

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G220	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408
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W 000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: February 25, 26, 27, March 2 and 3, 2015</p> <p>Facility Number: 000744 Provider Number: 15G220 AIM Number: 100234860</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/6/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 10 of 32 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility neglected to implement its policies and procedures to prevent neglect of the clients, submit incident reports to the Bureau of Developmental</p>	W 149	<p>1) Plan ofCorrection: Client #3 and #5 active treatment and partnering schedules wereupdated (attachment b). Client #5 BSP updated to include strategies to</p>	03/20/2015

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

TITLE

(X6) DATE

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

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	<p>Disabilities Services (BDDS) in a timely manner, thoroughly investigate client #4's missing television, reimburse client #4 appropriately for the amount of money he spent on his television, thoroughly investigate an incident of choking, and take appropriate preventative measures of further potential abuse while an investigation was in progress involving an incident of possible sexual abuse between clients #3 and #5.</p> <p>Findings include:</p> <p>On 2/25/15 at 11:57 AM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) This incident report was reviewed on 2/27/15 at 9:07 AM: On 2/26/15 at 6:45 PM, clients #3 and #5 went into the bathroom together. The Stone Belt ARC, Inc. incident report, dated 2/26/15, indicated, "[Client #5] then locked the door according to [client #3]. [Client #5] says that he was in the bathroom to take his shower. [Client #3] stated that [client #5] started kissing his neck, rubbing his back and rubbing his genitals. [Client #3] told [client #5] to stop but [client #5] refused. I knocked on the door because I heard both [clients #3 and #5] voice (sic) coming from the upstairs bathroom from</p>		<p>prevent further incidents (attachment c).</p> <p>Plan of Prevention: Facility coordinator / QIDP trained on following written policies and procedures that prohibit mistreatment, neglect or abuse of the client (attachment a). Facility staff trained on active treatment schedules (attachment d). Facility staff trained on client #5 BSP (attachment e).</p> <p>Plan of monitoring: Facility quality assurance team meet biweekly to discuss facility policy and procedure that prohibit mistreatment, neglect or abuse on the client. Facility coordinator QIDP will ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment a). Facility house manager trained to monitor active treatment, partneringschedules, and BSPs are being followed (attachment f).</p>	

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	<p>the kitchen. I proceed (sic) to knock on the door asking them to open the door. It took them ten seconds to open the door up. I asked them what's going on and both replied, 'nothing.' I asked them (sic) please not be in the bathroom together. Later in the office [client #3] told me that [client #5] was rubbing his back, kissing his neck, and rubbing his genitals. [Client #3] says when [client #5] was doing this, he told [client #5] to stop. [Client #5] says he did something he shouldn't of (sic) done."</p> <p>On 2/26/15 at 9:57 PM the Group Home Director (GHD) indicated in an email, "I called the house and instructed that clients were separated for remaining of evening. [Name of Behavior Support Services Coordinator] was forwarded copy of IR (incident report) to initiate investigation."</p> <p>On 2/27/15 at 9:07 AM, the GHD indicated in an email, "Once [name of support staff] submits this I will send you a copy. Wanted to let you know it's being investigated."</p> <p>On 2/27/15 at 11:58 AM the GHD indicated there was an allegation of sexual contact between clients #3 and #5. The GHD indicated client #3 reported he was in the restroom when client #5</p>		<p>2) Plan of Correction: Facility associatemanager / Staff # 9 will receive a performance action review for failure tocontact pager following a client choking and not completing an IR (attachmentg). the IR andper Plan ofPrevention: Client #1 dining plan was trained with the staff (attachment h).Facility staff were trained on incident reporting and choking (attachment i).Client #1 underwent a swallow evaluation 3/27/15 and new dining plan will bedevised and trained to facility staff to follow (attachment j).</p> <p>Plan ofmonitoring: Facility house manager / associate manager will monitor to ensuredining plans and ensure that policies prohibiting mistreatment, neglect, orabuse of clients are followed (attachment f). Facility coordinator QIDP willensure that policies prohibiting mistreatment, neglect, or abuse of clients arefollowed (attachment a).</p>	

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	<p>entered and touched his genitals, kissed his neck and rubbed his back. The GHD indicated the incident occurred shortly after the surveyor left the home on 2/26/15. The GHD indicated there were 2 staff and 3 clients in the home at the time of the incident. The GHD indicated neither staff was suspended. The GHD indicated the facility was going to investigate the incident. The GHD indicated there was a previous incident between the clients. The GHD indicated following the previous incident, the clients' bedroom doors had alarms installed. The GHD indicated the facility staff needed to supervise the clients more closely and ensure the clients were not on the same floor.</p> <p>On 2/27/15 at 2:24 PM, client #3 indicated he was using the restroom when client #5 entered. Client #3 indicated client #5 reached around him, grabbed his genitals and buttocks, and kissed his neck. Client #3 indicated he asked client #5 to stop but he did not stop. Client #3 indicated he called for help from the staff. Client #3 indicated client #5 stopped once staff #6 knocked on the door. Client #3 indicated this happened once before but he could not recall when. Client #3 stated, "I don't like it." Client #3 indicated the next time he went into the restroom he would lock the door.</p>		<p>3) Plan of Correction: Client #1 BSP was reviewed by support team and determined appropriate (attachment k). Client on client investigation deemed that the incident was not intent to harm but merely horseplay. IR and per Plan of Prevention: Client #1 BSP was trained with the day program staff (attachment I).</p> <p>Plan of monitoring: Day program instructor will monitor to ensure dining plans and ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment m). Facility coordinator QIDP will ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment a).</p> <p>4) Plan of Correction: Client #4 television was replaced. House manager present during the missing item is no longer employed with Stone Belt and is indelible for rehire due to an unrelated issue. er</p>	

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	<p>On 3/3/15 at 10:21 AM, the Behavior Specialist (BS) who conducted the investigation indicated, to his knowledge, the two staff who were present at the time of the incident were not removed from having contact with the clients. The BS indicated the incident was not investigated for abuse, neglect or exploitation on the part of the staff. The BS indicated he was investigating an incident of client to client sexual abuse. The BS indicated the two staff who were present were in the kitchen at the time of the incident. The BS indicated staff #6 heard the clients' voices coming from the bathroom and went to check on them. The second staff remained in the kitchen and did not witness the incident or what was reported. The BS indicated the results of the investigation were inconclusive. Client #5 did not give much information. The BS indicated it was clear contact was made between the two but he was not sure if it was intentional or abusive. The BS stated, "More of a sexual acting out." The BS indicated he would recommend counseling for both of them for accurate reporting, self advocacy, healthy relationships and informed consent. The BS indicated the recommendations would come from the Group Home Director.</p>		<p>Plan ofPrevention: Client #4 personal inventory was updated and will be maintained byhouse / associate managers (attachment n).</p> <p>Plan ofmonitoring: Facility house manager / associate manager will monitor to ensure inventoriesare updated /monitored and ensure that policies prohibiting mistreatment,neglect, or abuse of clients are followed (attachment f). Facility coordinatorQIDP will ensure inventories are monitored and that policies prohibitingmistreatment, neglect, or abuse of clients are followed (attachment a).</p> <p>5)</p> <p>Plan of Correction: Client #1 BSP was reviewedby support team and determined appropriate (attachment k). per</p> <p>Plan ofPrevention: Client #1 BSP was trained with the facility staff (attachment 0).</p>				

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	<p>2) On 2/25/15 at 11:57 AM when client #1's incident reports were reviewed, there was no documentation of an incident on 2/22/15 involving client #1 choking. On 2/26/15 at 1:14 PM client #1's incident reports were reviewed again and there was no documentation of an incident report involving client #1 choking on 2/22/15.</p> <p>An observation was conducted at the group home on 2/26/15 from 5:56 AM to 7:48 AM. At 6:55 AM during client #1's medication pass, staff #9 stated she was taking client #1's temperature due to a "choking fit" on Sunday (2/22/15).</p> <p>On 2/22/15 at 1:09 PM, staff #2 documented in an email, "Hi All, [client #1] had a choking fit this morning. I am not sure what he was eating that caused him to choke. But he got it up coughing. From what I saw it seemed to be (sic) big bite. After I made sure he was okay, I asked him how he was and he said that was scary. He seems to be A-Okay by now. But if he tells you his throat is sore that might be because of him choking today. Just a heads up!"</p> <p>On 2/22/15 at 1:11 PM, the GHD indicated in an email, "Was the nursing pager contacted?"</p>		<p>Plan of monitoring: Facility house / associate manager will monitor to ensure client #1 and client #2 BSPs are trained monthly with staff and ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment m). Facility coordinator QIDP will ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment a).</p> <p>6)</p> <p>Plan of Correction: Client #1 BSP was reviewed by support team and determined appropriate (attachment k). Client on client investigation deemed that the incident was not an intent to harm but merely horseplay. IR and per Plan of Prevention: Client #1 BSP was trained with the day program staff (attachment l).</p> <p>Plan of monitoring: Day program instructor will monitor to ensure dining plans and ensure that policies prohibiting mistreatment,</p>	

