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 05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	1006 W 11TH ST BLOOMINGTON, IN 47404

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W000000	This visit was for the post certification revisit (PCR) to the PCR (dated 3/14/14) to the fundamental recertification and state licensure survey completed on 11/15/13. Survey Dates: May 1, 2, 5, and 8, 2014 Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/14/14 by Ruth Shackelford, QIDP.	W000000		
W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all	W000122	W122 Plan of correction: Training protocols for the facility operated day program and facility residence have been audited to specify that facility coordinator will train staff	06/06/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	clients to be free of abuse and neglect. The facility failed to implement its policies and procedures prohibiting client abuse and neglect. The facility failed to prevent client to client abuse. The facility failed to implement sufficient corrective actions to ensure client #5 did not injure client #1 after an incident on 4/16/14. The facility failed to conduct a thorough investigation of an incident on 4/23/14. The facility failed to report to the Bureau of Developmental Disabilities Services (BDDS), within 24 hours, an incident of staff using an unapproved restraint. The facility failed to ensure there was sufficient staff to implement the clients' program plans and evacuation drills during the overnight shift. The facility failed to ensure staff received initial and continuing training to enable the staff to perform their duties effectively, efficiently and competently. Findings include: 1. Please refer to W149. For 8 of 35 incident/investigative reports reviewed affecting clients #1, #2, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, staff neglect of the clients, ensure a Bureau of Developmental Disabilities Services (BDDS) incident report was submitted		and/or determine who is able to train other staff. Training checklists have been updated to include facility and client specific training, as well as increased communication between staff about clients present in the home in order to raise awareness and prevent client to client aggression. Facility staff have been retrained on prevention of abuse and neglect, including preventing client to client aggression on 5/23/14. Facility staff have been retrained on facility clients' behavior support plans and completed competency based test on behavior support plans on 5/9/14 and 5/23/14. Staff have reviewed facility approved physical restraints on 5/16/14 and will receive additional retraining on CPI on 5/30/14. Staff who failed to report the incident within 24 hours was retrained on incident reporting procedure, including reporting to BDDS within 24 hours in accordance with state law on 5/14/14. Recommendations were added to the original investigation (noted as "preliminary" investigation in the survey report). Director of SGL reviewed facility's investigation protocol. A second overnight staff has been added to the facility's master schedule to ensure management and supervision of clients in accordance with individual program plans. Facility staff have completed competency based training on all clients' behavior support plans.	

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	timely, ensure staff did not use unapproved restraints on a client, ensure the 4/23/14 final investigation was thorough, and implement sufficient corrective actions to ensure client #5 did not injure client #1 after an incident on 4/16/14. 2. Please refer to W153. For 1 of 35 incident/investigative reports reviewed affecting client #5, the facility failed to ensure an incident of staff using a non-approved restraint was reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. 3. Please refer to W154. For 1 of 35 incident/investigative reports reviewed affecting clients #1 and #5, the facility failed to ensure a thorough investigation was conducted. 4. Please refer to W157. For 2 of 35 incident/investigative reports reviewed affecting clients #1 and #5, the facility failed to implement sufficient corrective action at the group home to ensure client #1 was not injured by client #5. 5. Please refer to W186. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure there was sufficient staff to		Plan of prevention: Facility staff will receive training on prevention of A/N/E upon hire, staff will receive additional training on prevention of A/N/E during facility specific training, as well as annual retraining, retraining incident reporting procedures, including reporting all allegations of mistreatment, neglect or abuse to administrator in accordance with state law. Facility will follow its protocol for completing a thorough investigation for all alleged violations, reviewed by administrator or representative designee within five business days. Program Directors will communicate all corrective action taken following an alleged violation to ensure necessary action is taken across program areas to prevent further incident. Competency based training will be completed when changes are made to clients' behavior support plans. Facility staff will participate in facility's monthly trainings. Additional trainings may be provided at weekly house meetings as needed. Quality Assurance Monitoring: Facility coordinator will complete facility visits to observe client and staff interactions on a weekly basis. Coordinator will complete Quality Assurance checklist monthly which includes interviewing a random sample of staff about how to prevent client mistreatment; monitoring for	

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	implement the clients' program plans during the overnight shift. 6. Please refer to W189. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure staff received initial and continuing training to enable the staff to perform their duties effectively, efficiently and competently. 9-3-2(a)		sufficient staff to implement individual program plans. The QA team process includes 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. The need for additional staff training will be reviewed by the support team during monthly meetings, and implemented during weekly house meetings and/or individual training sessions.	
W000149	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 8 of 35 incident/investigative reports reviewed affecting clients #1, #2, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, staff neglect of the clients, ensure a Bureau of Developmental Disabilities Services (BDDS) incident report was submitted timely, ensure staff did not use unapproved restraints on a client, ensure the 4/23/14 final investigation was thorough, and implement sufficient	W000149	W149 Plan of Correction: Training protocols for the facility operated day program and facility residence have been audited to specify that facility coordinator will train staff and/or determine who is able to train other staff. Training checklists have been updated to include increased communication between staff about clients present in the home in order to raise awareness and prevent client to client aggression. Facility staff have been retrained on prevention of	06/06/2014

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	corrective actions to ensure client #5 did not injure client #1 after an incident on 4/16/14. Findings include: On 5/1/14 at 12:50 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 4/16/14 at 8:15 AM, the Bureau of Developmental Disabilities Services (BDDS) report, dated 4/16/14, indicated, "[Client #1] was in his room waiting for an appointment. [Client #5] was in the living room with his one on one staff (#7) and an additional staff that was training (staff #8). [Client #5] was given choices of what he could do, and he started walking to his room. Instead of going to his room, he entered the (sic) [client #1's] room. [Client #5] aggressed upon [client #1], opening up a wound on his check (cheek) and above his lip. Staff entered the room and got between the two clients and prompted [client #5] to go to his room. [Client #5] had a tantrum in his room. Staff provided first aid to [client #1]. Staff waited for [client #5] to calm, then helped him clean up and talked about keeping his hands to himself. [Client #5] is scheduled to have his blood drawn due to possible coming in contact		abuse and neglect, including preventing client to client aggression, 5/23/14. Facility staff have been retrained on facility clients' behavior support plans and completed competency based test on behavior support plans on 5/9/14 and 5/23/14. Staff reviewed facility approved physical restraints on 5/16/14 and will receive additional retraining on CPI on 5/30/14. Plan of prevention: Facility staff will receive training on prevention of A/N/E upon hire, staff will receive additional training on prevention of A/N/E during facility specific training, as well as annual retraining. Quality Assurance Monitoring: Facility coordinator will complete facility visits to observe client and staff interactions on a weekly basis. Coordinator will complete Quality Assurance checklist monthly which includes interviewing a random sample of staff about how to prevent client mistreatment.	

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	with another client's blood." The Nursing Consultation note, dated 4/16/14, was reviewed on 5/1/14 at 1:59 PM. The note indicated, "[Client #1] was visited by nurse at his home as f/u (follow up) to ER (Emergency Room) visit the previous day d/t (due to) wounds incurred from biting incident from another client. Upon assessment the following was noted: Two lacerations noted to right cheek just below cheek bone area, both (approximately) 1 inch in length, width of outer laceration (approximately) 1/8 of an inch, width of inner laceration (approximately) 1/10 of an inch; depth of lacerations hard to determine at this time. Both areas appear to be healing/scabbing over. Small thin cut noted just below nose (approximately) 1/4 of an inch long, inside of upper lip in the middle noted to be swollen, 'off white' in color but does not look infected at this time. [Client #1] also noted to have abrasions to upper part of both shins (one abrasion on each shin) which appear to be scabbing over. When asked if he was bitten on the legs [client #1] responded, 'Maybe, I don't remember.' Staff directed to continue treatment orders from hospital (oral ATB (antibiotics) and topical ointment) and to watch for signs/symptoms of infection, abnormal color drainage from wounds - if			

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	noted they are to contact nurse for further directives." The investigation, dated 4/22/14, indicated, in part, "The attack on [client #1] resulted in significant injuries that reveal that [client #5] had an extended amount of time in which to aggress upon his victim. [Client #5's] 1 on 1 (one on one) staff had a responsibility to remain within arm's reach of [client #5] while he was in the house with other clients, in order to provide a safe environment for other clients. There was a failure to provide that care. The definition of neglect, according to Stone Belt, is as follows: Neglect: Any action of behavioral interventions that risks that physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan. According to [client #5's] Behavior Support Plan, he is to be within arm's			

