

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 08/06/2012
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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 the post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on 6/26/12.</p> <p>This visit was in conjunction with the investigation of complaint #IN00112677.</p> <p>Survey Dates: July 31 and August 1, 2, 3 and 6, 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 was completed on 8/13/12 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 interview and record review for 4 of 5 clients living in the group home (A, B, C and D), the governing body failed to exercise policy and operating direction over the facility to ensure its policies and procedures to prevent abuse and neglect were implemented and a thorough investigation was conducted.</p> <p>Findings include:</p> <p>Please refer to W149. For 15 of 15 incident/investigative reports reviewed affecting clients A, B, C, and D, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, ensure staff immediately reported suspected abuse, conduct a thorough investigation and take appropriate corrective action.</p> <p>Please refer to W154. For 1 of 14 incident/investigative reports reviewed affecting client A, the facility failed to conduct a thorough investigation into an allegation of abuse.</p> <p>This deficiency was cited on 6/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>	W0104	<p>W 104</p> <p>GOVERNING BODY</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that specific governing body and management requirements are met. Specifically, Stone Belt will ensure that the policy of prevention of abuse and neglect are followed, alleged abuse is reported immediately to an administrator and will have increased monitoring by administrative staff following an incident of substantiated abuse.</p> <p>Responsible Person:</p> <p>Festive House Coordinator & SGL Director</p> <p>Date of Completion:</p> <p>August 24, 2012</p> <p>Plan of Prevention:</p> <p>House Staff and all SGL staff were retrained on Stone Belt's policy of prevention of abuse and neglect. (Attachment # 1 & # 1A).</p>	08/24/2012	

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			<p>This training also included immediate reporting and was also reviewed at SGL In-service on 8/3/2012. (Attachment # 2). House Manager and House Coordinator received Performance Reviews for not reporting allegation of abuse & neglect (Attachment # 3 & # 3A). House Coordinator, SGL Director and other administrative staff will provide administrative oversight if other incidents occur in the future. Visits will be documents on Stone Belt Program Visit Report for SGL Director and House Coordinator. (Attachment # 4). Social Worker, Nurse and Behaviorist will document their visit on the Professional Services Sign-in Sheet. (Attachment # 5)</p> <p>Quality Assurance Monitoring:</p> <p>Training staff on Stone Belt's policy of prevention of abuse and neglect will continue as needed with current staff and covered during initial staff orientation of new hires. House Coordinator and SGL Director will document both announced and unannounced visits to the homes on the Program Visit Report. SGL Director will review this, at a minimum, on a monthly basis. In addition, SGL Director will review visit by other administrative staff using the Professional Sign-In Sheet. These visits will be at least</p>		

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			twice a month. If an allegation of abuse/neglect occurs in the future, Coordinator and Director and other administrative staff will go to the home as instructed by SGL Director.	

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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 15 of 15 incident/investigative reports reviewed affecting clients A, B, C, and D, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, ensure staff immediately reported suspected abuse, and conduct a thorough investigation.</p> <p>Findings include:</p> <p>A review of the facility incident/investigative reports was conducted on 7/31/12 at 1:48 PM.</p> <p>1) On 7/9/12 at 6:45 PM, the Home Manager (HM) was in the medication room preparing to administer medications to clients. The HM heard staff #3 call out, "[client A] won't get in the shower, I tried." The HM went to talk with client A. The HM observed client A's shirt/dress to be wet in the front and in the back. The HM asked client A how her shirt got wet and client A did not respond. The HM asked client A if she could look in her shirt. The HM found ice cubes in the front and back of client A's shirt/dress. The HM removed the ice cubes and assisted client A with her shower. The HM noted red marks where the ice cubes had been against her skin and her skin was cold to the touch. Once client A was in the shower, the HM went to ask staff where the ice cubes came from. Staff #3 responded she had, "used the ice cube technique" before and generally client A would take the ice cubes out and do whatever she was prompted to do. The HM informed staff this was unacceptable and it caused red marks on client A's skin. The facility incident report was completed on 7/17/12. The incident</p>	W0149	<p>W 149</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt has and implements written policies and procedures that prohibit mistreatment, neglect or abuse of a client.</p> <p>Date of Completion:</p> <p>August 24, 2012</p> <p>Responsible Person:</p> <p>Festive Coordinator</p> <p>Plan of Prevention:</p> <p>House Staff and all SGL staff were retrained on Stone Belt's policy of prevention of abuse and neglect. (Attachment # 1). This training also included immediate reporting and was also reviewed at SGL Inservice on 8/3/2012. (Attachment # 2).</p> <p>Quality Assurance Monitoring:</p> <p>Festive Coordinator and SGL</p>	08/24/2012			

