

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2012
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3502 FESTIVE DR BLOOMINGTON, IN 47401
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: June 19, 20, 21, 22 and 26, 2012.</p> <p>Facility Number: 000872 Provider Number: 15G357 AIM Number: 100239670</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed on 6/29/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 5 of 5 clients living in the group home and attending the facility-operated day program (#1, #2, #3, #4 and #5), the governing body failed to ensure the day program had a system to ensure staff received training on the clients' program plans.</p> <p>Findings include:</p> <p>On 6/19/12 from 12:52 PM to 1:39 PM, observations were conducted at the facility-operated day program. Day program staff #6, #7 and #8 were working in the room with clients #1, #2, #3 and #5. Client #1 was sitting outside on a bench. Client #2 was sitting in a recliner looking at a magazine. Client #3 was sitting in her wheelchair next to a table with a keyboard on it. Client #5 was lying on an exercise mat on his belly listening to music.</p> <p>On 6/20/12 from 9:25 AM to 10:32 AM, observations were conducted at the facility-operated day program. At 9:25 AM, client #4 was in Room 1 sitting at a table looking at a magazine. Staff #9 was working in the room. At 9:31 AM, staff</p>	W0104	<p>W 104 GOVERNING BODY</p> <p>Plan of Correction: Stone Belt exercises general policy, budget, and operating direction over the facility.</p> <p>Date of Completion: July 26, 2012</p> <p>Person Responsible: Festive Coordinator & Day Coordinator</p> <p>Plan of Prevention: Stone Belt will establish a system to ensure that staff working in day programming are trained on clients program plans.</p> <p>Quality Assurance Monitoring: Coordinators will review on a regular basis, training records to assure that staff working in designated areas are trained on the specific clients program</p>	07/26/2012			

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	<p>#9 stated client #4 did not receive a snack since she was on a "diet." At 9:34 AM, client #4 walked past this surveyor and there was a smell of feces. At 9:36 AM, client #4 obtained a straw from a container on a shelf. Staff #9 indicated client #4 used to have unlimited access to straws but it was getting expensive due to client #4 throwing them away. Staff #9 indicated on 6/20/12 at 9:37 AM client #4 received 5 straws in the morning and 5 after lunch. At 9:40 AM, client #4 walking around the room. There was a smell of feces when client #4 passed. At 9:51 AM, client #4 was assisted in the restroom by staff #9 after taking the newspaper to a different program area. At 10:00 AM, client #4 entered the classroom wearing different pants.</p> <p>On 6/20/12 at 10:23 AM to 10:37 AM, an observation was conducted for clients #1, #2, #3 and #5. Client #5 was on the mat listening to music. Client #2 was sitting in a recliner. Client #3 was sitting in her wheelchair next to a table with a keyboard. Client #1 was seated on her rolling walker. Staff #4 and #6 were working in the room.</p> <p>On 6/21/12 from 11:25 AM to 12:19 PM, an observation was conducted at the facility-operated day program where clients #1, #2, #3 and #5 were attending.</p>		plans.				

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	<p>Staff #4 and #8 were working in the room. Client #5 was on the mat listening to music. Client #2 was in a recliner. Client #3 was sitting in her wheelchair. Client #1 was sitting at a table. There was no staff to client interaction. At 11:30 AM, client #1 got her own lunch out. Client #3 was playing a keyboard on a table near her. Client #5 was on the mat and client #2 was in her recliner. At 11:32 AM, day program administrative staff #1 entered the room to provide one on one staffing to client #2 for lunch. At 11:37 AM, staff #8 prepared client #5's lunch (got client #5's lunchbox out, used microwave to heat up food, put the food onto a divided plate, and prepared his drink with Thick It). Client #5 was lying on the mat. At 11:37 AM, client #3 fell asleep in her wheelchair; staff had not interacted with her during the observation. At 11:42 AM, client #5 was on the mat. At 11:47 AM, staff #8 told the other staff he was going to assist client #5 with his lunch. At 11:49 AM, staff #8 prompted client #5 for lunch; client #5 did not respond or react. At 11:50 AM, client #3 was sitting in her wheelchair with no interaction from staff. At 11:52 AM, client #5 was assisted off the mat to his chair for lunch. At 11:55 AM, client #3 was sitting in her wheelchair with no interaction from staff. Client #3 received a brief verbal</p>				

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	<p>interaction from staff #10; first staff interaction since observation began at 11:25 PM.</p> <p>A review of client #4's record was conducted on 6/22/12 at 10:07 AM. There was no documentation in client #4's record indicating client #4 had a plan to limit the number of straws she could have.</p> <p>When asked, the facility did not provide documentation verifying the day program staff observed working in the program areas received training to implement the clients' program plans.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 6/22/12 at 8:55 AM. AS #1 indicated the day program was unable to locate documentation indicating the staff working in the program areas received training to work with the clients. AS #1 stated there was a "gap" in the training documentation.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/22/12 at 10:55 AM. The PC indicated the day program was unable to locate training documentation for the staff observed to work in the program areas. The PC indicated she was told there was no system in place to ensure the day</p>						

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	<p>program staff received training to implement the clients' plans.</p> <p>An interview with AS #2 was conducted on 6/22/12 at 11:28 AM. AS #2 indicated the day program staff received training however the training was not documented. AS #2 indicated the facility was going to implement steps to ensure the staff received documented training on the clients' plans.</p> <p>9-3-1(a)</p>			

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 35 of 47 incident reports reviewed affecting 1 of 5 clients (#2), the facility failed to implement its policies and procedures to prevent neglect of a client in regard to falls.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/19/12 at 11:26 AM.</p> <p>The following falls occurred at the group home (7):</p> <p>-On 4/12/12 at 4:45 PM, client #2 was exiting the restroom with her right hand on the sink. Client #2 fell to her backside due to losing her balance. The report indicated, "No other environmental factors would (sic) of caused the fall." No injury.</p> <p>-On 4/16/12 at 6:45 AM, client #2 was transitioning from the dining room table to the kitchen counter when she lost her balance and fell to her backside. No injury.</p> <p>-On 4/25/12 at 6:15 AM, client #2 was in the shower with direct care staff (DCS) #7 assisting her. Client #2 lost her balance and fell backward landing on her bottom.</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>Specifically, changes will be made and training completed on clients fall risk plan and behavior plan.</p> <p>Responsible Person:</p> <p>Festive Coordinator</p> <p>Date of Completion:</p> <p>July 26, 2012</p> <p>Plan of Prevention:</p> <p>The clients behavioral support plan and risk plan are being reviewed and updated to include strategies that will limit the number of falls the client experiences. One addition, includes the use of a gait belt and continued training both in the home and at day programming.</p>	07/26/2012			

