

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2014
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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W000000	<p>This visit was for the investigation of complaint #IN00151850.</p> <p>Complaint #IN00151850 - Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149, W153, W154 and W249.</p> <p>Survey Dates: July 16 and 17, 2014</p> <p>Facility Number: 001209 Provider Number: 15G634 AIM Number: 100240160</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/24/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for</p>	W000149	Addendum: Facility #:	07/18/2014

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

TITLE

(X6) DATE

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

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	<p>1 of 49 incident/investigative reports reviewed affecting client B, the facility neglected to submit a Bureau of Developmental Disabilities Services (BDDS) report in a timely manner and conduct a thorough investigation of the incident.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/16/14 at 8:52 AM and indicated the following:</p> <p>On 6/23/14 at 9:00 PM, the BDDS report, dated 6/25/14, indicated, "When staff arrived, [client B] was in the road spraying cars with the hose. As staff pulled in the driveway he ran at staff's car and sprayed it down. For the entirety of three hours staff tried talking with [client B] about coming out of the road and not running at or spraying cars as they are driving by the house. [Client B] would not listen to the prompts or the options staff would give him. Staff would ask him if he wanted to go into the formal room and talk. He would simply yell, 'Nuh uh' and then attempt to spray staff with the hose or act as if he were throwing something at me. This continued until about 12:03 am. At this point [client E] had been woken up by</p>		<p>001209 Provider #: 15G634 Survey Event ID: GWCG11 Survey Date: July 17, 2014 W149-A more frequent monitoringsystem is initially needed to ensure compliance. House manager / assistant manager (weekends) will provide daily monitoring to ensure that all incidents are reported in a timely manner. House Coordinator will cover one shift weekly and provide training on reporting abuse and neglect. This may taper down to twice monthly when the behaviors decrease in the home and staff who are comfortable in following bsp are selected, trained, and scheduled. Facility Director covers a minimal of one shift weekly of direct care that will taper down to one shift monthly until issues are resolved or other housing arrangements are made for problematic housemate situation. Team will continue to meet weekly to discuss. W149 483.420 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Corrective action for resident(s) found to have been affected (Plan of correction) Client's behavior consultant has revised behavior plan and trained staff on behavior strategies including restraints when deemed necessary. (Attachment W149-A) (Attachment W149-B) How</p>				

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	[client B's] yelling and he was curious about what was happening. Staff was able to have [client E] go back to his room and avoid extra conflict, but [client B] was still attempting to spray cars that were driving by the house. Around 12:07 (AM) staff turned the water off. [Client B] ran to the faucet where staff was standing and attempted to hit and bite staff. Staff told him that we couldn't have him running around in the road when cars were driving by because it was not safe for him or the people driving. He constantly was saying 'nuh uh.' After multiple attempts to hit and bite staff, staff told [client B] that he may have to be escorted to his room or put in a hold to prevent him and staff from getting injured. He continued to attempt to hit and bite staff and even attempted to go after another car even though the water was off. At that point staff put [client B] in a basket hold for approximately 2 minutes until releasing him. At this point they were standing in the entrance way. After [client B] was released, he attempted to hit staff with his shoes but calmed down after a few minutes and started to help staff clean up the mud that he tracked into the hallway. Plan to Resolve: [client B] calmed down, they talked about what had happened, and they cleaned some of the house together." The facility did not indicate who the staff was		facility will identify other residents potentially affected & what measures taken – (Plan of identify and plan of correction) All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility coordinator and house manager will complete weekly observations of interactions between direct care staff and provide training of behavior plans as needed (<i>Attachment – 149C</i>). How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility director and behavior consultant will provide monthly observations and provide training as needed .				