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	reach of staff whenever he is in the home with other clients. This level of supervision was not provided by [client #5's] 1 on 1 staff or the staff that was being trained to work with [client #5]." The findings of the investigation indicated, "It is the finding of this investigation that the two staff members who were assigned to work with [client #5] - [staff #7 and #8] - were neglectful in their failure to provide a safe environment and an appropriate level of supervision and care." The investigation indicated, in part, "Training issues: These interviews have revealed that there may be issues with the training of new staff at [name of group home]. If [staff #8] was supposed to be [client #5's] 1 on 1 at the time of the incident, it is unclear that this was made clear to him. This could be due to an isolated situation of neglect or it could be indicative of a need for greater oversight of the training process for staff. It seems clear that [client #5's] potential to become immediately dangerous and destructive to other clients may not have been adequately understood by [staff #8]. The techniques for training new staff to work with a potentially aggressive client like [client #5] do not appear to be standardized (some staff reported that a few days of observation are necessary,			

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	while other (sic) put a trainee in the position of being [client #5's] 1 on 1 on his second morning). Also, the 'client info checklist' that some supervisors believe is being used to train new staff does not appear to be in use anymore." On 5/2/14 at 1:24 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the group home could not take any responsibility for the incident since the incident occurred during the day program hours and day program staff were supervising client #5 at the time. The QIDP indicated the day program staff were aware client #1 was in the home prior to the incident. The QIDP stated the incident was "a day program error." The QIDP indicated it was clear to him the day program staff made a mistake of the trainee confusing which bedroom was client #5's. The QIDP indicated there was no corrective action taken with the group home staff. On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated incidents of client to client aggression were considered abuse. The Director indicated the facility had a policy/procedure prohibiting abuse of the clients. The Director indicated the staff should prevent client to client abuse. The Director indicated the incident occurred			

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	at the group home while client #5 was being supervised by the day program staff. The Director indicated one staff was training another staff while clients #1 and #5 were in the home. Client #5 requested to go to his room. Client #5 went into client #1's room instead of his room. The Director indicated there was no corrective action implemented with the group home staff since the incident involved the day program staff. 2) On 4/23/14 at 5:10 AM, client #5 was in the kitchen with staff #4 as staff #4 was loading the dishwasher. Client #5 just finished breakfast and was hanging around the kitchen. Client #5 appeared to be in a good mood. As staff #4 was filling the dishwasher, staff #4 heard client #1 scream. Client #5 had walked off when staff #4 had his back turned. When staff got to client #1's room, client #5 had pulled client #1 out of bed and was on top of him. Client #1 had several bite marks on him, three on his legs and 3 on his shoulder. The preliminary investigation, dated 4/30/14, indicated the following in the Statement of Findings section, "The mechanics of the incident that lead (sic) to [client #1's] victimization are fairly simple: [staff #4] turned his attention away from [client #5] for just long			

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	enough for [client #5] to dart to [client #1's] room and attack him. Stone Belt's definition of neglect is as follows: Neglect: Any action of behavioral interventions that risks that physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan. It could be argued that [staff #4] failed to provide a safe environment for [client #1] and [client #5] by allowing his attention to stray from [client #5's] whereabouts to the matter of loading the dishwasher, though in that latter function he was arguably providing clients with a sanitary environment. Still, client safety in the short term must take precedence over cleanliness. It could also be stated that [staff #4] allowed his level of supervision of [client #5] to become inappropriate in the moment he took to load the dishwasher. However, a careful reading of [client #5's] BSP (Behavior Support Plan) reveals the following:			

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	From [client #5's] Behavior Support Plan (2/24/14): [Client #5] will have a specific staff member assigned as his dedicated staff (intensive staffing), in anticipation of [client #5] waking in the morning, and during each shift, except the overnight shift... During overnight shifts, the night aide needs to be aware of [client #5's] whereabouts for safety reasons. [Client #5] does not need a dedicated staff during the night because he rarely wakes up during the night and his roommates sleep with their bedroom doors closed with pop locks. All staff working around [client #5] as well as his dedicated staff must always be aware of where [client #5] is, what he is doing, what he is looking at and what mood he is in. Often, [client #5's] aggression comes and goes; while he may appear calm, he had been observed to aggress without visible provocation." The findings of the investigation indicated, in part, "As overnight staff, [staff #4] was not required to be within arm's reach of [client #5] at the time of the incident. There are discrepancies about the use of pop locks on bedroom doors and how to support clients' choice of not follow (sic) the house restriction of locking doors at night. This investigation into the allegation of neglect is inconclusive in regard to this individual staff member."			

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	The preliminary investigation indicated, in part, "There appears to be a larger issue involving teaching and training of staff, in that it is not clear that [name of group home] staff members are being properly trained and their training properly documented. As this finding constitutes a 'failure to provide appropriate supervision, care, or training,' this investigation finds that there has been substantiated neglect on the part of the supervisory team responsible for providing training and ensuring its effectiveness. There could be many explanations for this deficiency - short staffing, unclear directives, ineffective communication - but the bottom line is that action must be taken to correct this tendency and ensure the safety of clients and staff. Some considerations: Competency-based training and assessment protocols need to be put in place and followed to ensure new staff members are being trained adequately to work with one of Stone Belt's most challenging clients." The investigation indicated, in part, "It has been difficult to obtain copies of competency based training forms that document that [name of group home] staff were trained to consistently close and lock client doors during the overnight shift or during other shifts. In looking for evidence of ongoing inservice trainings that related to			

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	the incident at hand, this investigator found little documentation in the past four months of such training." The investigation indicated an interview with the behaviorist was conducted on 4/24/14. The behaviorist indicated, "...a huge problem at [name of group home] is that the behaviorist is not informed when new staff members are hired until there's an incident. [Behaviorist] stated that new staff are supposed to be trained by [Qualified Intellectual Disabilities Professional (QIDP)] on BSPs... [Behaviorist] is familiar with the competency-based questionnaire used for training on the BSP, but does not have any for [name of group home]... The QIDP indicated in the investigation the behaviorist was not involved in training on [client #5's] BSP." The Nursing Consultation note, dated 4/16/14, was reviewed on 5/1/14 at 1:59 PM. The note indicated, "[Client #1] was visited by nurse at his home as f/u (follow up) to biting incident which occurred the previous day, assessment findings as follows: light yellow circular area noted to back of left shoulder - slightly smaller than a quarter in size, scabbed area noted to outside of left ankle (approximately) 1/3 of an inch in length and (approximately) 1/5 of an inch in width, small cut noted to area just			

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	below left knee to the outside (approximately) 1/10 of an inch circumference; two areas of very faint discoloration noted to right leg just below the knee. Staff directed to apply antibiotic ointment to area on ankle and to bandage as needed." A review of client #5's BSP, dated 2/24/14, was conducted on 5/2/14 at 1:45 PM. The BSP did not include a plan to address what the overnight shift staff should do if client #5 woke up prior to a second staff arriving at the home at 6:00 AM when there was one staff on duty during the overnight shift (10:30 PM to 6:00 AM). On 5/2/14 at 1:24 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he did not think staff #4 did anything incorrectly. The QIDP indicated the investigation was inconclusive. The QIDP indicated prior to the incident, staff #4 had shut and locked client #1's bedroom door and would not have known client #1 got up and opened the door. The QIDP indicated he did not think staff #4 was negligent. The QIDP indicated it was the responsibility of the group home staff to ensure the clients were safe at their home. On 5/5/14 at 12:27 PM, the Director of			

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	Supervised Group Living (Director) indicated incidents of client to client aggression were considered abuse. The Director indicated the facility had a policy/procedure prohibiting abuse of the clients. The Director indicated the staff should prevent client to client abuse. The Director indicated client #5 woke up early which was unusual for him. Staff #4 assisted client #5 with a shower and breakfast. While staff #4 was loading the dishwasher, client #5 walked out and went into client #1's bedroom. Staff #4 heard client #5 in client #1's bedroom and intervened. The Director indicated following the incident, she spoke with the Home Manager about being on call if client #5 woke up early and group home needed additional staffing. The Director indicated staff #4 received retraining. The Director indicated she needed to review the composition of the clients at the group home to maintain safety. The Director indicated the investigation was inconclusive about whether or not neglect was substantiated. On 5/8/14 at 10:54 AM, the Director of Supervised Group Living (Director) indicated she removed items from the preliminary investigation she thought were opinions and not pertinent to the investigation. The Director indicated the conclusion of the investigation seemed to			

