

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  01/22/2015
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404
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W 000  Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Survey Dates: January 15, 16, 20, 21 and 22, 2015</p> <p>Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/29/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 1 of 3 non-sampled clients (#2), the governing body failed to ensure client #2's bedroom wall was in good repair.</p> <p>Findings include:</p>	W 104	<p>PlanofCorrection:Facilityhireda contractor torepairthedamagecausedbythe vehiclerunningintothehome(attach ment a).</p> <p>PlanofPrevention:Facilityhouseman agerwillcontinuecontactingmain tenance</p>	02/01/2015

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

TITLE

(X6) DATE

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

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	<p>On 1/15/15 at 12:05 PM, the Group Home Director (GHD) indicated one of client #2's peer's guardian drove her car into the group home causing damage to client #2's bedroom wall on 1/11/15. The GHD indicated there was a crack in the drywall on the inside of client #2's bedroom wall. The GHD stated, "I'm sure maintenance has not repaired it yet." The GHD indicated there was a contractor involved due to the damage. The GHD indicated client #2 was not injured and was not in his room at the time.</p> <p>On 1/15/15 from 4:04 PM to 5:47 PM, an observation was conducted at the group home. On 1/15/15 at 4:21 PM, client #2 asked the surveyor to look at his bedroom wall. The bedroom wall facing the driveway (south wall) had a large hole in the wall and a crack running from the floor to the ceiling. The hole was 3 feet wide and 3 feet high. The hole exposed an electrical outlet in client #2's bedroom. Client #2 indicated someone drove into the side of the house. The drywall taken out of client #2's bedroom was sitting in the hallway outside of client #2's bedroom door.</p> <p>On 1/20/15 from 5:49 AM to 7:48 AM, an observation was conducted at the</p>		<p>department,byemail,whenitemsar einneedofrepair. PlanofMonitoring:Facilitycoordinat or/QIDP-Dwillensurethatrepairsha vebeen madeinatimelymanner (attachment f).</p>				

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W 125 Bldg. 00	<p>group home. At 7:34 AM, client #2 indicated there was a hole in his wall. Client #2 asked the surveyor to look at his bedroom wall. The bedroom wall facing the driveway (south wall) had a large hole in the wall and a crack running from the floor to the ceiling. The hole was 3 feet wide and 3 feet high. The hole exposed an electrical outlet in client #2's bedroom. Client #2 indicated someone drove into the side of the house. There was no change in the condition of the wall since the observation conducted at the group home on 1/15/15.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 3 non-sampled clients (#4), the facility failed to ensure the client had the right to due process in regard to restricting his access to the restrooms at the group home.</p> <p>Findings include:</p>	W 125	<p>W125 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS 1} Plan of Correction: Client BSP was revised to include restricting access to facility restrooms except for his own. Plan has interim hrc approval. Goal has been introduced to teach restroom use (attachment</p>	02/01/2015

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	<p>On 1/15/15 from 4:04 PM to 5:47 PM, an observation was conducted at the group home. At 4:15 PM, staff gave client #3 a key to unlock the restroom closest to the kitchen. Client #3 used the key to unlock the bathroom door.</p> <p>On 1/15/15 at 4:15 PM, the Coordinator indicated the bathroom doors (2 of 3) were locked due to the day program staff being at home with client #4. The Coordinator indicated the Day Program (DP) Coordinator would have more information about why the bathroom doors were being locked.</p> <p>On 1/15/15 at 4:15 PM, the DP Coordinator indicated the DP staff lock 2 of 3 bathroom doors due to client #4 going from one bathroom to another during the day during the day program hours (8:00 AM to 4:00 PM). The Coordinator indicated client #4 would leave feces smeared on the seats in each restroom causing the staff to have to spend too much time cleaning feces and not enough time providing programming to client #4. The DP Coordinator indicated he spoke to a former Home Manager who approved the locking of the bathroom doors. The DP Coordinator indicated there was no plan to lock the bathroom doors. The DP Coordinator</p>		<p>b).</p> <p>1) Plan of Correction: The restriction for restrooms being locked during the day has been added to BSP and approved through HRC (attachment b). Plan of Preventing: Plan of Preventing: House manager or associate house manager will provide daily supervision to ensure clients are provided privacy (attachment e).</p> <p>Plan of Monitoring: Facility coordinator/ QIDP-D will provide weekly supervision to ensure protection of client's rights. Facility coordinator / QIDP-D will provide oversight that HRC restrictions have been approved by support team and due process (attachment xx).</p>				

