IMPLEMENTATION Corrective action for resident(s) found to have been affected QIDP will be trained on risk plans. QIDP will implement specific objectives in the IPP to meet client needs, including medical supervision plan. Nursing staff will train QIDP and staff on client's medical supervision plan, risk plans. QIDP will review client formal and informal goals with staff and monitor for implementation.</p> <p>How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP will be trained and monitored for quality, implementation of goals and integration of doctor's orders and active treatment schedule for a client with high medical needs. QIDP and staff will be trained on risk plans and medical supervision plan. QIDP and</p>	05/05/2016	

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	<p>stairs. At 6:05 PM, staff #6 came upstairs while client #4 was in the shower. Staff #6 entered the kitchen briefly and then went to the office area of the group home. At 6:10 PM, staff #6 returned downstairs to a chair in the hallway with an electronic device while client #4 was still in the shower. During client #4's shower, staff #6 was located in the hallway of the basement. The bathroom was located several feet away. The basement bathroom was separated from the hallway by the laundry room. Staff #6 was not in a location to be able to provide stand by assistance while client #4 was in the shower.</p> <p>On 3/29/16 from 6:05 AM to 7:54 AM, an observation was conducted at the group home. At 6:05 AM, client #4 was in the shower in the basement. At 6:22 AM, staff #3 informed the Home Manager client #4 had been in the shower since 5:20 AM. Staff #3 was in the hallway in the basement on the outside of the laundry room. At 6:51 AM, client #4 was in the shower. Staff #3 was in the basement hallway. At 7:00 AM, staff #3 entered the kitchen area of the group home and indicated client #4 was in his room getting dressed. Staff #3 was not in a location to be able to provide stand by assistance while client #4 was in the shower.</p>		<p>director(or designee) will monitor staff in the home and/or day services for implementation of client goals 4 day a week. QIDP will review all goals with staff</p> <p>How corrective actions will be monitored to ensure no recurrence The QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4's 3/16/16 risk plan for falls indicated, in part, "Client has trouble with visual depth perception and a diagnosis of diabetes. In 2003 client had a fall secondary to hypoglycemia (low blood sugar) resulting in fracture. Client has a history of two falls in the last few years without injury due to trouble with depth perception. Client fell on 3/12/16 in the shower. He was found lying on the floor. Staff assisted him to a standing position and client slid down to the floor again. Xrays (sic) were taken on 3/14/16 and no evidence of fracture was found... Staff must provide stand by assist during showers. [Client #4] is not safe to shower alone...."</p> <p>On 3/31/16 at 1:15 PM, the Registered Nurse (RN) indicated client #4's risk plan for falls should be implemented as written. The RN indicated the staff needed to be right outside the shower door. The RN indicated client #4 should not be left in the shower by himself. The RN indicated the staff should not be sitting in a chair in the hallway. The RN stated, "the staff should know to not leave him in the shower."</p> <p>On 3/31/16 at 1:27 PM, the Qualified</p>				

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W 0250 Bldg. 00	<p>Intellectual Disabilities Professional (QIDP) indicated the staff should be standing by the shower door. The QIDP indicated the staff sitting in a chair in the hallway did not meet the stand by assist portion of his risk plan. The QIDP indicated the risk plan should be implemented as written. The QIDP stated client #4 "should always have a staff with him in the shower."</p> <p>On 4/1/16 at 10:38 AM, the Behavior Clinician (BC) indicated the risk plan for falls indicated the staff should be close enough to client #4 in order to assist him. The BC indicated staff sitting in a chair in the hallway two rooms away was not stand by assistance.</p> <p>9-3-4(a)</p> <p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on observation, record review and interview for 1 of 1 client in the sample (#4) who did not attend the facility-operated day program, the facility failed to develop an active treatment schedule for client #4 to participate in</p>	W 0250	<p>W250 PROGRAM IMPLEMENTATION Corrective action for resident(s) found to have been affected QIDP and staff will be trained on active treatment, including active treatment schedules based on</p>	05/05/2016			

