

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2011
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 214 E SOUTHERN DR BLOOMINGTON, IN47401
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W0000	<p>This visit was for the investigation of complaint #IN00098871.</p> <p>Complaint #IN00098871 - Substantiated, Federal/state deficiencies related to the allegation are cited at W149, W154, W157 and W227.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: November 9 and 10, 2011.</p> <p>Facility Number: 001210 Provider Number: 15G637 AIM Number: 100240200</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/28/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0125	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and</p>	W0125	W 125	12/10/2011

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>record review for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to ensure the clients had the right to due process in regard to a locked thermostat.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/9/11 from 4:20 PM to 5:27 PM. During the observation, the thermostat was covered with a plastic, locked box. This affected clients A, B, C, D, E and F.</p> <p>A review of client A's record was conducted on 11/10/11 at 10:05 AM. There was no documentation in her record indicating the thermostat needed to be locked.</p> <p>A review of client B's record was conducted on 11/10/11 at 10:07 AM. There was no documentation in her record indicating the thermostat needed to be locked.</p> <p>A review of client C's record was conducted on 11/10/11 at 10:10 AM. There was no documentation in her record indicating the thermostat needed to be locked.</p> <p>A review of client D's record was conducted on 11/10/11 at 10:11 AM. There was no documentation in her record indicating the thermostat needed to be locked.</p> <p>A review of client E's record was conducted on 11/10/11 at 10:13 AM. There was no documentation in her record indicating the thermostat needed to be locked.</p> <p>A review of client F's record was conducted on 11/10/11 at 10:15 AM. There was no</p>		<p>PROTECTION OF CLIENT RIGHTS</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure the rights of the clients served. Stone Belt will allow and encourage clients to exercise their rights and have the right to due process.</p> <p>Date of Completion:</p> <p>December 10, 2011</p> <p>Person Responsible:</p> <p>Southern Coordinator</p> <p>Plan of Prevention:</p> <p>The lock on the thermostat was removed at the time of the survey. The use of locks on thermostats was reviewed at the SGL Managers Meeting on 11/16/11 (Attachment #1) and all SGL Managers were trained that no locks are to be on thermostats.</p> <p>Quality Assurance Monitoring:</p> <p>All plans will be reviewed at Support Team meetings and the Coordinator and SGL Director will assure proper approvals are given for any restrictive devices.</p>		

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W0149	<p>documentation in her record indicating the thermostat needed to be locked.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/9/11 at 5:12 PM. The QMRP indicated she did not know why the thermostat was locked. The QMRP obtained a key from the home manager (HM) to unlock the thermostat. The QMRP indicated none of the clients (A, B, C, D, E and F) had access to the thermostat or plans for the thermostat to be locked.</p> <p>An interview with the HM was conducted on 11/9/11 at 5:13 PM. The HM indicated the locked thermostat cover was put on there while she was on leave. The HM did not know why the cover was put on the thermostat.</p> <p>9-3-2(a)</p> <p>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 2 of 18 incident/investigative reports reviewed affecting clients A and F, the facility failed to implement their policy to prevent client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/9/11 at 10:15 AM. -On 9/22/11 at 3:30 PM while at the facility-operated day program, client F smacked client A in the face.</p>	W0149	<p>W149</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt has policies and procedures that address mistreatment, neglect and abuse of clients.</p> <p>Southern House Staff have retrained on Stone Belt Prevention of Abuse and Neglect/Client Rights and Incident Reporting (Attachment #2) at the</p>	12/10/2011	

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	<p>-On 10/10/11 at 4:20 PM, client A attempted to force client F out of the way while in her wheelchair to get into the home. Client F was trying to close the front door before client A made it inside. Client F smacked client A "repeatedly" and client A continued to try to get into the home. Client A refused to move her wheelchair. Staff #4 had to move client A's wheelchair. Client A indicated she needed to use the restroom and that was why she was trying to get into the home. Client A iced her nose and the right side of her face. The incident report indicated the following, "[Client A] has been targeting [client F] and provoking such occurrences."</p> <p>A review of the facility's abuse and neglect policy and procedure, dated 10/2010, was conducted on 11/9/11 at 10:07 AM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical and emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual."</p> <p>An interview with the home manager (HM) was conducted on 11/9/11 at 4:47 PM. The HM indicated one year ago, there was a similar incident between clients A and F at the door. The HM</p>		<p>House Meeting on December 9, 2011.</p> <p>Responsible Person:</p> <p>Southern Coordinator</p> <p>Date of Completion:</p> <p>December 10, 2011</p> <p>Plan of Prevention:</p> <p>Stone Belt Director of Group Homes will review all Incident Reports to assure Consumer to Consumer aggression is being reviewed appropriately. Documentation will be kept to assure all such incidents are addressed within 5 working days.</p> <p>All Stone Belt staff working in a group home are trained on the Stone Belt Prevention of Abuse and Neglect/Client Rights and Incident Reporting policy (Attachment #2) and procedure during orientation training and annually.</p> <p>Quality Assurance Monitoring:</p> <p>Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed.</p> <p>The Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to</p>		