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	<p>On 2/22/15 at 9:31 PM, the Registered Nurse (RN) indicated in an email, "Nope, I didn't get a call. I called out to [name of group home] but got voicemail. Please check his temp (temperature) twice daily for a week. Document this on the MAR (Medication Administration Record). Let me know/ call the pager if you notice he is refusing meals or fluids, change in mood, cough or chest congestion. CALL 9-1-1 if you notice he is having difficulty breathing or his skin is turning blue."</p> <p>On 2/26/15 at 12:53 PM the GHD indicated in an email, "Was it confirmed if he actually choked or if it was a coughing fit? Also, [name of surveyor] is requesting and (sic) IR (incident report) if he truly choked one should have been completed along with he needed checked (sic) for aspiration ASAP (as soon as possible). He will also need a swallow evaluation and dining plan put in effect."</p> <p>On 2/26/15 at 1:15 PM, the RN indicated in an email, "It happened once during the meal. We say this is 'self corrected.' If it happens more than once in the same meal an IR is needed. That was my understanding."</p> <p>On 2/22/15 at 10:45 AM, an incident report dated 2/28/15 indicated, "On 02/22/2015 at 10:45 AM, [client #1] was</p>		<p>neglect, or abuse of clients are followed (attachment m). Facility coordinator QIDP will ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment a).</p> <p>7) Plan of Correction: Client #1 BSP was reviewed by support team and determined appropriate (attachment k). Client on client investigation deemed that the incident was not an intent to harm. and per Plan of Prevention: Client #1 BSP was trained with the day program staff (attachment l).</p> <p>Plan of monitoring: Day program instructor will monitor to ensure dining plans and ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment m). Facility coordinator QIDP will ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment a).</p>	

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	<p>in the kitchen at [name of group home] eating breakfast. [Client #1] started coughing a lot and signaling he was having problems swallowing what he was eating. No one saw the event, but each staff heard it. Staff went into the kitchen and asked if [client #1] was okay, and he verbally told staff he was fine and continued to cough. [Client #1] continued to cough, and another staff came in to make sure he was fine. [Client #1] finally got the food up, and it landed in the trash can so staff didn't get to see exactly what he was eating; it looked large enough to cause him to have difficulties swallowing. [Client #1] stated that the incident scared him. Staff explained to him the importance of taking small bites, chewing before swallowing, and slowing down while eating. Staff stayed in the kitchen and watched [client #1] finish his breakfast."</p> <p>There was no documentation the facility reported the incident to BDDS. There was no documentation the facility conducted an investigation.</p> <p>On 2/27/15 at 2:57 PM, the Nursing Manager indicated if the incident involved choking then an incident report should have been written. The NM indicated the RN attempted to call the house but no one answered. The NM</p>		<p>8)</p> <p>Plan of Correction: Client #1 BSP was reviewed by support team and determined appropriate (attachment k). Client on client investigation deemed that revision to client #1 active treatment schedule in the community was required (attachment p). IR and per Plan of Prevention: Client #1 BSP was trained with the day program staff (attachment l).</p> <p>Plan of monitoring: Day program instructor will monitor to ensure dining plans and ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment m). Facility coordinator QIDP will ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment a).</p> <p>9)</p> <p>Plan of Correction: Client #1 BSP was reviewed by support team and determined appropriate</p>	

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	<p>indicated he was not sure if the RN followed up with the staff. The NM indicated the RN sent out an email for precautions to take (taking temperature).</p> <p>On 2/27/15 at 3:15 PM the GHD indicated the staff failed to immediately report the incident to the administrator. The GHD indicated the incident was not reported to BDDS. The GHD indicated the facility did not investigate the incident.</p> <p>On 2/26/15 at 1:16 PM the Coordinator indicated the staff reported the incident but not immediately. The staff should have reported it to the pager immediately and the pager would have called the nursing pager. The Coordinator indicated the incident was not reported to BDDS and an investigation was not completed.</p> <p>3) On 1/28/15 at 2:15 PM at the facility operated day program, client #1 hugged a peer. The peer reached around client #1 and hugged client #1. The peer grabbed client #1's shirt and would not let go. Client #1 punched the peer's arm. The peer was not injured.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility</p>		<p>(attachment k). Client on client investigation deemed that the incident was not an intent to harm but merely horseplay. IR and per Plan of Prevention: Client #1 BSP was trained with the day program staff (attachment I).</p> <p>Plan of monitoring: Day program instructor will monitor to ensure dining plans and ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment m). Facility coordinator QIDP will ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment a).</p> <p>10) Plan of Correction: Staff (former) #10 was terminated for said neglect (attachment q). IR and per Plan of Prevention: Facility staff trained on keeping alert during shifts and sleeping is considered neglect (attachment r).</p> <p>Plan of monitoring: Staff (former) #10 was terminated</p>	

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	<p>had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/25/15 at 1:18 PM the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>4) On 1/16/15 at 7:00 PM, a Stone Belt ARC, Inc. Incident Report, dated 1/16/15, indicated, in part, "[Client #4] placed his TV in the garage in July and did not want to put it back in his room till (sic) he got a new TV stand. After [client #4] got a new TV stand staff went to get his TV out of the garage and could not find it. Staff searched the entire house and all of the clients (sic) rooms staff also asked all the clients if they have scene (sic) the TV anywhere and they all said no." The facility submitted an incident report to BDDS on 1/19/15. There was no documentation the facility investigated the incident. The BDDS report indicated, "Stone Belt will purchase and replace the TV for [client #4]. Support team will review."</p> <p>On 1/16/15 at 2:47 PM, the Social Worker indicated in an email to the Group Home Director (GHD), "Hi [name of GHD], I raised the issue with you last</p>		<p>for said neglect (attachment q). Facility house manager / associate manager will monitor to ensure inventories are updated /monitored and ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment f). Facility coordinator QIDP will provide monthly overnight monitoring to ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment a).</p>	

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	<p>week of [client #4's] missing TV set and the missing [name] house weight bench. I need to reiterate that this seems to me to require an allegation of exploitation and an investigation. I'm wondering what is being done about this. Thanks, [Name of Social Worker]."</p> <p>On 1/18/15 at 11:31 AM, the Coordinator sent an email to the GHD, Social Worker, the Home Manager and others indicating, "I had three staff search the house thoroughly [staff #1, #2 and #3]. None of these searches found the misplaced items. [Client #4] placed his TV in the garage prior to Halloween when his entertainment stand broke. Despite multiple prompts to leave the TV on his stand, as it could still hold it, he left it in the garage. When [clients #3 and #5] set up the garage for the haunted house, they put a load of items out with the trash. I searched thru (sic) the items to make sure that they were indeed garbage. The TV was not out there. I also had the staff ask [clients #3 and #5] if they had moved the TV, and both said that they hadn't. [Staff #1] reported seeing the TV a week before we noticed it was missing, after buying [client #4] a new stand and going to retrieve it... As the guys have a tendency to leave the door into the garage unlocked when they leave for day program, despite constant prompting and coaching about</p>						

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	<p>the dangers of leaving their home unlocked when no one is there, and the fact that staff sometimes forget to check to make sure that the garage door is locked after the guys have left the house, the possibility that someone could have merely entered the garage and stolen the items does exist...." A handwritten note on the printout of the email indicated, as documented by the Coordinator, "[Name of the former Manager of Clinical Services] and [name of the Director of Milestones (a division of Stone Belt) Health and Clinical Resources] said that no investigation was necessary & that we didn't need to file a police report."</p> <p>A review of client #4's receipt for his missing TV was conducted on 2/25/15 at 3:13 PM. Client #4 purchased his TV on 5/14/14 for \$388.08. The TV was a 32 inch Sony. Included in the price was the purchase of a 2 year service agreement for \$34.99. The facility purchased client #4 a TV on 2/20/15. The TV was a Samsung 32 inch TV totaling \$213.99. The facility did not purchase a 2 year service agreement. The difference in the amount client #4 spent and the replacement TV was \$174.09. There was no documentation the facility reimbursed client #4 \$174.09 for the difference in the cost client #4 incurred.</p>				

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	<p>On 2/27/15 at 3:04 PM, the GHD stated the facility should have purchased a TV "closer" to the amount client #4 spent when he purchased a TV.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated client #4's missing TV should have been investigated. The GHD indicated the facility should have reimbursed client #4 based on the money amount and not the size of the TV.</p> <p>On 2/26/15 at 1:50 PM the Fiscal Coordinator (FC) indicated the facility should have been comparable in client #4's replacement. The FC indicated the size of the television was comparable but not the dollar amount. The FC stated, "Stone Belt should pay him (client #4) more."</p> <p>On 2/25/15 at 1:18 PM, the Coordinator indicated he did not document conducting an investigation. He indicated the former Manager of Clinical Services and Director of Health and Clinical Resources told him an investigation did not need to be completed. The Coordinator indicated one of the glass doors of client #4's previous entertainment center broke and shattered. The Coordinator indicated client #4 took his TV out to the garage himself. The Coordinator indicated when</p>				

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	<p>client #4 agreed to purchase a new entertainment center his TV was discovered missing. The Coordinator indicated client #4's 32 inch TV was replaced with a 32 inch TV. On 2/27/15 at 12:04 PM, the Coordinator indicated the facility should have replaced client #4's TV based on the amount spent and not the size.</p> <p>5) On 1/16/15 at 7:00 PM, client #2 called client #1 a name. Client #1 kicked client #2 on the right foot. Client #2 kicked client #1's right foot. Client #1 went to another room to calm down. Client #1 went back into the area where client #2 was located and stated "he hated [client #2]" and hit client #2 on the head. Neither client was injured.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/25/15 at 1:18 PM the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p>			

