STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G220		05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	4700 HITE DR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a Post Certification Revisit to the full recertification and state licensure survey completed on 4/5/16. Survey Dates: May 18, 19 and 20, 2016 Facility Number: 000744 Provider Number: 15G220 AIM Number: 100234860 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/25/16.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview 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 failed to exercise operating direction over the facility by failing to ensure the clients received their medications as ordered by	W 0102	**W102** Governing Body and Management-CONDITION **Corrective action for resident(s) found to have been affected** House manager was terminated. Experienced house manager from another Stone Belt site is assigned to Hite House to ensure house staff are following policy and procedure to keep clients safe. New procedure for	06/19/2016

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

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

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	their physicians and there was an accurate process of counting medication errors in order to implement the facility's progressive disciplinary procedures. Findings include: 1) Please refer to W104. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the clients received their medications as ordered by their physicians and there was an accurate process of counting medication errors in order to implement the facility's progressive disciplinary procedures. 2) Please refer to W122. For 9 of 19 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #6, the facility's governing body failed to meet the Condition of Participation: Client Protections. The facility's governing body neglected to implement its policies and procedures to prevent neglect of client #2, client to client abuse involving client #1, recurring medication errors and implement recommended corrective actions from investigations. This deficiency was cited on 4/5/16. The facility failed to implement a systemic		transporting clients will be implemented to ensure all clients are accounted for before leaving any location. Staff will be trained in Prevention of Abuse and Neglect(ANE) of clients. Moreover, staff will be trained in timely reporting for ANE, medication errors and behavior tracking. Medication administration procedure will be reviewed with staff and expectations will be detailed. Day Aide will be responsible for transcribing and communicating all medication changes for clients. Day Aide will be responsible for checking medication DAILY to ensure all discontinued medications are sent in for medication destruction. Day Aide will be responsible for checking medication documentation DAILY for accuracy and for staff signatures, indicating proper medication administration. House manager and QIDP are responsible for 3 times weekly monitoring of medication administration accuracy. Nursing staff are responsible for full review of house medication, documentation and administration at least once weekly. Stone Belt Medication administration error policy will be reviewed with QIDP staff and implemented. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address	

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	plan of correction to prevent recurrence. 9-3-1(a)		the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** House Manager was terminated and an experienced house manager from another site is coming into Hite House to implement Stone Belt policy and procedure. New house manager, along with existing QIDP and Associate Director, will support existing staff to follow all policies and procedures, specifically medication administration, including proper discipline for medication errors, Prevention of Abuse Neglect and exploitation, including client to client abuse. Staff training and monitoring will occur. **How corrective actions will be monitored to ensure no recurrence** Director will ensure policies and procedures are being followed and clients are being supported appropriately by meeting with house manager, QIDP and associate director, weekly. During this meeting, all incidents will be discussed and follow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients. Medication errors will be discussed and discipline defined as per Stone Belt policy.	
W 0104	483.410(a)(1)			

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Bldg. 00	GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. 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's governing body failed to exercise operating direction over the facility by failing to ensure the clients received their medications as ordered by their physicians and there was an accurate process of counting medication errors in order to implement the facility's progressive disciplinary procedures. Findings include: On 5/18/16 at 1:55 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 4/21/16 at 11:15 AM, client #2 did not receive Gas X tab as ordered prior to his colonoscopy. The 4/22/16 BDDS report indicated, "On 04/21/2016 at 11:15 AM, staff did not administered (sic) medication to [client #2]. Physician's order is for [client #2] to be administered Gas X tab with 2 oz (ounces) water before leaving the house for his colonoscopy. However, this was not passed. This med error was found when coordinator identified that it was not	W 0104	**W104 Governing Body Corrective action for resident(s) found to have been affected** Medication administration procedure will be reviewed with staff and expectations will be detailed. Day Aide will be responsible for transcribing and communicating all medication changes for clients. Day Aide will be responsible for checking medication DAILY to ensure all discontinued medications are sent in for medication destruction.Day Aide will be responsible for checking medication documentation DAILY for accuracy and for staff signatures, indicating proper medication administration. House manager and QIDP are responsible for 3 times weekly monitoring of medication administration accuracy. Nursing staff are responsible for full review of house medication, documentation and administration at least once weekly. Stone Belt Medication administration error policy will be reviewed with QIDP staff and implemented. **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**	06/19/2016

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	passed later in the day. Pager was notified. There was no effect to [client #2] or the colonoscopy due to this med error." Staff #5 committed the error. 2) On 4/15/16 at 8:00 PM, client #4 did not receive Aripiprazole (behavior) 10mg (milligrams) and two Depakote Sprinkles (behavior) 125mg tablets. The 4/16/16 BDDS report indicated, in part, "The morning staff found the error and notified the pager on the morning of the 16th." Staff #1 and #4 committed the errors. Although two medication errors were committed by each staff, the facility counted the medication error as one error. 3) On 4/11/16 at 7:15 AM, staff failed to implement client #6's physician's orders. The 4/12/16 BDDS report indicated, in part, "On 04/11/2016 at 7:15 AM, staff failed to follow risk plan for [client #6]. Physician's order is for [client #6] to have his blood pressure taken on Monday, Thursday, and Saturday; however, blood pressure was not taken or recorded. On 04/12/2016, this med error was discovered by [name of group home] coordinator while passing AM meds and Nurse was notified. There was no adverse effect to [client #6] due to this med error." The Home Manager committed the error.		**put in place to ensure no recurrence** House Manager was terminated and an experienced house manager from another site is coming into Hite House toimplement Stone Belt policy and procedure. New house manager, along with existing QIDP and Associate Director, will support existing staff to follow all policies and procedures, specifically medication administration, including proper discipline for medication errors. Staff training and monitoring will occur. **How corrective actions willbe monitored to ensure no recurrence** Director will ensure policies and procedures are being followed and clients are being supported appropriately by meeting with house manager, QIDP and associate director, weekly. During this meeting, all incidents will be discussed andfollow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients. Medication errors will be discussed and discipline defined as per Stone Belt policy.	