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	<p>was reported to the Bureau of Developmental Disabilities Services (BDDS) on 7/18/12.</p> <p>A review of an email was conducted on 7/31/12 at 3:40 PM. The email, dated 7/13/12 at 2:00 PM, from the HM to the group home support team (email did not specify the addressees) indicated the following, "[Staff #2] and I have been aware for sometime about staffs (sic) interactions with [client A] during behaviors. It has been observed that staff use [staff #2] or my name in a threatening manner telling [client A] that she will be told on to use. Also been observed if [client A] refuses to do a task requested [staff #2] or I will be yelled for to get [client A] to accomplish the task. [Client A's] behavior plan covers all situations or her refusing to do tasks and no where in the plan does it say to call for [staff #2] or I. The only time I would like to be 'called' for would be if [client A] is sitting in a house on fire, if she is sitting in her own feces or urine and staff had used all approved techniques to get her in the shower to get cleaned and they were unsuccessful. If you are having a hard time getting [client A] to do something reference back to her behavior plan or ask staffs (sic) advice on what has worked for them in the past. 3 verbal prompts are to be done with each task with 5 minutes in between each prompt. All staff should be working with [client A] to gain a working relationship. Also I know in the mornings and other times water/ice cubes have been used to get [client A] to accomplish tasks. DO NOT USE EITHER OF THESE TECHNIQUES! It is not appropriate and is not in her behavior plan if you need retraining let [staff #2] or I know and we will be happy to retrain you. Thanks" An email, dated 7/13/12 at 2:16 PM, from the Social Worker to the team indicated, "Use of water or ice cubes to prompt [client A] out of bed (or to do anything) is not a Stone Belt approved intervention and could be considered</p>		Director will monitor for possible abuse and exploitation during scheduled and unscheduled site visits. Staff will be trained annually on abuse/exploitation policy at Stone Belt as well as initial new hire orientation and on a as needed basis.				

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	<p>abuse. If you witness this, your responsibility is to Interrupt, Protect the client, Report it to [name of Director] immediately and complete an IR (incident report) as an allegation of abuse. Please let me know if you have any questions." An email, dated 7/14/12 at 12:08 AM, from the Director to the team indicated, "I want to know by Monday morning at 10 AM, who as (sic) been using ice cubes and water in such a manner. I would also like to know why this tactic has been allowed to be used." An email, dated 7/14/12 at 9:51 AM, from the Qualified Mental Retardation Professional (QMRP) to the team indicated, "I don't know who did this or when it happened but I would like to know who was doing it. They used to open her bedroom window to make it cold in her room to wake up, which I was told was taught by [name of former home manager]. I put a stop to that the first week I was coordinator. I never found out exactly who was doing it though." An email, dated 7/16/12 at 9:07 AM, from staff #8 to the team indicated, "I have heard of water being used in the morning but I will say on mornings that I work I have never seen [staff #4], myself, or [staff #6] do anything like that. I agree with not using other staff to get [client A] to do things because it causes a lot of issues with staff that she [client A] does not prefer as much (like myself). Let me know if I can provide anymore information, thanks!" An email from the HM, dated 7/16/12 at 11:13 AM, indicated to the team, "7/9/12 Monday evening after company left I started doing meds staff [name of staff #3] said she could not get [client A] to the shower. When I went to converse with [client A] I noticed her shirt to be wet in the back and in the front. I peeked under the back of her shirt to discover an ice cube. I removed the ice cube as well as the one in the front of her dress. After assisting [client A] to the bathroom she needed help getting her dress off. I saw really red marks where the ice had been sitting</p>						

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	<p>for who knows how long.? (sic) I didn't see the actual act of the staff putting the ice in her clothing. When [client A] was settled in he (sic) I went to ask staff who put the ice in her shirt. [Staff #8] said she did not. So I asked [staff #3] the only other staff at the house. She said she had used this 'ice cube' technique before and generally [client A] would take the ice cubes out and do whatever she was prompted to do. I informed [staff #3] that this was not ok and to not do this again. I also informed [staff #3] that the ice cubes had caused really red marks on her. [Staff #3] went to see these marks. No other conversation was addressed before me leaving the site. I did not do an IR immediately. I did inform [name of QMRP] of this event on Wednesday. I obviously failed to report in a timely manor (sic) disciplinary actions should be bestowed upon me how ever you see fit. I made the assumption by me stating that is was not ok to put ice cubes in her shirt and sending an email in regards to [client A's] behavior plan would be suffice (sic). We all had brought up in a prior meeting about staff using water and like techniques to get [client A] to do things not being ok I don't know of any other staff to use these techniques. I know that staff will at times play with [client A] and joke with her about water such as myself, she will be giggling and then throw water back at me but never in a demon (sic) to get her to do things. Let me know what else you need from me. FYI the old house manager would use these type of techniques on [client A] and therefore trained staff in that manor (sic). So if your (sic) curious as to where these idea's (sic) may of originated."</p> <p>The facility's investigation, dated 7/23/12, indicated the allegation of abuse by staff #3 was unsubstantiated (the findings did not support the event as described). The findings indicated, "[Staff #3] reported concern over [client A's]</p>						

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	<p>color, feeling heat coming off her back, slurred speech, her small amount of food and fluid intake, sitting outside for almost an hour and a combination of Valium and Xanax. [Staff #3] reported telling [name of HM] and [name of staff #8] about her concerns for [client A]. [Staff #3] reported making both of them aware that she was going to use ice to cool [client A] down. [Staff #8's] interview supports [staff #3's] account of the incident... It appears that [staff #3] had no intent to willfully or purposefully inflict any pain. It appears that [staff #3's] decision was made to protect a client she thought was physically compromised. [Client A] reported no concerns about this incident and reported that staff are nice to her. It appears there was miscommunication between staff about the concerns over [staff #3's] symptoms. It appears [HM] was unaware of [staff #3's] observations of [client A] and the need to get her cooled off quickly. Staff did not follow Stone Belt's policy for reporting suspected abuse and neglect." The Corrective Actions resulting from the investigation were: 1) Retraining on incident reporting, 2) performance reviews with the QMRP and the HM for not reporting and 3) retraining on abuse and neglect.</p> <p>The facility's investigation did not clarify the conflicting statements from the home manager's written incident report and interview and staff #3's interview regarding the purpose of using the ice. The investigation did not specifically address the home manager's statement of staff #3 using an "ice cube technique." The investigation did not address the home manager's concern of staff #3 implementing client #3's Behavior Support Plan (BSP), as written. There was no documentation staff #3 received disciplinary action for using ice cubes on client A. There was no documentation staff #3 or any other staff received re-training on client A's BSP or when to contact the nurse with</p>						

