

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G643	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/15/2013
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: November 12, 13, 14 and 15, 2013.</p> <p>Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/21/13 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 3 of 3 clients in the sample (#1, #2 and #4), the governing body failed to exercise operating direction over the facility by failing to ensure personal possession inventories were completed.</p> <p>Findings include:</p>	W000104	<p>W104 Plan of Correction: Personal inventories have been completed for all clients in the home. An accurate account of personal belongings will be maintained for each client. Discarded and/or damaged items will be removed from the list and new items added upon acquiring. Plan of Prevention: Staff have been retained on agency policy and procedures for documenting</p>	12/15/2013

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>On 11/14/13 at 11:30 AM, an interview with client #2's guardian was conducted. The guardian indicated there have been times when she visited client #2 at the group home when he was wearing socks with holes in them. The guardian indicated client #2 had also been observed to be wearing old, torn shirts she instructed the staff to throw away. The guardian indicated she had provided new socks and shirts for client #2 in the past but the facility was not ensuring the client was wearing his new clothes. The guardian indicated she was not sure if the facility was accounting for the new clothes she purchased for client #2.</p> <p>On 11/13/13 at 12:13 PM, an interview with client #4's guardian was conducted. The guardian indicated she purchased and provided bedding and sheets for client #4. The guardian indicated she recently purchased a comforter the group home staff were not able to locate during a recent visit to the home. The guardian indicated she purchased two sets of sheets and bedding to ensure the staff were able to assist client #4 rotate the bedding however when she visited the group home, client #4 did not have the bedding and sheets on his bed. The guardian indicated she spoke to the weekend staff to ensure she informed the group home of what she wanted</p>		<p>clients' personal possessions. Quality Assurance Monitoring: Personal inventories will be reviewed monthly by the group home manager for the next quarter to ensure they are being properly maintained. Beginning in the second quarter, each client's personal inventory will be reviewed on a quarterly basis by the group home manager.</p>				

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	<p>done (rotating his own sheets and bedding). The guardian indicated she was not sure if the group home was accounting for the items she purchased and provided for client #4.</p> <p>A review of client #1's record was conducted on 11/13/13 at 2:45 PM. The record did not have documentation the group home accounted for client #1's personal possessions. There was no documentation the group home completed an inventory. The section in the electronic record for a personal possession inventory contained no documentation.</p> <p>A review of client #2's record was conducted on 11/13/13 at 2:03 PM. The record did not have documentation the group home accounted for client #2's personal possessions. There was no documentation the group home completed an inventory. The section in the electronic record for a personal possession inventory contained no documentation.</p> <p>A review of client #4's record was conducted on 11/13/13 at 12:48 PM. The record did not have documentation the group home accounted for client #4's personal possessions. There was no documentation the group home</p>				

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W000125	<p>completed an inventory. The section in the electronic record for a personal possession inventory contained no documentation.</p> <p>An interview with the Coordinator was conducted on 11/13/13 at 12:59 PM. The Coordinator indicated the clients' personal possession inventories should be completed upon admission, updated every time something was purchased and reviewed annually. The Coordinator indicated the facility was not completing personal possession inventories.</p> <p>On 11/14/13 at 2:05 PM, the Director of Supervised Group Living indicated the personal possession inventories should be completed upon admission and updated every time an item was purchased or thrown away.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 6 of 6 clients living in</p>	W000125	W125 Plan of Correction: Practice of locking the kitchen	12/15/2013	

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	<p>the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients had the right to due process by unnecessarily locking the door to the kitchen.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/13/13 from 5:59 AM to 7:40 AM. At 7:06 AM, client #1 went toward the kitchen door, which was open. Staff #6 informed staff #5 that client #1 wanted access to the kitchen. Staff #5 went over and closed and locked the kitchen door. Client #1 asked staff for help. Staff #6 asked client #1 what he needed. Client #1 indicated he was looking for food. Staff #6 then opened the kitchen door. Staff #6 got a breakfast bar and gave it to client #1. Staff #5 asked client #1 if he wanted to eat the bar in his room and client #1 said "yes." Staff #5 closed and locked the kitchen door. At 7:25 AM, client #3 was prompted by staff #6 to go into the kitchen to make a peanut butter bagel or "something." Client #3 stated, "I will." At 7:27 AM, client #3 asked the staff to open the locked kitchen door. Staff #5 opened the kitchen door. During the observation, staff and clients did not use the stove or oven for breakfast preparation. Client #2 was not</p>		<p>door has been discontinued. Plan of Prevention: Staff have been retrained on client rights including the right of clients to access the common areas of the home, unless the restriction is part of an individualized plan that has been approved by the human rights committee. Quality Assurance Monitoring: Facility coordinator will observe clients in the home three times a week for the first quarter during during weekday and evening shifts, fading weekly monitoring for the next quarter and fading to once a month weekday and weekend monitoring as written in the agency supervision and monitoring policy, to ensure clients are allowed and encouraged to exercise their rights in the facility. The agency's interdisciplinary support team will review client Behavior Support plans quarterly to ensure the rights of all clients.</p>				