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	<p>who was working with client B during the incident in the BDDS report. The facility did not provide documentation the incident was investigated. The facility did not submit the report to BDDS in a timely manner. The facility did not have documentation in client B's record of the facility's internal incident report regarding the incident.</p> <p>On 7/17/14 at 10:52 AM, the facility provided the Stone Belt ARC, Inc. Incident Report (IR), dated 6/23/14 - 6/24/14. The IR was completed by staff #7. The IR indicated the timeframe for the incident was 9:55 PM - 12:50 AM. The IR indicated, in part, "Before I arrived at the home, [client B] was in the road spraying cars with the hose. As I pulled in the driveway he ran at my car and sprayed it down. For the entirety of three hours I tried talking with [client B] about coming out of the road and not running at or spraying cars as they are driving by the house. During this time I was in contact with [Coordinator] and he was made aware of the situation... I was able to escort [client E] back to his room and avoid extra conflict, but [client B] was still attempting to spray cars that were driving by the house. Around 12:07 AM I turned the water off. [Client B] ran to the faucet where I was standing and attempted to him and bite me... After</p>						

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	<p>multiple attempts to hit and bite me and even attempted to go after another car even though the water was off. At that point I put [client B] in a basket hold for approximately 2 minutes until releasing him. At this point we were standing in the entrance way... For a more detailed account, there is an Active Treatment Monitoring sheet in the office." There was no documentation on the form indicating the Psychiatric pager was contacted.</p> <p>A review of client B's record was conducted on 7/17/14 at 11:46 AM. There was no documentation in client B's record of an Active Treatment Monitoring sheet in the record. The facility did not provide documentation of the Active Treatment Monitoring sheet. Client B's 6/11/14 Behavior Plan indicated client B had a targeted behavior of elopement. The plan indicated, in part, "During the overnight shifts, between 10P and 8A, when only one staff is at [name of group home], it can be challenging to proactively address [client B's] behavior and support the other clients in the house. If [client B] leaves the house during this shift, crosses to [name of street], and is not visible, staff will call the Emergency Pager and 911. If [client B] is still within staff sight, but has repeatedly left the property or is in</p>			

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	<p>[name of group home] drive, staff will call the Emergency Pager and may request that the Psychiatric pager be called."</p> <p>On 7/16/14 at 6:09 AM, staff #7 indicated he was working with client B during the incident on 6/23/14. Staff #7 indicated when he arrived, client B was outside spraying cars, which had occurred multiple times in the past. Staff #7 indicated client B was threatening to elope from the group home. Staff #7 indicated he was the only staff working during the incident. Staff #7 indicated he spoke, during the incident, to the Coordinator on the phone during the incident. Staff #7 indicated he was afraid during the incident client B was going to get hit by a car. Staff #7 indicated the incident ended, several hours later, when he unhooked the hose. Staff #7 indicated there was a second staff present who left the group home at the end of his shift in the middle of the incident. Staff #7 indicated the facility did not have enough staff during the overnight shift to provide adequate supervision. Staff #7 indicated during the incident, he was outside with client B leaving clients A, C, D and E unsupervised in the group home. On 7/17/14 at 10:33 AM, staff #7 indicated when he arrived to the group home, staff #2 was present but left soon after staff #7</p>			

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	<p>arrived for his shift. Staff #7 indicated it may have been helpful for staff #2 to stay but he was not sure having two staff would have been beneficial. Staff #7 indicated he stayed at the doorway to the group home during the incident doing his best to keep client B in line of sight and ensure clients A, C, D and E were safe in the home. Staff #7 indicated he was on the phone with his supervisor (Coordinator) during some of the time following the directives he was receiving from the Coordinator. Staff #7 indicated he had attempted to turn off the hose and unhook it earlier during the incident however when he did, client B aggressed toward staff #7.</p> <p>On 7/16/14 at 1:11 PM, the Coordinator indicated a BDDS report should be submitted within 24 hours of the incident. The Coordinator indicated he was unsure why the report was submitted late. The Coordinator indicated the incident on 6/23/14 was a new behavior client B had not exhibited before. He indicated he was on the phone with staff #7 during the incident. The Coordinator indicated staff #7 was attempting to avoid having client B going further out into the road and they (Coordinator and staff #7) were concerned about client B eloping from the group home. The Coordinator indicated he could not recall why, but he</p>			