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	<p>health concerns. The investigation did not address the lack of written documentation from the home manager addressing her concerns with staff #3's job performance in regard to using ice cubes to get client A to comply with her requests and failing to implement client A's BSP as written.</p> <p>The interview with the HM in the facility's investigative report indicated, "[Home Manager] reported that she asked [staff #8] if (sic) knew anything about the ice. She reportedly did not know. [Home Manager] reported that she went to ask [staff #3]. [Staff #3] reportedly said that she use (sic) ice cubes to gauge how tired [client A] is. [Staff #3] reportedly said that if [client A] is not tired, she takes them out. [Home Manager] reported that she walked away and [staff #3] went to see the red marks on [client A]. [Home Manager] reported that she did not think the incident was vindictive. She reported that she thinks [staff #3] does not always not (sic) what's appropriate or inappropriate. [Home Manager] reported that [staff #3] has power struggles with [client A] and asks for help from her or [staff #2]. When asked to clarify, [home manager] reported that [staff #3] will continue to answer [client A's] perseverating questions and trying (sic) to reason with her. She reported that [staff #3] does not follow [client A's] BSP (behavior support plan). When asked if she has addressed her concerns with [staff #3], [home manager] reported that she has given brief feedback, such as, 'stop answering.' When asked about not reporting it immediately, [home manager] reported that is can be confusing what needs to be reported. She stated that she had addressed this issue with [staff #3] that night. She reported that it was not a continuous occurrence and she thought it would not happen again. When asked if she reported it to anyone else, [home manager] stated that she told [QMRP]. [QMRP] reportedly said, 'that is wildly inappropriate.'</p>						

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	<p>[Home manager] reported that she talked to [staff #2] and [staff #8] on Friday. She reported that conversation was about how inappropriate it was and maybe people should re-read [client A's] BSP. [Home Manager] reported that she typed up the email that she sent to the house."</p> <p>The interview with staff #3 in the facility's investigative report indicated, in part, "...[client A] was sitting with her head on the table. [Staff #3] reported asking [client A] if she was (sic) to take a shower. [Staff #3] reported that [client A] had slurred speech and responded, 'I don't wanna.' [Staff #3] reported she was concerned about [client A] because she was red and she could feel heat coming off her. [Staff #3] reported that she told [home manager] she was going to put ice on [client A] because she was so hot. [Staff #3] reported that [home manager] had no response. [Staff #3] reported that [staff #8] was still in the kitchen. [Staff #3] reported telling [staff #8] she was going to get some ice to put on [client A]. [Staff #3] reported she wanted [staff #8] to know she was concerned. [Staff #3] reported taking cubes that were about half the size of a regular ice cube. [Staff #3] reported that she rubbed the ice on [client A's] neck then put it between her sports bra and t-shirt in the front and back. [Staff #3] reported asking [client A] again if she was ready to take a shower. [Staff #3] reported that the ice was on [client A] for five to seven minutes, while she walked down to the office... [Staff #3] reported that she went to see [client A's] red marks. [Staff #3] reported that [client A] was sitting naked on the toilet. [Staff #3] reported that she helped [client A] into the shower. She reported the mark was gone... [Staff #3] reported that if [client A] hadn't looked better, she would have called the nurse pager."</p> <p>A review of a Performance Review with the HM,</p>				

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	<p>dated 7/27/12, was conducted on 7/31/12 at 1:48 PM. The review indicated, "Not reporting possible allegation of abuse/neglect immediately." The HM refused to sign the form.</p> <p>A review of staff #3's employee file was conducted on 8/1/12 at 9:26 AM. There was no corrective action for staff #3's use of ice cubes on client A. There was no documentation in the employee file addressing the HMs concerns with staff #3 not implementing client A's BSP, as written. Staff #3 received training on client A's BSP on 6/25/12, 5/30/12 and 4/1/11. Staff #3 was trained on abuse and neglect on 1/6/12 and 3/21/11.</p> <p>A review of the facility's abuse and neglect policy, dated 10/15/10, was conducted on 7/31/12 at 2:47 PM. 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 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, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for</p>						