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	<p>No injury.</p> <p>-On 5/30/12 at 7:00 PM, client #2 was walking toward the dining room. She fell in between the door that opens into the kitchen and the dining room. No known cause for the fall. No injury.</p> <p>-On 6/7/12 at 6:10 AM, client #2 was walking in the living room and picked up a toy from the counter top. DCS #1 heard a noise and then observed client #2 on the floor on her bottom. DCS #1 documented there was nothing around that may have caused the fall or startled her. No injury.</p> <p>-On 6/12/12 at 4:30 PM, client #2 was walking in the hallway. Client #4 brushed client #2's arm "slightly" which caused client #2 to fall on her bottom and rocked back to her elbows. No injury.</p> <p>-On 6/13/12 at 6:30 PM, client #2 was walking around the dining room table focused on another client's ice cream. Client #2 tripped over the leg of a chair. Client #2 got up and went toward the ice cream laughing. No injury.</p> <p>The following falls occurred at the facility-operated day program (28):</p> <p>-On 3/26/12 at 9:50 AM, client #2 was holding onto day program staff (DPS) #1's hand. The report indicated, "All of a sudden tensed up and fell backwards parallel to the water fountains outside Rm (room) 16, landing on her buttocks and elbows." No injury.</p>		<p>Quality Assurance Monitoring:</p> <p>The Festive Coordinator and SGL Director will monitor the falls and number of occurrences to determine if further techniques need to be implemented to maintain the health and safety of the client.</p> <p>The Coordinator and other administrative staff will conduct visits to the home and day programming, both announced and unannounced, to assure methods and training are successful.</p>		

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	<p>-On 3/30/12 at 3:45 PM, client #2 was walking in room 16. The report indicated, "For no reason [client #2] tightened her arms and legs (rigid). She then slowly fell backward hitting her elbows and bottom on the floor." No injury.</p> <p>-On 4/4/12 at 9:30 AM, client #2 was walking around room 16 in between tables when [male peer] walk (sic) through between the tables and bumped in to [client #2] causing her to fall. When [client #2] fell her head hit a chair (sic) push the table as she landed on her bottom." No injury.</p> <p>-On 4/4/12 at 10:12 AM, client #2 was walking from the room 16 to the restroom. Client #2 took a step but did not lift her foot enough to move. She stumbled and fell. The report indicated, "She slowly dropped to her knees and laid on the floor." No injury.</p> <p>-On 4/13/12 at 8:30 AM, client #2 was standing in room 16 holding her wallet. Client #2 lost her balance and fell to her bottom, rolled backward and bumped helmeted area on the leg of a chair. No injury.</p> <p>-On 4/13/12 at 1:30 PM, client #2 was walking in room 16 and leaned against the table. Client #2 slumped/fell down to the floor, landing on her right side. No injury.</p> <p>-On 4/16/12 at 2:00 PM, client #2 "did a slow fall to her left side." Staff</p>						

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	<p>documented, "Unclear whether [male peer} bumped her or not, just saw [male peer] behind [client #2] as she was falling." No injury.</p> <p>-On 4/17/12 at 8:30 AM and 8:45 AM, client #2 was walking close to [male peer's] chair. The male peer looked at client #2 and put his arm out straight toward her. There was light contact and client #2 fell backward landing on her bottom. At 8:45 AM, client #2 walked behind the male peer's chair and the male peer pushed his chair back toward her and she fell landing on her bottom. No injury.</p> <p>-On 5/1/12 at 10:38 AM, client #2 was walking around room 16. She fell backward onto her bottom for "no apparent reason." No injury.</p> <p>-On 5/1/12 at 1:26 PM, client #2 was standing near the table listening to her music player. Her foot was under a rung of the chair. The peer sitting in the chair moved, causing client #2 to lose her balance. She attempted to catch herself on the table and chair. Client #2 fell to her left side landing on her left elbow and bottom. She stood up holding her music player and laughing. No injury.</p> <p>-On 5/7/12 at 11:20 AM, client #2 was walking around room 16. She lost her balance and fell backward onto her bottom. No injury.</p> <p>-On 5/9/12 at 12:25 PM, client #2 was walking around tables and chair. A male</p>						

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	<p>peer was eating lunch nearby. Client #2 stepped slightly backward, bumped into a chair, startled herself and fell backward. As she fell her head landed on an office chair a male peer was sitting on. The male peer's chair tipped over and he fell on top of client #2. The report indicated, "both were easy falls." No injury noted."</p> <p>-On 5/15/12 at 12:10 PM, client #2 was walking around room 16. She bumped her foot on a footstool, froze and fell backward landing on her bottom and elbows. No injury.</p> <p>-On 5/16/12 at 10:09 AM, client #2 was standing next to a desk. She fell backward landing on her bottom. The report indicated, "No apparent reason for fall." No injury.</p> <p>-On 5/16/12 at 11:30 AM, client #2 was walking around clients who were sitting at tables preparing for lunch. Client #2 bumped into a male peer's chair and laughed. The male peer pushed his chair back "slightly" causing client #2 to startle. Client #2 fell onto her bottom and elbows. The report indicated there was no injury at the time. At 4:00 PM, the report indicated a bruise formed on her left elbow.</p> <p>-On 5/16/12 at 1:20 PM, a male peer quickly walked by client #2 and startled her. Client #2 tried to step back, lost her balance, tried to grab a chair and then fell onto her bottom. No injury.</p>			

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	<p>-On 5/25/12 at 12:25 PM, client #2 was walking around room 16 and listening to her music. The left side of her body bumped into a chair and she fell on her right side. She had a long bruise forming on the inside of her left forearm.</p> <p>-On 5/25/12 at 1:35 PM, client #2 was walking around room 16. She stopped walking, stood for a few minutes and then fell for no apparent reason. No injury.</p> <p>-On 5/29/12 at 9:45 AM, client #2 was walking around room 16 and fell backward for no apparent reason. She landed on her bottom. No injury.</p> <p>-On 5/30/12 at 2:30 PM, client #2 was walking around room 16. Client #2 hit staff #3's bottom and laughed. She did it again and lost her balance and fell. She fell forward onto her right forearm/elbow area. No injury.</p> <p>-On 5/31/12 at 11:00 AM, client #2 was walking around room 16. Staff #4 heard client #2 fall to the floor. He turned and observed client #2 on her bottom laughing, nodding and waving. No injury.</p> <p>-On 6/5/12 at 9:45 AM, client #2 pulled her pants down some and staff #5 assisted her to pull them up. Client #2 attempted to pull her pants down again and fell backward to the floor, hitting a chair another client was sitting in on the way down. Her helmet his the arm of the chair and her helmet slid forward and knocked</p>				