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	<p>was unable to go to the house to assist staff #7 during the incident. The Coordinator indicated a formal investigation was not conducted. The Coordinator indicated he was comfortable, since he was on the phone during part of the incident, that staff #7 acted correctly and interacted correctly with client B. The Coordinator stated there were "probably" two staff there when he was spraying cars but he was not sure. The Coordinator indicated staff #7 called him after the second staff had left the group home. The Coordinator indicated staff #7 was trying to avoid, at all costs, restraining client B which may have made the situation worse. The Coordinator indicated it took staff #7 over 3 hours to turn off the water due to being at the group home by himself. The Coordinator indicated if staff #7 turned the water off earlier, client B may have eloped. The Coordinator indicated staff #7 was continuously interacting with client B to slow him down since there was not a continuous stream of cars. The Coordinator indicated staff #7 stayed at the doorway of the group home during the incident to ensure supervision of both client B and clients A, C, D and E. The Coordinator indicated staff #7 was successful in managing client B's behavior during the incident. Staff #7 stayed calm and redirected client B. The</p>			

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	<p>Coordinator indicated one staff during the overnight shift was sufficient to provide supervision of the clients. The Coordinator indicated it would have been helpful to have additional staff but staff #7 did the best he could in the situation. The Coordinator indicated client B was not injured, client B returned to the house, and no one else got injured. The Coordinator indicated there were no changes to client B's plan following the incident and there were no changes in the staffing level at the home. The Coordinator indicated the psychiatric pager was not called on 6/23/14 during the incident. The Coordinator indicated, in the past, client B would calm down once the psychiatric pager came to the house and then the behavior resumed when the psychiatric pager staff left the home.</p> <p>On 7/17/14 at 12:16 PM, the Supervised Group Living Director (SGLD) indicated she was unsure why the staff allowed client B's behavior to go on for so long. The SGLD indicated the facility should have obtained additional information regarding the incident. The SGLD indicated she was unsure why the Stone Belt ARC, Inc. Incident Report, dated 6/23/14 and the BDDS report, dated 6/25/14, did not match for the incident times. The SGLD indicated the BDDS</p>			

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	<p>report should have been submitted within 24 hours. The SGLD indicated staff #7 and the Coordinator should have ensured client B's plan to contact the psychiatric pager was implemented as written. The SGLD indicated had the staff contacted the psychiatric pager, additional staff assistance could have been requested.</p> <p>On 7/17/14 at 12:27 PM, the Staffing Assistant (SA) indicated staff #7 arrived to the group home, based on his clock in time, at 9:55 PM. The SA indicated staff #2 was scheduled to work until 10:30 PM however he clocked out at 9:52 PM. The SA indicated staff #2 should have worked until 10:30 PM.</p> <p>On 7/17/14 at 12:05 PM, the Program Support Staff (PSS) indicated the timeframe for submitting BDDS reports was 24 hours. The PSS indicated he should have ensured he submitted the BDDS report in a timely manner. The PSS indicated the report was late due to initially thinking the incident occurred on 6/24/14 instead of 6/23/14 when the incident started.</p> <p>On 7/16/14 at 8:47 AM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing</p>			

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	<p>the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law. Events Requiring Investigations. Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over client support; misuse of client or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct. This does not</p>			

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	<p>replace the obligation of employees to report immediately to supervisors, directors or to write incident reports. This provides for another level of notification beyond, and in addition to, incident reporting. The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days... Investigations must be started within 24 hours.</p> <p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events."</p> <p>This federal tag relates to complaint #IN00151850.</p> <p>9-3-2(a)</p>						

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 49 incident/investigative reports reviewed affecting client B, the facility failed to ensure a Bureau of Developmental Disabilities Services (BDDS) report was submitted within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/16/14 at 8:52 AM and indicated the following:</p> <p>On 6/23/14 at 9:00 PM, the BDDS report, dated 6/25/14, indicated, "When staff arrived, [client B] was in the road spraying cars with the hose. As staff pulled in the driveway he ran at staff's car and sprayed it down. For the entirety of three hours staff tried talking with [client B] about coming out of the road and not running at or spraying cars as they are</p>	W000153	<p>W153 483.420 (d)(2) Corrective action for resident(s) found to have been affected (Plan of correction) Facility staff have been trained on reporting abuse and neglect in a timely manner. <i>(Attachment W153-A)</i> How facility will identify other residents potentially affected & what measures taken – (Plan of identify and plan of correction) All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility staff will be trained monthly on reporting abuse and neglect protocol <i>(Attachment W149-C)</i>. How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility director will facilitate or review these trainings monthly and provide additional training as needed.</p>	07/18/2014			