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	<p>present during the observation at the group home due to being hospitalized. This restriction affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with staff #5 was conducted on 11/13/13 at 7:27 AM. Staff #5 indicated the kitchen door was locked to keep client #1 from going into the kitchen and taking drinks and overeat. Staff #5 indicated the door was also locked to protect the clients from sharps and the hot stove.</p> <p>A review of client #1's record was conducted on 11/13/13 at 2:45 PM. There was no documentation in the record indicating client #1 required the kitchen door to be locked. The Human Rights Approval for the group home, dated 4/17/13, indicated the guardian and HRC (Human Rights Committee) approved of the following restrictions but not the kitchen door being locked: lock for gate, keyless latch and chain on gate going out back, bedroom door alarm, and button release locks on bedroom doors.</p> <p>A review of client #2's record was conducted on 11/13/13 at 2:03 PM. There was no documentation in the record indicating client #2 required the kitchen door to be locked. Client #2's</p>						

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	<p>Behavioral Support Plan (BSP), dated 2/19/13, indicated, "When episodes of [client #2] swinging his rope/hat near the stove and oven when in use have decreased to zero per month for 6 consecutive months, the team will review the continued need for escort from the kitchen." There was no documentation in client #2's BSP the kitchen door needed to be locked. The Human Rights Approval for the group home, dated 4/17/13, indicated the guardian and HRC (Human Rights Committee) approved of the following restrictions but not the kitchen door being locked: lock for gate, keyless latch and chain on gate going out back, bedroom door alarm, and button release locks on bedroom doors.</p> <p>A review of client #4's record was conducted on 11/13/13 at 12:48 PM. There was no documentation in the record indicating client #4 required the kitchen door to be locked. The Human Rights Approval for the group home, dated 4/17/13, indicated the guardian and HRC (Human Rights Committee) approved of the following restrictions but not the kitchen door being locked: lock for gate, keyless latch and chain on gate going out back, bedroom door alarm, and button release locks on bedroom doors.</p>						

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	<p>An interview was conducted with the Coordinator on 11/13/13 at 1:21 PM. The Coordinator indicated the kitchen door was locked due to client #2. The Coordinator indicated, in the past, client #2 tried to put his head in the oven or grab something off the stove. The Coordinator indicated he was not certain since the incident occurred prior to him working at the group home. The Coordinator indicated the kitchen was not locked due to client #1 eating or overeating. The Coordinator indicated the kitchen door should not have been locked since client #2 was in the hospital.</p> <p>On 11/15/13 at 1:29 PM the interim Director of Supported Group Living indicated the kitchen door being locked was an unnecessary restriction since there was no plan addressing the restriction.</p> <p>9-3-2(a)</p>			

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W000148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2's guardian was promptly notified of staffing changes within the group home and received requested information regarding client #2's weight record.</p> <p>Findings include:</p> <p>An interview with client #2's guardian was conducted on 11/14/13 at 11:30 AM. The guardian stated of client #2's medical condition which led him to be hospitalized, "I probably didn't get the information to the right person." The guardian indicated she had communicated her concerns (weight loss, diarrhea) to the former House Manager. The guardian indicated she requested a meeting with the support team to discuss her concerns. The guardian indicated she met the current Coordinator and nurse at the meeting. The guardian indicated both were new to her. The guardian indicated she was not informed when there were staffing</p>	W000148	W148 Plan of Correction: Regular communication has been established with guardian through meetings with the interdisciplinary Support Team on 10/12/13, 12/11/13 to discuss her concerns and situations in addition to serious illness, accident, death, abuse, unauthorized absence, and significant change in client's condition. Plan of Prevention: The facility nurse has been established as the primary communicator with guardian regarding serious illness and significant change in client's condition. Coordinator has been established as the primary communicator involving accidents, abuse, and unauthorized absence. Quality Assurance Monitoring: Incident reports document the notification of the guardian; Interdisciplinary team receives email notification as incident reports are submitted within the 24 hours of their occurrence and the team reviews incidents, including incidents of accident, abuse, unauthorized absence and significant change in client's condition. Monthly interdisciplinary Support team	12/13/2013	