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	<p>her glasses down. Her head had a light red mark in line with the scuff on her helmet and she had a less than 1/4 inch light brown bruise on her inner right arm.</p> <p>-On 6/5/12 at 9:20 AM, client #2 approached a male peer in room 16 while he was sitting at a table. The male peer told client #2 to leave him alone. The report indicated, "Then he pushed [client #2] and she lost her balance and fell on bottom." No injury. The action taken section indicated, "[Initials of supervisor] when talked more to staff of the actual event it was believe to not be aggression. [Male peer] placed is hand out and tapped [client #2] causing her to loose (sic) balance." There was no documentation the client to client abuse was investigated by the facility.</p> <p>-On 6/6/12 at 8:45 AM, client #2 was walking and bumped into a chair. She fell onto her bottom. No injury.</p> <p>-On 6/6/12 at 9:25 AM, client #2 was walking around room 16. She lost her balance and fell on her bottom. After getting up with assistance, she walked and fell backward hitting her helmet on the table on the way down. No injury.</p> <p>-On 6/6/12 at 10:15 AM, client #2 was walking in between tables in room 16. A male peer was playing cards and abruptly decided to stop participating. He slid his chair out from under the table quickly and forcefully without looking to see if it was</p>			

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	<p>clear. The chair hit client #2 on the front part of her right hip. She fell backward landing on her bottom. She rolled onto her back and hit her helmet on the floor. No injury.</p> <p>-On 6/6/12 at 12:55 PM, client #2 was standing in an open space within room 16 listening to her music. Staff #6 observed her lean to the left a little bit, hang out for about 30 seconds and then she fell to her left. She landed on her left hip and hand/wrist. She did not stumble or trip and was not startled. No injury.</p> <p>A review of client #2's record was conducted on 6/21/12 at 1:58 PM.</p> <p>-Her Physician's Orders, dated 6/13/12, indicated the following, "Very poor balance, falls frequently. Helmet at all times when up. Wheelchair to be used for long distances and transport from house to van and van to house."</p> <p>-Client #2's Medication Information Sheet, dated 6/12/12, indicated she had a risk plan for falls. The risk plan indicated, "[Client #2] is at risk for falls due to her history and her diagnosis. [Client #2] is easily startled and may fall in reaction to a loud noise or sudden movement. These falls are quick. She appears to simply drop to the floor or onto an immediately close by surface - furniture, staff and roommates. Some of [client #2's falls] occur without any</p>						

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	evident cause. These falls are usually slow and gentle in nature and she usually will wind up in a sitting position on the floor. She may even laugh. Some of [client #2's] falls are due bumping into something or being bumped into by someone else. These falls can be quick or slow resulting in her landing on her side, back or seated depending on the contact that initiated the fall. [Client #2] walks slowly. She had difficulty changing surfaces, and even this may resulting (sic) in falls. Getting too close to furniture, walls or other people can cause her to lose her balance and fall. [Client #2] had frequently fallen out of chairs onto the ground or missed a chair she appeared to be attempting to sit on and fall. [Client #2's] falls are not seizure related. Due to a history of head trauma from these falls, [client #2] wears a soft helmet when she is out of bed. [Client #2] can refrain from wearing her helmet during late night or early morning hours when she is transitioning from her bedroom to the bathroom with 1:1 assistance." The procedure for the risk plan indicated, "Staff will assist [client #2] when she is walking outside, or inside if needed, by gently taking her arm or walking behind her and guiding her with their hands. Staff will apply [client #2's] helmet correctly and assure that she wears her helmet at all times when she is up (this				

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	<p>from BDDS - Bureau of Developmental Disabilities Services). Staff will assist [client #2] to sit down, gently guiding her bottom into the seat so she does not miss the chair or bench. Staff will assure that [client #2] is seated securely and correctly in her chair when sitting. Staff will assist [client #2] with performing the home exercise program recommended by the physical therapist. Staff will transport [client #2] via wheelchair from the house to the van and back. Staff has the option to walk [client #2]. Staff will always transport [client #2] via wheelchair when out in the community or on any outing. Staff will respond quickly to all falls and check [client #2] for injuries. Staff will notify the nurse, QMRP - Qualified Mental Retardation Professional, and [client #2's] mother (guardian) via voicemail or e-mail of any injuries due to falls immediately. Staff will notify the Central Region Pager of injuries or concerns regarding falls after routine business hours. Staff will document all falls and any pertinent information concerning the fall on an incident report." The risk plan indicated, "Staff has read and understands this plan. Only staff who have read and understand this plan can implement it will work with [client #2]. Staff will be trained in correct application of [client #2's] helmet. Staff will continually monitor [client #2] while</p>			

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	<p>allowing her as much independence as safe and possible." -On 11/28/11, client #2 had a physical therapy evaluation. The Treatment Plan/Recommendations section indicated, "...2. Trail using a gait belt to improve safety and assist with transfers, gait/mobility and to offer a solid hand hold for caregivers to hang onto to assist [client #2] if she loses her balance during waking hours. Continue to use if helpful; discontinue regular use if [client #2] does not tolerate it but keep on hand as needed. 3. Continue to make changes to environment as necessary and possible both at residence and day program facility. This will help eliminate tripping hazards, specifically minimizing or eliminating changes in walking surface levels in and between rooms and floor covering textures." There was no evidence in client #2's record indicating the physical therapist's recommendation for a trial of a gait belt was implemented.</p> <p>A review of the facility's Behavioral Intervention Policy, dated 10/2010, was conducted on 6/19/12 at 11:15 AM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an</p>						

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	<p>individual. Neglect is the failure to provide appropriate care, food medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated Events Requiring Investigations included, "Situations involving suspected or alleged abuse, neglect or exploitation of consumers or any rights issue as described in agency policies will be investigated by staff designated and trained by the agency for this role."</p> <p>An interview with client #2's guardian was conducted on 6/22/12 at 9:12 AM. The guardian indicated she contacted the day program administrative staff about a month ago to discuss client #2's falls. The guardian indicated the facility had tried numerous interventions over the years. The guardian indicated the use of a wheelchair was not appropriate. Tried previously however client #2 would run into others. The guardian indicated client #2 could not use a walker due to always having something in at least one of her hands. The guardian indicated client #2 needed 1:1 staffing at the day program due to her falls. The guardian indicated client #2 was going to fall and always had in the past due to medical issues. The</p>						

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	<p>guardian indicated she was not opposed to the use of a gait belt. The guardian indicated that although the physical therapist recommended a trial of a gait belt, she questioned whether or not it would be helpful unless client #2 also received 1:1 staffing. The guardian indicated client #2 had been seen by many medical specialists over the years for her falls. She indicated braces and pads had been attempted but not successful. The guardian did not believe the facility staff were negligent due to the actions they took when she wanted action to be taken (meetings, discussions, appointments).</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/22/12 at 10:55 AM. The PC indicated she did not understand why there were so many more falls at the day program. The PC indicated the day program classroom client #2 attended was overstimulating, crowded and client #2 was easily startled. The PC indicated she thought if client #2 was engaged in activities, the falls would be reduced; the PC indicated the staff in day program needed to be more involved and proactive with preventing the falls. The PC indicated using a wheelchair at the day program had been denied since client #2 ran into her peers when she used the wheelchair previously. The PC indicated she had suggested client #2 be</p>						