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	<p>indicated the staff at the time were trained to stay with client F when she was standing in a doorway. The HM indicated this was not part of client F's plan but should be. The HM indicated since this information was not part of the plan and the staff had changed, staff #4 did not receive training on this information.</p> <p>An interview with the behavior clinician (BC) was conducted on 11/10/11 at 10:00 AM. The BC indicated client F's behavior plan did not address standing in doorways. The BC indicated he would need to review the incident reports to ascertain if there were on-going issues involving doorways for client F.</p> <p>An interview with the social worker (SW) was conducted on 11/10/11 at 9:21 AM. The SW stated client F had an "obsession with doorways." The SW indicated the staff should go into the home prior to client F going into the home to prompt client F out of the doorway. The SW indicated the staff did not implement client F's plan regarding doorways.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/10/11 at 10:20 AM. The QMRP indicated staff #4 should have stepped in to resolve the conflict between clients A and F at the door prior to when</p>		assure appropriate reporting of incidents.		

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W0154	<p>she did.</p> <p>This federal tag relates to complaint #IN00098871.</p> <p>9-3-2(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 18 incident/investigative reports reviewed affecting clients A and F, the facility failed to conduct a thorough investigation of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/9/11 at 10:15 AM. On 10/10/11 at 4:20 PM, client A attempted to force client F out of the way while in her wheelchair to get into the home. Client F was trying to close the front door before client A made it inside. Client F smacked client A "repeatedly" and client A continued to try to get into the home. Client A refused to move her wheelchair. Staff #4 had to move client A's wheelchair. Client A indicated she needed to use the restroom and that was why she was trying to get into the home.</p>	W0154	<p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that all allegations are investigated thoroughly.</p> <p>Date of Completion</p> <p>December 10, 2011</p> <p>Responsible Person</p> <p>Southern Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>The Coordinator reviewed and completed training on Stone Belt investigation procedures. (Attachment #3). This included how to conduct proper investigations and who should be</p>	12/10/2011	

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	<p>Client A iced her nose and the right side of her face. The incident report indicated the following, "[Client A] has been targeting [client F] and provoking such occurrences." The initial incident report (dated 10/10/11), BDDS (Bureau of Developmental Disabilities Services) report (dated 10/11/11) and Inquiry of Consumer to Consumer Aggression report (dated 10/12/11) did not describe in detail the injuries client A sustained. The reports did not indicate the steps staff #4 took to intervene in the behavior.</p> <p>A review of email messages regarding the 10/10/11 incident between clients A and F was conducted on 11/9/11 at 11:30 AM. On 11/3/11, the Qualified Mental Retardation Professional (QMRP) sent an email to the social worker, Director, behavior clinician, home manager and assistant manager. The email indicated the following, "I should have sent this email last week when this occurred but I have forgot (sic) to do it several times... While I was talking to [client A's sister] she informed me that [client A] had told her that she had been 'beaten severely by [client F] and that [first names of QMRP, social worker and Director] had done nothing about it.'" The facility did not conduct an investigation into client A's concerns.</p>		<p>interviewed.</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure, after reviewing the incident, that investigations will be completed thoroughly.</p>		