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	<p>6) On 1/9/15 at 1:30 PM (reported to BDDS on 1/13/15) client #1 was using the computer. A peer walked behind client #1 and tapped and grabbed client #1's shoulder. Client #1 told the peer to stop or he was going to headbutt her. The peer tapped his shoulder again. Client #1 stated, "I warned you [name of peer] that if you did it again, I was going to headbutt you." Client #1 stood up and headbutted the peer in the stomach area. The peer was not injured.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/25/15 at 1:18 PM the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>7) On 12/16/14 at 8:00 PM while loading into the van to go to the store, client #2 hit client #1 on the head without warning. Client #1 bit client #2's right index finger drawing blood.</p> <p>On 2/25/15 at 12:43 PM the GHD</p>			

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	<p>indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/25/15 at 1:18 PM the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>8) On 12/16/14 at 2:25 PM at the facility operated day program, client #1 took two ornaments from the recycle center. Staff prompted client #1 to put one back so others could have one too. Client #1 refused to put one back and ran to the van. While in the van, client #1 was yelling and throwing items. Client #1 pushed a peer's face with his finger and told her to stop laughing. Client #1 poked another peer with a plastic fork. The peers were not injured.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/25/15 at 1:18 PM the Coordinator</p>			

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	<p>indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>9) On 12/12/14 at 2:45 PM (reported to BDDS on 12/15/14) at the facility operated day program, client #1 thought a peer was trying to take his snack. Client #1 hit the peer and threatened to run away. Client #1 grabbed client #5's arms and hit him. The peers were not injured.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/25/15 at 1:18 PM the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>10) On 9/25/14 at 5:50 AM, former staff #10 was asleep on the couch when former staff #11 arrived. The Stone Belt ARC, Inc. incident report, dated 9/25/14, indicated, "I pulled up @ [name of group home] to find all the lights in the house</p>			

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	<p>turned off. I walked in using my cell as a light and found [staff #10] on the couch in the l (living) room asleep. I woke him and asked what was going on and did he have permission to sleep and he said no. I walked away to go to the office and as (sic) passing the stairs I hear [client #3's] doorbell to his room ding, as I looked down the stairs he was entering his room. I put my things into the office and done (sic) a walk through of the house, finding BM (bowel movement) all over the toilet seat in the upstairs client bathroom. Trash cans overflowing, the kitchen dirty w/ (with) popcorn all over the place, dirty dishes and the trash can spilling over onto the floor, no floors swept or mopped. No cleaning done at all. That the house was left in bad condition from [staff #10] and the clients were left for them self (sic) while he slept when we have bedroom alarms for 2." Staff #10 was terminated on 10/7/14 due to a substantiated allegation of falling asleep while on shift.</p> <p>The 9/25/14 Stone Belt ARC, Inc. Incident Report indicated, as documented by the Group Home Director, "[Staff #11] needs training (sic) failed to contact myself and pager."</p> <p>On 2/25/15 at 12:43 PM, the GHD indicated the staff was terminated for</p>				

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	<p>falling asleep while on shift. The GHD indicated staff were to immediately report allegations of abuse and neglect to the administrator. The GHD indicated she was the administrator.</p> <p>On 2/25/15 at 11:43 AM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by</p>						

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	<p>Indiana Law... ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events." The Human Rights Policy, dated 2/17/14, indicated, in part, "Physical abuse: Consists of any intentional and/or punitive physical action or motion by which physical harm or emotional trauma may occur." The policy indicated, "Sexual abuse: Consists of any intentional inappropriate sexual behavior where an individual suffers emotional/psychological harm or trauma, to include touch of sexual genitalia, areas of the body considered private such as the breasts and buttocks, This also includes:</p> <ol style="list-style-type: none"> 1. Touching self in a sexual way with an unwilling audience. 2. Nonconsensual sexual activity or touching. 3. Sexual molestation. 4. Sexual coercion. 5. Sexual exploitation. 6. Sexual abuse 			

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W 153 Bldg. 00	<p>should not be confused with sexual acting out, which may involve inappropriate sexual behavior, such as vulgar sexual language, touching self, sexual advances towards another without intent to harm or injure another. Sexual acting out may also include consensual sexual acts between clients who both have the capacity to give consent, but where choice of timing, place or other factor determines the act to be inappropriate. Cognitive competence as well as the developmental and emotional stage of the client initiating the sexual behavior will be assessed by professionals."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 4 of 32 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and former client #6, the facility failed to ensure staff immediately reported allegations of abuse and neglect to the administrator and failed to submit</p>	W 153	1)Plan of Correction: Facility associatemanager / Staff # 9 will receive a performance action review for failure tocontact pager following a client choking and not completing an IR / immediatlycontacting administer (attachmentg). Investigation	03/13/2015

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	<p>incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>On 2/25/15 at 11:57 AM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/25/15 at 11:57 AM when client #1's incident reports were reviewed, there was no documentation of an incident on 2/22/15 involving client #1 choking. On 2/26/15 at 1:14 PM client #1's incident reports were reviewed again and there was no documentation of an incident report involving client #1 choking on 2/22/15.</p> <p>An observation was conducted at the group home on 2/26/15 from 5:56 AM to 7:48 AM. At 6:55 AM during client #1's medication pass, staff #9 stated she was taking client #1's temperature due to a "choking fit" on Sunday (2/22/15).</p> <p>On 2/22/15 at 1:09 PM, staff #2 documented in an email, "Hi All, [client #1] had a choking fit this morning. I am not sure what he was eating that caused him to choke. But he got it up coughing. From what I saw it seemed to be big bite.</p>		<p>completed (attachment m)the IR andper</p> <p>Plan ofPrevention: Client #1 dining plan was trained with the staff (attachment h).Facility staff were trained on incident reporting and choking (attachment i).Client #1 underwent a swallow evaluation 3/27/15 and new dining plan will bedevised and trained to facility staff to follow (attachment j).</p> <p>Plan ofmonitoring: Facility house manager / associate manager will monitor to ensuredining plans ensure that all allegations of mistreatment, neglect or abuse, aswell as injuries ofunknown source, are reported immediately to the administrator (attachment f).Facility coordinator QIDP will ensure that all allegations of mistreatment,neglect or abuse, as well as injuries of unknown source, are reportedimmediately to the administrator (attachment a).</p> <p>2)</p>		

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	<p>After I made sure he was okay, I asked him how he was and he said that was scary. He seems to be A-Okay by now. But if he tells you his throat is sore that might be because of him choking today. Just a heads up!"</p> <p>On 2/22/15 at 1:11 PM, the Group Home Director (GHD) indicated in an email, "Was the nursing pager contacted?"</p> <p>On 2/22/15 at 9:31 PM, the Registered Nurse (RN) indicated in an email, "Nope, I didn't get a call. I called out to [name of group home] but got voicemail. Please check his temp (temperature) twice daily for a week. Document this on the MAR (Medication Administration Record). Let me know/ call the pager if you notice he is refusing meals or fluids, change in mood, cough or chest congestion. CALL 9-1-1 if you notice he is having difficulty breathing or his skin is turning blue."</p> <p>On 2/26/15 at 12:53 PM the GHD indicated in an email, "Was it confirmed if he actually choked or if it was a coughing fit? Also, [name of surveyor] is requesting and (sic) IR (incident report) if he truly choked one should have been completed along with he needed checked (sic) for aspiration ASAP (as soon as possible). He will also need a swallow evaluation and dining plan put in effect."</p>		<p>Plan of Correction: Day program staff trained on incident reporting (attachment g). the IR and per Plan of Prevention: Facility staff were trained on incident reporting and choking (attachment i).</p> <p>Plan of monitoring: Facility house manager / associate manager will monitor to ensure dining plans ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator (attachment f). Facility coordinator QIDP will ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator</p> <p>3) Plan of Correction: Staff (former) #10 was terminated for said neglect (attachment q). IR and Plan of Prevention: Facility staff trained on keeping alert</p>	

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	<p>On 2/26/15 at 1:15 PM, the RN indicated in an email, "It happened once during the meal. We say this is 'self corrected.' If it happens more than once in the same meal an IR is needed. That was my understanding."</p> <p>On 2/22/15 at 10:45 AM, an incident report dated 2/28/15 indicated, "On 02/22/2015 at 10:45 AM, [client #1] was in the kitchen at [name of group home] eating breakfast. [Client #1] started coughing a lot and signaling he was having problems swallowing what he was eating. No one saw the event, but each staff heard it. Staff went into the kitchen and asked if [client #1] was okay, and he verbally told staff he was fine and continued to cough. [Client #1] continued to cough, and another staff came in to make sure he was fine. [Client #1] finally got the food up, and it landed in the trash can so staff didn't get to see exactly what he was eating; it looked large enough to cause him to have difficulties swallowing. [Client #1] stated that the incident scared him. Staff explained to him the importance of taking small bites, chewing before swallowing, and slowing down while eating. Staff stayed in the kitchen and watched [client #1] finish his breakfast."</p>		<p>during shifts and sleepings considered neglect (attachment r).</p> <p>Plan of monitoring:Staff (former) #10 was terminated for said neglect (attachment q). Facilityhouse manager / associate manager will monitor to ensure that all allegationsof mistreatment, neglect or abuse, as well as injuries ofunknown source, are reported immediately to the administrator (attachment f). Facilitycoordinator QIDP will provide monthly overnight monitoring to ensure ensurethat all allegations of mistreatment, neglect or abuse, as well as injuries ofunknown source, are reported immediately to the administrator (attachment f).</p>	