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	<p>moved to another program area but was told no by the Director of Life Long Learning. The PC indicated a gait belt was recommended by the physical therapist however client #2's guardian told her if she put on the gait belt the guardian would drive over to take it off; the guardian did not want the use of a gait belt. The PC indicated she recommended one on one (1:1) staffing however was told by the day program the increased staffing could not be provided. The PC indicated she thought the use of a gait belt with 1:1 staffing could reduce the number of falls at the day program.</p> <p>An interview with the Director of Life Long Learning was conducted on 6/22/12 at 11:28 AM. The Director indicated the day program had made numerous changes to reduce client #2's falls at the day program. The Director indicated the flooring was changed from carpet to linoleum, some clients were removed from the program area, obtained a comfortable chair for client #2 to sit in and removed some of the tables and chairs. The Director indicated the staffing level was increased in the program area. The Director indicated the team had met numerous times to discuss client #2's falls. The Director indicated a gait belt would not be beneficial unless client #2 had 1:1 staffing. The Director indicated</p>						

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	<p>the use of 1:1 staff would need to be made by the team. The Director indicated client #2 spent a lot of her time at the day program walking around. The Director indicated there was a difference in the way the group home and the day program report falls. The Director indicated the group home did not report "sit downs" as falls as the day program did. The Director indicated a sit down was client #2 going to the floor and rolling onto her back without injury. The Director indicated she was unable to locate documentation verifying the day program staff received training on client #2's plans.</p> <p>9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 35 incident reports affecting 1 of 5 clients (#2), the facility failed to conduct a thorough investigation into client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/19/12 at 11:26 AM. On 6/5/12 at 9:20 AM, client #2 approached a male peer at the facility-operated day program while he was sitting at a table. The male peer told client #2 to leave him alone. The report indicated, "Then he pushed [client #2] and she lost her balance and fell on bottom." No injury. The staff reported the incident to administrative staff at 9:22 AM. The action taken section on the incident report indicated, "[Initials of supervisor] when talked more to staff of the actual event it was believe (sic) to not be aggression. [Male peer] placed his hand out and tapped [client #2] causing her to loose (sic) balance." The facility did not conduct an investigation of client to client abuse.</p> <p>An interview with the Program</p>	W0154	<p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will ensure any incidents of Abuse, Neglect, and/or mistreatment are investigated thoroughly. This will include the day programming area.</p> <p>Person Responsible:</p> <p>SGL Director, Festive Coordinator, Day Programming Coordinator</p> <p>Date of Completion:</p> <p>July 26, 2012</p> <p>Plan of Prevention:</p> <p>Both day programming and residential Coordinators will be trained investigate thoroughly as indicated in the Stone Belt Investigation Protocols.</p> <p>Quality Assurance Monitoring:</p> <p>Stone Belt Director of Group Homes and Director of Lifelong Learning will review all incidents</p>	07/26/2012	

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	<p>Coordinator (PC) was conducted on 6/21/12 at 10:38 AM. The PC indicated she was not aware of the incident and had not been given the incident report to review as evidenced by the lack of her signature on the routing portion of the incident report. The PC indicated the facility should have investigated the client to client abuse.</p> <p>9-3-2(a)</p>		<p>and investigation reports to assure policy is being followed.</p>	

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, interview and record review for 5 of 5 clients living in the group home and attending the facility-operated day program (#1, #2, #3, #4 and #5), the facility failed to ensure the day program staff received training on the clients' program plans.</p> <p>Findings include:</p> <p>On 6/19/12 from 12:52 PM to 1:39 PM, observations were conducted at the facility-operated day program. Day program staff #6, #7 and #8 were working in the room with clients #1, #2, #3 and #5. Client #1 was sitting outside on a bench. Client #2 was sitting in a recliner looking at a magazine. Client #3 was sitting in her wheelchair next to a table with a keyboard on it. Client #5 was lying on an exercise mat on his belly listening to music.</p> <p>On 6/20/12 from 9:25 AM to 10:32 AM, observations were conducted at the facility-operated day program. At 9:25 AM, client #4 was in Room 1 sitting at a table looking at a magazine. Staff #9 was working in the room. At 9:31 AM, staff</p>	W0189	<p>W 189</p> <p>STAFF TRAINING PROGRAM</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that all staff are provided with initial and continuing training that enables the employee to perform their duties effectively, efficiently and competently.</p> <p>Date of Completion:</p> <p>July 26, 2012</p> <p>Person Responsible:</p> <p>Festive Coordinator and Lifelong Learning Coordinator</p> <p>Plan of Prevention:</p> <p>Staff receive initial training prior to working in a particular area of day programming with clients.</p> <p>In addition, staff will be retrained on a as needed basis based on changes in the clients individual plans.</p>	07/26/2012			

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	<p>#9 stated client #4 did not receive a snack since she was on a "diet." At 9:34 AM, client #4 walked past this surveyor and there was a smell of feces. At 9:36 AM, client #4 obtained a straw from a container on a shelf. Staff #9 indicated client #4 used to have unlimited access to straws but it was getting expensive due to client #4 throwing them away. Staff #9 indicated on 6/20/12 at 9:37 AM client #4 received 5 straws in the morning and 5 after lunch. At 9:40 AM, client #4 walking around the room. There was a smell of feces when client #4 passed. At 9:51 AM, client #4 was assisted in the restroom by staff #9 after taking the newspaper to a different program area. At 10:00 AM, client #4 entered the classroom wearing different pants.</p> <p>On 6/20/12 at 10:23 AM to 10:37 AM, an observation was conducted for clients #1, #2, #3 and #5. Client #5 was on the mat listening to music. Client #2 was sitting in a recliner. Client #3 was sitting in her wheelchair next to a table with a keyboard. Client #1 was seated on her rolling walker. Staff #4 and #6 were working in the room.</p> <p>On 6/21/12 from 11:25 AM to 12:19 PM, an observation was conducted at the facility-operated day program where clients #1, #2, #3 and #5 were attending.</p>		<p>Quality Assurance Monitoring:</p> <p>Festive Coordinator and Lifelong Learning Coordinators will ensure that staff are trained on specific clients and training records will be reviewed. Necessary documentation will be kept on record to assure training is being completed.</p>				

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	<p>Staff #4 and #8 were working in the room. Client #5 was on the mat listening to music. Client #2 was in a recliner. Client #3 was sitting in her wheelchair. Client #1 was sitting at a table. There was no staff to client interaction. At 11:30 AM, client #1 got her own lunch out. Client #3 was playing a keyboard on a table near her. Client #5 was on the mat and client #2 was in her recliner. At 11:32 AM, day program administrative staff #1 entered the room to provide one on one staffing to client #2 for lunch. At 11:37 AM, staff #8 prepared client #5's lunch (got client #5's lunchbox out, used microwave to heat up food, put the food onto a divided plate, and prepared his drink with Thick It). Client #5 was lying on the mat. At 11:37 AM, client #3 fell asleep in her wheelchair; staff had not interacted with her during the observation. At 11:42 AM, client #5 was on the mat. At 11:47 AM, staff #8 told the other staff he was going to assist client #5 with his lunch. At 11:49 AM, staff #8 prompted client #5 for lunch; client #5 did not respond or react. At 11:50 AM, client #3 was sitting in her wheelchair with no interaction from staff. At 11:52 AM, client #5 was assisted off the mat to his chair for lunch. At 11:55 AM, client #3 was sitting in her wheelchair with no interaction from staff. Client #3 received a brief verbal</p>						