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	<p>An interview with client A was conducted on 11/9/11 at 11:30 AM. Client A indicated about one month ago, while going into the group home, client F cut her off going into the home. Client A indicated she told client F she needed to use the restroom and client F pulled the door closed. Client A indicated this made her mad and she said something to client F about client F's dad which upset client F. Client A indicated she blocked the door with her wheelchair so the door would not shut. Client A indicated client F was pushing on her chair and client A hit client F with her chair. Client F hit client A in the face 18 times (an estimate according to client A). Client A indicated while trying to get client F to stop, she scratched client F's hand. Client A indicated staff #4 who was the only staff present, did not do anything physically to stop client F from hitting client A. Client A indicated staff #4 verbally prompted client F to stop hitting and for client A to move her chair. Client A indicated her chair was stuck and she was not able to move.</p> <p>An interview with staff #4 was conducted on 11/9/11 at 4:28 PM. Staff #4 indicated on 10/10/11, she was the only staff present for the incident (one staff on a doctor's appointment and the other was at the home assisting client C in the</p>			

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	<p>restroom). Staff #4 indicated client F got into the home through the front door and tried to close it. Client A went to the door and tried to get in. Staff #4 indicated she prompted client A several times to wait for her. She indicated client F started hitting client A while she was behind client A. Staff #4 indicated she reached around client A to move her wheelchair. Staff #4 indicated she blocked several of client F's hits with her body. She indicated she asked client A to move her chair away from the door before and during the incident. Staff #4 stated client A was being "stubborn" and would not move her chair. Staff #4 indicated client F did not attempt to push client A out of her chair at any time.</p> <p>An interview with the social worker (SW) was conducted on 11/10/11 at 9:21 AM. The SW stated client F had an "obsession with doorways." The SW indicated the staff should go into the home prior to client F going into the home to prompt client F out of the doorway. The SW indicated the staff did not implement client F's plan regarding doorways.</p> <p>A review of client F's behavior plan, dated 6/14/11, was conducted on 11/10/11 at 10:09 AM. There was no documentation in her plan addressing doorways.</p>				

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W0157	<p>An interview with the QMRP was conducted on 11/10/11 at 10:20 AM. The QMRP indicated she was not informed client A had sustained injuries until she spoke with client A's sister after the Inquiry was completed; she indicated she added a written statement to the report. The QMRP indicated staff #4 did not put in the initial incident report client A continuously pushed client F with her wheelchair. The QMRP indicated client A did express the facility did not do anything to address the situation. The QMRP indicated the facility did not investigate client A's statement the facility did not do anything to address the client to client incident since she showed client A the initial incident report, the BDDS report and the Inquiry.</p> <p>This federal tag relates to complaint #IN00098871.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 18 incident/investigative reports reviewed affecting clients A and F, the facility failed to take appropriate corrective actions to address client to client abuse.</p>	W0157	<p>W 157</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p>	12/10/2011	

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	<p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/9/11 at 10:15 AM. On 10/10/11 at 4:20 PM, client A attempted to force client F out of the way while in her wheelchair to get into the home. Client F was trying to close the front door before client A made it inside. Client F smacked client A "repeatedly" and client A continued to try to get into the home. Client A refused to move her wheelchair. Staff #4 had to move client A's wheelchair. Client A indicated she needed to use the restroom and that was why she was trying to get into the home. Client A iced her nose and the right side of her face. The incident report indicated the following, "[Client A] has been targeting [client F] and provoking such occurrences."</p> <p>A review of client F's Support Team Review Form, dated 9/29/11, was conducted on 11/9/11 at 11:34 AM. The form indicated, "Behaviorist to retrain staff on [client F's] behavior plan." This was in response to the team identifying "increased aggression."</p> <p>A review of the facility's Staff Training Form, dated 10/18/11, was conducted on</p>		<p>Stone Belt will assure that when alleged violations are verified, appropriate action will be taken.</p> <p>Date of Completion: December 10, 2011</p> <p>Person Responsible: Southern Coordinator/SGL Director</p> <p>Plan of Prevention: Retraining on Incident Reporting and Prevention of Abuse, Neglect and Reporting was completed on December 9, 2011 with all house staff. Behavior plan changes were made to both client A & Client F's behavior support plans to address recent issues and consumer A is being trained on CPI. (Attachments #4, #5 & #6).</p> <p>Quality Assurance Monitoring: Home Coordinator and SGL Director will review all incident reports to assure that appropriate training and, if necessary, disciplinary actions are taken for staff involved.</p>		