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	driving by the house. [Client B] would not listen to the prompts or the options staff would give him. Staff would ask him if he wanted to go into the formal room and talk. He would simply yell, 'Nuh uh' and then attempt to spray staff with the hose or act as if he were throwing something at me. This continued until about 12:03 am. At this point [client E] had been woken up by [client B's] yelling and he was curious about what was happening. Staff was able to have [client E] go back to his room and avoid extra conflict, but [client B] was still attempting to spray cars that were driving by the house. Around 12:07 (AM) staff turned the water off. [Client B] ran to the faucet where staff was standing and attempted to hit and bite staff. Staff told him that we couldn't have him running around in the road when cars were driving by because it was not safe for him or the people driving. He constantly was saying 'nuh uh.' After multiple attempts to hit and bite staff, staff told [client B] that he may have to be escorted to his room or put in a hold to prevent him and staff from getting injured. He continued to attempt to hit and bite staff and even attempted to go after another car even though the water was off. At that point staff put [client B] in a basket hold for approximately 2 minutes until releasing him. At this point			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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	<p>they were standing in the entrance way. After [client B] was released, he attempted to hit staff with his shoes but calmed down after a few minutes and started to help staff clean up the mud that he tracked into the hallway. Plan to Resolve: [client B] calmed down, they talked about what had happened, and they cleaned some of the house together." The facility did not submit the report to BDDS within 24 hours, in accordance with state law.</p> <p>On 7/16/14 at 1:11 PM, the Coordinator indicated a BDDS report should be submitted within 24 hours of the incident. The Coordinator indicated he was unsure why the report was submitted late.</p> <p>On 7/17/14 at 12:16 PM, the Supervised Group Living Director (SGLD) indicated the BDDS report should have been submitted within 24 hours.</p> <p>On 7/17/14 at 12:05 PM, the Program Support Staff (PSS) indicated the timeframe for submitting BDDS reports was 24 hours. The PSS indicated he should have ensured he submitted the BDDS report in a timely manner. The PSS indicated the report was late due to initially thinking the incident occurred on 6/24/14 instead of 6/23/14 when the incident started.</p>			

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W000154	<p>This federal tag relates to complaint #IN00151850.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 49 incident/investigative reports reviewed affecting client B, the facility failed to conduct a thorough investigation of an incident.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/16/14 at 8:52 AM and indicated the following:</p> <p>On 6/23/14 at 9:00 PM, the BDDS report, dated 6/25/14, indicated, "When staff arrived, [client B] was in the road spraying cars with the hose. As staff pulled in the driveway he ran at staff's car and sprayed it down. For the entirety of three hours staff tried talking with [client B] about coming out of the road and not</p>	W000154	<p>W154 483.420 (d)(3) Corrective action for resident(s) found to have been affected (Plan of correction) Facility staff have been trained on reporting abuse and neglect in a timely manner (<i>Attachment W154</i>). Facility coordinator / Qipd has been trained to investigate all incidents of abuse and neglect. How facility will identify other residents potentially affected & what measures taken – (Plan of identify and plan of correction) All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility coordinator / Qipd will complete investigations of all reported abuse and neglect or refer the case to social work department to initiate the investigation</p>	07/18/2014

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	<p>running at or spraying cars as they are driving by the house. [Client B] would not listen to the prompts or the options staff would give him. Staff would ask him if he wanted to go into the formal room and talk. He would simply yell, 'Nuh uh' and then attempt to spray staff with the hose or act as if he were throwing something at me. This continued until about 12:03 am. At this point [client E] had been woken up by [client B's] yelling and he was curious about what was happening. Staff was able to have [client E] go back to his room and avoid extra conflict, but [client B] was still attempting to spray cars that were driving by the house. Around 12:07 (AM) staff turned the water off. [Client B] ran to the faucet where staff was standing and attempted to hit and bite staff. Staff told him that we couldn't have him running around in the road when cars were driving by because it was not safe for him or the people driving. He constantly was saying 'nuh uh.' After multiple attempts to hit and bite staff, staff told [client B] that he may have to be escorted to his room or put in a hold to prevent him and staff from getting injured. He continued to attempt to hit and bite staff and even attempted to go after another car even though the water was off. At that point staff put [client B] in a basket hold for approximately 2</p>		<p><i>(Attachment W154).</i> How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility director will facilitate or review these trainings monthly and provide additional training as needed.</p>	