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	<p>There was no documentation the facility reported the incident to BDDS.</p> <p>On 2/27/15 at 2:57 PM, the Nursing Manager indicated if the incident involved choking then an incident report should have been written. The NM indicated the RN attempted to call the house but no one answered. The NM indicated he was not sure if the RN followed up with the staff. The NM indicated the RN sent out an email for precautions to take (taking temperature).</p> <p>On 2/27/15 at 3:15 PM the GHD indicated the staff failed to immediately report the incident to the administrator. The GHD indicated the incident was not reported to BDDS.</p> <p>On 2/26/15 at 1:16 PM the Coordinator indicated the staff reported the incident but not immediately. The staff should have reported it to the pager immediately and the pager would have called the nursing pager. The Coordinator indicated the incident was not reported to BDDS.</p> <p>2) On 1/9/15 at 1:30 PM (reported to BDDS on 1/13/15) client #1 was using the computer. A peer walked behind client #1 and tapped and grabbed client #1's shoulder. Client #1 told the peer to stop or he was going to headbutt her.</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The peer tapped his shoulder again. Client #1 stated, "I warned you [name of peer] that if you did it again, I was going to headbutt you." Client #1 stood up and headbutted the peer in the stomach area. The peer was not injured.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated BDDS reports were to be submitted within 24 hours.</p> <p>On 2/25/15 at 1:18 PM the Coordinator indicated BDDS reports were to be submitted within 24 hours.</p> <p>3) On 12/12/14 at 2:45 PM (reported to BDDS on 12/15/14) at the facility operated day program, client #1 thought a peer was trying to take his snack. Client #1 hit the peer and threatened to run away. Client #1 grabbed client #5's arms and hit him. The peers were not injured.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated BDDS reports were to be submitted within 24 hours.</p> <p>On 2/25/15 at 1:18 PM the Coordinator indicated BDDS reports were to be submitted within 24 hours.</p> <p>4) On 9/25/14 at 5:50 AM, former staff #10 was asleep on the couch when former staff #11 arrived. The Stone Belt</p>				

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	<p>ARC, Inc. incident report, dated 9/25/14, indicated, "I pulled up @ [name of group home] to find all the lights in the house turned off. I walked in using my cell as a light and found [staff #10] on the couch in the l (living) room asleep. I woke him and asked what was going on and did he have permission to sleep and he said no. I walked away to go to the office and as (sic) passing the stairs I hear [client #3's] doorbell to his room ding, as I looked down the stairs he was entering his room. I put my things into the office and done (sic) a walk through of the house, finding BM (bowel movement) all over the toilet seat in the upstairs client bathroom. Trash cans overflowing, the kitchen dirty w/ (with) popcorn all over the place, dirty dishes and the trash can spilling over onto the floor, no floors swept or mopped. No cleaning done at all. That the house was left in bad condition from [staff #10] and the clients were left for them self (sic) while he slept when we have bedroom alarms for 2." Staff #10 was terminated on 10/7/14 due to a substantiated allegation of falling asleep while on shift.</p> <p>The 9/25/14 Stone Belt ARC, Inc. Incident Report indicated, as documented by the Group Home Director, "[Staff #11] needs training (sic) failed to contact myself and pager."</p>				

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W 154 Bldg. 00	<p>On 2/25/15 at 12:43 PM, the GHD indicated the staff was terminated for falling asleep while on shift. The GHD indicated staff were to immediately report allegations of abuse and neglect to the administrator. The GHD indicated she was the administrator.</p> <p>9-3-2(a)</p> <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 2 of 32 incident/investigative reports reviewed affecting clients #1 and #4, the facility failed to conduct thorough investigations regarding an incident of client #1's choking and client #4's missing television.</p> <p>Findings include:</p> <p>On 2/25/15 at 11:57 AM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/25/15 at 11:57 AM when client #1's incident reports were reviewed, there</p>	W 154	<p>Plan of Correction: Incidents were investigated by director (attachment s) and it was determined that facility associate manager / Staff # 9 will receive a performance action review for failure to contact pager following a client choking and not completing an IR / immediately contacting administrator (attachment r). and per</p> <p>Plan of Prevention: Client #1 dining plan was trained with the staff (attachment h). Facility staff were trained on incident reporting and choking (attachment i). Client #1 underwent a swallow evaluation 3/27/15 and new</p>	03/20/2015

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	<p>was no documentation of an incident on 2/22/15 involving client #1 choking. On 2/26/15 at 1:14 PM client #1's incident reports were reviewed again and there was no documentation of an incident report involving client #1 choking on 2/22/15.</p> <p>An observation was conducted at the group home on 2/26/15 from 5:56 AM to 7:48 AM. At 6:55 AM during client #1's medication pass, staff #9 stated she was taking client #1's temperature due to a "choking fit" on Sunday (2/22/15).</p> <p>On 2/22/15 at 1:09 PM, staff #2 documented in an email, "Hi All, [client #1] had a choking fit this morning. I am not sure what he was eating that caused him to choke. But he got it up coughing. From what I saw it seemed to be (sic) big bite. After I made sure he was okay, I asked him how he was and he said that was scary. He seems to be A-Okay by now. But if he tells you his throat is sore that might be because of him choking today. Just a heads up!"</p> <p>On 2/22/15 at 1:11 PM, the GHD indicated in an email, "Was the nursing pager contacted?"</p> <p>On 2/22/15 at 9:31 PM, the Registered Nurse (RN) indicated in an email, "Nope,</p>		<p>dining plan will be devised and trained to facility staff to follow (attachment j).</p> <p>Plan of monitoring: Facility coordinator QIDP will ensure that all alleged violations are thoroughly investigated (attachment a).</p>	

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	<p>I didn't get a call. I called out to [name of group home] but got voicemail. Please check his temp (temperature) twice daily for a week. Document this on the MAR (Medication Administration Record). Let me know/ call the pager if you notice he is refusing meals or fluids, change in mood, cough or chest congestion. CALL 9-1-1 if you notice he is having difficulty breathing or his skin is turning blue."</p> <p>On 2/26/15 at 12:53 PM the GHD indicated in an email, "Was it confirmed if he actually choked or if it was a coughing fit? Also, [name of surveyor] is requesting and (sic) IR (incident report) if he truly choked one should have been completed along with he needed checked (sic) for aspiration ASAP (as soon as possible). He will also need a swallow evaluation and dining plan put in effect."</p> <p>On 2/26/15 at 1:15 PM, the RN indicated in an email, "It happened once during the meal. We say this is 'self corrected.' If it happens more than once in the same meal an IR is needed. That was my understanding."</p> <p>On 2/22/15 at 10:45 AM, an incident report dated 2/28/15 indicated, "On 02/22/2015 at 10:45 AM, [client #1] was in the kitchen at [name of group home] eating breakfast. [Client #1] started</p>			

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	<p>coughing a lot and signaling he was having problems swallowing what he was eating. No one saw the event, but each staff heard it. Staff went into the kitchen and asked if [client #1] was okay, and he verbally told staff he was fine and continued to cough. [Client #1] continued to cough, and another staff came in to make sure he was fine. [Client #1] finally got the food up, and it landed in the trash can so staff didn't get to see exactly what he was eating; it looked large enough to cause him to have difficulties swallowing. [Client #1] stated that the incident scared him. Staff explained to him the importance of taking small bites, chewing before swallowing, and slowing down while eating. Staff stayed in the kitchen and watched [client #1] finish his breakfast."</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/27/15 at 2:57 PM, the Nursing Manager indicated if the incident involved choking then an incident report should have been written. The NM indicated the RN attempted to call the house but no one answered. The NM indicated he was not sure if the RN followed up with the staff. The NM indicated the RN sent out an email for precautions to take (taking temperature).</p>			

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	<p>On 2/27/15 at 3:15 PM the GHD indicated the facility did not investigate the incident.</p> <p>On 2/26/15 at 1:16 PM the Coordinator indicated an investigation was not completed.</p> <p>2) On 1/16/15 at 7:00 PM, a Stone Belt ARC, Inc. Incident Report, dated 1/16/15, indicated, in part, "[Client #4] placed his TV in the garage in July and did not want to put it back in his room till (sic) he got a new TV stand. After [client #4] got a new TV stand staff went to get his TV out of the garage and could not find it. Staff searched the entire house and all of the clients (sic) rooms staff also asked all the clients if they have scene (sic) the TV anywhere and they all said no." The facility submitted an incident report to BDDS on 1/19/15. There was no documentation the facility investigated the incident. The BDDS report indicated, "Stone Belt will purchase and replace the TV for [client #4]. Support team will review."</p> <p>On 1/16/15 at 2:47 PM, the Social Worker indicated in an email to the Group Home Director (GHD), "Hi [name of GHD], I raised the issue with you last week of [client #4's] missing TV set and</p>			