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	<p>11/9/11 at 1:15 PM. The training form indicated 4 staff received training on client F's behavior plan. There were 4 staff (staff #3, #5, #6, #7 and #8) who were not trained.</p> <p>An interview with client A was conducted on 11/9/11 at 11:30 AM. Client A indicated about one month ago, while going into the group home, client F cut her off going into the home. Client A indicated she told client F she needed to use the restroom and client F pulled the door closed. Client A indicated this made her mad and she said something to client F about client F's dad which upset client F. Client A indicated she blocked the door with her wheelchair so the door would not shut. Client A indicated client F was pushing on her chair and client A hit client F with her chair. Client F hit client A in the face 18 times (an estimate according to client A). Client A indicated while trying to get client F to stop, she scratched client F's hand. Client A indicated staff #4 who was the only staff present, did not do anything physically to stop client F from hitting client A. Client A indicated staff #4 verbally prompted client F to stop hitting and for client A to move her chair. Client A indicated her chair was stuck and she was not able to move.</p>				

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	<p>An interview with staff #4 was conducted on 11/9/11 at 4:28 PM. Staff #4 indicated on 10/10/11, she was the only staff present for the incident (one staff on a doctor's appointment and the other was at the home assisting client C in the restroom). Staff #4 indicated client F got into the home through the front door and tried to close it. Client A went to the door and tried to get in. Staff #4 indicated she prompted client A several times to wait for her. She indicated client F started hitting client A while she was behind client A. Staff #4 indicated she reached around client A to move her wheelchair. Staff #4 indicated she blocked several of client F's hits with her body. She indicated she asked client A to move her chair away from the door before and during the incident. Staff #4 stated client A was being "stubborn" and would not move her chair. Staff #4 indicated client F did not attempt to push client A out of her chair at any time.</p> <p>An interview with the social worker (SW) was conducted on 11/10/11 at 9:21 AM. The SW stated client F had an "obsession with doorways." The SW indicated the staff should go into the home prior to client F going into the home to prompt client F out of the doorway. The SW indicated the behavior clinician indicated he could provide client A instruction on</p>			

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	<p>how to protect herself. The SW indicated he would modify the facility's training for CPI (Crisis Prevention Institute) to meet client A's needs.</p> <p>An interview with the behavior clinician (BC) was conducted on 11/10/11 at 10:00 AM. The BC indicated he discussed with the SW providing client A training to protect herself. The BC indicated the training had not occurred. The BC indicated he was asked on 11/9/11 about client F's plan addressing doorways. He indicated it was not part of her plan but could be added after he reviewed her incidents to ascertain if it was an issue.</p> <p>A review of client F's behavior plan, dated 6/14/11, was conducted on 11/10/11 at 10:09 AM. There was no documentation in her plan addressing doorways.</p> <p>An interview with the QMRP was conducted on 11/10/11 at 10:20 AM. The QMRP indicated staff #4 did not put in the initial incident report client A continuously pushed client F with her wheelchair. The QMRP indicated staff #4 should have intervened during the incident sooner. The QMRP indicated staff #4 was retrained on incident reporting; she indicated there was no disciplinary action taken with staff #4 regarding not intervening in the incident</p>				

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W0227	<p>prior to when she did. The QMRP indicated not all the staff working at the group home were retrained on client F's behavior plan. The QMRP indicated the home manager should have left the training documentation at the home for the staff who did not attend the training to read and sign. The QMRP indicated client F used to have a plan addressing doorways. She indicated client F's issue with doorways was becoming more of an issue and should be part of a plan. The QMRP indicated client A needed a plan to address hitting others or using her wheelchair to block others.</p> <p>This federal tag relates to complaint #IN00098871.</p> <p>9-3-2(a)</p> <p>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 record review and interview for 2 of 6 clients living in the group home (A and F), the facility failed to ensure their program plans addressed client A's use of her wheelchair to hit and block her peers and client F's plan addressed doorways.</p> <p>Findings include:</p>	W0227	<p>W227</p> <p>INDIVIDUAL PROGRAM PLAN</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that a client's individual program plan states the specific objectives necessary to meet the client's</p>	12/10/2011	