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	<p>minutes until releasing him. At this point they were standing in the entrance way. After [client B] was released, he attempted to hit staff with his shoes but calmed down after a few minutes and started to help staff clean up the mud that he tracked into the hallway. Plan to Resolve: [client B] calmed down, they talked about what had happened, and they cleaned some of the house together." The facility did not indicate who the staff was who was working with client B during the incident in the BDDS report. The facility did not provide documentation the incident was investigated. The facility did not have documentation in client B's record of the facility's internal incident report regarding the incident.</p> <p>On 7/17/14 at 10:52 AM, the facility provided the Stone Belt ARC, Inc. Incident Report (IR), dated 6/23/14 - 6/24/14. The IR was completed by staff #7. The IR indicated the timeframe for the incident was 9:55 PM - 12:50 AM. The IR indicated, in part, "Before I arrived at the home, [client B] was in the road spraying cars with the hose. As I pulled in the driveway he ran at my car and sprayed it down. For the entirety of three hours I tried talking with [client B] about coming out of the road and not running at or spraying cars as they are driving by the house. During this time I</p>				

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	<p>was in contact with [Coordinator] and he was made aware of the situation... I was able to escort [client E] back to his room and avoid extra conflict, but [client B] was still attempting to spray cars that were driving by the house. Around 12:07 AM I turned the water off. [Client B] ran to the faucet where I was standing and attempted to hit and bite me... After multiple attempts to hit and bite me and even attempted to go after another car even though the water was off. At that point I put [client B] in a basket hold for approximately 2 minutes until releasing him. At this point we were standing in the entrance way... For a more detailed account, there is an Active Treatment Monitoring sheet in the office." There was no documentation on the form indicating the Psychiatric pager was contacted.</p> <p>A review of client B's record was conducted on 7/17/14 at 11:46 AM. There was no documentation in client B's record of an Active Treatment Monitoring sheet in the record. The facility did not provide documentation of the Active Treatment Monitoring sheet. Client B's 6/11/14 Behavior Plan indicated client B had a targeted behavior of elopement. The plan indicated, in part, "During the overnight shifts, between 10P and 8A, when only one staff is at</p>						

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	<p>[name of group home], it can be challenging to proactively address [client B's] behavior and support the other clients in the house. If [client B] leaves the house during this shift, crosses to [name of street], and is not visible, staff will call the Emergency Pager and 911. If [client B] is still within staff sight, but has repeatedly left the property or is in [name of group home] drive, staff will call the Emergency Pager and may request that the Psychiatric pager be called."</p> <p>On 7/16/14 at 6:09 AM, staff #7 indicated he was working with client B during the incident on 6/23/14. Staff #7 indicated when he arrived, client B was outside spraying cars, which had occurred multiple times in the past. Staff #7 indicated client B was threatening to elope from the group home. Staff #7 indicated he was the only staff working during the incident. Staff #7 indicated he spoke, during the incident, to the Coordinator on the phone during the incident. Staff #7 indicated he was afraid during the incident client B was going to get hit by a car. Staff #7 indicated the incident ended, several hours later, when he unhooked the hose. Staff #7 indicated there was a second staff present who left the group home at the end of his shift in the middle of the incident. Staff #7</p>			

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	<p>indicated the facility did not have enough staff during the overnight shift to provide adequate supervision. Staff #7 indicated during the incident, he was outside with client B leaving clients A, C, D and E unsupervised in the group home. On 7/17/14 at 10:33 AM, staff #7 indicated when he arrived to the group home, staff #2 was present but left soon after staff #7 arrived for his shift. Staff #7 indicated it may have been helpful for staff #2 to stay but he was not sure having two staff would have been beneficial. Staff #7 indicated he stayed at the doorway to the group home during the incident doing his best to keep client B in line of sight and ensure clients A, C, D and E were safe in the home. Staff #7 indicated he was on the phone with his supervisor (Coordinator) during some of the time following the directives he was receiving from the Coordinator. Staff #7 indicated he had attempted to turn off the hose and unhook it earlier during the incident however when he did, client B aggressed toward staff #7.</p> <p>On 7/16/14 at 1:11 PM, the Coordinator indicated the incident on 6/23/14 was a new behavior client B had not exhibited before. He indicated he was on the phone with staff #7 during the incident. The Coordinator indicated staff #7 was attempting to avoid having client B going</p>			