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	4) On 4/2/16 through 4/11/16 at 7:00 AM, client #4 received Calcium 600 milligrams (mg). The physician discontinued Calcium on 3/30/16. The 4/12/16 BDDS report indicated, "On 04/02/2016 through 04/11/2016 at 7:00 AM, [name of group home] AM (morning) staff failed to properly transcribed (sic) medication orders for [client #4] resulting in incorrect administration of medication as ordered. Physician's order discontinued the administration of Calcium + Vit. (vitamin) D (600mg; 400 IU) on 03/30/2016; however, staff continued to pass this medication. On 04/12/2016, this med error was discovered by [name of group home] coordinator and nurse was notified. There was no adverse effect to [client #4] due to this med error." -The 4/12/16 Medication Error Report (MER) indicated on 4/2/16 and 4/9/16, staff #3 committed the error. The facility correctly counted the amount of errors as two. -The 4/12/16 MER indicated on 4/3/16 and 4/10/16, staff #4 committed the errors. The facility correctly counted the amount of errors as two. -The 4/12/16 MER indicated on 4/4/16 to 4/8/16 and 4/11/16, the Home Manager committed the errors. The facility counted the number of errors as two. The			

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	facility should have counted the number as 6 medication errors for the Home Manager. On 5/19/16 at 2:57 PM, the Group Home Director (GHD) indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered. On 5/19/16 at 2:04 PM, the GHD indicated the Home Manager did not ensure the medication was discontinued on the Medication Administration Record (MAR) and did not remove the medication from the home. The GHD stated, "no one did anything after the doctor discontinued the medication." The GHD stated the Home Manager "was neglectful." On 5/19/16 at 2:10 PM, the Registered Nurse (RN) indicated the staff did not write the medication as being discontinued on the MAR. The RN indicated the medication was discontinued on 3/30/16 however no one made changes to the MAR. The RN indicated she updated client #4's Medication Information Sheet (MIS) and			

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	sent the sheet and an email to the group home staff on 3/30/16. The RN indicated none of the staff printed off the MIS or updated the MAR to reflect the doctor's orders. The RN indicated she took client #4 to the appointment and communicated the information to the group home staff. On 5/19/16 at 2:19 PM, the RN forwarded the email she sent to the staff at client #4's group home. The email indicated, in part, "...These lab results also revealed his calcium level is too high. [Name of doctor] is also stopping his calcium/vit d supplement at this time... I have attached [client #4's] updated MIS. I have printed a copy of this to put in his appt binder already, and I'll put his appt binder in the [name of group home] Log Bag. The medication changes will need to be added to April MARs. Just to review those are: ...Stop Calcium/Vit D...." 5) On 4/4/16 at 2:00 PM, staff #3 administered client #4's Ferrous Sulfate 325 mg at the wrong time. The 4/4/16 Medication Error Report (MER) indicated, "Staff failed to follow med administration procedure resulting in med being passed at wrong time. Staff failed to check MIS and MAR... No effects noted." On 5/19/16 at 2:57 PM, the GHD indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or			

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	caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered. On 5/20/16 at 9:05 AM, the RN indicated she was not sure how the facility was counting medication errors for each staff when there were multiple errors in one Medication Error Report. The RN indicated the Nurse Manager received the information regarding the number of medication errors from the Information Technology (IT) department. The RN indicated the list included everyone who committed med error for a rolling calendar year. The RN indicated she was not sure who counted the errors or determined the number of medication errors included in one report. The RN indicated each medication error should be counted separately even if listed in the same report. On 5/20/16 at 9:25 AM, the GHD stated she was "confused" about how the facility was counting medication errors. The GHD indicated the IT department created spreadsheets and counted the staff who committed medication errors. The GHD indicated she remembered discussing the Medication Error Reports and being told to group errors on one report, but the meaning was to put the errors on one form, not count the errors as one. The GHD indicated each error should be counted individually even if there were multiple errors in one report. On 5/20/16 at 9:34 AM, the Nurse Manager (NM) stated the facility was counting multiple errors listed in one report as one error and this was "incorrect." The NM indicated each medication error should be counted individually even when there were multiple errors in one report. The NM indicated the staff should administer the clients'			

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	medications according to the physician's orders. On 5/19/16 at 2:03 PM, a review of the facility's 12/17/12 Medication Error Procedure defined a medication error as "failure to administer any medication as directed by a Physician." The policy indicated, in part, "Performance Improvement Plan for Key Medication Errors: 1st Error: 1. Verbal coaching/discussion/review will be given by the immediate supervisor. 2. Supervisor will provide staff retraining in the 6 Rights of Medication Administration. 3. Supervisor will review the Stone Belt Policy for Medication Pass with staff. 2nd Error: 1. A Performance Review will be given by the immediate supervisor. 2. Three Medication Pass observations will be done and documented by the supervisor with documentation via email sent to the nurse before passing meds without supervision. 3rd Error: 1. A written warning will be given by the immediate supervisor. 2. Staff will be required to complete and pass Medication Administration Retraining as soon as possible. 3. Med Pass privileges are suspended until retraining is completed. 4. Three Medication Pass observations will be done and documented by the supervisor with documentation returned to the nurse before passing meds without supervision. 4th Error (or critical error): 1. Immediate suspension of med pass privileges. 2. Immediate termination, or a. Staff will be required to again complete and pass Medication Administration Retraining as soon as possible. b. Six Medication Pass observations will be done and documented by the supervisor with documentation returned to the nurse before passing meds without supervision. c. One additional Medication Error within the next six months following retraining will result in immediate termination... Disciplinary action for Key Medication Errors will be on a rolling 12 month basis...." This			

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	affected clients #1, #2, #3, #4, #5 and #6. On 5/20/16 at 9:47 AM, a review of a weekly email with employees who had committed three or more medication errors in the past 12 months was sent to the surveyor by the Nurse Manager. The email indicated the following staff working at client #1, #2, #3, #4, #5 and #6's group home had committed three or more medication errors: -The Home Manager's count indicated he had committed 4 medication errors. -Staff #1's count indicated he had committed 4 medication errors. -Staff #3's count indicated he had committed 3 medication errors. -Staff #4's count indicated he had committed 3 medication errors. On 5/20/16 at 9:03 AM, a review of Med Error forms for each staff indicated the staff committed the following total of medication errors in the past 12 months: -The Home Manager had 10 medication errors. -Staff #1 had 8 medication errors. -Staff #3 had 5 medication errors. -Staff #4 had 4 medication errors. On 5/20/16 at 11:07 AM, the Human Resources Director (HRD) indicated each medication error should be counted individually. The HRD indicated the former GHD changed the way the facility counted medication errors. The former GHD changed the system for counting medication errors by counting all medication errors in one report as one error. The HRD indicated she was not in favor of the change and neither was the IT Director. The HRD indicated the facility's system of counting medication errors needed to be changed. Each medication error should be counted individually and not count the errors in one report as one error. The HRD indicated the			