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	<p>during the day program hours (8:00 AM to 4:00 PM).</p> <p>Findings include:</p> <p>On 3/28/16 at 11:38 AM, the Group Home Director (GHD) indicated client #4, who was new to the group home, was having on-going medical issues. The GHD indicated there was an emergency meeting regarding client #4 on 3/25/16 where it was determined client #4 was going to stay at home Monday through Friday, 8:00 AM to 4:00 PM, during the day program hours due to his medical needs. The GHD indicated client #4 would receive 1:1 (one on one) staffing during these hours.</p> <p>On 3/28/16 from 1:50 PM to 2:38 PM, an observation was conducted at the facility-operated day program. Client #4 was not present at the day program or the workshop on 3/28/16.</p> <p>On 3/28/16 at 4:51 PM, staff #6 indicated client #4 was at the group home with him all day due to on-going medical issues. Staff #6 indicated client #4 slept all day. Staff #6 indicated as soon as client #4 woke up, he was incontinent of bowel and bladder. Staff #6 indicated client #4's health had declined since moving into the group home a few months ago.</p>		<p>individual goals and needs from ISP. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP will develop an active treatment schedule, based on each client's ISP. Director will monitor for quality and relevance.</p> <p>How corrective actions will be monitored to ensure no recurrence The QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>Staff #6 indicated there was no active treatment schedule in place to implement.</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4's record did not include documentation of an active treatment schedule. There was no documentation in client #4's record indicating his schedule changed from attending the facility-operated day program Monday through Friday, 8:00 AM to 4:00 PM.</p> <p>On 3/31/16 at 1:25 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she had not developed an active treatment schedule for client #4. The QIDP indicated she was informed on 3/30/16 client #4 was going to have a medical one on one staff at the group home until at least 5/11/16. The QIDP indicated client #4 was not attending the facility-operated day program due to medical concerns, mainly related to falls. The QIDP indicated she needed to develop an active treatment schedule for client #4.</p> <p>On 3/31/16 at 2:47 PM, the QIDP provided the surveyor with an undated active treatment schedule. The active treatment schedule indicated the schedule was for another group home as evidenced by the other group home's name,</p>			

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W 0268 Bldg. 00	<p>"[Another group home's name] Weekly Active Treatment Schedule." The active treatment schedule provided by the QIDP indicated client #4 attended the facility operated day program Monday through Friday from 8:00 AM to 4:00 PM. There was no active treatment schedule provided specifically for client #4 indicating what activities he was going to engage in Monday through Friday, 8:00 AM to 4:00 PM.</p> <p>On 4/1/16 at 10:38 AM, the Behavior Clinician (BC) indicated she did not know what an active treatment schedule looked like. The BC indicated client #4 needed a schedule. The BC indicated client #4 needed to be engaged in activities during the day when he did not attend the facility-operated day program.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4's dignity when a staff informed another staff in front of client #3 that client #4 ""s---" in the</p>	W 0268	W268 CONDUCT TOWARD CLIENT Corrective action for resident(s) found to have been affected QIDP and staff will be trained on prevention of abuse, neglect and exploitation. How	05/05/2016

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	<p>shower.</p> <p>Findings include:</p> <p>On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the group home. At 6:05 AM while client #4 was taking a shower, staff #6 entered the kitchen area where staff #2 and client #3 were located. Staff #6 informed staff #2 that client #4 "s---" in the shower. Client #3 was in the dining room adjacent to the kitchen and could hear the statement staff #6 made in regards to client #4.</p> <p>On 4/1/16 at 10:38 AM, the Behavior Clinician (BC) indicated staff #6 should not have worded his statement in that manner, especially in front of another client. When asked if the statement was a dignity issue, the BC stated, "I can definitely interpret it that way."</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated, "it's a dignity issue." The QIDP indicated the staff involved needed to be retrained on abuse, neglect and exploitation.</p> <p>9-3-5(a)</p>		<p>facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP, Director or designee will monitor staff while working with clients in the house by actively visiting the home three times per calendar week. How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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W 0312 Bldg. 00	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 1 client (#4) in the sample with psychotropic medications, the facility failed to ensure his program plan included a plan to reduce the use of his psychotropic medications.</p> <p>Findings include:</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4's 3/23/16 Physician's Orders indicated he was prescribed two psychotropic medications for bipolar disorder (Abilify and Depakote). Client #4's 12/11/15 Transitional Behavior Support Plan (BSP) did not include a medication reduction plan for the psychotropic medications. There was no documentation of a medication reduction plan in client #4's record.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4 was prescribed Abilify and Depakote as psychotropic medications. The QIDP</p>	W 0312	<p>W312 DRUG USAGE</p> <p>Corrective action for resident(s) found to have been affected Behavior Clinicians, as part of the individual client's support team will implement a drug reduction plan to the existing behavior plan. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Behavior clinician will change client's BSP to reflect a drug reduction plan that is obtainable. How corrective actions will be monitored to ensure no recurrence The QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training.</p>	05/05/2016