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	<p>A review of the facility's incident/investigative reports was conducted on 11/9/11 at 10:15 AM. On 10/10/11 at 4:20 PM, client A attempted to force client F out of the way while in her wheelchair to get into the home. Client F was trying to close the front door before client A made it inside. Client F smacked client A "repeatedly" and client A continued to try to get into the home. Client A refused to move her wheelchair. Staff #4 had to move client A's wheelchair. Client A indicated she needed to use the restroom and that was why she was trying to get into the home. Client A iced her nose and the right side of her face. The incident report indicated the following, "[Client A] has been targeting [client F] and provoking such occurrences."</p> <p>A review of client F's behavior plan, dated 6/14/11, was conducted on 11/10/11 at 10:09 AM. There was no documentation in her plan addressing doorways.</p> <p>A review of client A's behavior plan, dated 1/9/10, was conducted on 11/10/11 at 10:11 AM. There was no documentation in her plan addressing using her wheelchair to hit or block others.</p> <p>An interview with client A was conducted</p>		<p>needs are identified by a comprehensive assessment.</p> <p>Date of Completion</p> <p>December 10, 2011</p> <p>Responsible Person</p> <p>Southern Coordinator</p> <p>Plan of Prevention</p> <p>Client F's behavior support plan was updated to address issues in doorways. All staff were trained on the plan on November 18, 2011. (Attachment #7)</p> <p>Quality Assurance Monitoring</p> <p>The Coordinator will monitor all incident reports for any issues pertaining to Client F's issues in doorways and will insure that all staff are following the behavioral support plan at all times.</p>		

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	<p>on 11/9/11 at 11:30 AM. Client A indicated about one month ago, while going into the group home, client F cut her off going into the home. Client A indicated she told client F she needed to use the restroom and client F pulled the door closed. Client A indicated this made her mad and she said something to client F about client F's dad which upset client F. Client A indicated she blocked the door with her wheelchair so the door would not shut. Client A indicated client F was pushing on her chair and client A hit client F with her chair. Client F hit client A in the face 18 times (an estimate according to client A). Client A indicated while trying to get client F to stop, she scratched client F's hand. Client A indicated staff #4 who was the only staff present, did not do anything physically to stop client F from hitting client A. Client A indicated staff #4 verbally prompted client F to stop hitting and for client A to move her chair. Client A indicated her chair was stuck and she was not able to move.</p> <p>An interview with the social worker (SW) was conducted on 11/10/11 at 9:21 AM. The SW stated client F had an "obsession with doorways." The SW indicated the staff should go into the home prior to client F going into the home to prompt client F out of the doorway. The SW</p>			

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W9999	<p>indicated this was part of client F's plan.</p> <p>An interview with the behavior clinician (BC) was conducted on 11/10/11 at 10:00 AM. The BC indicated client F did not have a plan addressing doorways. The BC indicated he needed to review previous incident reports to ascertain the extent of the incidents involving going through doorways.</p> <p>An interview with the QMRP was conducted on 11/10/11 at 10:20 AM. The QMRP indicated client F used to have a plan addressing doorways. She indicated client F's issue with doorways was becoming more of an issue and should be part of a plan. The QMRP indicated client A needed a plan to address hitting others or using her wheelchair to block others.</p> <p>This federal tag relates to complaint #IN00098871.</p> <p>9-3-4(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental</p>	W9999	<p>W9999 FINAL OBSERVATIONS Plan of Correction Stone Belt will ensure that all falls resulting in injury, regardless of the severity of the injury are reported within 24</p>	12/10/2011	

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	<p>Disabilities rule was not met:</p> <p>1) 460 IAC 9-3-1(a) Governing Body</p> <p>(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 (15. A fall resulting in injury, regardless of the severity of the severity of the injury.).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 18 incident/investigative reports reviewed affecting client C, the facility failed to ensure falls with injury were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/9/11 at 10:15 AM.</p> <p>-On 9/17/11 at 8:10 AM (reported to BDDS on 9/19/11), client C fell on her bedroom floor while getting dressed. She sustained a one inch bruise on her right upper arm and a cut on her lower lip with swelling. She had a one inch bruise above her left knee.</p> <p>-On 10/17/11 at 7:20 PM (reported to BDDS on 10/19/11), client C fell during a seizure while brushing her teeth. She bumped her ribs on the bathroom sink causing slight redness.</p>		<p>hours of the injury. Date of Completion December 10, 2011</p> <p>Responsible Person Southern Coordinator/SGL Director Plan of Prevention The Coordinator will ensure that all incident of falls resulting in injury regardless of the severity of the injury are reported within 24 hours of the injury. Quality Assurance Monitoring The SGL Director and Coordinator will review all incident reports regarding falls and insure that all reports are filed in a timely manner within 24 hours.</p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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	An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/9/11 at 10:31 AM. The QMRP indicated falls with injury should be reported to BDDS within 24 hours. 9-3-1(b)				