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	facility's Medication Error Procedure should be implemented as written to address medication errors with the staff. This deficiency was cited on 4/5/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 9 of 19 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #6, the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policies and procedures to prevent neglect of client #2, client to client abuse involving client #1, recurring medication errors and implement recommended corrective actions from investigations. Findings include: 1) Please refer to W149. For 9 of 19 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #6, the facility neglected to implement its policies and procedures to prevent neglect of client #2, client to client abuse	W 0122	**W122 Client Protections-CONDITION Corrective action for resident(s) found to have been affected** House manager was terminated.Experienced house manager from another Stone Belt site is assigned to Hite House to ensure house staff are following policy and procedure to keep clients safe. New procedure for transporting clients will be implemented to ensure all clients are accounted for before leaving any location. Staff will be trained in Prevention of Abuse and Neglect(ANE) of clients. Moreover, staff will be trained in timely reporting for ANE, medication errors and behavior tracking. Medication administration procedure will be reviewed with staff and expectations will be detailed. Day Aide will be responsible for transcribing and communicating	06/19/2016

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	involving client #1, recurring medication errors and implement recommended corrective actions from investigations. 2) Please refer to W157. For 2 of 19 incident/investigative reports reviewed affecting clients #1, #3 and #4, the facility failed to ensure recommended corrective actions from investigations were implemented as written. This deficiency was cited on 4/5/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)		all medication changes for clients. Day Aide will be responsible for checking medication DAILY to ensure all discontinued medications are sent in for medication destruction. Day Aide will be responsible for checking medication documentation DAILY for accuracy and for staff signatures, indicating proper medication administration. House manager and QIDP are responsible for 3 times weekly monitoring of medication administration accuracy. Nursing staff are responsible for full review of house medication, documentation and administration at least once weekly. Stone Belt Medication administration error policy will be reviewed with QIDP staff and implemented. **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** House Manager was terminated and an experienced house manager from another site is coming into Hite House to implement Stone Belt policy and procedure. New house manager, along with existing QIDP and Associate Director, will support existing staff to follow all policies and procedures, specifically medication administration, including proper discipline for	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			medication errors, Prevention of Abuse Neglect and exploitation, including client to client abuse. Staff training and monitoring will occur. **How corrective actions will be monitored to ensure no recurrence** Director will ensure policies and procedures are being followed and clients are being supported appropriately by meeting with house manager, QIDP and associate director, weekly. During this meeting, all incidents will be discussed and follow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients.Medication errors will be discussed and discipline defined as per Stone Belt policy.	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 9 of 19 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #6, the facility neglected to implement its policies and procedures to prevent neglect of client #2, client to client abuse involving client #1, recurring medication errors and implement recommended corrective actions from	W 0149	**W149 Staff treatment of Clients Corrective action for resident(s) found to have been affected** House manager was terminated. Experienced house manager from another Stone Belt site is assigned to Hite House to ensure house staff are following policy and procedure to keep clients safe. . New procedure for transporting clients will be	06/19/2016

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 05/20/2016
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	investigations. Findings include: On 5/18/16 at 1:55 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 5/17/16 at 9:40 AM, the facility-operated day program staff checked the calendar on the computer to see if client #2 had a doctor's appointment on 5/17/16 due to not being at the day program. Client #2 did not have an appointment scheduled. The day program staff contacted client #2's group home Coordinator. The Coordinator located client #2 at the group home. Client #2 was not injured and was not in distress. The 5/17/16 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, in part, "Staff at day program checked the schedule to see if [client #2] had an appointment on 05/17/16. Staff noticed that [client #2] did not have an appointment and was not a day program. Contacted Coordinator to report his absence. Coordinator found [client #2] at home. [Client #2] was not in distress and was comforted by staff. Investigation to follow. Staff member [Home Manager] suspended." The 5/18/16 Investigation		implemented to ensure all clients are accounted for before leaving any location. Staff will be trained in Prevention of Abuse and Neglect(ANE) of clients. Moreover, staff will be trained in timely reporting for ANE, medication errors and behavior tracking. Medication administration procedure will be reviewed with staff and expectations will be detailed. Day Aide will be responsible for transcribing and communicating all medication changes for clients. Day Aide will be responsible for checking medication DAILY to ensure all discontinued medications are sent in for medication destruction. Day Aide will be responsible for checking medication documentation DAILY for accuracy and for staff signatures, indicating proper medication administration. House manager and QIDP are responsible for 3 times weekly monitoring of medication administration accuracy. Nursing staff are responsible for full review of house medication, documentation and administration at least once weekly. Stone Belt Medication administration error policy will be reviewed with QIDP staff and implemented. **How facility will identify other residents potentially affected & what measures taken** All residents potentially areaffected, and corrective measures address the needs of all clients. **Measures**	

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	Report indicated, in part, "On Tuesday, May 17. 2016 at 9:40 AM, [client #2's] classroom instructor noticed that he was not in the classroom and did not have a scheduled appointment. She contacted the coordinator and the building was searched. The coordinator traveled to his home, [name], were (sic) he was found watching TV in his room, unsupervised. This investigation is to determine whether an allegation of neglect against house manager [name] is substantiated." The Analysis of Evidence & (and) Findings section indicated, "As the staff person in charge of [name] House on the morning of 5/17/16, [Home Manager] did not provide adequate care and supervision to [client #2]. This investigation has revealed that [Home Manager] did not assign anyone to transport [client #2] to SBC (Stone Belt Center). He did not ensure that [client #2] was not left alone in the home." The Disposition of the Investigation indicated the allegation was substantiated. The Recommended Corrective Action(s) section indicated, "[Home Manager] will be terminated. [Name] House staff will be retrained on the importance of safety procedures during morning transport, especially making sure all clients are accounted for." On 5/18/16 at 1:06 PM, the Coordinator		**or systemic changes facility put in place to ensure no recurrence** House Manager was terminated and an experienced house manager from another site is coming into Hite House to implement Stone Belt policy and procedure. New house manager, along with existing QIDP and Associate Director, will support existing staff to follow all policies and procedures, specifically medication administration, including proper discipline for medication errors, Prevention of Abuse Neglect and exploitation, including client to client abuse. Staff training and monitoring will occur. **How corrective actions willbe monitored to ensure no recurrence** Director will ensure policies and procedures are being followed and clients arebeing supported appropriately by meeting with house manager, QIDP and associate director, weekly. During this meeting, all incidents will be discussed and follow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients. Medication errors will be discussed and discipline defined as per Stone Belt policy.	