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	<p>the missing [name] house weight bench. I need to reiterate that this seems to me to require an allegation of exploitation and an investigation. I'm wondering what is being done about this. Thanks, [Name of Social Worker]."</p> <p>On 1/18/15 at 11:31 AM, the Coordinator sent an email to the GHD, Social Worker, the Home Manager and others indicating, "I had three staff search the house thoroughly [staff #1, #2 and #3]. None of these searches found the misplaced items. [Client #4] placed his TV in the garage prior to Halloween when his entertainment stand broke. Despite multiple prompts to leave the TV on his stand, as it could still hold it, he left it in the garage. When [clients #3 and #5] set up the garage for the haunted house, they put a load of items out with the trash. I searched thru (sic) the items to make sure that they were indeed garbage. The TV was not out there. I also had the staff ask [clients #3 and #5] if they had moved the TV, and both said that they hadn't. [Staff #1] reported seeing the TV a week before we noticed it was missing, after buying [client #4] a new stand and going to retrieve it... As the guys have a tendency to leave the door into the garage unlocked when they leave for day program, despite constant prompting and coaching about the dangers of leaving their home</p>			

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	<p>unlocked when no one is there, and the fact that staff sometimes forget to check to make sure that the garage door is locked after the guys have left the house, the possibility that someone could have merely entered the garage and stolen the items does exist...." A handwritten note on the printout of the email indicated, as documented by the Coordinator, "[Name of the former Manager of Clinical Services] and [name of the Director of Milestones (a division of Stone Belt Health and Clinical Resources)] said that no investigation was necessary & that we didn't need to file a police report."</p> <p>A review of client #4's receipt for his missing TV was conducted on 2/25/15 at 3:13 PM. Client #4 purchased his TV on 5/14/14 for \$388.08. The TV was a 32 inch Sony. Included in the price was the purchase of a 2 year service agreement for \$34.99. The facility purchased client #4 a TV on 2/20/15. The TV was a Samsung 32 inch TV totaling \$213.99. The facility did not purchase a 2 year service agreement. The difference in the amount client #4 spent and the replacement TV was \$174.09. There was no documentation the facility reimbursed client #4 \$174.09 for the difference in the cost client #4 incurred.</p> <p>On 2/27/15 at 3:04 PM, the GHD stated</p>			

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	<p>the facility should have purchased a TV "closer" to the amount client #4 spent when he purchased a TV.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated client #4's missing TV should have been investigated. The GHD indicated the facility should have reimbursed client #4 based on the money amount and not the size of the TV.</p> <p>On 2/25/15 at 1:18 PM, the Coordinator indicated he did not document conducting an investigation. He indicated the former Manager of Clinical Services and Director of Health and Clinical Resources told him an investigation did not need to be completed. The Coordinator indicated one of the glass doors of client #4's previous entertainment center broke and shattered. The Coordinator indicated client #4 took his TV out to the garage himself. The Coordinator indicated when client #4 agreed to purchase a new entertainment center his TV was discovered missing. The Coordinator indicated client #4's 32 inch TV was replaced with a 32 inch TV. On 2/27/15 at 12:04 PM, the Coordinator indicated the facility should have replaced client #4's TV based on the amount spent and not the size.</p>						

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W 155 Bldg. 00	<p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 1 of 32 incident/investigative reports reviewed affecting clients #3 and #5, the facility failed to take appropriate corrective actions to prevent further potential abuse while an investigation was in progress.</p> <p>Findings include:</p> <p>On 2/25/15 at 11:57 AM a review of the facility's incident/investigative reports was conducted and indicated the following: This incident report was reviewed on 2/27/15 at 9:07 AM: On 2/26/15 at 6:45 PM, clients #3 and #5 went into the bathroom together. The Stone Belt ARC, Inc. incident report, dated 2/26/15, indicated, "[Client #5] then locked the door according to [client #3]. [Client #5] says that he was in the bathroom to take his shower. [Client #3] stated that [client #5] started kissing his neck, rubbing his back and rubbing his genitals. [Client #3] told [client #5] to stop but [client #5] refused. I knocked on the door because I heard both [clients #3</p>	W 155	<p>Plan ofCorrection: Client #3 and #5 active treatment and partnering schedules wereupdated (attachment b). Client #5 BSP updated to include strategies to preventfurther incidents. (attachment c).</p> <p>Plan ofPrevention: Facility coordinator / QIDP trained on following written policiesand procedures that prohibit mistreatment, neglect or abuse of the client(attachment a). Facility staff trained on active treatment schedules(attachment d). Facility staff trained on client #5 BSP (attachment e).</p> <p>Plan ofmonitoring: Facility quality assurance team meet biweekly to discuss facilitypolicy and procedure</p>	03/20/2015			

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	<p>and #5] voice (sic) coming from the upstairs bathroom from the kitchen. I proceed (sic) to knock on the door asking them to open the door. It took them ten seconds to open the door up. I asked them what's going on and both replied, 'nothing.' I asked them (sic) please not be in the bathroom together. Later in the office [client #3] told me that [client #5] was rubbing his back, kissing his neck, and rubbing his genitals. [Client #3] says when [client #5] was doing this, he told [client #5] to stop. [Client #5] says he did something he shouldn't of (sic) done."</p> <p>On 2/26/15 at 9:57 PM the Group Home Director (GHD) indicated in an email, "I called the house and instructed that clients were separated for remaining of evening. [Name of Behavior Support Services Coordinator] was forwarded copy of IR (incident report) to initiate investigation."</p> <p>On 2/27/15 at 9:07 AM, the GHD indicated in an email, "Once [name of support staff] submits this I will send you a copy. Wanted to let you know it's being investigated."</p> <p>On 2/27/15 at 1:39 PM a review of client #3's record was conducted. Client #3's Behavioral Intervention Plan, dated 9/16/14, indicated client #3 had a</p>		<p>that prohibit mistreatment, neglect or abuse on the client. Facility coordinator QIDP will ensure that policies prohibiting mistreatment, neglect, or abuse of clients are followed (attachment a). Facility house manager trained to monitor active treatment, partneringschedules, and BSPs are being followed (attachment f).</p>	

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	<p>targeted behavior of sexual behavior and boundaries. The plan indicated the Operational Definition of sexual behavior and boundaries: sexual behavior/contact is defined as interaction and physical touching of a suggestive, sensual or romantic nature, including but not limited to: kissing, hugging, touching self or others in a sexual way, masturbation, oral sex, intercourse, or other similar behaviors... Violating boundaries is defined as [client #3] being in another individual's private space (i.e. bedrooms, staff office) without staff knowledge or permission. Behavior assessment: [Client #3's] inappropriate sexual behavior has been reported on several separate occasions at the group home, and includes possibly consensual sexual activity with a peer of the same functioning level, as well as non-consensual sexual contact with a peer of lower intellectual functioning...." The plan indicated, "[Client #3] has a recent history of sexually acting out with one of his housemates. As a result of this incident, there is now an alarm on [client #3's] bedroom door, which alerts staff when he has entered/left his bedroom. This restriction has been put into place as an emergency house restriction to support client safety. This restriction will be reviewed at a support team meeting in October 2014."</p>			

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	<p>On 2/27/15 at 11:58 AM the GHD indicated there was an allegation of sexual contact between clients #3 and #5. The GHD indicated client #3 reported he was in the restroom when client #5 entered and touched his genitals, kissed his neck and rubbed his back. The GHD indicated the incident occurred shortly after the surveyor left the home on 2/26/15. The GHD indicated there were 2 staff and 3 clients in the home at the time of the incident. The GHD indicated neither staff was suspended. The GHD indicated the facility was going to investigate the incident. The GHD indicated there was a previous incident between the clients. The GHD indicated following the previous incident, the clients' bedroom doors had alarms installed. The GHD indicated the facility staff needed to supervise the clients more closely and ensure the clients were not on the same floor.</p> <p>On 2/27/15 at 2:24 PM, client #3 indicated he was using the restroom when client #5 entered. Client #3 indicated client #5 reached around him, grabbed his genitals and buttocks, and kissed his neck. Client #3 indicated he asked client #5 to stop but he did not stop. Client #3 indicated he called for help from the staff. Client #3 indicated client #5</p>			

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W 157 Bldg. 00	<p>stopped once staff #6 knocked on the door. Client #3 indicated this happened once before but he could not recall when. Client #3 stated, "I don't like it." Client #3 indicated the next time he went into the restroom he would lock the door.</p> <p>On 3/3/15 at 10:21 AM, the Behavior Specialist (BS) who conducted the investigation indicated, to his knowledge, the two staff who were present at the time of the incident were not removed from having contact with the clients. The BS indicated the incident was not investigated for abuse, neglect or exploitation on the part of the staff. The BS indicated he was investigating an incident of client to client sexual abuse.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 32 incidents/investigative reports reviewed affecting clients #1 and #4, the facility failed to take appropriate corrective actions.</p> <p>Findings include:</p>	W 157	<p>Plan ofCorrection: Client #3 and #5 active treatment and partnering schedules wereupdated (attachment b). Client #5 BSP updated to include strategies to preventfurther incidents. (attachment c).</p>	03/20/2015			