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	<p>interaction from staff #10; first staff interaction since observation began at 11:25 PM.</p> <p>A review of client #4's record was conducted on 6/22/12 at 10:07 AM. There was no documentation in client #4's record indicating client #4 had a plan to limit the number of straws she could have.</p> <p>When asked for, the facility did not provide documentation verifying the day program staff observed working in the program areas received training to implement the clients' program plans.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 6/22/12 at 8:55 AM. AS #1 indicated the day program was unable to locate documentation indicating the staff working in the program areas received training to work with the clients. AS #1 stated there was a "gap" in the training documentation.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/22/12 at 10:55 AM. The PC indicated the day program was unable to locate training documentation for the staff observed to work in the program areas. The PC indicated she was told there was no system in place to ensure the day</p>						

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	<p>program staff received training to implement the clients' plans.</p> <p>An interview with AS #2 was conducted on 6/22/12 at 11:28 AM. AS #2 indicated the day program staff received training however the training was not documented.</p> <p>9-3-3(a)</p>				

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (#4) and 1 of 2 non-sampled clients (#5), the facility failed to ensure: 1) client #4's dining plan was updated as recommended by the support team and 2) client #5's behavior plan was revised to reflect current issues with maladaptive behavior.</p> <p>Findings include:</p> <p>1) A review of client #4's record was conducted on 6/22/12 at 10:07 AM. On 4/9/12, the Support Team Review form indicated the following, "update dining plan to use non-slip mat under plate to prevent sliding - nurse." Client #4's Medication Information Sheet, dated 5/29/12, indicated client #4 used a toddler size spoon and fork, covered cup with a straw and a 3 way divided plate. Client #4's assessment by the dietician was conducted on 3/20/12. The assessment indicated client #4 was to use a divided plate, cup with a lid and straw and a toddler spoon and fork. There was no documentation her plan was updated to include the use of a non-slip mat under her plate to prevent sliding.</p>	W0240	<p>W 240 INDIVIDUAL PROGRAM PLAN</p> <p>Plan of Correction: Stone Belt will ensure that individual program plans will describe relevant interventions to support the individual toward independence.</p> <p>Date of Completion: July 26, 2012</p> <p>Person Responsible: Festive Coordinator</p> <p>Plan of Prevention: 1) Nurse will update plan to include use of a non-slip mat. 2) Client's behavior plan will be updated to include biting and screaming at other times inclusive of meal times. Television will be turned off during meal time as outlined in the clients behavior plan. Behavior plan will be reviewed, updated and trained to include necessary restraints, walking and aggression.</p>	07/26/2012	

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	<p>On 6/22/12 at 10:43 AM, an interview with the Program Coordinator (PC) was conducted. The PC indicated the Support Team's recommendations had not been implemented into client #4's dining plan.</p> <p>2) An observation was conducted at the facility-operated day program on 6/21/12 from 11:25 AM to 12:19 AM. At 11:49 AM, staff #8 verbally prompted client #5 for lunch. Client #5 did not respond. At 11:50 AM, staff #10 sat down on the mat client #5 was lying on to try to encourage client #5 to get up for his lunch. At 11:52 AM, staff #8 physically assisted client #5 to his feet and assisted him to the table for lunch. At 11:56 AM, client #5 slid down in the chair he was sitting in. Staff #8 assisted client #5 to a seated position in the chair two times. Client #5 then stood up. Staff #8 took client #5 for a walk in the hallway after client #5 started rubbing his head. Staff #8 indicated, at 11:56 AM, he took client #5 for a walk due to client #5 showing signs of agitation. Client #5 and staff #8 returned to the program area for client #5 to resume lunch at 12:01 PM. The TV was on in the program area.</p> <p>A review of the facility's incident reports was conducted on 6/19/12 at 11:26 AM. -On 6/13/12 at 11:45 AM, client #5 had self-injurious behavior (hitting the side of</p>		<p>Quality Assurance Monitoring:</p> <p>Coordinator will review documentation to ensure that all client plans are being followed and updated as necessary.</p>		

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	<p>his head) and rubbing his fingers across his teeth at the facility-operated day program. Staff #4 attempted to block and he grabbed staff #4's hands and attempted to rub their thumbs across his teeth. He then bit the staff on the left pointer finger. -On 6/13/12 at 12:41 PM, client #5 had self-injurious behavior of hitting the sides of his head. Staff placed their arms/hands as a barrier. Client #5 scratched and pinched staff several times. While walking to the restroom, client #5 took staff #4's hand to his mouth and bit it.</p> <p>A review of client #5's record was conducted on 6/21/12 at 12:35 PM. His Behavioral Support Plan (BSP), dated 6/3/12, indicated his targeted behaviors included screaming and aggressive responses. Screaming was defined as using a voice louder than what was considered socially appropriate. Aggressive responses was defined as becoming aggressive toward himself or others. The Intervention/Reactive Strategies section of the BSP indicated for screaming, "1. When possible, staff should try to keep distractions low during meal times. TV and radios should be turned off and other distractions eliminated whenever possible. 2. If screaming is just beginning, staff may be able to change the environment to refocus [client #5] by taking him out of his</p>			

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	<p>wheelchair and permitting him to lay on the floor or bean bag. 3. During meal times when [client #5] screams, staff will remind him to use a quiet, inside or soft voice. 4. If [client #5] seems in distress or is unable to calm himself, staff may remove him to a chair in the kitchen for not more than 10 minutes. The goal is to find an area to decrease distractions. Prolonged screaming is likely to increase gas and cause more abdominal distress. 5. When [client #5] is calm, he may return to the table. 6. If [client #5] cannot calm after three 10 minute breaks, staff may offer him the opportunity to eat later in the evening. Staff may give [client #5] a break for an hour and offer his meal again. 7. [Client #5's] programming may be done in his bedroom as necessary to gain his participation and eliminate distractions. This will also prevent [client #5's] screaming from becoming unnecessarily disruptive to other clients." The Interventions/Reactive Strategies section for aggressive responses indicated, "In the event [client #5] engages in an aggressive response to self or others, staff may briefly hold his hands down to prevent further attempts. 2. Staff should look directly into [client #5's] eyes, making sure there is eye contact. You may briefly touch or hold his chin to gain eye. Staff may say 'No.' 3. Staff may use the</p>						