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	ramble and it was confusing. The Director stated the preliminary and final investigation included the same information however the information was "streamlined." The Director indicated she did not remove pertinent information from the preliminary investigation to the final version of the investigation. The Director indicated she revised the investigation since the investigator was new. The Director indicated she had not revised prior investigations. The Director indicated she thought the investigation was thorough after her revisions to the investigation. The Director stated, "I felt the information in the final report captured the initial investigation." 3) On 4/2/14 at 9:20 AM at the facility-operated day program, client #6 was head butted on the top of his head by a male peer. On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated incidents of client to client aggression were considered abuse. The Director indicated the facility had a policy/procedure prohibiting abuse of the clients. The Director indicated the staff should prevent client to client abuse. 4) On 4/2/14 at 2:00 PM at the facility-operated day program, client #2			

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	was kicked by a male peer on the leg. On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated incidents of client to client aggression were considered abuse. The Director indicated the facility had a policy/procedure prohibiting abuse of the clients. The Director indicated the staff should prevent client to client abuse. 5) On 4/3/14 at 8:40 AM at the facility-operated day program, client #6 was grabbed by the shirt by a male peer. On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated incidents of client to client aggression were considered abuse. The Director indicated the facility had a policy/procedure prohibiting abuse of the clients. The Director indicated the staff should prevent client to client abuse. 6) On 4/5/14 at 3:15 PM, client #5 ran to staff #9's seat and hit staff #9 on the right side of his face and grabbed the collar of staff #9's shirt with his right hand. The BDDS report, dated 4/10/14, indicated, in part, "Staff pulled his hand off of my shirt and he fell to the floor. Staff stood up from the chair and said, '[Client #5] go to your room.' [Client #5] screamed and ran to his room. He was there for about			

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	30 seconds to 1 minutes and then he ran back down the hall. He threw something at staff, and then he ran at staff again trying to bite staff and hit staff. [Client #5] kept trying to hold staff and he continued to lunge at me trying to bite. Staff attempted to hold his arms but staff could not. Staff kept telling [client #5] that he needed to go to his room. Initially, staff was in front of him but during the course of him trying to bite and lunge at staff, staff got behind him and put him in a bear hug. Staff asked him to calm down. He continued to attempt to bite staff. He was able to bite staff, but not break the skin. [Client #5] then started to sit down on the ground. [Client #5] got all the way down to the floor and staff was in a squat position behind him, asking him to calm down. Staff realized that this was not working and after (approximately) 2 minutes, staff let him go. At this point, staff's back was to the kitchen. [Client #5] was still flailing around but was not screaming. [Client #5] stood up and came at staff again in the kitchen. This time, staff was able to get his arms and staff moved him back towards the living room. He dropped to the floor again at the edge of the living room carpet and started kicking and flailing at staff. He continued to attempt to bite. Staff turned [client #5] on his left side and grabbed his wrists and			

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	held his head so that he would not continue to SIB (self injurious behavior), or bite staff. Staff kept asking [client #5] if he was calm. He eventually said, 'Done. I'm done.' [Client #5] got up and pulled up his pants and went to get a glass of water. Staff noticed that [client #5's] elbows and upper arms were red." The BDDS report indicated, in part, "[Staff #9] will be retrained on Crisis Prevention Intervention. He will be retrained on [client #5's] Behavioral Support Plan. He will be retrained on Incident Report completion procedures. [Staff #9] will receive support from a [name of facility] clinician with respect to strategies for supporting [client #5]. [Staff #9] will be trained on supporting [client #5] in 1:1 (one on one) settings. The Support Team met to discuss the use of unapproved restraints." The investigation, dated 4/7/14 indicated, in part, "His legs were on the carpeted part of the living room. Then he was still moving. I flipped him over on to his chest. Which side of his body? Onto his left side. I was standing over him. I put my left hand on his head and both of his arms in my right hand. His wrists were in my right hand." The investigation indicated, in part, "It was obvious that his elbows and arms had been injured. It looked like something had happened. [Staff #2] later told me that there were			

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	bruises on his back. My shift ended about 15 minutes after [staff #2 and #3] got back." On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated the timeframe for reporting incidents to BDDS was 24 hours. The Director indicated she was unsure why the BDDS report was not submitted timely. The Director indicated the staff used a non-approved CPI (Crisis Prevention Institute) restraint to keep the staff and client #5 safe. The Director indicated the staff used a non-approved method to address client #5's behavior. 7) On 4/25/14 at 8:15 AM at the facility-operated day program, a female peer pushed a chair into client #6. Client #6 was startled by the bump. Client #6 proceeded to grab the peer's hair, on the right side. Staff intervened and performed a grab release on client #6's hand. On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated incidents of client to client aggression were considered abuse. The Director indicated the facility had a policy/procedure prohibiting abuse of the clients. The Director indicated the staff should prevent client to client abuse.			

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	8) On 5/5/14 at 9:15 AM at the facility-operated day program, client #1 was hit by a female peer with a closed fist on the left side of his head. On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated incidents of client to client aggression were considered abuse. The Director indicated the facility had a policy/procedure prohibiting abuse of the clients. The Director indicated the staff should prevent client to client abuse. On 5/1/14 at 1:19 PM, a review of the facility's policies and procedures was conducted. The Behavioral Intervention Policy, dated 9/2013, indicated, in part, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma. Emotional/Verbal abuse: Consists of the intentional use of actions, words, or			

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	activities where an individual suffers emotional/psychological harm or trauma. This includes, but is not limited to the following: 9. Intimidation/Coercion: To dominate, force or bring about by force, fear or threat behavior or compliance." The Incident Reporting Procedure, dated 9/2010, indicated, in part, "...are to be reported to the State following state guidelines and timeframes." This deficiency was cited on 3/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W000153	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 1 of 35 incident/investigative reports reviewed affecting client #5, the facility failed to ensure an incident of staff using a non-approved restraint was reported to the Bureau of Developmental Disabilities	W000153	W153 Plan of correction: Staff who failed to report the incident within 24 hours was retrained on incident reporting procedure, including reporting to	06/06/2014

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	Services (BDDS), within 24 hours, in accordance with state law. Findings include: On 5/1/14 at 12:50 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/5/14 at 3:15 PM, client #5 ran to staff #9's seat and hit staff #9 on the right side of his face and grabbed the collar of staff #9's shirt with his right hand. The BDDS report, dated 4/10/14, indicated, in part, "[Staff #9] will be retrained on Crisis Prevention Intervention. He will be retrained on [client #5's] Behavioral Support Plan. He will be retrained on Incident Report completion procedures. [Staff #9] will receive support from a [name of facility] clinician with respect to strategies for supporting [client #5]. [Staff #9] will be trained on supporting [client #5] in 1:1 (one on one) settings. The Support Team met to discuss the use of unapproved restraints." On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated the timeframe for reporting incidents to BDDS was 24 hours. The Director indicated she was unsure why the BDDS report was not submitted timely.		BDDS within 24 hours in accordance with state law on 5/14/14. Plan of prevention: Facility staff received retraining on incident reporting procedures, including reporting all allegations of mistreatment, neglect or abuse to administrator in accordance with state law on 5/16/14. Quality Assurance Monitoring: Facility coordinator will complete Quality Assurance Checklist monthly, which includes interviewing a random sample of staff about how to prevent client mistreatment	

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	This deficiency was cited on 3/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 35 incident/investigative reports reviewed affecting clients #1 and #5, the facility failed to ensure a thorough investigation was conducted. Findings include: On 5/1/14 at 12:50 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/23/14 at 5:10 AM, client #5 was in the kitchen with staff #4 as staff #4 was loading the dishwasher. Client #5 just finished breakfast and was hanging around the kitchen. Client #5 appeared to be in a good mood. As staff #4 was filling the dishwasher, staff #4 heard client #1 scream. Client #5 had walked off when staff #4 had his back	W000154	W154 Plan of correction: Recommendations were added to the original investigation (noted as "preliminary" investigation in the survey report). Director of SGL reviewed facility's investigation protocol. Plan of prevention: Facility will follow its protocol for completing a thorough investigation for all alleged violations and it will be reviewed by administrator or representative designee within five business days in accordance with state regulations. Quality Assurance Monitoring: The QA team process includes 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	06/06/2014

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	turned. When staff got to client #1's room, client #5 had pulled client #1 out of bed and was on top of him. Client #1 had several bite marks on him, three on his legs and 3 on his shoulder. The preliminary investigation (provided to the surveyor on 5/1/14 and did not include recommendations), dated 4/30/14, indicated the following in the Statement of Findings section (none of the information was in the final report with the exception of the definition of neglect), "The mechanics of the incident that lead (sic) to [client #1's] victimization are fairly simple: [Staff #4] turned his attention away from [client #5] for just long enough for [client #5] to dart to [client #1's] room and attack him. Stone Belt's definition of neglect is as follows: Neglect: Any action of behavioral interventions that risks that physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical		actions.	