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	<p>stated it was "informal."</p> <p>On 1/20/15 at 11:56 AM, a review of client #4's record was conducted. There was no documentation in client #4's record indicating there was a plan to lock the restroom doors at the group home during day program hours. Client #4's most recent Behavioral Support Plan, dated 10/15/14, did not include an intervention to lock the restroom doors.</p> <p>On 1/20/15 at 12:03 PM, the Coordinator indicated the DP Coordinator reported to her he received permission to lock the bathroom doors from a former Home Manager. The Coordinator indicated there was no plan to lock the bathroom doors and the facility should not be locking the bathroom doors.</p> <p>On 1/22/15 at 1:37 PM, the Group Home Director forwarded an email from the Day Program Coordinator. The email indicated, in part, "[Client #4] sits too far back on toilet seats and leaves BM (bowel movement) on (sic) seat. He is independent with going to restroom and urinating, but needs help with hand washing, and cleaning up if he's had a BM. LL (name of day program) staff are trained to check on [client #4] each time he has entered a bathroom. [Client #4's] habit (if he has a BM) is to BM on toilet</p>			

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	<p>seat, and then close lid on top of it. This makes a big mess, and even soils the hinges of toilet seat which requires deep cleaning. Historically, while [client #4's] staff is preparing one bathroom for his shower and making the toilet a place where he can sit again, he has gone around house leaving BM on all other toilet seats. This would sometimes take away an additional hour of programming cleaning bathrooms behind [client #4] to keep them clean for his housemates at the end of the day when they return. To remedy this, the LL staff have been trained to check all of the bathrooms in the morning to ensure that they are clean. Two are locked, which keeps them clean throughout day. One (the closest one to [client #4's] room with the double shower head) is left unlocked and open for [client #4's] use all day. When [client #4] soils the toilet seat, staff can clean it while [client #4] is in the shower, and then [client #4] can sit on that clean seat when he's getting dressed. This process has helped [client #4] keep his house and himself more clean. It's more janitorial than behavioral, and leaves other restrooms nice for housemates when they return home. Also, by locking his housemates' bedroom doors during the day, [client #4] does not go in their rooms and tantrum on or soil their beds if he has become incontinent. During the</p>			

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W 130 Bldg. 00	<p>day [client #4] has had access to his bedroom, his bathroom, the kitchen, living room, and backyard, and he also enjoys sitting with staff in office when they're checking email."</p> <p>9-3-2(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 2 of 3 clients in the sample (#5 and #6), the facility failed to ensure the privacy of the clients during care of personal needs.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/20/15 from 5:49 AM to 7:48 AM. At 5:59 AM, client #5 was observed to use to walker to ambulate to the shower. While ambulating from his bedroom to the restroom in another part of the house, client #5 was naked. Staff #4 walked with client #5 and did not prompt client #5 to put on a robe, underwear or a towel. Staff #4 did not attempt to protect client #5's privacy when he walked from his bedroom to the</p>	W 130	<p><b>W130</b> <b>483.420(a)(7)PROTECTION OFCLIENTSRIGHTS</b></p> <p>Planofcorrection:Facilitystaffwastrainedonprovidingprivacyforallclients(attachment d). PlanofPreventing: Housemanager orassociatehousemanagerwillprovidedaily supervisiontoensureclientsareprovidedprivacy(attachmente). PlanofMonitoring:Facilitycoordinator /QIDP-Dwillprovideweeklysupervisionto ensureclientsareprovidedprivacy(attachment f).</p>	02/01/2015