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	indicated the Home Manager (HM) was terminated on 5/18/16 due to neglect. The Coordinator indicated the HM left client #2 at home without supervision. The Coordinator indicated the day program instructor contacted her to inform her of client #2's absence around 10:00 AM. The Coordinator indicated she called the day aid to confirm client #2 was not at an appointment. Client #2 was not at an appointment. The Coordinator contacted staff #6 who worked the overnight shift on 5/16/16 to 5/17/16. Staff #6 indicated she transported clients #3, #4 and #6 to the day program. Staff #6 indicated she did not transport client #2 to the day program. The Coordinator indicated staff #7 transported client #1 to the day program but not client #2. The Coordinator indicated the Home Manager transported client #4 to the day program but not client #2. The Coordinator indicated the Home Manager had client #2's lunchbox in his car. The Home Manager asked client #2 to go back into the group home to change his clothes. The Home Manager left client #2 at the group home. The Coordinator indicated client #2 was at the group home without staff supervision from approximately 8:30 AM to 10:00 AM. The Coordinator indicated she went to the group home and found client #2 in his bedroom watching television. The Coordinator indicated			

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	client #2 was unaware he was left alone at the group home and he was not harmed or in distress. On 5/19/16 at 1:54 PM, the Group Home Director (GHD) indicated client #2 was left at the group home unsupervised. The GHD stated the Home Manager "was not instrumental to ensure everyone was on transport." The GHD stated the Home Manager was "under the impression someone else had him (client #2)." The GHD indicated the staff failed to ensure the clients were accounted for. The GHD indicated the Home Manager was terminated due to neglect. 2) On 5/5/16 at 10:00 AM while at the facility-operated day program, client #1 was found to have a baseball sized bruise on his right forearm. The 5/5/16 BDDS report indicated, in part, "Instructor asked [client #1] what happened, and his first response was that his weekend staff attacked him. Instructor pulled [client #1] aside and had him explain to her what he was talking about. [Client #1] said he got mad at his [name of group home] residential staff, [staff #4], and his staff 'attacked back.' [Client #1] then said that he tried to hit his staff, [staff #4], and the staff blocked him. [Client #1's] story changed multiple times and then he said that he really didn't know			

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	what happened, but he had the right to defend himself...." The 5/9/16 Investigation Report indicated, in part, "It seems clear that the force of [client #1's] blows against [staff #4's] arm caused the bruising on [client #1's] forearm. The evidence suggests that [staff #4] was acting in a defensive manner, and did not strike out or push [client #1]. The incident of physical aggression between [client #1] and [staff #4] which took place around 7pm on May 1 was not properly documented or reported. In addition, the earlier instance of physical aggression, for which [client #1] lost an outing per his BSP (behavior support plan), was also not documented or reported. Again, neither of these episodes were documented or reported properly or in a timely manner." The Recommended Corrective Action(s) section indicated, in part, "...There should be disciplinary consequences for [staff #3, staff #4 and staff #1] for their failure to document the two episodes of physical aggression that took place on May 1." There was no documentation staff #3 received disciplinary action. On 5/19/16 at 2:55 PM, the GHD indicated staff #3 should have received disciplinary action. The GHD indicated there was no documentation staff #3			

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	received disciplinary action. 3) On 4/27/16 at 1:25 PM, client #1 yanked open a desk drawer causing the drawer to hit a peer on the leg. Client #1 attempted to apologize to the peer by patting the peer's head. The peer grabbed client #1's hand and hit himself on the top of his own head. Client #1 slapped the peer on the top of the head with an open hand. The peer was not injured. On 5/19/16 at 1:54 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients. 4) On 4/21/16 at 11:15 AM, client #2 did not receive Gas X tab as ordered prior to his colonoscopy. The 4/22/16 BDDS report indicated, "On 04/21/2016 at 11:15 AM, staff did not administered (sic) medication to [client #2]. Physician's order is for [client #2] to be administered Gas X tab with 2 oz (ounces) water before leaving the house for his colonoscopy. However, this was not passed. This med error was found when coordinator identified that it was not passed later in the day. Pager was notified. There was no effect to [client #2] or the colonoscopy due to this med			

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	error." On 5/19/16 at 2:57 PM, the GHD indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered. 5) On 4/15/16 at 8:00 PM, client #4 did not receive Aripiprazole (behavior) 10mg (milligrams) and two Depakote Sprinkles (behavior) 125mg tablets. The 4/16/16 BDDS report indicated, in part, "The morning staff found the error and notified the pager on the morning of the 16th." On 5/19/16 at 2:57 PM, the GHD indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered.			