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	further out into the road and they (Coordinator and staff #7) were concerned about client B eloping from the group home. The Coordinator indicated he could not recall why, but he was unable to go to the house to assist staff #7 during the incident. The Coordinator indicated a formal investigation was not conducted. The Coordinator indicated he was comfortable, since he was on the phone during part of the incident, that staff #7 acted correctly and interacted correctly with client B. The Coordinator stated there were "probably" two staff there when he was spraying cars but he was not sure. The Coordinator indicated staff #7 called him after the second staff had left the group home. The Coordinator indicated staff #7 was trying to avoid, at all costs, restraining client B which may have made the situation worse. The Coordinator indicated it took staff #7 over 3 hours to turn off the water due to being at the group home by himself. The Coordinator indicated if staff #7 turned the water off earlier, client B may have eloped. The Coordinator indicated staff #7 was continuously interacting with client B to slow him down since there was not a continuous stream of cars. The Coordinator indicated staff #7 stayed at the doorway of the group home during the incident to ensure supervision of both						

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	<p>client B and clients A, C, D and E. The Coordinator indicated staff #7 was successful in managing client B's behavior during the incident. Staff #7 stayed calm and redirected client B. The Coordinator indicated one staff during the overnight shift was sufficient to provide supervision of the clients. The Coordinator indicated it would have been helpful to have additional staff but staff #7 did the best he could in the situation. The Coordinator indicated client B was not injured, client B returned to the house, and no one else got injured. The Coordinator indicated there were no changes to client B's plan following the incident and there were no changes in the staffing level at the home. The Coordinator indicated the psychiatric pager was not called on 6/23/14 during the incident. The Coordinator indicated, in the past, client B would calm down once the psychiatric pager came to the house and then the behavior resumed when the psychiatric pager staff left the home.</p> <p>On 7/17/14 at 12:16 PM, the Supervised Group Living Director (SGLD) indicated she was unsure why the staff allowed client B's behavior to go on for so long. The SGLD indicated the facility should have obtained additional information regarding the incident. The SGLD</p>				

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W000249	<p>indicated she was unsure why the Stone Belt ARC, Inc. Incident Report, dated 6/23/14 and the BDDS report, dated 6/25/14, did not match for the incident times. The SGLD indicated staff #7 and the Coordinator should have ensured client B's plan to contact the psychiatric pager was implemented as written. The SGLD indicated had the staff contacted the psychiatric pager, additional staff assistance could have been requested.</p> <p>On 7/17/14 at 12:27 PM, the Staffing Assistant (SA) indicated staff #7 arrived to the group home, based on his clock in time, at 9:55 PM. The SA indicated staff #2 was scheduled to work until 10:30 PM however he clocked out at 9:52 PM. The SA indicated staff #2 should have worked until 10:30 PM.</p> <p>This federal tag relates to complaint #IN00151850.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient</p>						

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	<p>number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview for 1 of 49 incident/investigative reports reviewed affecting client B, the facility failed to ensure staff implemented client B's Behavior Plan as written for contacting the emergency psychiatric pager.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/16/14 at 8:52 AM and indicated the following:</p> <p>On 6/23/14 at 9:00 PM, the BDDS report, dated 6/25/14, indicated, "When staff arrived, [client B] was in the road spraying cars with the hose. As staff pulled in the driveway he ran at staff's car and sprayed it down. For the entirety of three hours staff tried talking with [client B] about coming out of the road and not running at or spraying cars as they are driving by the house. [Client B] would not listen to the prompts or the options staff would give him. Staff would ask him if he wanted to go into the formal room and talk. He would simply yell, 'Nuh uh' and then attempt to spray staff with the hose or act as if he were</p>	W000249	<p>Addendum:</p> <p>Name (nick name) has been removed from POC</p> <p>W249 483.440 Corrective action for resident(s) found to have been affected (Plan of correction) Facility staff have been trained on client's behavior support plan (Attachment W250B). How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Facility behavior consultant chosen by client will continue to observe and document minimally weekly on clients progress. Team will continue to discuss client #1 monthly support meetings and create strategies to assist in keeping him and others safe (Attachment W249-A) (Attachment W250-B).</p> <p>Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility staff will be trained monthly on reporting abuse and neglect protocol <i>and calling the psych pager when needed</i>(Attachment W154).</p> <p>How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility director will attend or</p>	08/01/2014			