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	<p>review upon request. An investigation of any incident may be requested by a Client, parent/guardian, advocate, staff member, or other involved party."</p> <p>An interview with the HM was conducted on 7/31/12 at 5:18 PM. The HM indicated staff #3 called out for her assistance due to client A not wanting to take a shower. The HM found client A's shirt wet in the front and back and then she discovered two cubes underneath her sports bra. The HM indicated staff #8 did not know anything about the ice cubes when asked. When she asked staff #3 about the ice cubes, staff #3 indicated she used ice cubes to see if client A was alert/awake. The HM indicated staff #3 made it sound like she had used ice cubes prior to this incident. The HM indicated staff #3 never indicated she placed the ice cubes in client A's bra due to client A being hot. The HM indicated she (HM) was mad about the use of ice cubes. The HM indicated, in regard to the purpose of using the ice, "Someone's whose a__ on the line going to make up stuff." She indicated she removed the ice cubes and addressed the issue with staff #3 at the time. The HM indicated she did not report the incident immediately. The HM indicated she felt this was in a "gray area" for reporting. The HM indicated staff #3 was supposed to be retrained by the behavior consultant but it was not conducted. The HM indicated staff #3 did not implement client A's BSP as written in regard to perseveration. The HM indicated she had not documented her concerns in regard to staff #3 not implementing client A's plan as written.</p> <p>An interview with staff #8 was conducted on 8/1/12 at 10:01 AM. Staff #8 indicated she was present at the time the ice cubes were discovered in client A's shirt. Staff #8 indicated she did not put the ice cubes in client A's shirt. Staff #8</p>						

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	<p>indicated staff #3 was concerned about client A's skin being red in color and warm to the touch. Staff #8 indicated she thought client A felt warm. Staff #8 indicated she did not witness staff #3 put the ice cubes in client A's shirt. Staff #8 indicated she had never seen staff use ice cubes to get client A to comply with requests. Staff #8 indicated staff #3 contacted her after staff #3 was suspended. Staff #3 told staff #8 she was trying to cool client A off by using ice cubes. Staff #8 indicated staff #3's "execution" of trying to cool client A was a little "odd." Staff #8 indicated staff #3 should have used a Ziploc bag. Staff #8 indicated staff #3 had "trouble" implementing client A's BSP in regard to addressing perseveration. Staff #8 indicated staff #3 did not do active ignoral and would talk to her and try to reason with client A. Staff #8 indicated trying to discuss client A's perseveration caused the behavior to escalate. Staff #8 indicated staff #3 means well but does not implement the plan as written in regard to active ignoral (ignoring the behavior but not the client).</p> <p>An interview with staff #3 was conducted on 8/6/12 at 10:42 AM. Staff #3 indicated she has never used ice to get client A to comply with her requests. Staff #3 indicated she did put ice in the front and back of client A's sports bra (between bra and shirt) to cool client A down. Staff #3 indicated she was concerned about client A being overheated and slurring her words. Staff #3 indicated she did inform both the HM and staff #8 about her concerns. Staff #3 indicated she told both the HM and staff #8 she was going to use ice prior to using ice. Staff #3 indicated she did not contact the on-call pager or nurse pager about her concerns. Staff #3 indicated she never used the term "ice cube technique" with the HM; staff #3 indicated there was no technique, she was trying to cool client A off. Staff #3 indicated client A did</p>						

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	<p>not react to the use of ice. Staff #3 indicated she did see red marks on client A's skin prior to client A getting into the shower however the marks went away during her shower.</p> <p>An interview with the Social Worker (SW) who conducted the investigation was conducted on 7/31/12 at 2:22 PM. The SW indicated abuse was unsubstantiated due to staff #3 using ice cubes to cool off client A; the SW indicated staff #3 was not abusive toward client A. The SW indicated client A did not indicate any of the staff were abusive toward her. The SW indicated the HM was staff #3's supervisor and should address personnel issues such as not implementing a client's plan with the staff. The SW indicated she did not address the HM's statement that staff #3 used the "ice cube technique." The SW indicated both the HM and QMRP for the home were aware of the incident and failed to report to the Director. The SW indicated staff #3 should receive a "refresher" on client A's BSP.</p> <p>An interview with the QMRP was conducted on 8/1/12 at 10:38 AM. The QMRP indicated informed her on 7/12/12 of the incident. The QMRP indicated they were out shopping and did not think much of it when she was informed. The QMRP indicated on 7/13/12 when the HM sent out an email to the team was when she realized there was an issue. The QMRP indicated the HM was off on 7/16/12 so when she returned to work on 7/17/12, the HM was directed to document the incident on an incident report. The QMRP indicated staff #3 was suspended on 7/17/12. The QMRP initially indicated she increased her monitoring of the home from one day per week to two due to the investigation being conducted but later in the interview indicated she conducted visits 1-2 times per week. The QMRP indicated she was not instructed by the Director to increase</p>			

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	<p>monitoring at the home. The QMRP indicated she should have reported the incident immediately but did not realize there was an allegation of abuse until the HM sent out an email. The QMRP indicated she was not aware of staff #3 receiving corrective action for not implementing client A's plan as written. The QMRP indicated the HM should have immediately reported her concerns to administrative staff.</p> <p>An interview with the Director was conducted on 8/2/12 at 9:45 AM. The Director indicated he was first aware of ice cubes being used from an email the HM sent out. The Director indicated he asked in the email to be informed of the incident by Monday morning. At 11:30 AM on Monday morning, the HM told him staff #3 used the ice cube technique. The Director indicated the allegation of abuse was unsubstantiated. The Director told the HM and QMRP to retrain staff #3 and all the other staff on client A's BSP by 7/27/12 and this did not occur. The HM told the Director she forgot to retrain the staff. The Director indicated both the HM and the QMRP failed to report. The Director indicated the HM refused to sign her Performance Review form due to the allegation being unsubstantiated therefore the incident did not happen and there was nothing to report. The Director indicated there had been no increase in the monitoring of the home since the incident. The Director stated, "there needs to be increased monitoring."</p> <p>2) On 7/8/12 at 11:40 AM after church, client D did not want to leave. Staff #9 prompted client D to the exit. Staff #9 was assisting client C in her wheelchair when client D reached over staff's arm and grabbed client C's hair with one and then both hands. Client C was not injured.</p> <p>3) On 7/3/12 at 12:20 PM at the facility-operated</p>						