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	6) On 4/11/16 at 7:15 AM, staff failed to implement client #6's physician's orders. The 4/12/16 BDDS report indicated, in part, "On 04/11/2016 at 7:15 AM, staff failed to follow risk plan for [client #6]. Physician's order is for [client #6] to have his blood pressure taken on Monday, Thursday, and Saturday; however, blood pressure was not taken or recorded. On 04/12/2016, this med error was discovered by [name of group home] coordinator while passing AM meds and Nurse was notified. There was no adverse effect to [client #6] due to this med error." On 5/19/16 at 2:57 PM, the GHD indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered. 7) On 4/2/16 through 4/11/16 at 7:00 AM, client #4 received Calcium 600 milligrams (mg). The physician discontinued Calcium on 3/30/16. The 4/12/16 BDDS report indicated, "On 04/02/2016 through 04/11/2016 at 7:00			

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	AM, [name of group home] AM (morning) staff failed to properly transcribed (sic) medication orders for [client #4] resulting in incorrect administration of medication as ordered. Physician's order discontinued the administration of Calcium + Vit. (vitamin) D (600mg; 400 IU) on 03/30/2016; however, staff continued to pass this medication. On 04/12/2016, this med error was discovered by [name of group home] coordinator and nurse was notified. There was no adverse effect to [client #4] due to this med error." On 5/19/16 at 2:57 PM, the GHD indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered. On 5/19/16 at 2:04 PM, the GHD indicated the Home Manager did not ensure the medication was discontinued on the Medication Administration Record (MAR) and did not remove the medication from the home. The GHD stated, "no one did anything after the doctor discontinued the			

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	medication." The GHD stated the Home Manager "was neglectful." On 5/19/16 at 2:10 PM, the Registered Nurse (RN) indicated the staff did not write the medication as being discontinued on the MAR. The RN indicated the medication was discontinued on 3/30/16 however no one made changes to the MAR. The RN indicated she updated client #4's Medication Information Sheet (MIS) and sent the sheet and an email to the group home staff. The RN indicated none of the staff printed off the MIS or updated the MAR to reflect the doctor's orders. The RN indicated she took client #4 to the appointment and communicated the information to the group home staff. On 5/19/16 at 2:19 PM, the RN forwarded the email she sent to the staff at client #4's group home. The email indicated, in part, "...These lab results also revealed his calcium level is too high. [Name of doctor] is also stopping his calcium/vit d supplement at this time... I have attached [client #4's] updated MIS. I have printed a copy of this to put in his appt binder already, and I'll put his appt binder in the [name of group home] Log Bag. The medication changes will need to be added to April MARs. Just to review those are: Add			

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	Ferrous Sulfate 325mg po (by mouth) three times daily. Stop Calcium/Vit D, Metformin, and Simvastatin...." 8) On 4/4/16 at 2:00 PM, staff #3 administered client #4's Ferrous Sulfate 325 mg at the wrong time. The 4/4/16 Medication Error Report (MER) indicated, "Staff failed to follow med administration procedure resulting in med being passed at wrong time. Staff failed to check MIS (Medication Information Sheet) and MAR (Medication Administration Record)... No effects noted." On 5/19/16 at 2:57 PM, the GHD indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered. 9) 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 #4 entered the kitchen area where staff #1 and client #3 were located. Staff #4 informed staff #1 that client #4 "s---" in the shower. Client #3 was in the dining room adjacent to the kitchen and could hear the statement staff #4 made in regards to client #4. The 4/1/16 Investigation Report indicated, in part, in the Recommended Corrective Action(s) section, "...Retrain [staff #1] on timely reporting of incidents." There was no documentation staff #1 was retrained. On 5/19/16 at 2:49 PM, the GHD stated, "that we			

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	didn't do." The GHD indicated the corrective action should have been implemented as written in the investigation. On 5/18/16 at 2:59 PM, a review of the facility's policy titled, Incident 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...." The September 2014 Human Rights Policy indicated, in part, "...Neglect: Any action or behavioral interventions that risks the physical or emotional safety and wellbeing of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care, or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan...."			

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	This deficiency was cited on 4/5/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 19 incident/investigative reports reviewed affecting clients #1, #3 and #4, the facility failed to ensure recommended corrective actions from investigations were implemented as written. Findings include: On 5/18/16 at 1:55 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 5/5/16 at 10:00 AM while at the facility-operated day program, client #1 was found to have a baseball sized bruise on his right forearm. The 5/5/16 BDDS report indicated, in part, "Instructor asked [client #1] what happened, and his first response was that his weekend staff attacked him. Instructor pulled [client	W 0157	**W157 Staff Treatment of Clients Corrective action for resident(s) found to have been affected** Staff will be disciplined for not reporting suspected ANE and behavior interventions immediately. Staff willbe trained in proper and timely behavior tracking and communication to the team. Weekly incident review meeting will occur to review all incidents that occur with clients to ensure proper follow up is implemented. **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** House Manager was terminated and an experienced house manager from another site is coming into Hite House to implement Stone Belt policy and	06/19/2016

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	#1] aside and had him explain to her what he was talking about. [Client #1] said he got mad at his [name of group home] residential staff, [staff #4], and his staff 'attacked back.' [Client #1] then said that he tried to hit his staff, [staff #4], and the staff blocked him. [Client #1's] story changed multiple times and then he said that he really didn't know what happened, but he had the right to defend himself...." The 5/9/16 Investigation Report indicated, in part, "It seems clear that the force of [client #1's] blows against [staff #4's] arm caused the bruising on [client #1's] forearm. The evidence suggests that [staff #4] was acting in a defensive manner, and did not strike out or push [client #1]. The incident of physical aggression between [client #1] and [staff #4] which took place around 7pm on May 1 was not properly documented or reported. In addition, the earlier instance of physical aggression, for which [client #1] lost an outing per his BSP (behavior support plan), was also not documented or reported. Again, neither of these episodes were documented or reported properly or in a timely manner." The Recommended Corrective Action(s) section indicated, in part, "...There should be disciplinary consequences for [staff #3, staff #4 and staff #1] for their failure		procedure. New house manager, along with existing QIDP and Associate Director, will support existing staff to follow all policies and procedures, including Prevention of Abuse Neglect and exploitation, including client to client abuse. Staff training and monitoring will occur. **How corrective actions will be monitored to ensure no recurrence**Director will ensure policies and procedures are being followed and clients are being supported appropriately by meeting with house manager, QIDP and associate director, weekly. During this meeting, all incidents will be discussed and follow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients. Medication errors will be discussed and discipline defined as per Stone Belt policy.	