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	<p>appropriate release for hair pulls as needed. 4. Again staff may move [client #5] from the environment for short intervals as needed to interrupt the behaviors." His BSP did not address screaming outside of mealtimes. The BSP did not address biting. The BSP did not include proactive steps to take when client #5 initially showed signs of agitation.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/21/12 at 12:56 PM. The PC indicated the BSP for client #5 needed to be updated. The PC indicated the plan for screaming was focused on his dining at home issues and needed to be revised to include the day program. The PC indicated the plan did not address biting. The PC indicated the plan needed to address being proactive when he started to become agitated.</p> <p>9-3-4(a)</p>				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure staff implemented the clients' plans as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the facility-operated day program on 6/20/12 from 9:25 AM to 10:37 AM. At 10:02 AM, staff #9 looked for client #4's adaptive spoon and fork in client #4's lunchbox. Staff #9 was unable to locate client #4's adaptive spoon and fork in her lunchbox. Staff #9 indicated there should be extras at the day program however she was unable to locate them.</p> <p>A review of client #4's record was conducted on 6/22/12 at 10:07 AM. Client #4's Medication Information Sheet, dated 5/29/12, indicated client #4 used a toddler size spoon and fork, covered cup with a straw and a 3 way divided plate. Client #4's assessment by the dietician</p>	W0249	<p>W 249 PROGRAM IMPLEMENTATION Plan of Correction: Stone Belt will ensure that each client will receive continuous active treatment as designated by each individual's program plan. This will include interventions and services frequent enough to support the achievement of the objectives. Date of Completion: July 26, 2012 Person Responsible: Festive Coordinator Plan of Prevention: The Stone Belt Support Team will ensure that behavior and active treatment plans are followed in general and specifically as follows 1) a checklist was established (Attachment # 1) was placed in the home to ensure that all necessary steps are taken to ensure lunches at day programming are packed appropriately, 2) clients training objective has been changed to ensure that staff and client follow appropriate dining (Attachment # 2) 3) staff were retrained on clients BSP regarding the clients access to unlimited straws. (Attachment # 3) 4) Day</p>	07/26/2012			

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	<p>was conducted on 3/20/12. The assessment indicated client #4 was to use a divided plate, cup with a lid and straw and a toddler spoon and fork. On 4/9/12, the Support Team Review form indicated the following, "update dining plan to use non-slip mat under plate to prevent sliding - nurse." There was no documentation her plan was updated.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/22/12 at 10:55 AM. The PC indicated client #4 should have her mealtime adaptive equipment at the facility-operated day program.</p> <p>2) An observation was conducted at the group home on 6/19/12 from 4:06 PM to 5:50 PM. At 5:26 PM, client #2 started eating dinner. Client #2 was being assisted by staff #10 who was sitting next to client #2 at the table. Staff #10 used a second spoon to assist client #2 with appropriate sized bites. Staff #10 did not prompt client #2 to put her spoon down after every third bite.</p> <p>A review of client #2's record was conducted on 6/21/12 at 1:58 PM. Client #2's Individual Support Plan (ISP), dated 2/6/12, indicated she had a training objective to put her spoon down after every third bite. Her Medication</p>		<p>programming staff will be retrained on active treatment/engagement. Training will occur as necessary in applicable areas. Quality Assurance Monitoring: Coordinator and other Administrative Staff will conduct announced and announced visits to ensure that plans are being carried out as presented at both the residential site and day programming area.</p>				

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	<p>Information Sheet (MIS), dated 6/12/12, indicated client #2 was at risk of choking due to a decrease in her chewing action. The dining plan in the MIS indicated the following, in part, "5. Staff will sit near [client #2] and prompt not to take more than 1 bite. 6. Staff will also assist her to put her spoon down if she tries to take more than 1 bite at a time. 7. Staff may use an additional spoon to remove excess food from [client #2's] spoon. This is to assist [client #2] in taking appropriate bite sizes." The MIS dining plan for choking did not include putting her spoon down after every third bite.</p> <p>An interview with the PC was conducted on 6/21/12 at 10:38 AM. The PC indicated the ISP training objective did not match the risk plan for choking. The PC indicated client #2 did not need to put her spoon down after every third bite. The PC indicated the ISP needed to be revised to match the risk plan.</p> <p>3) On 6/20/12 from 9:25 AM to 10:32 AM, observations were conducted at the facility-operated day program. At 9:34 AM, client #4 was walking around the room carrying a straw. At 9:36 AM, client #4 obtained a straw from a container on a shelf. At 9:38 AM, client #4 threw the straw she was carrying into the trash and obtained another one from</p>			

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	<p>the box on the shelf. At 9:39 AM, client #4 threw away the straw in the trash. At 9:42 AM, client #4 took the newspaper to another program area in the building. At 9:49 AM, client #4 went into an office and signed for a straw; the staff did not have one. Client #4 then went into another office and got a straw from Administrative staff #1 and walked back to the program room.</p> <p>An interview with day program staff #9 was conducted on 6/20/12 at 9:37 AM. Staff #9 indicated client #4 used to have unlimited access to straws but it was getting expensive due to client #4 throwing them away. Staff #9 indicated client #4 received 5 straws in the morning and 5 after lunch in her box.</p> <p>A review of client #4's record was conducted on 6/22/12 at 10:07 AM. There was no documentation in her record indicating there was a plan for limiting her access to straws. A Support Team Meeting form, dated 10/10/11, indicated no limiting of straws for client #4. Her Behavioral Support Plan, dated 2/29/12, indicated the following, "[Client #4] enjoys playing with straws and desires to have straws with her quite often while at the group home. [Client #4] has free access to her straws."</p>						

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	<p>An interview with the PC was conducted on 6/22/12 at 10:45 AM. The PC indicated there used to be a plan for 5 straws in the morning and after lunch however the plan was discontinued. The PC indicated she had spoken to day program staff #9 several times about not limiting client #4's access to straws. The PC indicated day program staff #9 was still implementing the discontinued plan and should not be implementing it.</p> <p>4) On 6/19/12 from 12:52 PM to 1:39 PM, observations were conducted at the facility-operated day program. Day program staff #6, #7 and #8 were working in the room with clients #1, #2, #3 and #5. Client #1 was sitting outside on a bench. Client #2 was sitting in a recliner looking at a magazine. Client #3 was sitting in her wheelchair next to a table with a keyboard on it. Client #5 was lying on an exercise mat on his belly listening to music. At 1:10 PM, client #2 was sitting in a recliner with no staff interaction. Client #5 was assisted to the restroom. Client #1 was sitting on a bench outside the room. Client #3 was sitting in her wheelchair with no staff interaction. At 1:15 PM, client #1 started to come inside after being prompted by staff #6 but sat back down on the bench. Staff #6 went out to assist her with entering the building. At 1:19 PM, client #2 stood up</p>						