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	<p>day program, client B hit staff's left foot and fell to her knees. No injury.</p> <p>On 7/6/12 at 1:10 PM at the facility-operated day program, client B attempted to turn, lost her balance and fell on the ground. No injury.</p> <p>On 7/6/12 at 6:40 PM, client B was in the dining room trying to pull her pants down. Client B fell backward and hit her head on the kitchen door. She was wearing a helmet at the time of the fall and was not injured.</p> <p>On 7/10/12 at 9:25 AM at the facility-operated day program, client B was leaning down trying to get an item from a crate. Client B fell forward into the crate and then onto her knees. She scraped her right forearm and her knees were red.</p> <p>On 7/12/12 at 9:35 AM at the facility-operated day program, client B fell to her left and onto the floor after getting up out of a chair. No injury.</p> <p>On 7/15/12 at 5:45 AM, client B was taking a shower and she fell. She bumped her right elbow and landed on her bottom. No injury.</p> <p>On 7/18/12 at 7:11 AM, client B was walking around the dining room table. She lost her balance and fell backward onto her bottom, hitting her head (wearing helmet) on the wall. No injury.</p> <p>On 7/25/12 at 9:15 AM at the facility-operated day program, client B fell on her right back side. No injury.</p> <p>A review of client #2's record was conducted on 7/31/12 at 2:33 PM. -Her Physician's Orders, dated 6/13/12, indicated the following, "Very poor balance, falls frequently. Helmet at all times when up.</p>			

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	<p>Wheelchair to be used for long distances and transport from house to van and van to house." -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 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 from BDDS - Bureau of Developmental Disabilities Services). Staff will assist [client #2]</p>						

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	<p>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 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</p>						

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	<p>surface levels in and between rooms and floor covering textures."</p> <p>4) On 7/17/12 at 6:53 AM, client A was in the hallway attempting to turn when she lost her balance and fell backward, hitting her back on the half door to the kitchen. No injury.</p> <p>On 7/20/12 at 7:22 PM, client A was in the bathroom getting ready for a shower. While walking into the shower, she fell onto her bottom. The HM did not witness the fall just heard a noise and found her on the floor. No injury.</p> <p>On 7/24/12 at 10:45 PM, staff #4 heard crying from client A's bedroom. Staff found client A on the floor wrapped up in her comforter, unable to get up. No injury.</p> <p>On 7/25/12 at 6:55 AM, staff #8 heard a loud thud while assisting another client. Staff #8 asked staff #4 to see what the noise was. Staff #4 found client A on the floor in her bedroom, on top of her walker. No injury.</p> <p>On 7/26/12 at 8:05 AM, the HM was assisting client A out of the van. Client A lost her balance and fell on her bottom, hitting her back on the van step. No injury.</p> <p>A review of client A's record was conducted on 8/6/12 at 10:52 AM. Client A did not have a plan addressing falls. There was no documentation in her record addressing falls.</p> <p>An interview with the Director was conducted on 8/6/12 at 11:03 AM. The Director indicated a risk plan for falls was being created and would be implemented this week. The Director indicated there was no plan in place currently.</p>						

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	<p>This deficiency was cited on 6/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</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.</p> <p>Based on record review and interview for 1 of 15 incident/investigative reports reviewed affecting client A, the facility failed to conduct a thorough investigation into an allegation of abuse.</p> <p>Findings include:</p> <p>A review of the facility incident/investigative reports was conducted on 7/31/12 at 1:48 PM.</p> <p>On 7/9/12 at 6:45 PM, the Home Manager (HM) was in the medication room preparing to administer medications to clients. The HM heard staff #3 call out, "[client A] won't get in the shower, I tried." The HM went to talk with client A. The HM observed client A's shirt/dress to be wet in the front and in the back. The HM asked client A how her shirt got wet and client A did not respond. The HM asked client A if she could look in her shirt. The HM found ice cubes in the front and back of client A's shirt/dress. The HM removed the ice cubes and assisted client A with her shower. The HM noted red marks where the ice cubes had been against her skin and her skin was cold to the touch. Once client A was in the shower, the HM went to ask staff where the ice cubes came from. Staff #3 responded she had, "used the ice cube technique" before and generally client A would take the ice cubes out and do whatever she was prompted to do. The HM informed staff this was unacceptable and it caused red marks on client A's skin. The facility incident report was completed on 7/17/12. The incident was reported to the Bureau of Developmental Disabilities Services (BDDS) on 7/18/12.</p> <p>A review of an email was conducted on 7/31/12 at</p>	W0154	<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>August 24, 2012</p> <p>Responsible Person</p> <p>Festive Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>The Coordinator and Social Worker reviewed and completed training on Stone Belt investigation procedures. (Attachment # 7). This included how to conduct proper investigations and who should be interviewed. (Attachment # 8)</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure, after reviewing the incident, that investigations will be completed thoroughly.</p>	08/24/2012			