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	to document the two episodes of physical aggression that took place on May 1." There was no documentation staff #3 received disciplinary action. On 5/19/16 at 2:55 PM, the GHD indicated staff #3 should have received disciplinary action. The GHD indicated there was no documentation staff #3 received disciplinary action. 2) 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 #4 entered the kitchen area where staff #1 and client #3 were located. Staff #4 informed staff #1 that client #4 "s---" in the shower. Client #3 was in the dining room adjacent to the kitchen and could hear the statement staff #4 made in regards to client #4. The 4/1/16 Investigation Report indicated, in part, in the Recommended Corrective Action(s) section, "...Retrain [staff #1] on timely reporting of incidents." There was no documentation staff #1 was retrained. On 5/19/16 at 2:49 PM, the GHD stated, "that we didn't do." The GHD indicated the corrective action should have been implemented as written in the investigation.			

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	This deficiency was cited on 4/5/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0226 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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. Findings include: On 5/18/16 at 1:45 PM, 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	W 0226	**W226 Individual Program Plan Corrective action for resident(s) found to have been affected** QIDP will be disciplined for not following policy for new admission, by not creating an IPP within 30 days. IPP has been completed. **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** Weekly incident review meeting will address all policies, including new admission policies. **How corrective actions will be monitored to ensure no recurrence** Director will ensure policies and procedures are being followed and clients are being supported appropriately by	06/19/2016

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	(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. On 5/18/16 at 1:45 PM, the Qualified Intellectual Disabilities Professional (called Coordinator) indicated client #5's IPP was not reviewed or revised since his admission to the group home on 8/17/15. This deficiency was cited on 4/5/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		meeting with house manager, QIDP and associate director, weekly. During this meeting, all incidents will be discussed and follow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients. Medication errors will be discussed and discipline defined as per Stone Belt policy.	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 3 of 6 clients living in the group home (#2, #4 and #6), the facility's nursing services failed to ensure staff administered the clients' medication in accordance with the physician's orders. Findings include: On 5/18/16 at 1:55 PM, a review of the	W 0331	**W331 Nursing Services Corrective action for resident(s) found to have been affected** Medication administration procedure will be reviewed with staff and expectations will be detailed. Day Aide will be responsible for transcribing and communicating all medication changes for clients. Day Aide will be responsible for checking medication DAILY to	06/19/2016

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	facility's incident/investigative reports was conducted and indicated the following: 1) On 4/21/16 at 11:15 AM, client #2 did not receive Gas X tab as ordered prior to his colonoscopy. The 4/22/16 BDDS report indicated, "On 04/21/2016 at 11:15 AM, staff did not administered (sic) medication to [client #2]. Physician's order is for [client #2] to be administered Gas X tab with 2 oz (ounces) water before leaving the house for his colonoscopy. However, this was not passed. This med error was found when coordinator identified that it was not passed later in the day. Pager was notified. There was no effect to [client #2] or the colonoscopy due to this med error." 2) On 4/15/16 at 8:00 PM, client #4 did not receive Aripiprazole 10mg and two Depakote Sprinkles 125mg tablets. The 4/16/16 BDDS report indicated, in part, "The morning staff found the error and notified the pager on the morning of the 16th." 3) On 4/11/16 at 7:15 AM, staff failed to implement client #6's physician's orders. The 4/12/16 BDDS report indicated, in part, "On 04/11/2016 at 7:15 AM, staff failed to follow risk plan for [client #6].		ensure all discontinued medications are sent in for medication destruction.Day Aide will be responsible for checking medication documentation DAILY for accuracy and for staff signatures, indicating proper medication administration. House manager and QIDP are responsible for 3 times weekly monitoring of medication administration accuracy. Nursing staff are responsible for full review of house medication, documentation and administration at least once weekly. Stone Belt Medication administration error policy will be reviewed with QIDP staff and implemented. **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** House Manager was terminated and an experienced house manager from another site is coming into Hite House to implement Stone Belt policy and procedure. New house manager, along with existing QIDP and Associate Director, will support existing staff to follow allpolicies and procedures, specifically medication administration, including proper discipline for medication errors. Staff training and monitoring will occur. **How corrective actions will be**	

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	Physician's order is for [client #6] to have his blood pressure taken on Monday, Thursday, and Saturday; however, blood pressure was not taken or recorded. On 04/12/2016, this med error was discovered by [name of group home] coordinator while passing AM meds and Nurse was notified. There was no adverse effect to [client #6] due to this med error." 4) On 4/2/16 through 4/11/16 at 7:00 AM, client #4 received Calcium 600 milligrams (mg). The physician discontinued Calcium on 3/30/16. The 4/12/16 BDDS report indicated, "On 04/02/2016 through 04/11/2016 at 7:00 AM, [name of group home] AM (morning) staff failed to properly transcribed (sic) medication orders for [client #4] resulting in incorrect administration of medication as ordered. Physician's order discontinued the administration of Calcium + Vit. (vitamin) D (600mg; 400 IU) on 03/30/2016; however, staff continued to pass this medication. On 04/12/2016, this med error was discovered by [name of group home] coordinator and nurse was notified. There was no adverse effect to [client #4] due to this med error." On 5/19/16 at 2:57 PM, the Group Home		**monitored to ensure no recurrence** Director will ensure policies and procedures are being followed and clients are being supported appropriately by meeting with house manager, QIDP and associate director, weekly. During this meeting, all incidents will be discussed andfollow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients. Medication errors will be discussed and discipline defined as per Stone Belt policy.	

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	Director (GHD) indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered. On 5/19/16 at 2:04 PM, the GHD indicated the Home Manager did not ensure the medication was discontinued on the Medication Administration Record (MAR) and did not remove the medication from the home. The GHD stated, "no one did anything after the doctor discontinued the medication." The GHD stated the Home Manager "was neglectful." On 5/19/16 at 2:10 PM, the Registered Nurse (RN) indicated the staff did not write the medication as being discontinued on the MAR. The RN indicated the medication was discontinued on 3/30/16 however no one made changes to the MAR. The RN indicated she updated client #4's Medication Information Sheet (MIS) and sent the sheet and an email to the group home staff. The RN indicated none of the staff printed off the MIS or updated the MAR to reflect the doctor's orders. The RN indicated she took client #4 to			