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W 148 Bldg. 00	<p>shower.</p> <p>On 1/20/15 at 6:19 AM, client #6 exited his bedroom wearing a shirt. Staff #4 was with client #6 as client #6 exited his bedroom to go to the restroom close to his bedroom. Staff #4 did not prompt client #6 to put on pants, underwear or a robe as he exited his bedroom without pants or underwear.</p> <p>On 1/20/15 at 12:17 PM, the Coordinator indicated the clients should be prompted to put on a robe or towel to protect their privacy. The Coordinator indicated the staff need to ensure the clients' privacy.</p> <p>9-3-2(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp; The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on interview and record review for 1 of 3 clients in the sample (#6) and one additional client (#3), the facility failed to promptly notify the clients' guardians of any significant incidents or changes in the clients' condition.</p>	W 148	<p><b>W148</b> <b>483.420(c)(6)COMMUNICATION WITHCLIENTS,PARENTS&amp;GUA RDIAN</b> Plan ofcorrection:Facilitystaffwastraine doncommunicatingwithguardians(</p>	02/01/2015

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	<p>Findings include:</p> <p>On 1/16/15 at 2:10 PM, client #3's guardian indicated the past 6 months the communication with the group home had not been good. The guardian indicated when she communicated to the weekend staff, the weekend staff were not communicating her upcoming visits to the weekday staff. The guardian indicated she was not notified when client #3 recently started destroying his clothing again (used to be an issue but not seen until recently). The guardian indicated she requested an Occupational and Physical Therapy evaluation however she had not been told of the status. The guardian indicated she was not informed when client #3 started having incontinence. The guardian indicated she wanted to be notified of what was going on and she was not currently being notified. The guardian indicated she did not want daily reports but regular updates from the group home.</p> <p>On 1/16/15 at 2:36 PM, client #6's guardian indicated although the communication with the group home had been better lately, she wanted regular updates from the group home staff about her son.</p>		<p>attachment d). PlanofPreventing: Housemanager orassociatehousemanagerwillprovidedaaily supervisiontoensurecommunicationwithguardiansisoccurring(attachment e). PlanofMonitoring:Facilitycoordinator/QIDP-Dwillprovideweeklysupervisionto ensurecommunicationwithguardiansisoccurringtheywillalsoupdateguardiansmonthly followingsupportteammeetings(attachment g).</p>				

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	<p>On 1/20/15 at 11:56 AM, a review of client #3's record was conducted. There was no documentation in the record indicating when the group home staff contacted the client's guardian.</p> <p>On 1/20/15 at 2:06 PM, a review of client #6's record was conducted. There was no documentation in the record indicating when the group home staff contacted the client's guardian.</p> <p>On 1/20/15 at 3:08 PM, the Coordinator indicated client #3's guardian wanted to be involved but when the Coordinator spoke to the guardian, the guardian indicated she did not want to know. The Coordinator indicated she had a meeting scheduled with the guardian on 1/23/15 to discuss the guardian's concerns and determine the things the guardian wanted to notified of. On 1/21/15 at 2:59 PM, the Coordinator indicated she did not document her contact with the clients' guardians. The Coordinator indicated her personal cell phone records and the group home phone records would be the only verification she contacted the guardians. The Coordinator indicated the guardians were not regularly contacted by the previous Coordinator. The Coordinator indicated she contacted the clients' guardians on a regular basis. The Coordinator indicated some of the</p>				

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W 149 Bldg. 00	<p>guardians were upset when she initially contacted them to introduce herself about not being notified of recent staffing changes at the group home with the Home Manager, Coordinator and Group Home Director positions.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 56 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent staff to client neglect, client to client abuse and ensure Bureau of Developmental Disabilities Services (BDDS) incident reports were submitted in a timely manner.</p> <p>Findings include:</p> <p>On 1/15/15 at 12:40 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/11/15 at 6:30 AM, staff #2</p>	W 149	<p><b>W149</b> Plan of correction: Facility staff trained on prevention of abuse and neglect each month Plan of Preventing: House manager or associate house manager will provide daily supervision to ensure policies and procedures preventing abuse and neglect are being followed (attachment e). Monitoring: Facility coordinator / QIDP-D will provide weekly supervision to ensure policies and procedures preventing abuse and neglect are being followed(attachment g).</p>	02/01/2015