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	<p>throwing something at me. This continued until about 12:03 am. At this point [client E] had been woken up by [client B's] yelling and he was curious about what was happening. Staff was able to have [client E] go back to his room and avoid extra conflict, but [client B] was still attempting to spray cars that were driving by the house. Around 12:07 (AM) staff turned the water off. [Client B] ran to the faucet where staff was standing and attempted to hit and bite staff. Staff told him that we couldn't have him running around in the road when cars were driving by because it was not safe for him or the people driving. He constantly was saying 'nuh uh.' After multiple attempts to hit and bite staff, staff told [client B] that he may have to be escorted to his room or put in a hold to prevent him and staff from getting injured. He continued to attempt to hit and bite staff and even attempted to go after another car even though the water was off. At that point staff put [client B] in a basket hold for approximately 2 minutes until releasing him. At this point they were standing in the entrance way. After [client B] was released, he attempted to hit staff with his shoes but calmed down after a few minutes and started to help staff clean up the mud that he tracked into the hallway. Plan to Resolve: [client B] calmed down, they</p>		<p>review meetings / trainings monthly and provide additional training as needed. Director is currently working direct care in the home to monitor 8-14 hours of continual interactions and training new staff, coordinator, and potential house manager. This is occurring minimally once a week to taper off once home is no longer in crisis.</p>	

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	<p>talked about what had happened, and they cleaned some of the house together."</p> <p>There was no documentation in the BDDS report indicating the emergency psychiatric pager was contacted.</p> <p>On 7/17/14 at 10:52 AM, the facility provided the Stone Belt ARC, Inc. Incident Report (IR), dated 6/23/14 - 6/24/14. The IR was completed by staff #7. The IR indicated the timeframe for the incident was 9:55 PM - 12:50 AM. The IR indicated, in part, "Before I arrived at the home, [client B] was in the road spraying cars with the hose. As I pulled in the driveway he ran at my car and sprayed it down. For the entirety of three hours I tried talking with [client B] about coming out of the road and not running at or spraying cars as they are driving by the house. During this time I was in contact with [Coordinator] and he was made aware of the situation... I was able to escort [client E] back to his room and avoid extra conflict, but [client B] was still attempting to spray cars that were driving by the house. Around 12:07 AM I turned the water off. [Client B] ran to the faucet where I was standing and attempted to hit and bite me... After multiple attempts to hit and bite me and even attempted to go after another car even though the water was off. At that point I put [client B] in a basket hold for</p>				

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	<p>approximately 2 minutes until releasing him. At this point we were standing in the entrance way... For a more detailed account, there is an Active Treatment Monitoring sheet in the office." There was no documentation on the form indicating the emergency psychiatric pager was contacted.</p> <p>A review of client B's record was conducted on 7/17/14 at 11:46 AM. Client B's 6/11/14 Behavior Plan indicated client B had a targeted behavior of elopement. The plan indicated, in part, "During the overnight shifts, between 10P and 8A, when only one staff is at [name of group home], it can be challenging to proactively address [client B's] behavior and support the other clients in the house. If [client B] leaves the house during this shift, crosses to [name of street], and is not visible, staff will call the Emergency Pager and 911. If [client B] is still within staff sight, but has repeatedly left the property or is in [name of group home] drive, staff will call the Emergency Pager and may request that the Psychiatric pager be called." There was no documentation in client B's record indicating the emergency psychiatric pager was contacted for the incident on 6/23/14.</p> <p>On 7/16/14 at 6:09 AM, staff #7</p>						