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	<p>changes at the group home. The guardian indicated she was not informed when the former House Manager left and when a new House Manager was hired. The guardian indicated she used to receive letters when key staff left the group home and new staff were hired. The guardian stated she had not received a letter in "years" with the exception of when the former Director was no longer employed at the facility. The guardian indicated it took the facility from February to September 2013 to provide her documentation of client #2's weight record. The guardian indicated she had to contact the Social Worker in order to figure out who was working at the home and their position within the group home.</p> <p>A review of client #2's record was conducted on 11/13/13 at 2:03 PM. Client #2's record had no documentation, during the past 12 months, indicating the facility notified the guardian when staffing changes occurred at the group home. There was no documentation in the record indicating when staff from the group home contacted the guardian.</p> <p>An interview with the interim Director of Supervised Group Living was conducted on 11/14/13 at 2:05 PM. The</p>		meetings will review any significant changes in the clients' condition and if the guardian has been notified.		

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W000149	<p>Director indicated the client's interdisciplinary team needed to convene with the guardian to discuss who the guardian wanted to contact them and the information the guardian wanted to be notified of. The Director indicated the guardian should receive notifications of the things they wanted to be notified of and requested documentation.</p> <p>9-3-2(a)</p> <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 record review and interview for 6 of 50 incident/investigative reports reviewed affecting clients #2, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, conduct investigations of client to client abuse and neglect and ensure staff immediately reported abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/12/13 at 11:16 AM.</p> <p>1) On 9/12/13 at 9:25 AM at the facility</p>	W000149	<p>Plan of Correction: The agency has implemented a new internal incident reporting system designed to address various failures in implementing the agency's procedures on reporting and investigation allegation A/N/E. The process included the following steps: The written incident report is submitted within 24 hours (or immediately if it contains an allegation A/N/E) to a designated administrative staff. The staff enters the incident into the electronic system, attaches required follow up/investigative forms, completes a BDDS report if indicated, notifies a supervisor if indicated and sends an electronic copy of the report to the facility support team. Each member of</p>	12/06/2013			

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	<p>operated day program, client #4 kicked client #5 on the shin as they passed each other in the hallway. Client #5 was not injured.</p> <p>2) On 8/13/13 at 7:15 AM, client #2 was walking out of his room down the hallway. Client #5 was standing in the hallway. Client #5 grabbed client #2 and attempted to bite him. Client #2 was not injured. The facility did not conduct an investigation.</p> <p>3) On 7/16/13 at 5:45 AM, client #5 grabbed the back of client #6's shirt and pulled on it. The BDDS report, dated 7/16/13, indicated it took staff 2 minutes to get client #5 to release his grip of client #6's shirt. Client #6 was not injured.</p> <p>4) On 7/3/13 at 10:20 AM at the facility operated day program, client #6 was hugged from behind by a male peer. Client #6 attempted to headbutt the peer. The peer yelled at client #6 and punched client #6 on the top of his head. Client #6 was not injured.</p> <p>5) On 6/4/13 at 3:15 PM, clients #2 and #5 were at the group home. The BDDS report, dated 6/5/13, indicated, in part, "There were multiple staff at the group home because [client #2] was at home</p>		<p>the support team reads, reviews, documents actions taken and signs the report. The report requires the review and signature of the director before the report is electronically files. Facility staff will receive additional training on incident reporting procedures. To be completed by 12/6/13. Plan of Prevention: The implementation of an electronic system to deliver reports quickly to multiple members of the support team. The department will arrange for staff training in incident reporting and investigations from an outside expert. Quality Assurance Monitoring: The QA team process will be revised to include a review of all ISDH surveys; a review and report of all SGL A/N/E investigations by third party QA team member and the QA team will recommend and monitor corrective actions.</p>		

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	<p>while [client #5] was at home. Normally [client #5] is home by himself with staff during that part of the afternoon. The second staff, who was not [client #5's] 1-1 (one on one), was outside, attempting to be discreet, when [client #5] began to have a tantrum. [Client #5] ran to his room and the second staff went to the office, which is house policy, as a way to remove himself from the situation, because that second staff believed that his presence was partially the cause of [client #5's] increased agitation. [Client #5's] 1-1 also removed himself from the situation and came into the office. He did so in an attempt to protect himself from harm. [Client #2] was in his room with the door locked at the time. It is believed that while all staff were in the office, [client #2] opened his door. [Client #5] then ran into [client #2's] room and aggressed upon him. Staff immediately heard the incident and ran to [client #2's] room. [Client #5] was removed from [client #2]. The second staff stayed with [client #2] and administered First Aid. The third staff who had arrived on the scene in the midst of things, assisted [client #5] with getting back to his room...". The Stone Belt ARC, Inc. Incident Report, dated 6/4/13, indicated, "[Client #5] aggressed towards [client #2] causing injuries on his face/back/leg,</p>			