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	supplies or safety equipment as indicated in the individualized support plan. It could be argued that [staff #4] failed to provide a safe environment for [client #1] and [client #5] by allowing his attention to stray from [client #5's] whereabouts to the matter of loading the dishwasher, though in that latter function he was arguably providing clients with a sanitary environment. Still, client safety in the short term must take precedence over cleanliness. It could also be stated that [staff #4] allowed his level of supervision of [client #5] to become inappropriate in the moment he took to load the dishwasher. However, a careful reading of [client #5's] BSP (Behavior Support Plan) reveals the following: From [client #5's] Behavior Support Plan (2/24/14): [Client #5] will have a specific staff member assigned as his dedicated staff (intensive staffing), in anticipation of [client #5] waking in the morning, and during each shift, except the overnight shift. The dedicated 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 clients present. [This directive conflicts with a later directive in the same document, which states that, 'Dedicated staff will maintain a distance of no greater than arm's length from [client #5] when he displays any signs of agitation or			

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	aggression, unless he is in a private space by himself, such as his room, the bathroom, or at home with no other clients present.' This discrepancy could account for house staff not remaining vigilant at all time, and should be corrected.] During overnight shifts, the night aide needs to be aware of [client #5's] whereabouts for safety reasons. [Client #5] does not need a dedicated staff during the night because he rarely wakes up during the night and his roommates sleep with their bedroom doors closed with pop locks. All staff working around [client #5] as well as his dedicated staff must always be aware of where [client #5] is, what he is doing, what he is looking at and what mood he is in. Often, [client #5's] aggression comes and goes; while he may appear calm, he had been observed to aggress without visible provocation. If other clients become aggressive, staff should assist [client #5] with leaving the area for self protection as necessary. Staff may encourage [client #5] to remain apart from the area where aggression is occurring until the aggressor as (sic) calmed. If [client #5] chooses to go to his room during the aggression, he may utilize the pop lock on his door. As [client #5] has no dedicated staff during the overnight shift, then [staff #4] was not [client #5's] dedicated staff, and is not			

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	required to stay within arm's length of [client #5] at all times. In this case, 'appropriate supervision' does not mean 'within arm's length,' but rather defaults back to the definition given for all staff working with [client #5], that they 'must always be aware of where [client #5] is, what he is doing, what he is looking at and what mood he is in.' In this sense, it can be argued that although [staff #4] did well working with [client #5] during the unusual episode of his early morning waking by keeping him occupied, away from other clients, sticking to his routine and so forth, he also had a momentary lapse in his knowledge of [client #5's] location. In terms of 'providing a safe environment,' there is a simple technique identified by several of the staff interviewed that would serve to ensure the safety of clients: keeping their bedroom doors shut and locked. While most [name of group home] clients lock their own doors or allow staff to keep them locked, [client #1] is resistant to having his door closed or locked. [Staff #4's] failure to ensure that [client #1's] door was closed and locked could be seen as neglectful, but this investigation has revealed that the issue is larger than one staff's actions. The 'pop locks' that are installed in the bedroom doors at [name of group home] are meant to keep clients safe from [client #5], yet there are only			

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	two mentions of them in his BSP. One mention simply states that 'his roommates sleep with their bedroom doors closed with pop locks,' while the other mentions that during an episode of client aggression that does not involve [client #5], 'If [client #5] chooses to go to his room during the aggression, he may utilize the pop lock on his door.' At no point in [client #5's] BSP does it specifically stipulate that [name of group home] staff are to close and lock client doors. This may explain the confusion that arose during interviews, when managerial staff felt certain that staff were closing and locking the door, while DSPs (Direct Support Professionals) revealed that this is not the case. As [staff #4] was trained primarily by former Stone Belt staff [name of staff], it is possible that he was not trained to close and lock the doors by another staff who had in turn not been trained to do so. In examining the house restrictions for [name of group home], however, the following comes to light: From Human Rights [name of group home] Revised April 17, 2013: Restriction #4: Button Release Locks on Bedroom Doors. Rationale: A resident entered another resident's room during the night and bit his peer on the back. During evening hours there is only one staff on duty, and should another resident need staff			

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	attention during the night, this resident needs to be prevented from entering the rooms of other residents. Therefore bedroom doors will remain closed during the nighttime hours with the use of button release locks that prevent entry from the hall to the room, but do not prevent exit by the resident of the room. This provides another level of prevention should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom. Training: This resident has a behavior plan in effect to address his aggression toward others. This restriction will be evaluated annually to determine the continued need. Progress: The resident has improved and had had a reduction of aggressive behavior. However, he still needs the restriction to remain in place for the safety of all residents. The risk that [client #5] might enter other clients' rooms and cause them harm was addressed in this restriction. The way it is worded does seem to imply that staff will be responsible for keeping all doors closed and locked throughout the night. It is not clear how the staff were to be trained on this aspect of the job, and it has been difficult to obtain documentation of this training occurring with veteran or new staff members. This brings forward a more significant finding of this investigation: There appears to be			

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	a systemic problem with staff training at [name of group home]. From Stone Belt's Behavior Intervention Policy: Staff Training. Staff members who are responsible for implementing behavioral intervention techniques shall receive competency based training in the general area of behavioral intervention principles and techniques, agency policy regarding behavioral intervention techniques, as well as charting and documentation. Regular in-services will be held on positive behavior supports, proper physical intervention and self protection. New staff will be provided with this training during their orientation. Those staff responsible for implementing behavioral intervention techniques will receive training and be provided with experience in the specific techniques that they will use. The use of any physical interventions, whether in an emergency or as a part of an approved behavior support plan, can only be done by trained individuals as noted above. The provision of such training is the responsibility of the Behavior Consultants and/or the service coordinators, residential coordinators, or the site managers. The staff's supervisor may also provide behavioral intervention training specific to a behavior support plan after receiving training on the behavior plan and appropriate			

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	interventions by the behavior consultant. Stone Belt policy mandates that staff receive competency-based training on behavior plans. Competency-based training forms are available to the staff responsible for providing the training, and it is the expectation that new staff will be assessed on their competency at performing the duties for which they have been trained. Simply signing off that a DSP has read the Behavior Plan is not sufficient. There interviews reveal that between the house's behaviorist, coordinator and managers, there exist different styles and understandings of what is required by Stone Belt's competency-based training requirement. There does not appear to be a standardized, consistent manner in which to assess a DSP's levels of competence. There also appear to be communication breakdowns between managerial staff and the behaviorist that have had negative effects of house staff's level of training and preparedness... It has been difficult to obtain copies of competency based training forms that document that [name of group home] staff were trained to consistently close and lock client doors during the overnight shift or during other shifts. In looking for evidence of ongoing inservice trainings that related to the incident at hand, this investigator found little documentation in the past			

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	four months of such trainings. One exception is the following: From [name of group home] House Meeting Notes, 2/14/14: Reminder that when [client #5] has aggressed, even in the slightest, towards client OR staff, it isn't sufficient to merely send him to his room, HE MUST BE ESCORTED ALL THE WAY DOWN THE HALL!!! This is, of course, to ensure both his safe passage AND anyone else's safety along the way. It is then necessary for staff to remain outside his door until behavior subsides. And, for that matter, keep him staffed 1:1 while other clients are at home. We're seeing spikes in aggression. STAY VIGILANT! This meeting took place two months before these latest attacks by [client #5], and it is clear that the house staff knew that there was a looming issue with his aggression. It can be assumed that there was much more informal, verbal training and coaching on [client #5] during that time as well, and yet there have been, in the past 12 days, two separate incidents in which three staff members allowed their attention to stray from [client #5] long enough for him to attack [client #1]. This appears to point to the larger issue of staff training, rather than simply neglect by three separate staff members...". The findings of the preliminary investigation indicated, in part, "As overnight staff, [staff #4] was			

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	not required to be within arm's reach of [client #5] at the time of the incident. There are discrepancies about the use of pop locks on bedroom doors and how to support clients' choice of not follow (sic) the house restriction of locking doors at night. This investigation into the allegation of neglect is inconclusive in regard to this individual staff member. There appears to be a larger issue involving teaching and training of staff, in that it is not clear that [name of group home] staff members are being properly trained and their training properly documented. As this finding constitutes a 'failure to provide appropriate supervision, care, or training,' this investigation finds that there has been substantiated neglect on the part of the supervisory team responsible for providing training and ensuring its effectiveness. There could be many explanations for this deficiency - short staffing, unclear directives, ineffective communication - but the bottom line is that action must be taken to correct this tendency and ensure the safety of clients and staff. Some considerations: Competency-based training and assessment protocols need to be put in place and followed to ensure new staff members are being trained adequately to work with one of Stone Belt's most challenging clients. Communication			