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	<p>arrived to the group home. Former staff #11 was asleep on the couch. Staff #2's interview in the investigation indicated, "...she woke up shortly after his arrival and laughed." Staff #11 left the group home at 7:00 AM. Staff #2 indicated when he and staff #3 checked the clients, client #6's ileostomy (opening in the abdomen which allows the small intestine to protrude and allows stool to pass into an ostomy pouch) bag was "busted" and client #3 was incontinent of urine. Staff #2 indicated client #1 was incontinent in his bed. The investigation's interview with staff #11 indicated she reported she was asleep from 4:00 AM until staff #2 arrived to the group home. The investigation indicated, "The [name of group home] Overnight Checklist details tasks and duties of the overnight staff while working at [name of group home]. This checklist was not completed on the night of 1/10/15/morning of 1/11/15. This shift was filled by [staff #11]. [Staff #11] admits to not completing tasks on the list including checking on the clients aside from one time in the night. She indicates that she doesn't even know how to change or empty [client #6's] ostomy bag. According to the [name of group home] Overnight Checklist, staff should check beds every two hours after arrival. Staff should document on a separate bed check form. The documentation on bed</p>			

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	<p>check form was not completed by [staff #11] on this night either."</p> <p>The investigation indicated, "Substantiated, the findings support the event as neglect." The investigation indicated, "In conducting the interviews and reviewing the documentation pertinent to the incident in question, the evidence examined indicates that neglect did occur. Although there are some inconsistencies in statements concerning the events on Sunday morning January 11th, 2015, the overall recollections and reports from that morning are consistent. It has been determined that [staff #11], did in fact fail to provide appropriate supervision, as well as a safe, clean, and sanitary environment for the residents of [name of group home] while working as a direct support professional on the night of January 10th, 2015 and the morning of January 11th, 2015. [Staff #11] admitted that she was sleeping through large portions of her overnight shift at Stone Belt's [name of group home]. [Staff #11] also acknowledged that she did not check on the client's (sic) consistently throughout the night. [Staff #11] maintains that she was hired for the sleeping overnight shift at [name of group home] and was not informed, at anytime, that her role had changed. [Coordinator] and [staff #2] both stated</p>			

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	<p>they advised [staff #11] that she was not allowed to be sleeping during her shift at [name of group home] if she were the only staff on duty. In addition, training forms from 2014 are included in the folder. On the training forms it indicates [staff #11] had training on the overnight binder which included the overnight checklist."</p> <p>There was no documentation the facility reported the incident to BDDS for clients #2, #3, #4 and #5.</p> <p>On 1/20/15 at 3:03 PM, the Coordinator indicated staff #11 was terminated for neglect. The Coordinator indicated the facility submitted BDDS reports for clients #1 and #6. The Coordinator indicated BDDS reports should have been submitted for clients #2, #3, #4 and #5.</p> <p>2) On 12/16/14 at 12:40 PM at the facility-operated day program, client #5 was hit by a peer two times with her lunchbox. The BDDS report, dated 12/16/14, indicated, in part, "Staff was not able to get there in time to stop the behavior."</p> <p>On 1/15/15 at 1:41 PM, the Group Home Director (GHD) indicated client to client aggression was abuse and the facility</p>						

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	<p>should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>3) On 12/12/14 at 6:45 PM (reported to BDDS on 12/14/14), staff #8 was assisting clients #5 and #6 during a fire drill. The BDDS report indicated, "While returning inside [client #6] stepped on [client #5's] foot while approaching the front door. As a result of this [client #5] halted to determine what had happened. [Client #6] persisted forward pushing [client #5] while attempting to get inside the home. Staff used sign language to communicate to [client #5] that [client #6] was trying to enter the home and requested that [client #5] step to the side to assist with this. [Client #5] reacted in midst of communication by turning around and grabbing [client #6's] hair. In the process of turning [client #5] made contact with his walker ([client #5] ambulates via his knees using a walker to assist with balance) and knocked his glasses off his face. Staff intervened immediately completing a hand release to get [client #5] to release [client #6's] hair and stood in between the two clients to prevent further altercation."</p> <p>On 1/15/15 at 1:41 PM, the GHD</p>			

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	<p>indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>4) On 11/25/14 at 6:00 PM, client #4 grabbed client #1's sweatshirt causing client #1 to fall. Client #1 was not injured.</p> <p>On 1/15/15 at 1:41 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 1/15/15 at 11:49 AM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's</p>			

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	<p>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 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</p>			