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	<p>shoulder, minor injuries... Blood draw will take place 6/5 in the arm." The Client to Client Aggression Inquiry, dated 6/4/13, indicated, "[Staff #9] was retrained and disciplined for not following [client #5's] plan." Staff #9's Performance Review, dated 6/5/13, indicated, "On 6.4.13 client [#5] attacked his house mate [client #2] in his bedroom. It has been reported that at the time of the attack [client #5's] 1:1 staff had entered the [name of group home] office, and was not within arm's length of [client #5] or on the other side of [client #5's] bedroom door. Below are references to [client #5's] plan: '1:1 staff will stay within arm's length of [client #5] unless he is in a private space by himself, such as his room, the bathroom, or at home with no other consumers present.' 'Staff will supervise [client #5] so that he does not enter the personal space of his housemates or others. This will decrease [client #5's] opportunities to aggress on peers.' 'When [client #5] is in seclusion, staff will monitor [client #5] from the other side of the door.' The Performance Review indicated, "As [client #5's] Lifelong Learning Coordinator, I do not feel that [client #5's] BSP (Behavioral Support Plan) was followed in this instance and was a contributing factor to a (sic) [client #5's] house mate becoming injured." The</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404		
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	Nursing Consultation note, dated June 4, 2013, indicated, "Staff at [name of group home] contacted nurse stating that another client had attacked [client #2] and bit/scratched him repeatedly, breaking the skin in some areas. Nurse went to the house to assess [client #2] who at this time was in the shower, findings as follows: numerous scratches of various length noted just below and behind right ear; bite mark (approximately) 1 1/2" x 1" noted to right side of lower neck, reddish purple in color with bruising, skin broken; bite mark (approximately) 1/2 dollar size noted to right shoulder at the joint, reddish-purple in color with bruising, also various scratches noted (red in color) in same area, skin intact; bite mark (approximately) 1 1/2" long noted on right side of mid-upper back, red in color, skin intact; bruise reddish in color (approximately) size of a quarter noted to mid-center back; bite mark/abrasion (approximately) 2" x 1 1/2" noted to left side of cheek just below cheek bone, skin broken. Staff were directed to let [client #2] continue his shower and once finished to apply standing order bacitracin ointment to all bite marks which caused skin breaks and to dress them with gauze/bandage." The facility did not conduct an investigation into neglect.				

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	<p>6) On 5/25/13 at 8:30 PM (reported to the administrator on 5/26/13), former staff #8 used forceful verbal prompts to encourage client #2 to get up and take a shower. Once in the bathroom, staff continued to use forceful verbal prompting to get client #2 to take off his clothes and get into the shower. The follow-up BDDS report, dated 6/26/13, indicated, "There was an allegation of verbal abuse reported by one staff on another staff... The allegation was unsubstantiated... An investigation was conducted by the social worker, who interviewed all staff members working at the time of the alleged incident. The social worker determined that while the staff, alleged to have committed verbal abuse, did use language that was not client centered and supported, the language did not rise to the level of abuse... While the allegation was unsubstantiated, it was determined, with staff input, that the best thing would be for the alleged staff to no longer work at [name of group home]." The investigation, dated 5/31/13, indicated, in part, "The incident was not reported for 18 hours and [staff #2] placed [staff #8] to supervise a client alone who had aggressed against him on the next day following the event, before reporting the incident to the pager at 5:30 PM on</p>			

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	<p>5-26-13."</p> <p>On 11/13/13 at 1:26 PM the Coordinator indicated client to client aggression was considered abuse. The Coordinator indicated the staff should prevent client to client abuse. The Coordinator indicated staff should immediately report abuse to the administrator. The Coordinator indicated there was no additional review of the incident on 6/4/13. The Coordinator indicated staff #8 was removed from the group home at the conclusion of the investigation. The Coordinator indicated client to client abuse should be investigated.</p> <p>On 11/15/13 at 1:29 PM, the interim Director of Supported Group Living indicated the 6/4/13 incident should have been investigated due to the injuries client #2 sustained.</p> <p>A review of the facility's abuse and neglect policy, dated September 2013, was conducted on 11/13/13 at 11:37 AM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide</p>				