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	<p>indicated he was working with client B during the incident on 6/23/14. Staff #7 indicated when he arrived, client B was outside spraying cars, which had occurred multiple times in the past. Staff #7 indicated client B was threatening to elope from the group home. Staff #7 indicated he was the only staff working during the incident. Staff #7 indicated he spoke, during the incident, to the Coordinator on the phone during the incident. Staff #7 indicated he was afraid during the incident client B was going to get hit by a car. Staff #7 indicated the incident ended, several hours later, when he unhooked the hose. Staff #7 indicated there was a second staff present who left the group home at the end of his shift in the middle of the incident. Staff #7 indicated the facility did not have enough staff during the overnight shift to provide adequate supervision. Staff #7 indicated during the incident, he was outside with client B leaving clients A, C, D and E unsupervised in the group home. On 7/17/14 at 10:33 AM, staff #7 indicated when he arrived to the group home, staff #2 was present but left soon after staff #7 arrived for his shift. Staff #7 indicated it may have been helpful for staff #2 to stay but he was not sure having two staff would have been beneficial. Staff #7 indicated he stayed at the doorway to the group home during the incident doing his</p>			

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	<p>best to keep client B in line of sight and ensure clients A, C, D and E were safe in the home. Staff #7 indicated he was on the phone with his supervisor (Coordinator) during some of the time following the directives he was receiving from the Coordinator. Staff #7 indicated he had attempted to turn off the hose and unhook it earlier during the incident however when he did, client B aggressed toward staff #7. Staff #7 indicated he was not directed to call the emergency psychiatric pager.</p> <p>On 7/16/14 at 1:11 PM, the Coordinator indicated a BDDS report should be submitted within 24 hours of the incident. The Coordinator indicated he was unsure why the report was submitted late. The Coordinator indicated the incident on 6/23/14 was a new behavior client B had not exhibited before. He indicated he was on the phone with staff #7 during the incident. The Coordinator indicated staff #7 was attempting to avoid having client B going further out into the road and they (Coordinator and staff #7) were concerned about client B eloping from the group home. The Coordinator indicated he could not recall why, but he was unable to go to the house to assist staff #7 during the incident. The Coordinator indicated a formal investigation was not conducted. The</p>						

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	<p>Coordinator indicated he was comfortable, since he was on the phone during part of the incident, that staff #7 acted correctly and interacted correctly with client B. The Coordinator stated there were "probably" two staff there when he was spraying cars but he was not sure. The Coordinator indicated staff #7 called him after the second staff had left the group home. The Coordinator indicated staff #7 was trying to avoid, at all costs, restraining client B which may have made the situation worse. The Coordinator indicated it took staff #7 over 3 hours to turn off the water due to being at the group home by himself. The Coordinator indicated if staff #7 turned the water off earlier, client B may have eloped. The Coordinator indicated staff #7 was continuously interacting with client B to slow him down since there was not a continuous stream of cars. The Coordinator indicated staff #7 stayed at the doorway of the group home during the incident to ensure supervision of both client B and clients A, C, D and E. The Coordinator indicated staff #7 was successful in managing client B's behavior during the incident. Staff #7 stayed calm and redirected client B. The Coordinator indicated one staff during the overnight shift was sufficient to provide supervision of the clients. The Coordinator indicated it would have been</p>			

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	<p>helpful to have additional staff but staff #7 did the best he could in the situation. The Coordinator indicated client B was not injured, client B returned to the house, and no one else got injured. The Coordinator indicated there were no changes to client B's plan following the incident and there were no changes in the staffing level at the home. The Coordinator indicated the psychiatric pager was not called on 6/23/14 during the incident. The Coordinator indicated, in the past, client B would calm down once the psychiatric pager came to the house and then the behavior resumed when the psychiatric pager staff left the home.</p> <p>On 7/17/14 at 12:16 PM, the Supervised Group Living Director (SGLD) indicated staff #7 and the Coordinator should have ensured client B's plan to contact the psychiatric pager was implemented as written. The SGLD indicated had the staff contacted the psychiatric pager, additional staff assistance could have been requested.</p> <p>This federal tag relates to complaint #IN00151850.</p> <p>9-3-4(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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