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	<p>3:40 PM. The email, dated 7/13/12 at 2:00 PM, from the HM to the group home support team (email did not specify the addressees) indicated the following, "[Staff #2] and I have been aware for sometime about staffs (sic) interactions with [client A] during behaviors. It has been observed that staff use [staff #2] or my name in a threatening manner telling [client A] that she will be told on to use. Also been observed if [client A] refuses to do a task requested [staff #2] or I will be yelled for to get [client A] to accomplish the task. [Client A's] behavior plan covers all situations or her refusing to do tasks and no where in the plan does it say to call for [staff #2] or I. The only time I would like to be 'called' for would be if [client A] is sitting in a house on fire, if she is sitting in her own feces or urine and staff had used all approved techniques to get her in the shower to get cleaned and they were unsuccessful. If you are having a hard time getting [client A] to do something reference back to her behavior plan or ask staffs (sic) advice on what has worked for them in the past. 3 verbal prompts are to be done with each task with 5 minutes in between each prompt. All staff should be working with [client A] to gain a working relationship. Also I know in the mornings and other times water/ice cubes have been used to get [client A] to accomplish tasks. DO NOT USE EITHER OF THESE TECHNIQUES! It is not appropriate and is not in her behavior plan if you need retraining let [staff #2] or I know and we will be happy to retrain you. Thanks" An email, dated 7/13/12 at 2:16 PM, from the Social Worker to the team indicated, "Use of water or ice cubes to prompt [client A] out of bed (or to do anything) is not a Stone Belt approved intervention and could be considered abuse. If you witness this, your responsibility is to Interrupt, Protect the client, Report it to [name of Director] immediately and complete an IR (incident report) as an allegation of abuse. Please</p>						

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	<p>let me know if you have any questions." An email, dated 7/14/12 at 12:08 AM, from the Director to the team indicated, "I want to know by Monday morning at 10 AM, who as (sic) been using ice cubes and water in such a manner. I would also like to know why this tactic has been allowed to be used." An email, dated 7/14/12 at 9:51 AM, from the Qualified Mental Retardation Professional (QMRP) to the team indicated, "I don't know who did this or when it happened but I would like to know who was doing it. They used to open her bedroom window to make it cold in her room to wake up, which I was told was taught by [name of former home manager]. I put a stop to that the first week I was coordinator. I never found out exactly who was doing it though." An email, dated 7/16/12 at 9:07 AM, from staff #8 to the team indicated, "I have heard of water being used in the morning but I will say on mornings that I work I have never seen [staff #4], myself, or [staff #6] do anything like that. I agree with not using other staff to get [client A] to do things because it causes a lot of issues with staff that she [client A] does not prefer as much (like myself). Let me know if I can provide anymore information, thanks!" An email from the HM, dated 7/16/12 at 11:13 AM, indicated to the team, "7/9/12 Monday evening after company left I started doing meds staff [name of staff #3] said she could not get [client A] to the shower. When I went to converse with [client A] I noticed her shirt to be wet in the back and in the front. I peeked under the back of her shirt to discover an ice cube. I removed the ice cube as well as the one in the front of her dress. After assisting [client A] to the bathroom she needed help getting her dress off. I saw really red marks where the ice had been sitting for who knows how long.? (sic) I didn't see the actual act of the staff putting the ice in her clothing. When [client A] was settled in he (sic) I went to ask staff who put the ice in her shirt.</p>						

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	<p>[Staff #8] said she did not. So I asked [staff #3] the only other staff at the house. She said she had used this 'ice cube' technique before and generally [client A] would take the ice cubes out and do whatever she was prompted to do. I informed [staff #3] that this was not ok and to not do this again. I also informed [staff #3] that the ice cubes had caused really red marks on her. [Staff #3] went to see these marks. No other conversation was addressed before me leaving the site. I did not do an IR immediately. I did inform [name of QMRP] of this event on Wednesday. I obviously failed to report in a timely manor (sic) disciplinary actions should be bestowed upon me how ever you see fit. I made the assumption by me stating that is was not ok to put ice cubes in her shirt and sending an email in regards to [client A's] behavior plan would be suffice (sic). We all had brought up in a prior meeting about staff using water and like techniques to get [client A] to do things not being ok I don't know of any other staff to use these techniques. I know that staff will at times play with [client A] and joke with her about water such as myself, she will be giggling and then throw water back at me but never in a demon (sic) to get her to do things. Let me know what else you need from me. FYI the old house manager would use these type of techniques on [client A] and therefore trained staff in that manor (sic). So if your (sic) curious as to where these idea's (sic) may of originated."</p> <p>The facility's investigation, dated 7/23/12, indicated the allegation of abuse by staff #3 was unsubstantiated (the findings did not support the event as described). The findings indicated, "[Staff #3] reported concern over [client A's] color, feeling heat coming off her back, slurred speech, her small amount of food and fluid intake, sitting outside for almost an hour and a combination of Valium and Xanax. [Staff #3]</p>						