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	<p>appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a client, parent/guardian, advocate, staff member, or other involved party."</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>Based on record review and interview for 1 of 50 incident/investigative reports reviewed affecting client #2, the facility failed to ensure staff immediately reported abuse to the administrator, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/12/13 at 11:16 AM.</p> <p>On 5/25/13 at 8:30 PM (reported to the administrator on 5/26/13), former staff #8 used forceful verbal prompts to encourage client #2 to get up and take a shower. Once in the bathroom, staff continued to use forceful verbal prompting to get client #2 to take off his clothes and get into the shower. The follow-up BDDS report, dated 6/26/13, indicated, "There was an allegation of verbal abuse reported by one staff on another staff... The allegation was unsubstantiated... An investigation was conducted by the social worker, who</p>	W000153	<p>Plan of Correction: Facility staff will be retrained on 12/6/13 on all aspects of incident reporting including what constitutes an incident, timelines including reporting to the administrator immediately and to the state agency within 24 hours of a reportable condition. The facility has also reorganized the home management system to include more coordination (Q) positions in order to increase client support, staff training and supervision, facility monitoring and compliance with incident reporting and investigation. Plan of Prevention: The facility has developed a new electronic incident reporting system to ensure that all allegations of mistreatment, abuse, neglect and injuries of unknown source are reported immediately to the administrator or designated staff in accordance with state law. The department will arrange for staff training in incident reporting and investigations form an outside expert. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA</p>	12/06/2013			

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W000154	<p>interviewed all staff members working at the time of the alleged incident. The social worker determined that while the staff, alleged to have committed verbal abuse, did use language that was not client centered and supported, the language did not rise to the level of abuse... While the allegation was unsubstantiated, it was determined, with staff input, that the best thing would be for the alleged staff to no longer work at [name of group home]." The investigation, dated 5/31/13, indicated, in part, "The incident was not reported for 18 hours and [staff #2] placed [staff #8] to supervise a client alone who had aggressed against him on the next day following the event, before reporting the incident to the pager at 5:30 PM on 5-26-13."</p> <p>On 11/13/13 at 1:26 PM the Coordinator indicated staff should immediately report abuse to 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 50 incident/investigative reports</p>	W000154	<p>member including failure to comply with state law regarding A/N/E reports and the QA team will recommend and monitor corrective actions.</p> <p>Plan of Correction: The facility has developed a new electronic incident reporting system to</p>	12/03/2013			

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	<p>reviewed affecting clients #2 and #5, the facility failed to conduct investigations of client to client abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/12/13 at 11:16 AM.</p> <p>1) On 8/13/13 at 7:15 AM, client #2 was walking out of his room down the hallway. Client #5 was standing in the hallway. Client #5 grabbed client #2 and attempted to bite him. Client #2 was not injured. The facility did not conduct an investigation.</p> <p>2) On 6/4/13 at 3:15 PM, clients #2 and #5 were at the group home. The BDDS report, dated 6/5/13, indicated, in part, "There were multiple staff at the group home because [client #2] was at home while [client #5] was at home. Normally [client #5] is home by himself with staff during that part of the afternoon. The second staff, who was not [client #5's] 1-1 (one on one), was outside, attempting to be discreet, when [client #5] began to have a tantrum. [Client #5] ran to his room and the second staff went to the office, which is house policy, as a way to remove himself from the situation, because that</p>		<p>ensure that all allegations of mistreatment, abuse, neglect, injuries of unknown source, and elopement are reported immediately to the administrator or designated staff in accordance with state law. The department will arrange for staff training in incident reporting and investigations form an outside expert. Plan of Prevention: The new electronic incident reporting system allows for Qs to document follow up on incidents as needed. Clients will review house rules from agency handbook, which address notifying staff when leaving the residence. Quality Assurance Monitoring: The agency's QA process will be revised to include a review and report of all ISDH surveys by a third party QA member including failure to do follow up investigations on allegations A/N/E, injuries of unknown source, and client elopement and the QA team will recommend and monitor corrective action.</p>				