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	between house staff, coordinator and behaviorist needs improvement and documentation, especially when it comes to new staff beginning to work at [name of group home]. If the regular shutting and locking of client doors is to become standard practice, it needs to be stated in the Behavior Plans as well as in the House Restrictions. There needs to be documented training on his critical safety measure. Also, some resolution needs to be found to [client #1's] resistance to closing his door in order to ensure his safety from [client #5's] attacks...". The final investigation (provided to the surveyor on 5/5/14 due to a request to obtain the recommendations for the investigation that were not included in the preliminary investigation), dated 4/30/14, indicated, "It appears that [staff #4] was actively engaged with [client #5] during the early hours on the morning of the incident. It appears that he turned his attention briefly while addressing the dishes which was enough time for [client #5] to leave his line of sight, allowing [client #5] to gain access to [client #1's] bedroom. According to [client #5's] BSP, overnight staff are not required to be in arm's length of [client #5]. There appears to be discrepancies in how [staff #4] was trained in regards to use of pop locks on client bedrooms and monitoring			

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	the hallway if a client's door is open. Agency policy states that staff should complete a competency based training form on BSPs. It is unclear if this training took place according to policy." On 5/8/14 at 10:54 AM, the Director of Supervised Group Living (Director) indicated she removed items from the preliminary investigation she thought were opinions and not pertinent to the investigation. The Director indicated the conclusion of the investigation seemed to ramble and it was confusing. The Director stated the preliminary and final investigation included the same information however the information was "streamlined." The Director indicated she did not remove pertinent information from the preliminary investigation to the final version of the investigation. The Director indicated she revised the investigation since the investigator was new. The Director indicated she had not revised prior investigations. The Director indicated she thought the investigation was thorough after her revisions to the investigation. The Director stated, "I felt the information in the final report captured the initial investigation." This deficiency was cited on 3/14/14. The facility failed to implement a systemic plan of correction to prevent			

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	recurrence. 9-3-2(a)			
W000157	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 35 incident/investigative reports reviewed affecting clients #1 and #5, the facility failed to implement sufficient corrective action at the group home to ensure client #1 was not injured by client #5. Findings include: On 5/1/14 at 12:50 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 4/16/14 at 8:15 AM, the Bureau of Developmental Disabilities Services (BDDS) report, dated 4/16/14, indicated, "[Client #1] was in his room waiting for an appointment. [Client #5] was in the living room with his one on one staff (#7) and an additional staff that was training (#8). [Client #5] was given choices of	W000157	W157 Plan of correction: Training protocols for the facility operated day program and facility residence have been audited to specify that the coordinator will train staff and determine who is able to become a trainer. Training checklists have been updated to include increased communication between staff about clients present in the home in order to raise awareness and prevent client to client aggression. Facility staff have been retrained on prevention of abuse and neglect, including preventing client to client aggression, 5/23/14. Facility staff have been retrained on facility clients' behavior support plans and completed competency based test on behavior support plans on 5/9/14 and 5/23/14 . Staff reviewed facility approved physical restraints on 5/16/14 and will receive additional retraining on CPI on 5/30/14. A second overnight staff has been added to the master	06/06/2014

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	what he could do, and he started walking to his room. Instead of going to his room, he entered the (sic) [client #1's] room. [Client #5] aggressed upon [client #1], opening up a wound on his check (cheek) and above his lip. Staff entered the room and got between the two clients and prompted [client #5] to do to his room. [Client #5] had a tantrum in his room. Staff provided first aid to [client #1]. Staff waited for [client #5] to calm, then helped him clean up and talked about keeping his hands to himself. [Client #5] is scheduled to have his blood drawn due to possible coming in contact with another client's blood." The Nursing Consultation note, dated 4/16/14, was reviewed on 5/1/14 at 1:59 PM. The note indicated, "[Client #1] was visited by nurse at his home as f/u (follow up) to ER (Emergency Room) visit the previous day d/t (due to) wounds incurred from biting incident from another client. Upon assessment the following was noted: Two lacerations noted to right cheek just below cheek bone area, both (approximately) 1 inch in length, width of outer laceration (approximately) 1/8 of an inch, width of inner laceration (approximately) 1/10 of an inch; depth of lacerations hard to determine at this time. Both areas appear to be healing/scabbing over. Small thin		schedule to ensure personal program plans are appropriately implemented and ensure prevention of client to client abuse. Plan of prevention: Program Directors will communicate all corrective action taken following an alleged violation to ensure necessary action is taken across program areas to prevent further incident. Quality Assurance Monitoring: The QA team process includes 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.	

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	cut noted just below nose (approximately) 1/4 of an inch long, inside of upper lip in the middle noted to be swollen, 'off white' in color but does not look infected at this time. [Client #1] also noted to have abrasions to upper part of both shins (one abrasion on each shin) which appear to be scabbing over. When asked if he was bitten on the legs [client #1] responded, 'Maybe, I don't remember.' Staff directed to continue treatment orders from hospital (oral ATB (antibiotics) and topical ointment) and to watch for signs/symptoms of infection, abnormal color drainage from wounds - if noted they are to contact nurse for further directives." The investigation, dated 4/22/14, indicated, in part, "The attack on [client #1] resulted in significant injuries that reveal that [client #5] had an extended amount of time in which to aggress upon his victim. [Client #5's] 1 on 1 (one on one) staff had a responsibility to remain within arm's reach of [client #5] while he was in the house with other clients, in order to provide a safe environment for other clients. There was a failure to provide that care. The definition of neglect, according to Stone Belt, is as follows: Neglect: Any action of behavioral interventions that risks that physical or emotional safety and well			

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	being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan. According to [client #5's] Behavior Support Plan, he is to be within arm's reach of staff whenever he is in the home with other clients. This level of supervision was not provided by [client #5's] 1 on 1 staff or the staff that was being trained to work with [client #5]." The findings of the investigation indicated, "It is the finding of this investigation that the two staff members who were assigned to work with [client #5] - [staff #7 and #8] - were neglectful in their failure to provide a safe environment and an appropriate level of supervision and care." On 5/2/14 at 1:24 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the group home could not take any responsibility for the incident since the incident occurred			

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	during the day program hours and day program staff were supervising client #5 at the time. The QIDP indicated the day program staff were aware client #1 was in the home prior to the incident. The QIDP stated the incident was "a day program error." The QIDP indicated it was clear to him the day program staff made a mistake of the trainee confusing which bedroom was client #5's. The QIDP indicated there was no corrective action taken with the group home staff. On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated the incident occurred at the group home while client #5 was being supervised by the day program staff. The Director indicated one staff was training another staff while clients #1 and #5 were in the home. Client #5 requested to go to his room. Client #5 went into client #1's room instead of his room. The Director indicated there was no corrective action implemented with the group home staff since the incident involved the day program staff. 2) On 4/23/14 at 5:10 AM, client #5 was in the kitchen with staff #4 as staff #4 was loading the dishwasher. Client #5 just finished breakfast and was hanging around the kitchen. Client #5 appeared to be in a good mood. As staff #4 was			

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	filling the dishwasher, staff #4 heard client #1 scream. Client #5 had walked off when staff #4 had his back turned. When staff got to client #1's room, client #5 had pulled client #1 out of bed and was on top of him. Client #1 had several bite marks on him, three on his legs and 3 on his shoulder. The investigation, dated 4/30/14, indicated the following in the Statement of Findings section, "The mechanics of the incident that lead (sic) to [client #1's] victimization are fairly simple: [staff #4] turned his attention away from [client #5] for just long enough for [client #5] to dart to [client #1's] room and attack him. Stone Belt's definition of neglect is as follows: Neglect: Any action of behavioral interventions that risks that physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan. It could be argued that [staff #4] failed to provide a safe environment for			