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	<p>completion of all investigations within 5 working days... Investigations must be started within 24 hours.</p> <p><b>ABUSE/NEGLECT/EXPLOITATION -</b> Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events." The Human Rights Policy, dated 2/17/14, indicated, in part, "Physical abuse: Consists of any intentional and/or punitive physical action or motion by which physical harm or emotional trauma may occur." The policy indicated, in part, "Neglect: Any action or behavioral interventions that risks the physical or emotional safety and wellbeing 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</p>						

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W 153 Bldg. 00	<p>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." The Incident Reporting Procedure, dated 7/25/13, indicated, in part, "Incidents listed 1 through 16 are to be reported to the State following state guidelines and timeframes. Incidents occurring in residential settings are delivered/faxed/sent to regional offices within 24 hours for review (1. All alleged or suspected or actual abuse, neglect, or exploitation. All incidents falling into this category must be reported to Adult Protective Services or Child Protective Services.)"</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 56 incident/investigative reports reviewed affecting clients #2, #3, #4, #5 and #6, the facility failed to ensure Bureau of Developmental Disabilities</p>	W 153	<p><b>W153</b> <b>483.420(d){2}</b> <b>STAFFTREATMENTOF</b> <b>CLIENTS</b> Planofcorrection: Facilitystaffwast rainedatShiloh216/15onreportingi</p>	02/01/2015			

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	<p>Services (BDDS) incident reports were submitted in within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 1/15/15 at 12:40 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/11/15 at 6:30 AM, staff #2 arrived to the group home. Former staff #11 was asleep on the couch. Staff #2's interview in the investigation indicated, "...she woke up shortly after his arrival and laughed." Staff #11 left the group home at 7:00 AM. Staff #2 indicated when he and staff #3 checked the clients, client #6's ileostomy (opening in the abdomen which allows the small intestine to protrude and allows stool to pass into an ostomy pouch) bag was "busted" and client #3 was incontinent of urine. Staff #2 indicated client #1 was incontinent in his bed. The investigation's interview with staff #11 indicated she reported she was asleep from 4:00 AM until staff #2 arrived to the group home. The investigation indicated, "The [name of group home] Overnight Checklist details tasks and duties of the overnight staff while working at [name of group home]. This checklist was not completed on the</p>		<p>ncident reportstoBODSwithin 24hours and again at house meeting(attachment h). Planofprevention:Facilitycoordinat or/QIDP-Dweretrainedonreporting incident reportstoBODSwithin 24hours(attachment g). Planofmonitoring:Facilitydirector willreviewincidentsandensurethey arereported toBDDSwthin 24hours.</p>	

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	<p>night of 1/10/15/morning of 1/11/15. This shift was filled by [staff #11]. [Staff #11] admits to not completing tasks on the list including checking on the clients aside from one time in the night. She indicates that she doesn't even know how to change or empty [client #6's] ostomy bag. According to the [name of group home] Overnight Checklist, staff should check beds every two hours after arrival. Staff should document on a separate bed check form. The documentation on bed check form was not completed by [staff #11] on this night either."</p> <p>The investigation indicated, "Substantiated, the findings support the event as neglect." The investigation indicated, "In conducting the interviews and reviewing the documentation pertinent to the incident in question, the evidence examined indicates that neglect did occur. Although there are some inconsistencies in statements concerning the events on Sunday morning January 11th, 2015, the overall recollections and reports from that morning are consistent. It has been determined that [staff #11], did in fact fail to provide appropriate supervision, as well as a safe, clean, and sanitary environment for the residents of [name of group home] while working as a direct support professional on the night of January 10th, 2015 and the morning of</p>			

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	<p>January 11th, 2015. [Staff #11] admitted that she was sleeping through large portions of her overnight shift at Stone Belt's [name of group home]. [Staff #11] also acknowledged that she did not check on the client's (sic) consistently throughout the night. [Staff #11] maintains that she was hired for the sleeping overnight shift at [name of group home] and was not informed, at anytime, that her role had changed. [Coordinator] and [staff #2] both stated they advised [staff #11] that she was not allowed to be sleeping during her shift at [name of group home] if she were the only staff on duty. In addition, training forms from 2014 are included in the folder. On the training forms it indicates [staff #11] had training on the overnight binder which included the overnight checklist."</p> <p>There was no documentation the facility reported the incident to BDDS for clients #2, #3, #4 and #5.</p> <p>On 1/15/15 at 1:41 PM, the GHD indicated BDDS reports should be submitted within 24 hours. The GHD indicated she did not submit reports for clients #2, #3, #4 and #5 since they were not affected.</p> <p>On 1/20/15 at 3:03 PM, the Coordinator</p>			