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	<p>second staff believed that his presence was partially the cause of [client #5's] increased agitation. [Client #5's] 1-1 also removed himself from the situation and came into the office. He did so in an attempt to protect himself from harm. [Client #2] was in his room with the door locked at the time. It is believed that while all staff were in the office, [client #2] opened his door. [Client #5] then ran into [client #2's] room and aggressed upon him. Staff immediately heard the incident and ran to [client #2's] room. [Client #5] was removed from [client #2]. The second staff stayed with [client #2] and administered First Aid. The third staff who had arrived on the scene in the midst of things, assisted [client #5] with getting back to his room...". The Stone Belt ARC, Inc. Incident Report, dated 6/4/13, indicated, "[Client #5] aggressed towards [client #2] causing injuries on his face/back/leg, shoulder, minor injuries... Blood draw will take place 6/5 in the arm." The Client to Client Aggression Inquiry, dated 6/4/13, indicated, "[Staff #9] was retrained and disciplined for not following [client #5's] plan." Staff #9's Performance Review, dated 6/5/13, indicated, "On 6.4.13 client [#5] attacked his house mate [client #2] in his bedroom. It has been reported that at the time of the attack [client #5's] 1:1 staff</p>			

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	<p>had entered the [name of group home] office, and was not within arm's length of [client #5] or on the other side of [client #5's] bedroom door. Below are references to [client #5's] plan: '1:1 staff will stay within arm's length of [client #5] unless he is in a private space by himself, such as his room, the bathroom, or at home with no other consumers present.' 'Staff will supervise [client #5] so that he does not enter the personal space of his housemates or others. This will decrease [client #5's] opportunities to aggress on peers.' 'When [client #5] is in seclusion, staff will monitor [client #5] from the other side of the door.' The Performance Review indicated, "As [client #5's] Lifelong Learning Coordinator, I do not feel that [client #5's] BSP (Behavioral Support Plan) was followed in this instance and was a contributing factor to a (sic) [client #5's] house mate becoming injured." The Nursing Consultation note, dated June 4, 2013, indicated, "Staff at [name of group home] contacted nurse stating that another client had attacked [client #2] and bit/scratched him repeatedly, breaking the skin in some areas. Nurse went to the house to assess [client #2] who at this time was in the shower, findings as follows: numerous scratches of various length noted just below and behind right ear; bite mark</p>			

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	<p>(approximately) 1 1/2" x 1" noted to right side of lower neck, reddish purple in color with bruising, skin broken; bite mark (approximately) 1/2 dollar size noted to right shoulder at the joint, reddish-purple in color with bruising, also various scratches noted (red in color) in same area, skin intact; bite mark (approximately) 1 1/2" long noted on right side of mid-upper back, red in color, skin intact; bruise reddish in color (approximately) size of a quarter noted to mid-center back; bite mark/abrasion (approximately) 2" x 1 1/2" noted to left side of cheek just below cheek bone, skin broken. Staff were directed to let [client #2] continue his shower and once finished to apply standing order bacitracin ointment to all bite marks which caused skin breaks and to dress them with gauze/bandage." The facility did not conduct an investigation into neglect.</p> <p>On 11/13/13 at 1:26 PM the Coordinator indicated there was no additional review of the incident on 6/4/13. The Coordinator indicated client to client abuse should be investigated.</p> <p>9-3-2(a)</p>			

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure there was sufficient staff to manage and supervise the clients during the overnight shift (10:00 PM to 6:00 AM).</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 11/12/13 at 12:27 PM. There were no drills conducted during the night shift (10:00 PM to 6:00 AM) from 11/12/12 to 3/19/13 and 6/24/13 to 11/12/13. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 11/13/13 at 6:37 AM, the overnight shift staff indicated he had worked as the overnight staff for 3-4 months. The staff indicated he had not conducted an evacuation drill during the overnight shift.</p>	W000186	<p>W186 Plan of Correction: The interdisciplinary team members of this facility met to discuss staffing ratios needed for routine and specialized activities for all residents in general and for specific residents as needed. A detailed evacuation plan was devised to address overnight drill situations that ensures the safety of all residents. Overnight drills have been completed using this plan. Client #5's ISP and Behavior Plan have been revised to address situations and times when more intensive staffing is needed to both meet his needs and to insure the safety of others. Plan of Prevention: The facility staff will be trained on reviewing and following the revised master staffing schedule which lists required staffing ratios for all days and shifts, on revised evacuation drills, revised ISPs and Behavior Plans. Quality Assurance Monitoring: The facility coordinator is responsible for entering all changes into the facility master staffing schedule. The facility director is then</p>	12/13/2013	