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	<p>from her recliner, turned it and sat back down. At 1:21 PM, client #2 was praised by staff #6 for standing up on her own. At 1:27 PM, staff #6 tossed a beach ball with client #3. Client #2 walked around the room until 1:30 PM.</p> <p>On 6/20/12 from 9:25 AM to 10:32 AM, observations were conducted at the facility-operated day program. At 9:25 AM, client #4 was in Room 1 sitting at a table looking at a magazine. Staff #9 was working in the room. At 9:31 AM, staff #9 stated client #4 did not receive a snack since she was on a "diet." At 9:34 AM, client #4 walked past this surveyor and there was a smell of feces. At 9:36 AM, client #4 obtained a straw from a container on a shelf. Staff #9 indicated client #4 used to have unlimited access to straws but it was getting expensive due to client #4 throwing them away. Staff #9 indicated on 6/20/12 at 9:37 AM client #4 received 5 straws in the morning and 5 after lunch. At 9:40 AM, client #4 walking around the room. There was a smell of feces when client #4 passed. At 9:51 AM, client #4 was assisted in the restroom by staff #9 after taking the newspaper to a different program area. At 10:00 AM, client #4 entered the classroom wearing different pants.</p> <p>On 6/20/12 at 10:23 AM to 10:37 AM, an</p>			

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	<p>observation was conducted for clients #1, #2, #3 and #5. Client #5 was on the mat listening to music. Client #2 was sitting in a recliner. Client #3 was sitting in her wheelchair next to a table with a keyboard. Client #1 was seated on her rolling walker. Staff #4 and #6 were working in the room.</p> <p>On 6/21/12 from 11:25 AM to 12:19 PM, an observation was conducted at the facility-operated day program where clients #1, #2, #3 and #5 were attending. Staff #4 and #8 were working in the room. Client #5 was on the mat listening to music. Client #2 was in a recliner. Client #3 was sitting in her wheelchair. Client #1 was sitting at a table. There was no staff to client interaction. At 11:30 AM, client #1 got her own lunch out. Client #3 was playing a keyboard on a table near her. Client #5 was on the mat and client #2 was in her recliner. At 11:32 AM, day program administrative staff #1 entered the room to provide one on one staffing to client #2 for lunch. At 11:37 AM, staff #8 prepared client #5's lunch (got client #5's lunchbox out, used microwave to heat up food, put the food onto a divided plate, and prepared his drink with Thick It). Client #5 was lying on the mat. At 11:37 AM, client #3 fell asleep in her wheelchair; staff had not interacted with her during the</p>			

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	<p>observation. At 11:42 AM, client #5 was on the mat. At 11:47 AM, staff #8 told the other staff he was going to assist client #5 with his lunch. At 11:49 AM, staff #8 prompted client #5 for lunch; client #5 did not respond or react. At 11:50 AM, client #3 was sitting in her wheelchair with no interaction from staff. At 11:52 AM, client #5 was assisted off the mat to his chair for lunch. At 11:55 AM, client #3 was sitting in her wheelchair with no interaction from staff. Client #3 received a brief verbal interaction from staff #10; first staff interaction since observation began at 11:25 PM.</p> <p>A review of client #1's record was conducted on 6/21/12 at 1:11 PM. Her Individual Support Plan (ISP), dated 1/16/12, indicated she had the following training objectives: money management using the next dollar strategy, learn to spell her full name, prepare a meal from a recipe, social boundaries, brushing her teeth thoroughly, med administration and mealtime safety.</p> <p>A review of client #2's record was conducted on 6/21/12 at 1:58 PM. Her ISP, dated 2/6/12, indicated she had the following training objectives: sign yes/no to indicate wants, signs "meds" and goes to the med room, spoon down every third</p>						

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	<p>bite, points to a choice and toilets every 2 hours.</p> <p>A review of client #3's record was conducted on 6/26/12 at 11:51 AM. Her ISP, dated 1/30/12, indicated she had the following training objectives: occupational (OT) and physical therapy (PT) exercises, attend and participate in programming, increase tolerance to personal care and wet and dry training, toothbrushing, med training, dressing and showering, making a choice with pictures and pedestrian safety skills.</p> <p>A review of client #4's record was conducted on 6/22/12 at 10:07 AM. Her ISP, dated 1/31/12, indicated she had the following training objectives: signs "eat", "more food," and "more drink" at meals, stay on task for 30 minutes, practice writing her name, PT exercises, pedestrian safety, points at caddy, observes med sign, goes to med room, takes meds, prepares a meal, and increase independence with toileting and showering.</p> <p>A review of client #5's record was conducted on 6/21/12 at 12:35 PM. His ISP, dated 9/12/11, indicated he had the following training objectives: OT and PT exercises, awareness social story, med administration, shoe desensitization,</p>						

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	brushing teeth, drinking from a cup, toileting, self care desensitization, meal time independence, bathing, and making choices between objects. Client #5's Active Support for Day Program, dated 4/1/11, indicated the following, "[Client #5] does best with a highly structured schedule. he needs to know what to expect and what his choices are. Staff will review this schedule with [client #5] at the beginning of each day." Schedule: 8:00 AM - 9:30 AM Schedule and life skills (review schedule with him, with hand over hand assistance, staff will help him organize and straighten his personal objects in preparation for the day. 9:30 AM to 10:00 AM Break (Assist client #5 with snack, going to the restroom and having 15 minutes of mat time). 10:00 AM to 11:00 AM Gym (choice of walking, participating in physical activity or game or relaxing in a chair). 11:00 AM to 11:30 AM Current Events (Staff will read a portion of a newspaper article directly to client #5 and show and discuss with him interesting photos from the paper). 11:30 AM to 12:00 PM Lunch. 12:00 PM to 12:30 PM Break (assisted in restroom after lunch and then have 30 minutes of mat time). 12:30 PM to 2:30 PM Academic (staff will read a portion of the This Day in History lesson directly to client #2 and show and discuss photos. Client #2 will be given opportunity to				

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	<p>complete a project or play a game with hand over hand assistance and/or given a choice of preferred sensory activities).</p> <p>An interview with the Director of Life Long Learning (DLLL) was conducted on 6/22/12 at 11:28 AM. The DLLL indicated the staff should be providing consistent training and active treatment with the clients. The DLLL indicated client #3 should never go 50 minutes without staff interaction.</p> <p>An interview with the PC was conducted on 6/22/12 at 10:55 AM. The PC indicated the day program staff needed to be more involved with the clients in the rooms. The PC indicated the staff were not engaged with the clients in Room 16 (clients #1, #2, #3 and #5).</p> <p>9-3-4(a)</p>				