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	<p>indicated the facility submitted BDDS reports for clients #1 and #6. The Coordinator indicated BDDS reports should have been submitted for clients #2, #3, #4 and #5.</p> <p>2) On 12/12/14 at 6:45 PM (reported to BDDS on 12/14/14), staff #8 was assisting clients #5 and #6 during a fire drill. The BDDS report indicated, "While returning inside [client #6] stepped on [client #5's] foot while approaching the front door. As a result of this [client #5] halted to determine what had happened. [Client #6] persisted forward pushing [client #5] while attempting to get inside the home. Staff used sign language to communicate to [client #5] that [client #6] was trying to enter the home and requested that [client #5] step to the side to assist with this. [Client #5] reacted in midst of communication by turning around and grabbing [client #6's] hair. In the process of turning [client #5] made contact with his walker ([client #5] ambulates via his knees using a walker to assist with balance) and knocked his glasses off his face. Staff intervened immediately completing a hand release to get [client #5] to release [client #6's] hair and stood in between the two clients to prevent further altercation."</p>			

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W 159 Bldg. 00	<p>On 1/15/15 at 1:41 PM, the GHD indicated BDDS reports should be submitted within 24 hours.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 3 clients in the sample (#5 and #6), the Qualified Intellectual Disabilities Professional (QIDP - called Coordinator) failed to conduct regular review of the clients' progress on their individual support plans.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 1/20/15 at 1:40 PM. During the past 12 months (January 2014 to January 2015), the Coordinator completed quarterly reviews of the client's progress on his ISP training objectives on 2/25/14, 4/18/14 and 9/10/14.</p> <p>A review of client #6's record was conducted on 1/20/15 at 2:06 PM.</p>	W 159	<p><b>W159</b> <b>483.430{a}</b> <b>QUALIFIEDMENTALRETARDAT IONPROFESSIONAL</b> Planofcorrection: Client#6wasnota dmittedatthetimethatthequarterlyis missing. HewasdischargedinNovemberand didn'treturnuntilMarch. ThemissingquarterlywasinMarch, whichwouldaccountforJanuary,Fe bruaryandMarch. Therefore, client #6 wouldnothaveaquarterly reviewd uetohewasnotadmittedtofacilityatt hattime. Client#5quarterlywascompleted andsharedwithhisteam(attachmen t i). Planofprevention: Facilitycoordinat or/QIDP-Dwastrained onreviewingand monitoringclient'sactivetreatment plans(attachment f). Planofmonitoring: Agencywilldistri bute electronicnotificationswhenq uarterly and</p>	02/01/2015

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W 186 Bldg. 00	<p>During the past 12 months (January 2014 to January 2015), the Coordinator completed quarterly reviews of the client's progress on his ISP training objectives on 6/8/14, 9/10/14 and 12/5/14. There were no quarterly reviews from January 2014 to June 8, 2014.</p> <p>On 1/21/15 at 2:59 PM, the Coordinator indicated the clients' progress on their training objectives should be completed quarterly. The Coordinator stated, "I've done as much as I can." The Coordinator indicated a former staff who was terminated was responsible for entering the data into the computer to run the quarterly reports.</p> <p>9-3-3(a)</p> <p>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.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility</p>	W 186	<p>annualplansarenotsubmittedinelectronicstorage database.</p> <p><b>W186</b> <b>483.430{d}{1-2}</b> <b>DIRECTCARESTAFF</b> Planofcorrection:Facilityhumanres</p>	02/01/2015			