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	<p>reported telling [name of HM] and [name of staff #8] about her concerns for [client A]. [Staff #3] reported making both of them aware that she was going to use ice to cool [client A] down. [Staff #8's] interview supports [staff #3's] account of the incident... It appears that [staff #3] had no intent to willfully or purposefully inflict any pain. It appears that [staff #3's] decision was made to protect a client she thought was physically compromised. [Client A] reported no concerns about this incident and reported that staff are nice to her. It appears there was miscommunication between staff about the concerns over [staff #3's] symptoms. It appears [HM] was unaware of [staff #3's] observations of [client A] and the need to get her cooled off quickly. Staff did not follow Stone Belt's policy for reporting suspected abuse and neglect." The Corrective Actions resulting from the investigation were: 1) Retraining on incident reporting, 2) performance reviews with the QMRP and the HM for not reporting and 3) retraining on abuse and neglect.</p> <p>The facility's investigation did not clarify the conflicting statements from the home manager's written incident report and interview and staff #3's interview regarding the purpose of using the ice. The investigation did not specifically address the home manager's statement of staff #3 using an "ice cube technique." The investigation did not address the home manager's concern of staff #3 implementing client #3's Behavior Support Plan (BSP), as written. There was no documentation staff #3 received disciplinary action for using ice cubes on client A. There was no documentation staff #3 or any other staff received re-training on client A's BSP or when to contact the nurse with health concerns. The investigation did not address the lack of written documentation from the home manager addressing her concerns with staff #3's job performance in regard to using ice cubes to get</p>				

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	<p>client A to comply with her requests and failing to implement client A's BSP as written.</p> <p>The interview with the HM in the facility's investigative report indicated, "[Home Manager] reported that she asked [staff #8] if (sic) knew anything about the ice. She reportedly did not know. [Home Manager] reported that she went to ask [staff #3]. [Staff #3] reportedly said that she use (sic) ice cubes to gauge how tired [client A] is. [Staff #3] reportedly said that if [client A] is not tired, she takes them out. [Home Manager] reported that she walked away and [staff #3] went to see the red marks on [client A]. [Home Manager] reported that she did not think the incident was vindictive. She reported that she thinks [staff #3] does not always not (sic) what's appropriate or inappropriate. [Home Manager] reported that [staff #3] has power struggles with [client A] and asks for help from her or [staff #2]. When asked to clarify, [home manager] reported that [staff #3] will continue to answer [client A's] perseverating questions and trying (sic) to reason with her. She reported that [staff #3] does not follow [client A's] BSP (behavior support plan). When asked if she has addressed her concerns with [staff #3], [home manager] reported that she has given brief feedback, such as, 'stop answering.' When asked about not reporting it immediately, [home manager] reported that is can be confusing what needs to be reported. She stated that she had addressed this issue with [staff #3] that night. She reported that it was not a continuous occurrence and she thought it would not happen again. When asked if she reported it to anyone else, [home manager] stated that she told [QMRP]. [QMRP] reportedly said, 'that is wildly inappropriate.' [Home manager] reported that she talked to [staff #2] and [staff #8] on Friday. She reported that conversation was about how inappropriate it was and maybe people should re-read [client A's] BSP.</p>						

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	<p>[Home Manager] reported that she typed up the email that she sent to the house."</p> <p>The interview with staff #3 in the facility's investigative report indicated, in part, "...[client A] was sitting with her head on the table. [Staff #3] reported asking [client A] if she was (sic) to take a shower. [Staff #3] reported that [client A] had slurred speech and responded, 'I don't wanna.' [Staff #3] reported she was concerned about [client A] because she was red and she could feel heat coming off her. [Staff #3] reported that she told [home manager] she was going to put ice on [client A] because she was so hot. [Staff #3] reported that [home manager] had no response. [Staff #3] reported that [staff #8] was still in the kitchen. [Staff #3] reported telling [staff #8] she was going to get some ice to put on [client A]. [Staff #3] reported she wanted [staff #8] to know she was concerned. [Staff #3] reported taking cubes that were about half the size of a regular ice cube. [Staff #3] reported that she rubbed the ice on [client A's] neck then put it between her sports bra and t-shirt in the front and back. [Staff #3] reported asking [client A] again if she was ready to take a shower. [Staff #3] reported that the ice was on [client A] for five to seven minutes, while she walked down to the office... [Staff #3] reported that she went to see [client A's] red marks. [Staff #3] reported that [client A] was sitting naked on the toilet. [Staff #3] reported that she helped [client A] into the shower. She reported the mark was gone... [Staff #3] reported that if [client A] hadn't looked better, she would have called the nurse pager."</p> <p>A review of a Performance Review with the HM, dated 7/27/12, was conducted on 7/31/12 at 1:48 PM. The review indicated, "Not reporting possible allegation of abuse/neglect immediately." The HM refused to sign the form.</p>						

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	<p>A review of staff #3's employee file was conducted on 8/1/12 at 9:26 AM. There was no corrective action for staff #3's use of ice cubes on client A. There was no documentation in the employee file addressing the HMs concerns with staff #3 not implementing client A's BSP, as written. Staff #3 received training on client A's BSP on 6/25/12, 5/30/12 and 4/1/11. Staff #3 was trained on abuse and neglect on 1/6/12 and 3/21/11.</p> <p>A review of the facility's abuse and neglect policy, dated 10/15/10, was conducted on 7/31/12 at 2:47 PM. 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 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, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a Client, parent/guardian, advocate, staff member, or other involved party."</p>			