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#2), the nurse failed to ensure: 1) recommendations for the trial use of a gait belt was implemented for client #2 and 2) client #1 had a gynecological exam under general anesthesia.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 6/19/12 from 4:06 PM to 5:50 PM and 6/20/12 from 5:52 AM to 7:52 PM. Observations were conducted at the facility-operated day program on 6/19/12 from 12:52 PM to 1:34 PM, 6/20/12 from 9:25 AM to 10:37 AM, and 6/21/12 from 11:25 AM to 12:19 PM. During the observations, client #2 did not wear a gait belt.</p> <p>A review of client #2's record was conducted on 6/21/12 at 1:58 PM. On 11/28/11, client #2 had a physical therapy evaluation. The Treatment Plan/Recommendations section indicated, "...2. Trail using a gait belt to improve safety and assist with transfers, gait/mobility and to offer a solid hand hold for caregivers to hang onto to assist</p>	W0331	<p>W 331</p> <p>NURSING SERVICES</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that clients will receive nursing services consistent with their needs.</p> <p>Date of Completion:</p> <p>July 26, 2012</p> <p>Person Responsible:</p> <p>Coordinator and Nursing Services Manager</p> <p>Plan of Prevention:</p> <p>1) Gait belt will be implemented and trained on for specific client and 2) client will have a gynecological exam under general anesthesia. This was completed on July 10, 2012.</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator and other Administrative Staff will conduct announced and unannounced visits to both day programming</p>	07/26/2012			

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	<p>[client #2] if she loses her balance during waking hours. Continue to use if helpful; discontinue regular use if [client #2] does not tolerate it but keep on hand as needed.</p> <p>3. Continue to make changes to environment as necessary and possible both at residence and day program facility. This will help eliminate tripping hazards, specifically minimizing or eliminating changes in walking surface levels in and between rooms and floor covering textures." There was no evidence in client #2's record indicating the physical therapist's recommendation for a trial of a gait belt was implemented.</p> <p>An interview with client #2's guardian was conducted on 6/22/12 at 9:12 AM. The guardian indicated client #2 was going to fall and always had in the past due to medical issues. The guardian indicated she was not opposed to the use of a gait belt. The guardian indicated that although the physical therapist recommended a trial of a gait belt, she questioned whether or not it would be helpful unless client #2 also received 1:1 staffing.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/22/12 at 10:55 AM. The PC indicated a gait belt was recommended by the physical therapist however client #2's</p>		and the home to review the use of the gait belt. The OBGYN appointments will be added to the monthly review of significant documents.		

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	<p>guardian told her if she put on the gait belt the guardian would drive over to take it off; the guardian did not want the use of a gait belt.</p> <p>An interview with the Director of Life Long Learning was conducted on 6/22/12 at 11:28 AM. The Director indicated a gait belt would not be beneficial unless client #2 had 1:1 staffing.</p> <p>An interview with the Director of Health Services (DHS) was conducted on 6/26/12 at 10:52 AM. The DHS indicated the recommendation should have been implemented unless the guardian did not want to try it. The DHS indicated the facility should have documented the guardian did not want the gait belt and sent to the physician for recommendations.</p> <p>2) A review of client #1's record was conducted on 6/21/12 at 1:11 PM. On 8/18/11, client #1 had a gynecological exam. The follow-up for other problems identified on the Outside Services Report form indicated, "Schedule exam under anesthesia." Group home direct care staff #9 documented on the form, "Going to get sedated for pap-smear and blood work." There was no documentation in client #1's record indicating the exam was conducted under general anesthesia.</p>						

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	<p>An interview with the Program Coordinator (PC) was conducted on 6/22/12 at 10:05 AM. The PC indicated the recommendation for the exam had not been conducted. The PC indicated client #1's current gynecologist would not do a sedated exam; the gynecologist indicated, in January 2012, he would not treat client #1 any longer. The PC indicated the facility needed to find client #1 a new gynecologist.</p> <p>An interview with the DHS was conducted on 6/26/12 at 10:52 AM. The DHS indicated the exam should have been scheduled by the group home staff and conducted by now. The DHS was unaware if the appointment was held or not.</p> <p>9-3-6(a)</p>			

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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review for 1 of 5 medications administered to 1 of 4 clients (#2) observed to receive their medications, the facility failed to administer her medications without error.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 6/20/12 from 5:52 AM to 7:52 AM. At 5:58 AM, client #2 received her medications from staff #9. Staff #9 administered a multivitamin as a supplement, Lipitor for cholesterol, Calcium as a supplement, Glucosamine Chond for arthritis and Loratadine for allergies. Staff #9 administered sweet oil for ear wax; the medication was ordered for HS (bedtime).</p> <p>A review of client #2's record was conducted on 6/21/12 at 1:58 PM. Her Physician's Orders, dated 6/13/12, indicated sweet oil was to be given at HS.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/21/12 at 10:38 AM. The PC indicated</p>	W0369	<p>W 369</p> <p>DRUG ADMINISTRATION</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that a system for drug administration will be implemented for all drugs, including those that are self-administered without error.</p> <p>Date of Completion:</p> <p>July 26, 2012</p> <p>Person Responsible:</p> <p>Festive Coordinator</p> <p>Plan of Prevention:</p> <p>Stone Belt staff will follow the Medication Protocol. Staff will receive disciplinary action as warranted. (Attachment # 5)</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator and Nursing Manager will conduct training as necessary to ensure that staff pass medications without error. Medication Administration is</p>	07/26/2012			

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	<p>the staff administered client #2's medication (sweet oil) at the wrong time which was a medication error. The PC indicated the order was for bedtime and the staff gave in the morning which was an error.</p> <p>9-3-6(a)</p>		<p>trained during initial orientation, annually and on a as needed basis.</p>	

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample with adaptive equipment (#4), the facility-operated day program failed to ensure client #4 had her adaptive spoon for lunch.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated day program on 6/20/12 from 9:25 AM to 10:37 AM. At 10:02 AM, staff #9 looked for client #4's adaptive spoon and fork in client #4's lunchbox. Staff #9 was unable to locate client #4's adaptive spoon and fork in her lunchbox. Staff #9 indicated there should be extras at the day program however she was unable to locate them.</p> <p>A review of client #4's record was conducted on 6/22/12 at 10:07 AM. Client #4's Medication Information Sheet, dated 5/29/12, indicated client #4 used a toddler size spoon and fork, covered cup with a straw and a 3 way divided plate.</p>	W0436	<p>W 436</p> <p>SPACE AND EQUIPMENT</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that proper adaptive equipment is furnished, in good repair and training is conducted to teach clients the use of the particular devices. These devices are identified by the Support Team and needed by the client.</p> <p>Date of Completion:</p> <p>July 26, 2012</p> <p>Person Responsible:</p> <p>Festive Coordinator</p> <p>Plan of Prevention:</p> <p>A checklist was created to ensure staff are aware of proper equipment that needs to be taken</p>	07/26/2012			

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	<p>Client #4's assessment by the dietician was conducted on 3/20/12. The assessment indicated client #4 was to use a divided plate, cup with a lid and straw and a toddler spoon and fork.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/22/12 at 10:55 AM. The PC indicated client #4 should have her mealtime adaptive equipment at the facility-operated day program.</p> <p>9-3-7(a)</p>		<p>to day programming. (Attachment # 1)</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator will make unannounced observations to ensure that the client is using the necessary adaptive equipment.</p>	