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	<p>failed to provide sufficient staff (two staff) during the overnight shift.</p> <p>Findings include:</p> <p>On 1/15/15 at 12:40 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 1/11/15 at 6:30 AM, staff #2 arrived to the group home. Former staff #11 was asleep on the couch. Staff #2's interview in the investigation indicated, "...she woke up shortly after his arrival and laughed." Staff #11 left the group home at 7:00 AM. Staff #2 indicated when he and staff #3 checked the clients, client #6's ileostomy (opening in the abdomen which allows the small intestine to protrude and allows stool to pass into an ostomy pouch) bag was "busted" and client #3 was incontinent of urine. Staff #2 indicated client #1 was incontinent in his bed. The investigation's interview with staff #11 indicated she reported she was asleep from 4:00 AM until staff #2 arrived to the group home. The investigation indicated, "The [name of group home] Overnight Checklist details tasks and duties of the overnight staff while working at [name of group home]. This checklist was not completed on the night of 1/10/15/morning of 1/11/15. This shift was filled by [staff #11]. [Staff #11]</p>		<p>ourceswillrecruitovernight stafftofillshifts (attachment j). Planofprevention:Staffingcoordina torwillprioritizefacilityovernight shiftstoensure thatsufficientdirectcarestaffarescheduledtomanageandsuperviseclientsin accordancewiththeirindividual programplans(attachment k). Planofmonitoring:Facilitycoordinator/Qidp-Dwillreviewstaffscheduledailywith staffingofficetoensureshiftsarecovered(attachment f)</p>	

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	<p>admits to not completing tasks on the list including checking on the clients aside from one time in the night. She indicates that she doesn't even know how to change or empty [client #6's] ostomy bag. According to the [name of group home] Overnight Checklist, staff should check beds every two hours after arrival. Staff should document on a separate bed check form. The documentation on bed check form was not completed by [staff #11] on this night either." This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>The investigation indicated, "Substantiated, the findings support the event as neglect." The investigation indicated, "In conducting the interviews and reviewing the documentation pertinent to the incident in question, the evidence examined indicates that neglect did occur. Although there are some inconsistencies in statements concerning the events on Sunday morning January 11th, 2015, the overall recollections and reports from that morning are consistent. It has been determined that [staff #11], did in fact fail to provide appropriate supervision, as well as a safe, clean, and sanitary environment for the residents of [name of group home] while working as a direct support professional on the night of January 10th, 2015 and the morning of January 11th, 2015. [Staff #11] admitted</p>			

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	<p>that she was sleeping through large portions of her overnight shift at Stone Belt's [name of group home]. [Staff #11] also acknowledged that she did not check on the client's (sic) consistently throughout the night. [Staff #11] maintains that she was hired for the sleeping overnight shift at [name of group home] and was not informed, at anytime, that her role had changed. [Coordinator] and [staff #2] both stated they advised [staff #11] that she was not allowed to be sleeping during her shift at [name of group home] if she were the only staff on duty. In addition, training forms from 2014 are included in the folder. On the training forms it indicates [staff #11] had training on the overnight binder which included the overnight checklist."</p> <p>On 1/20/15 at 11:55 AM, the Coordinator indicated staff #11 was terminated for neglect. The Coordinator stated there was one staff working during the overnight shift "about" one time per week.</p> <p>A review of the staffing schedule for the group home was conducted on 1/22/15 at 12:29 PM. The schedule indicated the following dates and times there was one staff working during the overnight shift during the past 3 months: 1/11/15,</p>			

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	<p>12/27/14, 12/25/14, 12/24/14, 12/23/14, 12/22/14, 12/21/14, 12/20/14, 12/19/14, 12/15/14, 12/13/14, 12/8/14, 12/6/14, 12/5/14, 12/4/14, 12/1/14, 11/30/14, 11/29/14, 11/27/14, 11/25/14, 11/24/14, 11/22/14, 11/17/14, 11/15/14, 11/11/14, 11/10/14, 11/9/14, 11/7/14, 11/6/14, 11/5/14, 11/4/14, 11/2/14, 10/31/14, 10/30/14, 10/29/14, 10/28/14, 10/27/14, 10/25/14, 10/24/14, 10/23/14, 10/22/14, 10/21/14, 10/20/14, 10/19/14, 10/18/14, 10/17/14, 10/16/14, 10/15/14 and 10/14/14.</p> <p>On 1/22/15 at 10:12 AM, a review of client #4's Behavioral Support Plan, dated 10/15/14, indicated, in part, "During overnight shifts, there are currently two staff members present at [name of group home] to ensure that [client #4's] staffing needs are met, in the event that he wakes up during the night. The night aide needs to be aware of [client #4's] whereabouts for safety reasons. [Client #4's] bedroom door has a chime/alarm that alerts staff of any time when he leaves his room. If [client #4] wakes during the overnight shift, the two staff present should communicate about [client #4's] whereabouts. Once [client #4] is awake, one staff will assume the role of his dedicated staff." The plan indicated, "[Client #4] will have a specific staff member assigned as his</p>			