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	<p>indicated client #4 had a plan to reduce his psychotropic medications. The QIDP indicated she was not sure where the plan was located and was unable to provide a copy to the surveyor during the survey.</p> <p>On 3/31/16 at 1:15 PM, the Registered Nurse (RN) indicated client #4 was prescribed Abilify and Depakote as psychotropic medications. The RN indicated she was unsure if there was a plan to reduce client #4's psychotropic medications.</p> <p>On 4/1/16 at 10:33 AM, the Behavior Clinician (BC) indicated client #4 was prescribed two psychotropic medications (Abilify and Depakote) for bipolar disorder. The BC indicated client #4's transitional BSP did not include a medication reduction plan for his psychotropic medications. The BC indicated she completed a new BSP which included a medication reduction plan however the plan had not been approved by client #4's guardian and the Human Rights Committee. The BC indicated the new BSP had not been implemented.</p> <p>9-3-5(a)</p>		The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey. Support team meetings occur once a month and behavior clinicians attend these meetings QIDP will monitor drug reduction plans as part of this meeting	

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W 0356 Bldg. 00	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4 received recommended dental treatment in a timely manner.</p> <p>Findings include:</p> <p>On 3/31/16 at 11:29 AM, a review of client #4's record was conducted. Client #4's 2/10/16 Stone Belt Outside Services Report (Dental) indicated, in part, "6 month dental check up/Stone Belt intake visit." The dental report indicated, "Are there any decayed teeth? Yes... Is there evidence of improper brushing? Yes... Please list future treatments (if needed): Patient has multiple areas of decay. 4, 15, & (and) 14 will need RCT (root canal treatment) to save teeth. #9 also has decay & #22... The back of the Outside Services Report indicated, "We are recommending 4, 14 & 15 have RCT with BU (build up) & crowns to save teeth. He has deep decay. #9 has an existing crown with decay around margins. He needs a new crown. These services are not covered by his dental</p>	W 0356	<p>W356 COMPREHENSIVE DENTAL TREATMENT Corrective action for resident(s) found to have been affected QIDP and staff will be trained on ensuring proper medical/dental treatment is sought for all clients, including follow up and follow through with doctor/dentist recommendations. Client with significant dental issues, will obtain dental treatment. Guardian has requested a second opinion and that dentist appointment is scheduled for May 5, 2016 at Southern Indiana Smiles. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Director and QIDP will communicate with doctors and guardians immediately when there are medical recommendations for our clients. Moreover, recommendations will be followed in a timely manner. How corrective actions will be monitored to ensure no recurrenceThe QIDP is</p>	05/05/2016