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	<p>An interview with the HM was conducted on 7/31/12 at 5:18 PM. The HM indicated staff #3 called out for her assistance due to client A not wanting to take a shower. The HM found client A's shirt wet in the front and back and then she discovered two cubes underneath her sports bra. The HM indicated staff #8 did not know anything about the ice cubes when asked. When she asked staff #3 about the ice cubes, staff #3 indicated she used ice cubes to see if client A was alert/awake. The HM indicated staff #3 made it sound like she had used ice cubes prior to this incident. The HM indicated staff #3 never indicated she placed the ice cubes in client A's bra due to client A being hot. The HM indicated she (HM) was mad about the use of ice cubes. The HM indicated, in regard to the purpose of using the ice, "Someone's whose a__ on the line going to make up stuff." She indicated she removed the ice cubes and addressed the issue with staff #3 at the time. The HM indicated she did not report the incident immediately. The HM indicated she felt this was in a "gray area" for reporting. The HM indicated staff #3 was supposed to be retrained by the behavior consultant but it was not conducted. The HM indicated staff #3 did not implement client A's BSP as written in regard to perseverance. The HM indicated she had not documented her concerns in regard to staff #3 not implementing client A's plan as written.</p> <p>An interview with staff #8 was conducted on 8/1/12 at 10:01 AM. Staff #8 indicated she was present at the time the ice cubes were discovered in client A's shirt. Staff #8 indicated she did not put the ice cubes in client A's shirt. Staff #8 indicated staff #3 was concerned about client A's skin being red in color and warm to the touch. Staff #8 indicated she thought client A felt warm. Staff #8 indicated she did not witness staff #3 put</p>						

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	<p>the ice cubes in client A's shirt. Staff #8 indicated she had never seen staff use ice cubes to get client A to comply with requests. Staff #8 indicated staff #3 contacted her after staff #3 was suspended. Staff #3 told staff #8 she was trying to cool client A off by using ice cubes. Staff #8 indicated staff #3's "execution" of trying to cool client A was a little "odd." Staff #8 indicated staff #3 should have used a Ziploc bag. Staff #8 indicated staff #3 had "trouble" implementing client A's BSP in regard to addressing perseveration. Staff #8 indicated staff #3 did not do active ignoral and would talk to her and try to reason with client A. Staff #8 indicated trying to discuss client A's perseveration caused the behavior to escalate. Staff #8 indicated staff #3 means well but does not implement the plan as written in regard to active ignoral (ignoring the behavior but not the client).</p> <p>An interview with staff #3 was conducted on 8/6/12 at 10:42 AM. Staff #3 indicated she has never used ice to get client A to comply with her requests. Staff #3 indicated she did put ice in the front and back of client A's sports bra (between bra and shirt) to cool client A down. Staff #3 indicated she was concerned about client A being overheated and slurring her words. Staff #3 indicated she did inform both the HM and staff #8 about her concerns. Staff #3 indicated she told both the HM and staff #8 she was going to use ice prior to using ice. Staff #3 indicated she did not contact the on-call pager or nurse pager about her concerns. Staff #3 indicated she never used the term "ice cube technique" with the HM; staff #3 indicated there was no technique, she was trying to cool client A off. Staff #3 indicated client A did not react to the use of ice. Staff #3 indicated she did see red marks on client A's skin prior to client A getting into the shower however the marks went away during her shower.</p>			

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	<p>An interview with the Social Worker (SW) who conducted the investigation was conducted on 7/31/12 at 2:22 PM. The SW indicated abuse was unsubstantiated due to staff #3 using ice cubes to cool off client A; the SW indicated staff #3 was not abusive toward client A. The SW indicated client A did not indicate any of the staff were abusive toward her. The SW indicated the HM was staff #3's supervisor and should address personnel issues such as not implementing a client's plan with the staff. The SW indicated she did not address the HM's statement that staff #3 used the "ice cube technique." The SW indicated both the HM and QMRP for the home were aware of the incident and failed to report to the Director. The SW indicated staff #3 should receive a "refresher" on client A's BSP.</p> <p>An interview with the QMRP was conducted on 8/1/12 at 10:38 AM. The QMRP indicated informed her on 7/12/12 of the incident. The QMRP indicated they were out shopping and did not think much of it when she was informed. The QMRP indicated on 7/13/12 when the HM sent out an email to the team was when she realized there was an issue. The QMRP indicated the HM was off on 7/16/12 so when she returned to work on 7/17/12, the HM was directed to document the incident on an incident report. The QMRP indicated staff #3 was suspended on 7/17/12. The QMRP initially indicated she increased her monitoring of the home from one day per week to two due to the investigation being conducted but later in the interview indicated she conducted visits 1-2 times per week. The QMRP indicated she was not instructed by the Director to increase monitoring at the home. The QMRP indicated she should have reported the incident immediately but did not realize there was an allegation of abuse until the HM sent out an email. The QMRP</p>			

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	<p>indicated she was not aware of staff #3 receiving corrective action for not implementing client A's plan as written. The QMRP indicated the HM should have immediately reported her concerns to administrative staff.</p> <p>An interview with the Director was conducted on 8/2/12 at 9:45 AM. The Director indicated he was first aware of ice cubes being used from an email the HM sent out. The Director indicated he asked in the email to be informed of the incident by Monday morning. At 11:30 AM on Monday morning, the HM told him staff #3 used the ice cube technique. The Director indicated the allegation of abuse was unsubstantiated. The Director told the HM and QMRP to retrain staff #3 and all the other staff on client A's BSP by 7/27/12 and this did not occur. The HM told the Director she forgot to retrain the staff. The Director indicated both the HM and the QMRP failed to report. The Director indicated the HM refused to sign her Performance Review form due to the allegation being unsubstantiated therefore the incident did not happen and there was nothing to report. The Director indicated there had been no increase in the monitoring of the home since the incident. The Director stated, "there needs to be increased monitoring."</p> <p>This deficiency was cited on 6/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				