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	[client #1] and [client #5] by allowing his attention to stray from [client #5's] whereabouts to the matter of loading the dishwasher, though in that latter function he was arguably providing clients with a sanitary environment. Still, client safety in the short term must take precedence over cleanliness. It could also be stated that [staff #4] allowed his level of supervision of [client #5] to become inappropriate in the moment he took to load the dishwasher. However, a careful reading of [client #5's] BSP (Behavior Support Plan) reveals the following: From [client #5's] Behavior Support Plan (2/24/14): [Client #5] will have a specific staff member assigned as his dedicated staff (intensive staffing), in anticipation of [client #5] waking in the morning, and during each shift, except the overnight shift... During overnight shifts, the night aide needs to be aware of [client #5's] whereabouts for safety reasons. [Client #5] does not need a dedicated staff during the night because he rarely wakes up during the night and his roommates sleep with their bedroom doors closed with pop locks. All staff working around [client #5] as well as his dedicated staff must always be aware of where [client #5] is, what he is doing, what he is looking at and what mood he is in. Often, [client #5's] aggression comes and goes; while he may appear			

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	calm, he had been observed to aggress without visible provocation." The findings of the investigation indicated, in part, "As overnight staff, [staff #4] was not required to be within arm's reach of [client #5] at the time of the incident. There are discrepancies about the use of pop locks on bedroom doors and how to support clients' choice of not follow (sic) the house restriction of locking doors at night. This investigation into the allegation of neglect is inconclusive in regard to this individual staff member." The Nursing Consultation note, dated 4/16/14, was reviewed on 5/1/14 at 1:59 PM. The note indicated, "[Client #1] was visited by nurse at his home as f/u (follow up) to biting incident which occurred the previous day, assessment findings as follows: light yellow circular area noted to back of left shoulder - slightly smaller than a quarter in size, scabbed area noted to outside of left ankle (approximately) 1/3 of an inch in length and (approximately) 1/5 of an inch in width, small cut noted to area just below left knee to the outside (approximately) 1/10 of an inch circumference; two areas of very faint discoloration noted to right leg just below the knee. Staff directed to apply antibiotic ointment to area on ankle and to bandage as needed."			

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	A review of client #5's BSP, dated 2/24/14, was conducted on 5/2/14 at 1:45 PM. The BSP did not include a plan to address what the overnight shift staff should do if client #5 woke up prior to a second staff arriving at the home at 6:00 AM when there was one staff on duty during the overnight shift (10:30 PM to 6:00 AM). On 5/2/14 at 1:24 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he did not think staff #4 did anything incorrectly. The QIDP indicated the investigation was inconclusive. The QIDP indicated prior to the incident, staff #4 had shut and locked client #1's bedroom door and would not have known client #1 got up and opened the door. The QIDP indicated he did not think staff #4 was negligent. The QIDP indicated it was the responsibility of the group home staff to ensure the clients were safe at their home. On 5/5/14 at 12:27 PM, the Director of Supervised Group Living (Director) indicated client #5 woke up early which was unusual for him. Staff #4 assisted client #5 with a shower and breakfast. While staff #4 was loading the dishwasher, client #5 walked out and went into client #1's bedroom. Staff #4			

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	heard client #5 in client #1's bedroom and intervened. The Director indicated following the incident, she spoke with the Home Manager about being on call if client #5 woke up early and group home needed additional staffing. The Director indicated staff #4 received retraining. The Director indicated she needed to review the composition of the clients at the group home to maintain safety. The Director indicated the investigation was inconclusive about whether or not neglect was substantiated. 9-3-2(a)			
W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. 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. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure there was sufficient staff to implement the clients' program plans during the overnight shift.	W000186	W186 Plan of correction: A second overnight staff has been added to the facility's master schedule to ensure management and supervision of clients in accordance with individual	06/06/2014

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	Findings include: 1) A review of the facility's evacuation drills was conducted on 5/1/14 at 2:22 PM. On 12/4/13 at 10:30 PM an overnight shift (10:00 PM to 6:00 AM) fire drill was conducted with three staff (the Qualified Intellectual Disabilities Professional, Home Manager and one direct care staff). The drill took 23 minutes to complete. The drill indicated, in part, "All clients asleep. [Client #4] and [client #6] couldn't hear the alarm, were confused and combative while trying to convince them what we were doing. [Client #5] went into a tantrum, with SIBs (self injurious behavior); very groggy due to his high HS (hour of sleep) dose of Seroquel. [Client #1] refused to get out of bed and was yelling at staff, took the longest to engage in the drill. [Clients #1 and #6] both required multiple prompts." The plan of correction for the drill indicated, "The team will discuss. A plan will be put in place to ensure efficient evacuation of all clients. The team will execute more drills to address the time issue." On 3/18/14, a fire drill was conducted taking 2 minutes was conducted with three staff present. On 3/20/14 at 5:54 AM, a fire drill was conducted taking 1 minute and 33 seconds to complete with three staff present. On 3/22/14 at 5:50 AM, a fire		program plans. Plan of prevention: All staff, including the additional overnight staff, are trained on all clients' individual program plans. Competency based tests will administered to all new staff supporting clients in the facility. Quality Assurance Monitoring: Facility coordinator will complete Quality Assurance Checklist monthly, which includes monitoring for sufficient staff to implement individual program plans.	

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	drill was conducted taking 2 minutes to complete with two staff. On 4/4/14 at 6:00 AM, a fire drill was conducted taking 1 minute and 45 seconds to complete with four staff. On 4/6/14 at 5:50 AM, a fire drill was conducted taking 3 minutes to complete with two staff. On 4/26/14 at 5:50 AM, a fire drill was conducted taking 4 minutes to complete with two staff. A review of the facility's Emergency Fire Drill Evacuation Plan, not dated, was conducted on 5/2/14 at 2:22 PM. The plan indicated, "In the event of an emergency, especially one that occurs during the hours of 10P and 6A, when one staff is present, staff should do the following: 1) Alert all clients by knocking on their doors. 2) Awake [client #5] and take him out to his [name] van and ensure that he is safe. 3) Ensure that [client #3] is awake and have him exit the house, if he has done so independently. 4) Ensure that [client #6] is awake and assist him in preparing to leave the house. 5) Ensure that [client #1] is awake and assist him in preparing to leave the house. 6) If [client #4] is not already up, prompt him with physical and verbal cues to get him moving. 7) Assist [client #2] with getting out of the house into the van."			

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	On 5/1/14 at 2:55 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated staffing had not increased during the overnight shift. The QIDP indicated there was one staff working during the overnight shift. The QIDP indicated the current overnight staff was new so the QIDP had additional staff work during the evacuation drills to ensure the drills were implemented correctly. The QIDP stated, "We have clients who roam." The QIDP stated, "We need to ensure the drills go without blips and hiccups. We don't want anything to happen. The second staff ensures no one wanders into the street." The QIDP indicated the second staff was there to ensure things run smoothly. The QIDP stated, "I don't have the power to add a second staff to the overnight." On 5/2/14 at 1:24 PM, the QIDP indicated normally during the overnight shift there was one staff working. The QIDP indicated an evacuation drill had not been completed in the past few months with one staff during the overnight shift. On 5/5/14 at 1:19 PM, the Director of Supervised Group Living indicated the night shift (10:30 PM to 6:00 AM) was supervised by one staff. The Director indicated additional staff were brought in to conduct intensive teaching and training during the drills. The Director indicated			

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	one staff conducted the drills with the additional staff there to ensure the drill ran without issues. The Director indicated the targeted time for conducting drills was 90 seconds. The Director indicated one staff was able to evacuate the home in 90 seconds. The Director indicated the facility had not had an overnight drill with one staff to ensure one staff could complete the drill in the targeted time. 2) On 5/1/14 at 12:50 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/23/14 at 5:10 AM, client #5 was in the kitchen with staff as staff was loading the dishwasher. Client #5 just finished breakfast and was hanging around the kitchen. Client #5 appeared to be in a good mood. As staff was filling the dishwasher, staff heard client #1 scream. Client #5 had walked off when staff had his back turned. When staff got to client #1's room, client #5 had pulled client #1 out of bed and was on top of him. Client #1 had several bite marks on him, three on his legs and 3 on his shoulder. The investigation, dated 4/30/14, indicated the following in the Statement of Findings section, "The mechanics of the incident that lead (sic) to [client #1's] victimization are fairly simple: [staff #4] turned his attention			

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	away from [client #5] for just long enough for [client #5] to dart to [client #1's] room and attack him. Stone Belt's definition of neglect is as follows: Neglect: Any action of behavioral interventions that risks that physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan. It could be argued that [staff #4] failed to provide a safe environment for [client #1] and [client #5] by allowing his attention to stray from [client #5's] whereabouts to the matter of loading the dishwasher, though in that latter function he was arguably providing clients with a sanitary environment. Still, client safety in the short term must take precedence over cleanliness. It could also be stated that [staff #4] allowed his level of supervision of [client #5] to become inappropriate in the moment he took to load the dishwasher. However, a careful reading of [client #5's] BSP (Behavior			