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	<p>insurance. Please check if he has help available to save teeth. If not 4, 14 & 15 will need to be extracted."</p> <p>A 3/8/16 Nursing Consultation note indicated, "This writer contacted client's guardian via email and presented the options again regarding client's recommended dental procedures, and requested a decision as it has been more than a month since he has seen the dentist. Client's insurance does not cover recommended procedures, and the cost is rather expensive. Guardian does not want to use client's ARC trust as it will nearly deplete his funds. Guardian stated she would like to speak with the dental provider to weigh the pros and cons of each offered procedure (root canals/crowns vs. (versus) extractions). Following the email communication with guardian, this writer received email correspondence from guardian's lawyer, who suggests deviation of liability. Writer supplied lawyer with financial coordinator's contact info (information) as well as the dental provider's info and explained that writer was not equipped to answer questions regarding finances. No decision of dental care has been reached at this time."</p> <p>On 3/31/16 at 1:15 PM, the Registered Nurse (RN) indicated the recommended</p>		<p>supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>dental care had not been completed as of this date. The RN indicated the recommended treatment was \$7000.00. The RN indicated client #4's insurance would not cover the expense. The RN indicated client #4's guardian had not made a decision whether or not to use client #4's ARC trust money to cover the dental expenses. The RN indicated client #4's insurance would cover extractions but not root canals or crowns. The RN indicated the facility was going to get a second opinion from another dentist regarding client #4's dental recommendations and procedures needed. The RN indicated the appointment to obtain a second opinion, to her knowledge, had not been scheduled.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4's guardian had not made a decision regarding the dental work client #4's dentist recommended. The QIDP indicated the cost was almost \$7000.00. The QIDP indicated client #4's guardian was trying to figure out what she could pay for. The QIDP stated the facility's Chief Financial Officer requested a second opinion for a "cheaper option." The QIDP indicated the appointment for a second opinion was scheduled on 5/5/16.</p>			

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W 0365 Bldg. 00	<p>9-3-6(a)</p> <p>483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation, record review and interview for 1 of 1 medication administered to client #1 during the evening observation, the facility failed to ensure staff did not initial client #1's Medication Administration Record (MAR) prior to client #1 ingesting the medication.</p> <p>Findings include:</p> <p>On 3/28/16 from 4:23 PM to 6:10 PM, an observation was conducted at the group home. At 5:01 PM, client #1 received Fenofibrate (cholesterol) from staff #6. Prior to client #1 taking the medication, staff #6 initialed client #1's March 2016 MAR indicating client #1 had taken his medication.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional indicated the staff should initial the MAR after the client takes the medication.</p> <p>On 3/31/16 at 1:15 PM, the Registered Nurse indicated the staff should initial</p>	W 0365	<p>W365 DRUG REGIMEN REVIEW Corrective action for resident(s) found to have been affected QIDP and staff will be trained in medication administration and monitored for compliance. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP, Director, nurse or designee will monitor staff for compliance after any medication error. Staff that make a key medication error will be supervised and have to show compliance before continuing to perform medication administration unsupervised. How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or</p>	05/05/2016			

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W 0436 Bldg. 00	<p>the MAR after the client takes the medication.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 3 clients in the sample with adaptive equipment (#5), the facility failed to ensure client #5 had a plan to wear his glasses.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated day program for client #5 on 3/28/16 from 1:50 PM to 2:38 PM. Observations were conducted at the group home on 3/28/16 from 4:23 PM to 6:10 PM and 3/29/16 from 6:05 AM to 7:54 AM. During the observations, client #5 was not wearing glasses. During the observations, client #5 was not provided his glasses. During the observations, client #5 was not encouraged to wear his</p>	W 0436	<p>designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p>W436 SPACE AND EQUIPMENT Corrective action for resident(s) found to have been affected QIDP will be trained on client use and implementation of goals for adaptive equipment. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP will create goals for each client that uses adaptive equipment and train staff accordingly. How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for</p>	05/05/2016

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	<p>glasses.</p> <p>On 3/31/16 at 10:55 AM, a review of client #5's record was conducted. On 11/20/14, client #5 had a vision appointment. The 11/20/14 Stone Belt Outside Services Report (Vision) indicated, in part, "Myopia - needs new glasses." The 8/4/15 Stone Belt Outside Services Report (Vision) indicated, in part, "New glasses fitting/adjustment." Client #5's 7/9/15 Individual Support Plan did not include a program plan to increase his use of his glasses. There was no documentation in client #5's record indicating he was taught the benefits of wearing his glasses.</p> <p>On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she did not know client #5 had glasses. The QIDP indicated she had never seen client #5 wear glasses. The QIDP indicated client #5 needed a plan to wear his glasses.</p> <p>On 3/31/16 at 1:15 PM, the Registered Nurse (RN) indicated she had never seen client #5 wear glasses. The RN indicated client #5 should have a plan to increase his use of his glasses.</p> <p>9-3-7(a)</p>		<p>an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>				