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	<p>A review of client #5's Behavioral Support Plan (BSP), dated 5/3/13, was conducted on 11/15/13 at 10:08 AM. The BSP indicated, in part, in the General Proactive Strategies section, "On each shift, [client #5] will have a specific staff member assigned as his 1:1 staff AT ALL TIMES during all waking hours, and in anticipation of [client #5] waking in the morning. This staff will supervise [client #5] so that he does not enter the personal space of his housemates or others, in order to ensure that [client #5] does not have any opportunities to aggress on peers. 1:1 (one on one) staff will stay within arm's length of [client #5] unless he is in a private space by himself, such as his room, the bathroom, or at home with no other consumers present. Staff may keep a light touch or loose grasp on part of [client #5's] clothing in order to keep up with his often darting and unpredictable movements. Any staff assigned to be [client #5's] 1:1 staff will retain these responsibilities unless another staff specifically agrees to take over. Staff should request relief as necessary, and all staff on shift at the group home should agree on a strategy for maintaining [client #5's] 1:1 staffing."</p>		<p>electronically alerted to review and approve all changes to the master staffing schedule thus providing a double check to ensure appropriate levels of staffing.</p>	

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	<p>On 11/13/13 at 1:21 PM, the Coordinator indicated the group home should conduct one drill per shift per quarter. The Coordinator indicated he was aware the group home was missing drills. The Coordinator stated, "How do you conduct a drill successfully with those 6 guys?" The Coordinator indicated it was a challenge to make it happen. The Coordinator asked, "How do I do a drill appropriately at 3:00 AM successfully?" The Coordinator indicated Stone Belt administration informed him there was one overnight staff at the houses. The Coordinator indicated one staff works during the overnight shift at the group home with 6 clients.</p> <p>On 11/15/13 at 1:29 PM the interim Director of Supported Group Living indicated there was one staff at the group home from 10:00 PM to 6:00 AM.</p> <p>On 11/15/13 at 11:32 AM, the Support Services Supervisor (SSS) indicated there were not enough staff during the overnight shift to manage and supervise the clients according to their program plans. The SSS indicated the team needed to convene to discuss client #5's program plan and determine if he needed to have 1:1 staff during evacuation drills. The SSS indicated the</p>			

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W000249	<p>team needed to develop and implement a plan to address how to safely evacuate the clients.</p> <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.</p> <p>Based on observation, record review and interview for 1 of 2 clients (#3) observed to receive their medications, the facility failed to ensure staff implemented the client's medication administration training objectives.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/13/13 from 5:59 AM to 7:40 AM. At 6:12 AM, client #3 received his medications from staff #6. Staff #6 prompted client #3 to repeat the names of his medications however staff #6 did not ask client #3 to state the dosage and purpose of his medications. Staff #6 informed client #3 of the</p>	W000249	<p>W249 Plan of Correction: Staff have been retrained on clients' Individualized Habilitation Plans (IHPs), to include medication administration goals. Date of Completion: 12/6/13. Plan of Prevention: During the first quarter the facility coordinator will provide supervision and monitoring of active treatment (including medication administration training) at least three times per week. During the second quarter, the facility coordinator will provide supervision and monitoring at least twice a week and then fading to the per agency's supervision and monitoring policy. Quality Assurance Monitoring: SGL Director will review supervision and</p>	12/06/2013

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	<p>purpose of his medications however staff #6 did not ask client #3 to state the purpose prior to informing him of the purpose of his medications. Staff #6 did not inform client #3 of the dosage of his medications.</p> <p>A review of client #3's Individual Support Plan (ISP), dated 8/1/13, was conducted on 11/13/13 at 12:37 PM. The ISP indicated he had a medication training objective to know the name, dosage and purpose of his medications.</p> <p>An interview with the Coordinator was conducted on 11/13/13 at 1:21 PM. The Coordinator indicated client #3's medication training objective should be implemented at each medication administration time.</p> <p>9-3-4(a)</p>		<p>monitoring data, per agency policy.</p>				
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2's hearing and vision were evaluated annually.</p>	W000323	<p>Plan of Correction: Client #2 is unable to participate in hearing and vision tests as documented on his 4/19/12 annual physical. This was not clearly documented on his 4/4/13. Facility nurse will retrain staff on supporting clients</p>	12/13/2013			