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	Support Plan) reveals the following: From [client #5's] Behavior Support Plan (2/24/14): [Client #5] will have a specific staff member assigned as his dedicated staff (intensive staffing), in anticipation of [client #5] waking in the morning, and during each shift, except the overnight shift... During overnight shifts, the night aide needs to be aware of [client #5's] whereabouts for safety reasons. [Client #5] does not need a dedicated staff during the night because he rarely wakes up during the night and his roommates sleep with their bedroom doors closed with pop locks. All staff working around [client #5] as well as his dedicated staff must always be aware of where [client #5] is, what he is doing, what he is looking at and what mood he is in. Often, [client #5's] aggression comes and goes; while he may appear calm, he had been observed to aggress without visible provocation." An interview with the behaviorist included in the investigation indicated, in part, "[Behaviorist] felt that [name of group home] needs extra night-time staff in order to ensure a safe environment." A review of client #5's BSP, dated 2/24/14, was conducted on 5/2/14 at 1:45 PM. The BSP did not include a plan to address what the overnight shift staff should do if client #5 woke up prior to a			

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	second staff arriving at the home at 6:00 AM when there was one staff on duty during the overnight shift (10:00 PM to 6:00 AM). On 5/2/14 at 1:24 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility could not implement client #5's plan for dedicated staffing and staff the other 5 clients with one staff. The QIDP stated, "The facility can't implement [client #5's] dedicated staffing pattern with one staff. It's not possible to implement [client #5's] plan to high enough degree to sufficiently supervise the other clients appropriately. Can't provide active treatment to others with [client #5] awake." The QIDP indicated there was no plan in place to call in additional staff when client #5 woke up during the overnight shift. On 5/5/14 at 12:27 PM, the Director of Supervised Group Living indicated one staff was sufficient to supervise the clients during the night shift (10:30 PM to 6:00 AM). The Director stated the incident involved some choices made by the staff that "were mistakes." The Director indicated the facility was assessing the staffing situation during the overnight shift. This deficiency was cited on 3/14/14.			

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)			
W000189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure staff received initial and continuing training to enable the staff to perform their duties effectively, efficiently and competently. Findings include: On 5/1/14 at 12:50 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 4/16/14 at 8:15 AM, the Bureau of Developmental Disabilities Services (BDDS) report, dated 4/16/14, indicated, "[Client #1] was in his room waiting for an appointment. [Client #5] was in the	W000189	W189 Plan of correction: Training protocols for the facility operated day program and facility residence have been audited to specify that the coordinator will train staff and/or determine who is able to become a trainer. The facility training checklist has been updated, which includes facility and client specific training. Facility staff have completed competency based training on all clients' behavior support plans on 5/9/14 and 5/23/14. Plan of prevention: Competency based training will be completed when changes are made to clients' behavior support plans by facility coordinator or designated representative. Facility staff will participate in facility's monthly	06/06/2014

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	living room with his one on one staff (#7) and an additional staff that was training (#8). [Client #5] was given choices of what he could do, and he started walking to his room. Instead of going to his room, he entered the (sic) [client #1's] room. [Client #5] aggressed upon [client #1], opening up a wound on his check (cheek) and above his lip. Staff entered the room and got between the two clients and prompted [client #5] to do to his room. [Client #5] had a tantrum in his room. Staff provided first aid to [client #1]. Staff waited for [client #5] to calm, then helped him clean up and talked about keeping his hands to himself. [Client #5] is scheduled to have his blood drawn due to possible coming in contact with another client's blood." The investigation, dated 4/22/14, indicated, in part, "The attack on [client #1] resulted in significant injuries that reveal that [client #5] had an extended amount of time in which to aggress upon his victim. [Client #5's] 1 on 1 (one on one) staff had a responsibility to remain within arm's reach of [client #5] while he was in the house with other clients, in order to provide a safe environment for other clients. There was a failure to provide that care." The findings of the investigation indicated, "It is the finding of this investigation that the two staff		trainings. Additional trainings may be provided at weekly house meetings as need is determined by support team. Quality Assurance Monitoring: The need for additional staff training will be reviewed by the support team during monthly meeting and/or following incident reports and implemented during weekly house meetings and/or individual training sessions.	

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	members who were assigned to work with [client #5] - [staff #7 and #8] - were neglectful in their failure to provide a safe environment and an appropriate level of supervision and care." The investigation indicated, in part, "Training issues: These interviews have revealed that there may be issues with the training of new staff at [name of group home]. If [staff #8] was supposed to be [client #5's] 1 on 1 at the time of the incident, it is unclear that this was made clear to him. This could be due to an isolated situation of neglect or it could be indicative of a need for greater oversight of the training process for staff. It seems clear that [client #5's] potential to become immediately dangerous and destructive to other clients may not have been adequately understood by [staff #8]. The techniques for training new staff to work with a potentially aggressive client like [client #5] do not appear to be standardized (some staff reported that a few days of observation are necessary, while other (sic) put a trainee in the position of being [client #5's] 1 on 1 on his second morning). Also, the 'client info checklist' that some supervisors believe is being used to train new staff does not appear to be in use anymore." On 5/2/14 at 11:20 AM, an interview			

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	with the Life Long Learning Coordinator (Day Program) indicated he had not yet developed a train-the-trainer checklist for client #5 as recommended in the investigation. On 5/5/14 at 1:19 PM, the Director of Supervised Group Living (Director) indicated the facility needed to develop a train-the-trainer checklist. 2) On 4/23/14 at 5:10 AM, client #5 was in the kitchen with staff #4 as staff #4 was loading the dishwasher. Client #5 just finished breakfast and was hanging around the kitchen. Client #5 appeared to be in a good mood. As staff #4 was filling the dishwasher, staff #4 heard client #1 scream. Client #5 had walked off when staff #4 had his back turned. When staff got to client #1's room, client #5 had pulled client #1 out of bed and was on top of him. Client #1 had several bite marks on him, three on his legs and 3 on his shoulder. The preliminary investigation, dated 4/30/14, indicated the following in the Statement of Findings section, "The mechanics of the incident that lead (sic) to [client #1's] victimization are fairly simple: [staff #4] turned his attention away from [client #5] for just long enough for [client #5] to dart to [client			

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	#1's] room and attack him...". The findings of the investigation indicated, in part, "As overnight staff, [staff #4] was not required to be within arm's reach of [client #5] at the time of the incident. There are discrepancies about the use of pop locks on bedroom doors and how to support clients' choice of not follow (sic) the house restriction of locking doors at night. This investigation into the allegation of neglect is inconclusive in regard to this individual staff member." The preliminary investigation indicated, "In examining the house restrictions for [name of group home], however, the following comes to light: From Human Rights [name of group home] Revised April 17, 2013: Restriction #4: Button Release Locks on Bedroom Doors. Rationale: A resident entered another resident's room during the night and bit his peer on the back. During evening hours there is only one staff on duty, and should another resident need staff attention during the night, this resident needs to be prevented from entering the rooms of other residents. Therefore bedroom doors will remain closed during the nighttime hours with the use of button release locks that prevent entry from the hall to the room, but do not prevent exit by the resident of the room. This provides another level of prevention			

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	should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom. Training: This resident has a behavior plan in effect to address his aggression toward others. This restriction will be evaluated annually to determine the continued need. Progress: The resident has improved and had had a reduction of aggressive behavior. However, he still needs the restriction to remain in place for the safety of all residents. The risk that [client #5] might enter other clients' rooms and cause them harm was addressed in this restriction. The way it is worded does seem to imply that staff will be responsible for keeping all doors closed and locked throughout the night. It is not clear how the staff were to be trained on this aspect of the job, and it has been difficult to obtain documentation of this training occurring with veteran or new staff members. This brings forward a more significant finding of this investigation: There appears to be a systemic problem with staff training at [name of group home]." The preliminary investigation indicated, in part, "There appears to be a larger issue involving teaching and training of staff, in that it is not clear that [name of group home] staff members are being properly trained and their training			

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	properly documented. As this finding constitutes a 'failure to provide appropriate supervision, care, or training,' this investigation finds that there has been substantiated neglect on the part of the supervisory team responsible for providing training and ensuring its effectiveness. There could be many explanations for this deficiency - short staffing, unclear directives, ineffective communication - but the bottom line is that action must be taken to correct this tendency and ensure the safety of clients and staff. Some considerations: Competency-based training and assessment protocols need to be put in place and followed to ensure new staff members are being trained adequately to work with one of Stone Belt's most challenging clients." The investigation indicated, in part, "It has been difficult to obtain copies of competency based training forms that document that [name of group home] staff were trained to consistently close and lock client doors during the overnight shift or during other shifts. In looking for evidence of ongoing inservice trainings that related to the incident at hand, this investigator found little documentation in the past four months of such training." The investigation indicated an interview with the behaviorist was conducted on 4/24/14. The behaviorist indicated, "...a			