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W 0441 Bldg. 00	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills under varied conditions.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure evacuation drills were held under varied conditions at the routine supervision level.</p> <p>Findings include:</p> <p>On 3/28/16 at 1:17 PM, a review of the facility's evacuation drills was conducted. From March 28, 2015 to March 28, 2016, the facility conducted 7 evacuation drills during the night shift (10:00 PM to 6:00 AM). All of the drills were conducted between 10:01 PM and 10:42 PM. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>The following evacuation drills were conducted with two staff present (4 of 7 evacuation drills from March 28, 2015 to March 28, 2016 were conducted with two staff):</p> <p>-3/28/15 at 10:38 PM -6/28/16 at 10:01 PM -9/3/15 at 10:30 PM -9/27/15 at 10:05 PM</p> <p>On 3/31/16 at 1:27 PM, the Qualified</p>	W 0441	<p>W441 EVACUATION DRILLS</p> <p>Corrective action for resident(s) found to have been affected QIDP will be trained on evacuation policy and procedure. QIDP will implement plan for house staff to hold evacuation drills during various times on various shifts and train staff on plan How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP will be trained. Evacuation drill plan will be implemented and staff will be trained. How corrective actions will be monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training.</p>	05/05/2016

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W 0488 Bldg. 00	<p>Intellectual Disabilities Professional (QIDP) indicated the facility should vary the times evacuation drills were conducted during the night shift. The QIDP indicated during the night shift (10:00 PM to 6:00 AM), one staff was scheduled to work. The QIDP indicated the night shift evacuation drills should be conducted with one staff.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 1 of 3 clients in the sample (#2) and 2 additional clients (#1 and #3), the facility failed to ensure the clients were involved with preparing their eggs for breakfast.</p> <p>Findings include: On 3/29/16 from 6:05 AM to 7:54 AM, an observation was conducted at the group home. At 6:42 AM, client #1 indicated to the Home Manager (HM) he wanted scrambled eggs for breakfast. The HM began to prepare scrambled eggs for client #1. The HM got out the eggs,</p>	W 0488	<p>The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p>W488 DINING AREAS AND SERVICE Corrective action for resident(s) found to have been affected QIDP and staff will be trained on active treatment, including clients being involved in the operation of their household, including meal preparation. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff training will be conducted. How corrective actions will be</p>	05/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408
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	<p>milk, cheese and bowl to prepare the eggs. At 6:47 AM, the HM asked client #3 if he wanted scrambled eggs. Client #3 indicated he wanted eggs, too. The HM indicated to client #3 he would make another egg. At 6:48 AM, client #1 sat down at the dining room table to eat his cereal while the HM made his eggs. Client #3 carried a cup of milk to the table and then went down to his bedroom while the HM made his eggs. At 6:53 AM, the HM continued to make eggs without the clients being involved. Client #1 was eating cereal and client #3 was walking around the group home. At 6:55 AM when client #6 walked into the kitchen, the HM asked client #6 if he wanted breakfast. The HM stated, "I'm making scrambled eggs." Client #6 declined to eat breakfast. At 6:57 AM, the HM took a plate with client #1's eggs and cheese to him at the table. Client #1 asked the HM for catsup. The HM got the catsup out of the refrigerator and poured it onto client #1's eggs. At 7:04 AM when client #2 entered the kitchen, the HM told him he could eat the rest of the eggs. Client #2 ate the rest of the eggs without being involved with preparing the eggs.</p> <p>Clients #1, #2 and #3 were not involved with preparing their eggs for breakfast.</p>		<p>monitored to ensure no recurrenceThe QIDP is supervised by the SGL Director, they will meet weekly for an oversight meeting to ensure that all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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	On 3/31/16 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients should be involved with preparing their breakfast. 9-3-8(a)				