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	<p>Findings include:</p> <p>A review of client #2's record was conducted on 11/13/13 at 2:03 PM. Client #2's most recent hearing examination was completed on 7/12/10. Client #2's most recent vision examination was completed on 11/3/11. Client #2's most recent physical examination was conducted on 4/4/13. At the physical examination, client #2's hearing and vision were not assessed. There was no documentation in client #2's record indicating his hearing had been evaluated since 7/12/10 and his vision was evaluated since 11/3/11.</p> <p>An interview with the nurse was conducted on 11/15/13 at 12:06 PM. The nurse indicated client #2's hearing and vision should be assessed annually during his annual physical. The nurse indicated client #2 should have a hearing test every 3 years or sooner, if recommended. The nurse indicated client #2 should have a vision exam every two years or sooner, if recommended.</p> <p>9-3-6(a)</p>		<p>with medical appointments and annual physicals. Date of completion by 12/13/13. Plan of Prevention: Facility will provide specific training for staff accompanying clients to medical appointments, to ensure proper documentation is obtained. Quality Assurance Monitoring: Facility Program Coordinator (Q) will review all required physical exams to ensure they are fully completed in a timely manner. SGL Nurses will complete checklists on a quarterly basis to ensure exams are fully completed in a timely manner.</p>				

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W000440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 11/12/13 at 12:27 PM. There were no drills conducted during the night shift (10:00 PM to 6:00 AM) from 11/12/12 to 3/19/13 and 6/24/13 to 11/12/13. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 11/13/13 at 6:37 AM, the overnight shift staff indicated he had worked as the overnight staff for 3-4 months. The staff indicated he had not conducted an evacuation drill during the overnight shift.</p> <p>On 11/13/13 at 1:21 PM, the Coordinator indicated the group home should conduct one drill per shift per quarter. The Coordinator indicated he was aware the group home was missing drills. The Coordinator stated, "How do you conduct a drill successfully with</p>	W000440	<p>Plan of Correction: Facility will conduct a sleep time fire drill. Facility staff will be retrained on fire drill protocol and procedures on 12/6/13. Fire drills will be conducted according to agency schedule (See attachment labeled W440). Plan of Prevention: The agency has implemented a new electronic fire drill notification system overseen by the agency's Organizational Effectiveness Coordinator. Quality Assurance Monitoring: This system will notify the SGL Director who will ensure agency fire drill protocols are being followed.</p>	12/06/2013			

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W000488	<p>those 6 guys?" The Coordinator indicated it was a challenge to make it happen. The Coordinator asked, "How do I do a drill appropriately at 3:00 AM successfully?" The Coordinator indicated Stone Belt administration informed him there was one overnight staff at the houses.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 5 of 6 clients living at the group home (#1, #2, #3, #4 and #6), the facility failed to ensure the clients participated in packing their lunches and preparing breakfast.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/12/13 from 6:00 PM to 7:10 PM and 11/13/13 from 5:59 AM to 7:40 AM. On 11/12/13 at 7:06 PM, staff #3 was in the kitchen making</p>	W000488	W488 Plan of Correction: Facility staff have been retrained on active treatment including active treatment during meal preparation and meal time which targeted specifically the inclusion of clients, per their ISP goals and/or chore chart, in completing whatever activities and skill levels are indicated in their assessments and plans. Plan of Prevention: In the first quarter, the facility coordinator will provide supervision and monitoring of active treatment, including inclusion of clients in meal preparation during home visits at least three times per week; in the	12/13/2013

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	<p>sandwiches for clients #1, #2, #3, #4 and #6. While staff #3 was preparing the clients' sandwiches, clients #1, #2, #3, #4 and #6 were in their bedrooms. On 11/13/13 at 6:21 AM, staff #5 asked client #1 if he wanted more juice. Staff #5 then poured client #1's juice. At 6:25 AM, staff #6 packed the clients' lunchboxes. Staff #6 put the sandwiches, drinks and snacks into the clients' lunchboxes without asking the clients to assist her. At 6:27 AM, staff #6 took the clients' lunchboxes to the van. At 6:32 AM, staff #5 poured client #6's milk in a cup. At 6:42 AM, staff #5 carried client #1's bowl and spoon to the sink. At 6:47 AM, staff #6 was in the kitchen rinsing dishes.</p> <p>On 11/13/13 at 1:08 PM, the Coordinator indicated the clients should be assisting with making their lunches. The Coordinator indicated all the clients except client #5 pack their lunches. Client #5 eats his lunch at the group home therefore he did not need to pack a lunch. The Coordinator indicated clients #1, #2, #3, #4 and #6 should be involved with meal preparation.</p> <p>9-3-8(a)</p>		<p>second quarter twice a week; fading to the agency's supervision and monitoring policy. Quality Assurance Monitoring: SGL Director will review supervision and monitoring data, per agency policy.</p>				