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	the appointment and communicated the information to the group home staff. On 5/19/16 at 2:19 PM, the RN forwarded the email she sent to the staff at client #4's group home. The email indicated, in part, "...These lab results also revealed his calcium level is too high. [Name of doctor] is also stopping his calcium/vit d supplement at this time... I have attached [client #4's] updated MIS. I have printed a copy of this to put in his appt binder already, and I'll put his appt binder in the [name of group home] Log Bag. The medication changes will need to be added to April MARs. Just to review those are: Add Ferrous Sulfate 325mg po (by mouth) three times daily. Stop Calcium/Vit D, Metformin, and Simvastatin...." 5) On 4/4/16 at 2:00 PM, staff #3 administered client #4's Ferrous Sulfate 325 mg at the wrong time. The 4/4/16 Medication Error Report (MER) indicated, "Staff failed to follow med administration procedure resulting in med being passed at wrong time. Staff failed to check MIS (Medication Information Sheet) and MAR (Medication Administration Record)... No effects noted." On 5/19/16 at 2:57 PM, the GHD indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the			

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	Home Manager to ensure the client's medications were administered as ordered. On 5/20/16 at 9:05 AM, the RN indicated the staff should administer the clients' medications in accordance with their physician's orders. On 5/20/16 at 9:34 AM, the Nurse Manager (NM) indicated the staff should administer the clients' medications according to the physician's orders. 9-3-6(a)			
W 0356 Bldg. 00	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. 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. Findings include: On 5/18/16 at 1:03 PM, 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	W 0356	**W356 Comprehensive Dental treatment Corrective action for resident(s) found to have been affected** The client that needed dental care, has been discharged to nursing home due to high medical needs. Director spoke to this client's guardian at length, she was opposed to her brother(Stone Belt client) obtaining dental care while in our services. **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**	06/19/2016

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	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 insurance. Please check if he has help available to save teeth. If not 4, 14 & 15 will need to be extracted." 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		**systemic changes facility put in place to ensure no recurrence** Address all medical directives with client immediately. **How corrective actions will be monitored to ensure no recurrence** Director will ensure policies and procedures are being followed and clients are being supported appropriately by meeting with house manager, QIDP and associate director, weekly. During this meeting, all incidents will be discussed and follow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients. Medication errors will be discussed and discipline defined as per Stone Belt policy.	

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	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." On 4/19/16 at 6:14 PM, an email from client #4's guardian to the Group Home Director indicated, in part, "Thank you for contacting me to give additional guidance regarding [client #4's] dental care situation. I understand that staff members at [dental office] are concerned about the degree of decay [client #4] has, and that the options they outlined are to either pull the affected teeth, or have root canals done on them. As [client #4's] legal guardian, I would like to request a second opinion. I believe that it would be a mistake to extract his teeth (because of his swallowing issues, and fine motor/self-help issues), but would like to see if there are other options besides doing root canals. I further understand that there are potential risks to [client #4's] well-being by waiting, but I believe that we could possibly get this resolved within 30 days. This would also give me additional time to determine how all			

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	these expenses could be covered. I have been told that Medicaid will not cover these procedures, but have been told by an outside source that there is a way to deviate liability, so that the expenses could come out (in installments) of his monthly social security check. I would prefer this to using his ARC Trust because the dental procedures will exhaust almost his entire trust fund, and I am afraid there may be future medical expenses that Medicaid also will not cover. [Client #4's] monthly check and trust fund are his only source of income. I do fully intend to authorize you to proceed with a definite plan of action, as soon as possible, but I would like a second opinion first. Again, thank you for keeping me informed." On 5/18/16 at 1:06 PM, the Coordinator indicated client #4 had a second dental assessment. The Coordinator indicated although a second assessment was completed, client #4's dental care recommendations had not been addressed. The Coordinator indicated the second assessment was essentially the same as the first assessment. The Coordinator indicated client #4's guardian wants client #4 to be assessed by his former dentist from when he lived with the guardian. The Coordinator indicated the guardian did not believe all the			

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	recommended dental work was necessary. Client #4's 5/5/16 Outside Services Report (dental) indicated, in part, "Are there any decayed teeth? Yes... Is there evidence of improper brushing? Yes... Please list future treatments (if needed): Rec (recommend) RCT (root canal treatment)/crown/buildup on #4, #14, (and) #15. Rec crown/buildup replacement #9. Further evaluation to be completed after cleaning... Please help pt (patient) brush 2-3x (times)/day (and) floss 1x/day to remove plague." The dental Treatment Plan Total for the second opinion was $6954.87." Client #4's 5/5/16 Nursing Consultation indicated, "Client was seen at [name of dental practice] for second opinion of the work [name of first dental practice] claims client will need to have completed on his teeth. [Name of dental practice] mostly agrees with [name of first dental practice's] assessment, but would prefer to save the teeth rather than pull any of the teeth. In total, the difference in cost from one office to the other is roughly $300." This deficiency was cited on 4/5/16. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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	9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 3 of 6 clients living in the group home (#2, #4 and #6), the facility failed to ensure staff administered the clients' medication in accordance with the physician's orders. Findings include: On 5/18/16 at 1:55 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 4/21/16 at 11:15 AM, client #2 did not receive Gas X tab as ordered prior to his colonoscopy. The 4/22/16 BDDS report indicated, "On 04/21/2016 at 11:15 AM, staff did not administered (sic) medication to [client #2]. Physician's order is for [client #2] to be administered Gas X tab with 2 oz (ounces) water before leaving the house for his	W 0368	**W368 Drug Administration Corrective action for resident(s) found to have been affected** Medication administration procedure will be reviewed with staff and expectations will be detailed. Day Aide will be responsible for transcribing and communicating all medication changes for clients. Day Aide will be responsible for checking medication DAILY to ensure all discontinued medications are sent in for medication destruction. Day Aide will be responsible for checking medication documentation DAILY for accuracy and for staff signatures, indicating proper medication administration. House manager and QIDP are responsible for 3 times weekly monitoring of medication administration accuracy. Nursing staff are responsible for full review of house medication, documentation and administration at least once weekly. Stone Belt Medication administration error	06/19/2016