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	<p>On 2/25/15 at 11:57 AM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/25/15 at 11:57 AM when client #1's incident reports were reviewed, there was no documentation of an incident on 2/22/15 involving client #1 choking. On 2/26/15 at 1:14 PM client #1's incident reports were reviewed again and there was no documentation of an incident report involving client #1 choking on 2/22/15.</p> <p>An observation was conducted at the group home on 2/26/15 from 5:56 AM to 7:48 AM. At 6:55 AM during client #1's medication pass, staff #9 stated she was taking client #1's temperature due to a "choking fit" on Sunday (2/22/15).</p> <p>On 2/22/15 at 1:09 PM, staff #2 documented in an email, "Hi All, [client #1] had a choking fit this morning. I am not sure what he was eating that caused him to choke. But he got it up coughing. From what I saw it seemed to be big bite. After I made sure he was okay, I asked him how he was and he said that was scary. He seems to be A-Okay by now. But if he tells you his throat is sore that might be because of him choking today. Just a heads up!"</p>		<p>Plan ofPrevention: Facility coordinator / QIDP trained on following written policiesand procedures that prohibit mistreatment, neglect or abuse of the client(attachment a). Facility staff trained on active treatment schedules(attachment d). Facility staff trained on client #5 BSP (attachment e).</p> <p>Plan ofmonitoring: Facility quality assurance team meet biweekly to discuss facilitypolicy and procedure that prohibit mistreatment, neglect or abuse on theclient. Facility coordinator QIDP will ensure that policies prohibitingmistreatment, neglect, or abuse of clients are followed (attachment a).Facility house manager trained to monitor active treatment, partneringschedules, and BSPs are being followed (attachment f).</p>	

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	<p>On 2/22/15 at 1:11 PM, the GHD indicated in an email, "Was the nursing pager contacted?"</p> <p>On 2/22/15 at 9:31 PM, the Registered Nurse (RN) indicated in an email, "Nope, I didn't get a call. I called out to [name of group home] but got voicemail. Please check his temp (temperature) twice daily for a week. Document this on the MAR (Medication Administration Record). Let me know/ call the pager if you notice he is refusing meals or fluids, change in mood, cough or chest congestion. CALL 9-1-1 if you notice he is having difficulty breathing or his skin is turning blue."</p> <p>On 2/26/15 at 12:53 PM the GHD indicated in an email, "Was it confirmed if he actually choked or if it was a coughing fit? Also, [name of surveyor] is requesting and (sic) IR (incident report) if he truly choked one should have been completed along with he needed checked (sic) for aspiration ASAP (as soon as possible). He will also need a swallow evaluation and dining plan put in effect."</p> <p>On 2/26/15 at 1:15 PM, the RN indicated in an email, "It happened once during the meal. We say this is 'self corrected.' If it happens more than once in the same meal an IR is needed. That was my</p>			

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	<p>understanding."</p> <p>On 2/22/15 at 10:45 AM, an incident report dated 2/28/15 indicated, "On 02/22/2015 at 10:45 AM, [client #1] was in the kitchen at [name of group home] eating breakfast. [Client #1] started coughing a lot and signaling he was having problems swallowing what he was eating. No one saw the event, but each staff heard it. Staff went into the kitchen and asked if [client #1] was okay, and he verbally told staff he was fine and continued to cough. [Client #1] continued to cough, and another staff came in to make sure he was fine. [Client #1] finally got the food up, and it landed in the trash can so staff didn't get to see exactly what he was eating; it looked large enough to cause him to have difficulties swallowing. [Client #1] stated that the incident scared him. Staff explained to him the importance of taking small bites, chewing before swallowing, and slowing down while eating. Staff stayed in the kitchen and watched [client #1] finish his breakfast."</p> <p>On 2/27/15 at 11:33 AM a review of client #1's record was conducted. There was no documentation in client #1's record regarding the incident. There was no documentation client #1's interdisciplinary team convened to</p>						

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	<p>discuss the incident. There was no documentation the facility took corrective actions to ensure another choking incident did not occur.</p> <p>On 2/27/15 at 2:57 PM, the Nursing Manager indicated if the incident involved choking then an incident report should have been written. The NM indicated the RN attempted to call the house but no one answered. The NM indicated he was not sure if the RN followed up with the staff. The NM indicated the RN sent out an email for precautions to take (taking temperature).</p> <p>On 2/26/15 at 1:16 PM the Coordinator indicated the staff reported the incident but not immediately. The staff should have reported it to the pager immediately and the pager would have called the nursing pager. The Coordinator indicated the incident was not reported to BDDS and an investigation was not completed.</p> <p>2) On 1/16/15 at 7:00 PM, a Stone Belt ARC, Inc. Incident Report, dated 1/16/15, indicated, in part, "[Client #4] placed his TV in the garage in July and did not want to put it back in his room till (sic) he got a new TV stand. After [client #4] got a new TV stand staff went to get his TV out of the garage and could not find it. Staff searched the entire house and all of</p>				

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	<p>the clients (sic) rooms staff also asked all the clients if they have scene (sic) the TV anywhere and they all said no." The facility submitted an incident report to BDDS on 1/19/15. There was no documentation the facility investigated the incident. The BDDS report indicated, "Stone Belt will purchase and replace the TV for [client #4]. Support team will review."</p> <p>On 1/16/15 at 2:47 PM, the Social Worker indicated in an email to the Group Home Director (GHD), "Hi [name of GHD], I raised the issue with you last week of [client #4's] missing TV set and the missing [name] house weight bench. I need to reiterate that this seems to me to require an allegation of exploitation and an investigation. I'm wondering what is being done about this. Thanks, [Name of Social Worker]."</p> <p>On 1/18/15 at 11:31 AM, the Coordinator sent an email to the GHD, Social Worker, the Home Manager and others indicating, "I had three staff search the house thoroughly [staff #1, #2 and #3]. None of these searches found the misplaced items. [Client #4] placed his TV in the garage prior to Halloween when his entertainment stand broke. Despite multiple prompts to leave the TV on his stand, as it could still hold it, he left it in</p>						

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	<p>the garage. When [clients #3 and #5] set up the garage for the haunted house, they put a load of items out with the trash. I searched thru (sic) the items to make sure that they were indeed garbage. The TV was not out there. I also had the staff ask [clients #3 and #5] if they had moved the TV, and both said that they hadn't. [Staff #1] reported seeing the TV a week before we noticed it was missing, after buying [client #4] a new stand and going to retrieve it... As the guys have a tendency to leave the door into the garage unlocked when they leave for day program, despite constant prompting and coaching about the dangers of leaving their home unlocked when no one is there, and the fact that staff sometimes forget to check to make sure that the garage door is locked after the guys have left the house, the possibility that someone could have merely entered the garage and stolen the items does exist...." A handwritten note on the printout of the email indicated, as documented by the Coordinator, "[Name of the former Manager of Clinical Services] and [name of the Director of Milestones (a division of Stone Belt) Health and Clinical Resources] said that no investigation was necessary & that we didn't need to file a police report."</p> <p>A review of client #4's receipt for his missing TV was conducted on 2/25/15 at</p>			

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	<p>3:13 PM. Client #4 purchased his TV on 5/14/14 for \$388.08. The TV was a 32 inch Sony. Included in the price was the purchase of a 2 year service agreement for \$34.99. The facility purchased client #4 a TV on 2/20/15. The TV was a Samsung 32 inch TV totaling \$213.99. The facility did not purchase a 2 year service agreement. The difference in the amount client #4 spend and the replacement TV was \$174.09. There was no documentation the facility reimbursed client #4 \$174.09 for the difference in the cost client #4 incurred.</p> <p>On 2/26/15 at 1:50 PM the Fiscal Coordinator (FC) indicated the facility should have been comparable in client #4's replacement. The FC indicated the size of the television was comparable but not the dollar amount. The FC stated, "Stone Belt should pay him (client #4) more."</p> <p>On 2/27/15 at 3:04 PM, the GHD stated the facility should have purchased a TV "closer" to the amount client #4 spent when he purchased a TV.</p> <p>On 2/25/15 at 12:43 PM the GHD indicated client #4's missing TV should have been investigated. The GHD indicated the facility should have reimbursed client #4 based on the money</p>						

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W 159 Bldg. 00	<p>amount and not the size of the TV.</p> <p>On 2/25/15 at 1:18 PM, the Coordinator indicated he did not document conducting an investigation. He indicated the former Manager of Clinical Services and Director of Health and Clinical Resources told him an investigation did not need to be completed. The Coordinator indicated one of the glass doors of client #4's previous entertainment center broke and shattered. The Coordinator indicated client #4 took his TV out to the garage himself. The Coordinator indicated when client #4 agreed to purchase a new entertainment center his TV was discovered missing. The Coordinator indicated client #4's 32 inch TV was replaced with a 32 inch TV. On 2/27/15 at 12:04 PM, the Coordinator indicated the facility should have replaced client #4's TV based on the amount spent and not the size.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p>			
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	<p>Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure staff implemented client #1's Diabetic Risk Plan, client #2's comprehensive functional assessment (CFA) was reviewed for relevancy and updated at least annually, client #2 and #3's individualized program plans (IPP) were revised at least annually, obtain written informed consent from client #1's guardian for his Individualized Program Plan (IPP), failed to ensure quarterly evacuation drills for each shift were conducted affecting clients #1, #2, #3, #4 and #5, and ensure the facility did not lose the training documentation for clients #2 and #3.</p> <p>Findings include:</p> <p>1) Please refer to W249. For 1 of 3 clients in the sample (#1), the QIDP failed to ensure staff implemented client #1's Diabetic Risk Plan.</p> <p>2) Please refer to W259. For 1 of 3 clients in the sample (#2), the QIDP failed to ensure his comprehensive functional assessment (CFA) was reviewed for relevancy and updated at least annually.</p>	W 159	<p>1) Plan ofCorrection: Client #1 high risk plan was updated to include by team (attachments). Plan ofPrevention: Facility staff trained on following client #1 high risk plan fordiabetes (attachment t). Plan ofMonitoring: Facility house / associate manager trained on ensuring client #1HRP is being followed as written (attachment t). QIDP will provide frequentmonitoring to ensure staff are following HRP and physician orders (attachment). 2) Plan ofCorrection: QIDP reviewed client #2 comprehensive functional assessment CFA wasupdated for relevancy (attachment u). Plan ofPrevention: Facility QIDP trained to ensure all clients comprehensivefunctional assessment (CFA) is reviewed for relevancy and updated at leastannually (attachment v). Plan ofMonitoring: Electronic alert will be sent out when annual paperwork is notsubmitted to Fortis database by annual deadline (attachment w). 3) Plan ofCorrection: QIDP updated client #2 annual ISP (attachment x). Plan ofPrevention: Facility QIDP trained to ensure all clients comprehensivefunctional assessment (CFA) is reviewed</p>	03/13/2015			