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	huge problem at [name of group home] is that the behaviorist is not informed when new staff members are hired until there's an incident. [Behaviorist] stated that new staff are supposed to be trained by [Qualified Intellectual Disabilities Professional (QIDP)] on BSPs... [Behaviorist] is familiar with the competency-based questionnaire used for training on the BSP, but does not have any for [name of group home]... The QIDP indicated in the investigation the behaviorist was not involved in training on [client #5's] BSP." The final investigation, dated 4/30/14, indicated, "...There appears to be discrepancies in how [staff #4] was trained in regards to use of pop locks on client bedrooms and monitoring the hallway if a client's door is open. Agency policy states that staff should complete a competency based training form on BSPs. It is unclear if this training took place according to policy." On 5/5/14 at 1:19 PM, the Director of Supervised Group Living (Director) indicated the training needed to be consistent and inclusive for all the clients living in the group home. The Director indicated both investigations had findings related to staff training and it needed to be addressed.			

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	9-3-3(a)			
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (#4), the facility's nursing services failed to ensure staff implemented client #4's plan for diabetes. Findings include: A review of client #4's record was conducted on 5/1/14 at 12:44 PM. Client #4's Medication Information Sheet (MIS), dated 4/3/14, indicated he had a risk plan for High Blood Sugar Readings. The plan indicated when his blood sugar readings were between 251 to 400, the staff were to hold snacks (not meals), push water, encourage activity (walking), and recheck his blood sugar in 2 hours. The Medication Log, dated April 2014, indicated there were eight times (4/3/14, 4/5/14, 4/6/14, 4/12/14, 4/17/14, 4/24/14, 4/25/14, and 4/28/14) when client #4's blood sugar was between 251 to 400. There was no documentation client #4's blood sugar was rechecked after two hours. On 4/3/14 and 4/11/14, the	W000331	W331 Plan of correction: Facility staff have been retrained on client #4's blood sugar risk plan, 5/23/14. Use of a timer has been implemented to alert staff when a recheck of blood sugar is needed, according to risk plan. Staff will implement buddy check system to ensure risk plan is implemented in accordance with client needs. Plan of prevention: House training checklist will be completed for staff, which includes but is not limited to procedures on health, medication, risk plans and diabetes standing orders. Quality Assurance Monitoring: To ensure proper implementation and documentation of client #4's risk plan, the facility coordinator will call the facility (or email the facility using group email which includes all current staff), every morning and every evening to remind DSP staff to review, follow and correctly document client #4's diabetes risk plan for the next three months. The coordinator will review and revise the monitoring plan after three months with facility staff input to	06/06/2014

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	facility's nurse documented in client #4's record he reviewed the diabetes documentation and found no issues. The facility's nursing services failed to ensure the staff implemented the plan to recheck client #4's blood sugar after two hours. On 5/2/14 at 1:24 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4's diabetes plan should be implemented as written. The QIDP indicated the facility management and nursing staff should have reviewed and caught the rechecks were not being completed. The QIDP indicated the direct care staff also have another staff check their medication pass after completing it and the other staff should have caught the recheck was not being completed. On 5/5/14 at 1:19 PM, the Director of Supervised Group Living indicated the facility should ensure the staff implemented and documented the implementation of client #4's diabetes protocol. On 5/1/14 at 4:27 PM, the facility's nurse indicated the staff should recheck client #4's blood sugar after two hours, per the plan, and document the reading in the record.		continue to ensure the plan is implemented as written.	

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	This deficiency was cited on 3/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			
W000449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to take appropriate corrective action to address issues noted during evacuation drills. Findings include: A review of the facility's evacuation drills was conducted on 5/1/14 at 2:22 PM. On 12/4/13 at 10:30 PM an overnight shift (10:00 PM to 6:00 AM) fire drill was conducted with three staff (the Qualified Intellectual Disabilities Professional, Home Manager and one direct care staff). The drill took 23 minutes to complete. The drill indicated, in part, "All clients asleep. [Client #4] and [client #6] couldn't hear the alarm, were confused and combative while trying to convince	W000449	W449 Plan of correction: A second overnight staff has been added to the facility's master schedule to ensure management and supervision of clients in accordance with individual program plans, including safe evacuation of the home for drills and emergencies. Director of SGL made an inquiry with the Bloomington Fire Department, who is familiar with the facility, in regards to evacuation plans. The Bloomington Fire Department reported that two minutes would be an appropriate time frame to evacuate the facility. The agency administration will review current evacuation policy to determine if changes are needed to the agency evacuation policy. Plan of prevention: The facility	06/06/2014

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	them what we were doing. [Client #5] went into a tantrum, with SIBs (self injurious behavior); very groggy due to his high HS (hour of sleep) dose of Seroquel. [Client #1] refused to get out of bed and was yelling at staff, took the longest to engage in the drill. [Clients #1 and #6] both required multiple prompts." The plan of correction for the drill indicated, "The team will discuss. A plan will be put in place to ensure efficient evacuation of all clients. The team will execute more drills to address the time issue." On 3/18/14, a fire drill was conducted taking 2 minutes was conducted with three staff present. On 3/20/14 at 5:54 AM, a fire drill was conducted taking 1 minute and 33 seconds to complete with three staff present. On 3/22/14 at 5:50 AM, a fire drill was conducted taking 2 minutes to complete with two staff. On 4/4/14 at 6:00 AM, a fire drill was conducted taking 1 minute and 45 seconds to complete with four staff. On 4/6/14 at 5:50 AM, a fire drill was conducted taking 3 minutes to complete with two staff. On 4/26/14 at 5:50 AM, a fire drill was conducted taking 4 minutes to complete with two staff. A review of the facility's Emergency Fire Drill Evacuation Plan, not dated, was conducted on 5/5/14 at 1:44 PM. The		specific evacuation plan will be revised to include a second staff. The facility will conduct one overnight fire drill a month for the next quarter. Quality Assurance Monitoring: Facility coordinator will review drill reports, any problems or accidents during drills will be reviewed by support team and corrective action implemented as needed. Director will review the drill reports and implementation of any corrective action needed.	

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	plan indicated, "In the event of an emergency, especially one that occurs during the hours of 10P and 6A, when one staff is present, staff should do the following: 1) Alert all clients by knocking on their doors. 2) Awake [client #5] and take him out to his [name] van and ensure that he is safe. 3) Ensure that [client #3] is awake and have him exit the house, if he has done so independently. 4) Ensure that [client #6] is awake and assist him in preparing to leave the house. 5) Ensure that [client #1] is awake and assist him in preparing to leave the house. 6) If [client #4] is not already up, prompt him with physical and verbal cues to get him moving. 7) Assist [client #2] with getting out of the house into the van." On 5/1/14 at 2:55 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated staffing had not increased during the overnight shift. The QIDP indicated there was one staff working during the overnight shift. The QIDP indicated the current overnight staff was new so the QIDP had additional staff work during the evacuation drills to ensure the drills were implemented correctly. The QIDP stated, "We have clients who roam." The QIDP stated, "We need to ensure the drills go without blips and hiccups. We don't want			

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	anything to happen. The second staff ensures no one wanders into the street." The QIDP indicated the second staff was there to ensure things run smoothly. The QIDP stated, "I don't have the power to add a second staff to the overnight." On 5/2/14 at 1:24 PM, the QIDP indicated normally during the overnight shift there was one staff working. The QIDP indicated an evacuation drill had not been completed in the past few months with one staff during the overnight shift. On 5/5/14 at 1:19 PM, the Director of Supervised Group Living indicated the night shift (10:30 PM to 6:00 AM) was supervised by one staff. The Director indicated additional staff were brought in to conduct intensive teaching and training during the drills. The Director indicated one staff conducted the drills with the additional staff there to ensure the drill ran without issues. The Director indicated the targeted time for conducting drills was 90 seconds. The Director indicated one staff was able to evacuate the home in 90 seconds. The Director indicated the facility had not had an overnight drill with one staff to ensure one staff could complete the drill in the targeted time. This deficiency was cited on 3/14/14. The facility failed to implement a			

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	systemic plan of correction to prevent recurrence. 9-3-7(a)			