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	colonoscopy. However, this was not passed. This med error was found when coordinator identified that it was not passed later in the day. Pager was notified. There was no effect to [client #2] or the colonoscopy due to this med error." 2) On 4/15/16 at 8:00 PM, client #4 did not receive Aripiprazole 10mg and two Depakote Sprinkles 125mg tablets. The 4/16/16 BDDS report indicated, in part, "The morning staff found the error and notified the pager on the morning of the 16th." 3) On 4/11/16 at 7:15 AM, staff failed to implement client #6's physician's orders. The 4/12/16 BDDS report indicated, in part, "On 04/11/2016 at 7:15 AM, staff failed to follow risk plan for [client #6]. Physician's order is for [client #6] to have his blood pressure taken on Monday, Thursday, and Saturday; however, blood pressure was not taken or recorded. On 04/12/2016, this med error was discovered by [name of group home] coordinator while passing AM meds and Nurse was notified. There was no adverse effect to [client #6] due to this med error." 4) On 4/2/16 through 4/11/16 at 7:00 AM, client #4 received Calcium 600		policy will be reviewed with QIDP staff and implemented. **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** House Manager was terminated and an experienced house manager from another site is coming into Hite House to implement Stone Belt policy and procedure. New house manager, along with existing QIDP and Associate Director, will support existing staff to follow all policies and procedures, specifically medication administration, including proper discipline for medication errors. Staff training and monitoring will occur. **How corrective actions will be monitored to ensure no recurrence** Director will ensure policies and procedures are being followed and clients are being supported appropriately by meeting with house manager, QIDP and associate director, weekly. During this meeting, all incidents will be discussed and follow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients. Medication	

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	milligrams (mg). The physician discontinued Calcium on 3/30/16. The 4/12/16 BDDS report indicated, "On 04/02/2016 through 04/11/2016 at 7:00 AM, [name of group home] AM (morning) staff failed to properly transcribed (sic) medication orders for [client #4] resulting in incorrect administration of medication as ordered. Physician's order discontinued the administration of Calcium + Vit. (vitamin) D (600mg; 400 IU) on 03/30/2016; however, staff continued to pass this medication. On 04/12/2016, this med error was discovered by [name of group home] coordinator and nurse was notified. There was no adverse effect to [client #4] due to this med error." On 5/19/16 at 2:57 PM, the Group Home Director (GHD) indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered. On 5/19/16 at 2:04 PM, the GHD indicated the Home Manager did not ensure the medication was discontinued on the Medication		errors will be discussed and discipline defined as per Stone Belt policy.	

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	Administration Record (MAR) and did not remove the medication from the home. The GHD stated, "no one did anything after the doctor discontinued the medication." The GHD stated the Home Manager "was neglectful." On 5/19/16 at 2:10 PM, the Registered Nurse (RN) indicated the staff did not write the medication as being discontinued on the MAR. The RN indicated the medication was discontinued on 3/30/16 however no one made changes to the MAR. The RN indicated she updated client #4's Medication Information Sheet (MIS) and sent the sheet and an email to the group home staff. The RN indicated none of the staff printed off the MIS or updated the MAR to reflect the doctor's orders. The RN indicated she took client #4 to the appointment and communicated the information to the group home staff. On 5/19/16 at 2:19 PM, the RN forwarded the email she sent to the staff at client #4's group home. The email indicated, in part, "...These lab results also revealed his calcium level is too high. [Name of doctor] is also stopping his calcium/vit d supplement at this time... I have attached [client #4's] updated MIS. I have printed a copy of this to put in his appt binder already, and			

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	I'll put his appt binder in the [name of group home] Log Bag. The medication changes will need to be added to April MARs. Just to review those are: Add Ferrous Sulfate 325mg po (by mouth) three times daily. Stop Calcium/Vit D, Metformin, and Simvastatin...." 5) On 4/4/16 at 2:00 PM, staff #3 administered client #4's Ferrous Sulfate 325 mg at the wrong time. The 4/4/16 Medication Error Report (MER) indicated, "Staff failed to follow med administration procedure resulting in med being passed at wrong time. Staff failed to check MIS (Medication Information Sheet) and MAR (Medication Administration Record)... No effects noted." On 5/19/16 at 2:57 PM, the GHD indicated the staff should administer the client's medications according to their physician's orders. The GHD indicated the staff was not taking their time or caring to administer the client's medications. The GHD indicated there was no follow-up from the Home Manager to ensure the client's medications were administered as ordered. On 5/20/16 at 9:05 AM, the RN indicated the staff should administer the clients' medications in accordance with their physician's orders. On 5/20/16 at 9:34 AM, the Nurse Manager (NM) indicated the staff should administer the clients' medications according to the physician's orders. 9-3-6(a)			

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W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1(a) Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 11. An emergency intervention for the individual resulting from: a. a physical symptom, b. a medical or psychiatric condition, c. any other event. This state rule was not met as evidenced by: Based on record review and interview for 1 of 18 incident reports reviewed affecting client #2, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law. Findings include:	W 9999	**W9999 Final observation Corrective action for resident(s) found to have been affected** Staff that was involved with not reporting incident in a timely manner will be disciplined and retrained. All house staff will be trained on timely reporting. **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** House Manager was terminated and an experienced house manager from another site is coming into Hite House to implement Stone Belt policy and procedure. New house manager, along with existing QIDP and Associate Director, will support existing staff to follow all policies and procedures, specifically proper and timely reporting of incidents to BDDS. Staff training and monitoring will occur. **How corrective actions will be monitored to ensure no recurrence** Director will ensure policies and procedures are being followed and clients are being supported appropriately by meeting with house manager, QIDP and associate director, weekly. During this meeting, all	06/19/2016

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	On 5/18/16 at 1:55 PM, a review of the facility's incident reports was conducted and indicated the following: On 4/27/16 at 5:00 PM (reported to BDDS on 4/29/16), client #2 was taken to the emergency room due to vomiting. He was prescribed Promethazine 25 milligrams (mg) upon discharge. On 5/18/16 at 2:46 PM, the Assistant Group Home Director indicated the timeframe for reporting incidents to BDDS was 24 hours. On 5/19/16 at 1:57 PM, the Group Home Director indicated the timeframe for reporting incidents to BDDS was 24 hours. 9-3-1(b)		incidents will be discussed and follow up will be assigned until completion. Director and/or associate director will attend weekly house meeting to address any deviation from Stone Belt policy and procedure and to follow through with any issues that may effect clients. Medication errors will be discussed and discipline defined as per Stone Belt policy.	