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	<p>3) Please refer to W260. For 2 of 3 clients in the sample (#2 and #3), the QIDP failed to ensure the clients' individualized program plans (IPP) were revised at least annually.</p> <p>4) Please refer to W263. For 1 of 3 clients in the sample (#1), the QIDP failed to obtain written informed consent from client #1's guardian for his Individualized Program Plan (IPP).</p> <p>5) Please refer to W440. For 5 of 5 clients living at the group home (#1, #2, #3, #4 and #5), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>6) A review of client #2's record was conducted on 2/27/15 at 12:45 PM. Client #2's record contained a document, not dated, indicating, "Active Treatment Training Summary: IHP (individual habilitation program) tracking for the months of November and December (2014) were lost somewhere between [group home name] and the QIDP's desk. When consulted, the manager and house staff reported that they had been sent in, but to the wrong person. The attempt to track them down following this lead proved fruitless. Only one month's worth of training was recovered for one client. All staff have been trained on the proper</p>		<p>and annual ISP updated for relevancy and updated at least annually (attachment a). Plan of Monitoring: Electronic alert will be sent out when annual paperwork is not submitted to Fortis database by annual deadline (attachment w). 4) Plan of Correction: QIDP obtained guardian consent for #1 annual ISP (attachment y). Plan of Prevention: Facility QIDP trained to ensure all clients comprehensive functional assessment (CFA) is reviewed and annual ISP, including guardian consent) updated for relevancy and updated at least annually (attachment a). Plan of Monitoring: Electronic alert will be sent out when annual paperwork is not submitted to Fortis database by annual deadline (attachment w). 5) Facility created drill schedule and binder to ensure quarterly evacuation drills are conducted for each shift (attachment z). Plan of Prevention: Facility staff trained to follow schedule to ensure quarterly evacuation drills are conducted for each shift (attachment f). Plan of Monitoring: Facility house managers trained to follow schedule to ensure quarterly evacuation drills are conducted for each shift (attachment f).</p>	

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	<p>allocation of the end-of-month paperwork."</p> <p>A review of client #3's record was conducted on 2/27/15 at 1:39 PM. Client #3's record contained a document, not dated, indicating, "Active Treatment Training Summary: IHP (individual habilitation program) tracking for the months of November and December (2014) were lost somewhere between [group home name] and the QIDP's desk. When consulted, the manager and house staff reported that they had been sent in, but to the wrong person. The attempt to track them down following this lead proved fruitless. Only one month's worth of training was recovered for one client. All staff have been trained on the proper allocation of the end-of-month paperwork."</p> <p>On 3/3/15 at 11:40 AM, the Coordinator indicated the clients' documentation was not located. The Coordinator indicated the Home Manager and Associate Manager told him they submitted the end of the month documentation however he did not receive it. The Coordinator indicated the Home Manager was retrained to turn in all of the end of the month documentation to him and he would disseminate the data to the appropriate staff.</p>						

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W 249 Bldg. 00	<p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure staff implemented client #1's Diabetic Risk Plan.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/26/15 from 5:56 AM to 7:48 AM. At 6:47 AM, client #1 received his medications from staff #9. During the medication pass, client #1 checked his blood sugar with oversight from staff #9. Client #1's blood sugar was 58. Staff #9 documented the blood sugar reading on the Medication Administration Record. Staff #9 indicated there was no further action needed based on his blood sugar reading. Staff #9 indicated client #1 would be</p>	W 249	<p>Addendum Plan of prevention: Facility staff were trained at meeting on 4/6/15 by nurse and QIDP - HRP since then has been revised due to client #1 success in diabetes management and weight loss - staff was trained 4/17 - Competency training will occur with all staff on 4/24/15 (attachment zz) Plan of monitoring: House manager / associate house manager will provide daily monitoring to ensure that client #1 hrp is being followed - QIDP and Facility Nurse will provide bi-weekly monitoring and will ensure that physician orders are accurately depicted in client's HRPs (attachment yy).</p>	03/13/2015

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	<p>eating breakfast right after his medication pass.</p> <p>On 2/26/15 at 1:47 PM a review of client #1's Diabetic Risk Plan, dated 2/28/14, indicated, in part, "During [client #1's] initial physical (1/31/13) lab results revealed that his fasting blood sugar level as well as A1C (lab test to monitor the glucose control of diabetes over time) level was higher than the norm, leading the MD (medical doctor) to diagnose him with Diabetes Mellitus II. As a result of diagnosis, [client #1] is currently on Metformin ER 750 mg (milligrams) daily (2/17/13), is on a diabetes diet (ADA - American Diabetes Association, no concentrated sweets), and is also to get fasting blood sugar checks three times per week. [Client #1] is monitored by his PCP (primary care physician) [name] and will have blood work done as ordered by MD. Staff will observe [client #1] for any signs or symptoms of hypo/hyperglycemia (low or high blood sugar) and act accordingly (following risk plan)... Staff will follow Stone Belt Diabetic Standing Orders as needed..." The plan indicated, "Call 911 if consumer is very confused, lethargic or unresponsive with blood sugar reading over 400 or below 60."</p> <p>On 2/26/15 at 2:37 PM, the Registered</p>						

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W 259 Bldg. 00	<p>Nurse indicated in an email, "The risk plan says to 'Call 911 if consumer is very confused, lethargic or unresponsive with blood sugar reading over 400 or below 60.' It also states to use SBC (Stone Belt Center) standing orders as needed for high or low readings."</p> <p>On 2/26/15 at 3:39 PM, the RN sent the Standing Orders in an email. The Diabetic Standing Orders, not dated, indicated, "Low Blood Sugar Readings: Blood sugars 50 to 70: 6 oz (ounces) juice or milk. Then regularly scheduled meal." The email indicated, "Should have given juice and follow with a meal for 58 blood sugar reading. I need to update [client #1's] risk plan with his new med change & write individual orders specific for [client #1]."</p> <p>On 2/27/15 at 2:56 PM, the Nurse Manager indicated the staff should have implemented client #1's diabetic protocol.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p>			

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W 260 Bldg. 00	<p>Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure his comprehensive functional assessment (CFA) was reviewed for relevancy and updated at least annually.</p> <p>Findings include:</p> <p>On 2/27/15 at 12:45 PM a review of client #2's record was conducted. Client #2's most recent CFA was dated 2/10/14. There was no documentation in client #2's record indicating his CFA was reviewed and updated since 2/10/14.</p> <p>On 2/27/15 at 3:15 PM, the Group Home Director indicated client #2's CFA should be reviewed and updated annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure the clients' individualized program plans (IPP) were revised at least annually.</p>	W 259	<p>Plan of Correction: QIDP reviewed client #2 comprehensive functional assessment CFA was updated for relevancy (attachment u).</p> <p>Plan of Prevention: Facility QIDP trained to ensure all clients comprehensive functional assessment (CFA) is reviewed for relevancy and updated at least annually (attachment v).</p> <p>Plan of Monitoring: Electronic alert will be sent out when annual paperwork is not submitted to Fortis database by annual deadline (attachment w).</p>	03/13/2015			
		W 260	<p>Plan of Correction: QIDP updated client #2 annual ISP (attachment x).</p> <p>Plan of Prevention: Facility QIDP trained to ensure all clients comprehensive functional</p>	03/13/2015			

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W 263 Bldg. 00	<p>Findings include:</p> <p>On 2/27/15 at 12:45 PM a review of client #2's record was conducted. Client #2's most recent IPP was dated 2/10/14. There was no documentation his IPP was revised annually since 2/10/14.</p> <p>On 2/27/15 at 1:39 PM a review of client #3's record was conducted. Client #3's most recent IPP was dated 2/5/14. There was no documentation his IPP was revised annually since 2/5/14.</p> <p>On 2/27/15 at 3:15 PM, the Group Home Director indicated client #2 and #3's IPPs should be revised annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to obtain written informed consent from client #1's guardian for his Individualized Program Plan (IPP).</p>	W 263	<p>assessment (CFA) is reviewed and annual ISP updated for relevancy and updated at least annually (attachment a).</p> <p>Plan of Monitoring: Electronic alert will be sent out when annual paperwork is not submitted to Fortis database by annual deadline (attachment w).</p> <p>Plan of Correction: QIDP obtained guardian consent for #1 annual ISP (attachment y).</p> <p>Plan of Prevention: Facility QIDP trained to ensure all clients comprehensive functional</p>	03/13/2015			

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	<p>Findings include:</p> <p>On 2/27/15 at 11:33 AM a review of client #1's record was conducted. Client #1's current IPP, dated 3/3/14, indicated he had a guardian. The IPP, dated 3/3/14, did not include the guardian's signature. The facility did not have written informed consent from client #1's guardian for the implementation of the plan. The IPP section indicating the psychotropic medications was blank. Client #1's Behavioral Intervention Plan, dated 11/11/14, indicated client #1 was prescribed four psychotropic medications (Tenex, Trileptal, Zoloft, and Buspar). The Behavior/Psychological Summary section of the IPP was blank. The form the guardian would have signed indicated, as documented by the Coordinator, on an attached sticky note, "I was not the Client Support Coordinator at the time of [client #1's] annual. We have been unable to locate the Case Conference Summary in the previous Coordinator's records. He no longer works for Stone Belt." The Case Conference Summary Form form was not dated.</p> <p>On 2/27/15 at 3:15 PM, the Group Home Director indicated the facility should obtain written informed consent annually.</p>		<p>assessment (CFA) is reviewed and annual ISP, including guardian consent) updated for relevancy and updated at least annually (attachment a).</p> <p>Plan of Monitoring: Electronic alert will be sent out when annual paperwork is not submitted to Fortis database by annual deadline (attachment w).</p>		

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W 331 Bldg. 00	<p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 clients in the sample (#1), the facility's nursing services failed to ensure client #1's risk plan was revised when his medication was changed and included specific instructions for staff to implement when his blood sugar was low or high.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/26/15 from 5:56 AM to 7:48 AM. At 6:47 AM, client #1 received his medications from staff #9. During the medication pass, client #1 checked his blood sugar with oversight from staff #9. Client #1's blood sugar was 58. Staff #9 documented the blood sugar reading on the Medication Administration Record. Staff #9 indicated there was no further action needed based on his blood sugar reading. Staff #9 indicated client #1 would be eating breakfast right after his medication pass.</p>	W 331	<p>Plan ofCorrection: Client #1 high risk plan was updated to include by team (attachments).</p> <p>Plan ofPrevention: Facility staff trained on following client #1 high risk plan fordiabetes (attachment t).</p> <p>Plan ofMonitoring: Facility house / associate manager trained on ensuring client #1HRP is being followed as written (attachment t). QIDP will provide frequentmonitoring to ensure staff are following HRP and physician orders. Facilitynurse will provide monthly monitoring of MARs and medication administrationalong with training as needed (attachment a).</p>	03/13/2015

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	<p>On 2/26/15 at 1:47 PM a review of client #1's Diabetic Risk Plan, dated 2/28/14, indicated, in part, "During [client #1's] initial physical (1/31/13) lab results revealed that his fasting blood sugar level as well as A1C (lab test to monitor the glucose control of diabetes over time) level was higher than the norm, leading the MD (medical doctor) to diagnose him with Diabetes Mellitus II. As a result of diagnosis, [client #1] is currently on Metformin ER 750 mg (milligrams) daily (2/17/13), is on a diabetes diet (ADA - American Diabetes Association, no concentrated sweets), and is also to get fasting blood sugar checks three times per week. [Client #1] is monitored by his PCP (primary care physician) [name] and will have blood work done as ordered by MD. Staff will observe [client #1] for any signs or symptoms of hypo/hyperglycemia (low or high blood sugar) and act accordingly (following risk plan)... Staff will follow Stone Belt Diabetic Standing Orders as needed...."</p> <p>On 2/26/15 at 2:37 PM, the Registered Nurse indicated in an email, "The risk plan says to 'Call 911 if consumer is very confused, lethargic or unresponsive with blood sugar reading over 400 or below 60.' It also states to use SBC (Stone Belt Center) standing orders as needed for high or low readings."</p>						

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W 440 Bldg. 00	<p>On 2/26/15 at 3:39 PM, the RN sent the Standing Orders in an email. The Diabetic Standing Orders, not dated, indicated, "Low Blood Sugar Readings: Blood sugars 50 to 70: 6 oz (ounces) juice or milk. Then regularly scheduled meal." The email indicated, "Should have given juice and follow with a meal for 58 blood sugar reading. I need to update [client #1's] risk plan with his new med change & write individual orders specific for [client #1]."</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 5 clients living at the group home (#1, #2, #3, #4 and #5), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>On 2/25/15 at 12:53 PM a review of the facility's evacuation drills was conducted. There were no evacuation drills conducted on the evening shift (2:00 PM to 10:00 PM) from 2/18/14 to 7/20/14</p>	W 440	<p>Plan of correction: Facility created drill schedule and binder to ensure quarterly evacuation drills are conducted for each shift (attachment z).</p> <p>Plan of Prevention: Facility staff trained to follow schedule to ensure quarterly evacuation drills are conducted for each shift (attachment f).</p>	03/13/2015

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W 999 Bldg. 00	<p>and 7/22/14 to 1/19/15. There were no evacuation drills conducted on the night shift (10:00 PM to 6:00 AM) from 2/25/14 to 6/20/14 and 6/22/14 to 1/19/15. This affected clients #1, #2, #3, #4 and #5.</p> <p>On 2/25/15 at 1:14 PM, the Group Home Director (GHD) indicated the facility should conduct one evacuation drill per shift per quarter.</p> <p>On 2/25/15 at 1:32 PM, the Coordinator indicated the facility should conduct one evacuation drill per shift per quarter. The Coordinator indicated there was a several month period of time with no Home Manager therefore the drills were not conducted.</p> <p>9-3-7(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>1) 460 IAC 9-3-2 Resident Protections</p>	W 999	<p>Plan ofMonitoring: Facility house managers trained to follow schedule to ensurequarterly evacuation drills are conducted for each shift (attachment f).</p> <p>1) Plan of Correction: Facility human resourcescoordinator will ensure that each residential staff person shall completebackground checks on all new employees. Staff #1 bureau of vehicles record wascompleted and added to human resource record (attachment zz).</p>	03/13/2015

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	<p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (#1), the facility failed to ensure staff #1's bureau of motor vehicles record was obtained.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 2/25/15 at 2:24 PM. Staff #1's employee file did not contain documentation the facility checked staff #1's bureau of motor vehicles record. Staff #1 was hired on 3/21/14.</p>		<p>Plan ofPrevention: Facility human resource director will provide oversight to ensurerecords contain each residential staff person has a completed background check.</p> <p>Plan ofMonitoring: Facility coordinator / QIDP-D trained on monitoring staff files to ensure that their home's staffhuman resource record contains evidence that records contain each residentialstaff person has a completed background check (attachment a).</p> <p>2) 460 IAC 9-3-1 Governing Body (b) The residential provider shallreport the following circumstances to the divisionby telephone no later than the firstbusiness day followed by written summaries asrequested by the division: 16. A medication error ormedical treatment error as follows: a. Wrongmedication given; b. wrong medication dosagegiven; c. missed medication - not given; d.medication given wrong route; or e.</p>	

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	<p>On 2/26/15 at 1:16 PM, the Human Resources Director (HRD) indicated she was unable to locate documentation the facility checked staff #1's bureau of motor vehicles record. The HRD indicated this was typically completed prior to the staff being offered a position at the facility. The HRD indicated there was no documentation indicating the facility checked staff #1's motor vehicle record.</p> <p>On 2/27/15 at 2:48 PM, the Group Home Director (GHD) indicated staff #1 transported clients at the facility. The GHD indicated staff #1's motor vehicle record should have been obtained upon hire.</p> <p>2) 460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 16. A medication error or medical treatment error as follows: a. Wrong medication given; b. wrong medication dosage given; c. missed medication - not given; d. medication given wrong route; or e. medication error that jeopardizes an individual's health and welfare and required medical attention.</p>		<p>medicationerror that jeopardizes an individual's health andwelfare and required medical attention. Plan of Correction: Staff have been trained toreport incidents by end of their shifts so BDDS reports can be submitted withinthe 24 hour deadline (attachment f).and per Plan ofPrevention: Facility staff were trained on incident reporting includingmedication errors during a home visit (attachment j).</p> <p>Plan ofmonitoring: Facility coordinator QIDP will ensure that policies prohibitingmistreatment, neglect, or abuse of clients are followed (attachment a).</p>	

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	<p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 3 of 32 incident/investigative reports reviewed affecting clients #2 and #3, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, for client #2's refusals to take his medication/treatment and for client #3 failing to take his medication during a home visit.</p> <p>Findings include:</p> <p>On 2/25/15 at 11:57 AM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/7/15 at 7:00 PM (reported to BDDS on 2/9/15), client #2 refused to take his hour of sleep (HS) medications.</p> <p>2) On 1/16/15 at 5:00 PM (reported to BDDS on 1/23/15), client #2 refused to allow staff to administer Voltaren gel to his knees for arthritis.</p> <p>3) On 12/28/14 at 9:00 PM (reported to BDDS on 1/5/15), client #3 returned</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>from a home visit. He returned with two mornings worth of pills and one left over from another morning. Two nights of bedtime medications were returned with him from his home visit from 12/23/14 to 12/28/14.</p> <p>On 2/25/15 at 12:43 PM, the Group Home Director indicated the timeframe for submitting BDDS reports was 24 hours.</p> <p>On 2/25/15 at 1:18 PM, the Coordinator indicated the timeframe for submitting BDDS reports was 24 hours.</p> <p>9-3-2(c)(3) 9-3-1(b)</p>				