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	<p>dedicated staff (intensive staffing), in anticipation of [client #4] waking in the morning, and during each shift. The dedicated staff will supervise [client #4] so that he does not enter the personal space of his housemates or others, in order to ensure that [client #4] does not have any opportunities to aggress on peers. The dedicated staff will stay within arm's length of [client #4] unless he is in a private space by himself, such as his room, the bathroom, or at home with no other clients present...."</p> <p>On 1/22/15 at 12:48 PM, the Group Home Director (GHD) indicated the overnight shift was from 10:30 PM to 8:00 AM on weekdays and 9:00 PM to 7:00 AM on weekends. The GHD indicated client #4's plan indicated there should be two staff during the overnight shift. The GHD indicated the facility needed to provide two overnight staff. The GHD indicated the facility failed to ensure two staff were scheduled to work during the overnight shift. The GHD indicated she was not informed the group home was not being staffed with two staff consistently during the overnight shift.</p> <p>On 1/22/15 at 1:56 PM, the Coordinator indicated one staff was not sufficient, per client #4's plan, to supervise the clients.</p>				

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W 227 Bldg. 00	<p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 3 non-sampled clients (#4), the facility failed to ensure client #4 had a plan to teach him to use the restroom without smearing feces on the toilet seat.</p> <p>Findings include:</p> <p>On 1/15/15 from 4:04 PM to 5:47 PM, an observation was conducted at the group home. At 4:15 PM, staff gave client #3 a key to unlock the restroom closest to the kitchen. Client #3 used the key to unlock the bathroom door.</p> <p>On 1/15/15 at 4:15 PM, the Coordinator indicated the common bathroom doors (2 of 3) were locked due to the day program staff being at home with client #4. The Coordinator indicated the Day Program (DP) Coordinator would have more information about why the bathroom doors were being locked.</p>	W 227	<p><b>W227</b> <b>483.440(c)(4)</b> <b>INDIVIDUAL PROGRAM PLAN</b> Planofcorrection: Client#6highrisk planwasupdatedtoinclude relevant interventions including 2hour checks and assistance with care (attachment k). Planofprevention: Facility staff were trained on plan and monitoring checklist (attachment l) was introduced. Weekly training will continue until staff competency is achieved (attachment h). PlanofMonitoring: House manager or associate house manager will provide daily supervision to ensure client #6 HRP and Ostomy chart is completed every 2 hours (attachment e). Facility coordinator/QIDP-D will provide weekly supervision to ensure client #6 HRP and Ostomy chart is completed every 2 hours (attachment g).</p>	02/01/2015

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	<p>On 1/15/15 at 4:15 PM, the DP Coordinator indicated the DP staff locked 2 of 3 bathroom doors due to client #4 going from one bathroom to another during the day during the day program hours (8:00 AM to 4:00 PM). The Coordinator indicated client #4 would leave feces smeared on the seats in each restroom causing the staff to have to spend too much time cleaning feces and not enough time providing programming to client #4. The DP Coordinator indicated he spoke to a former Home Manager who approved the locking of the bathroom doors. The DP Coordinator indicated there was no plan to lock the bathroom doors. The DP Coordinator stated it was "informal."</p> <p>On 1/20/15 at 11:56 AM, a review of client #4's record was conducted. There was no documentation in client #4's record indicating there was a plan to teach client #4 to use the restroom without smearing feces on the toilet seat.</p> <p>On 1/20/15 at 12:03 PM, the Coordinator indicated client #4 did not intentionally smear feces on the toilet seat. The Coordinator indicated client #4 needed to be encouraged to sit forward on the toilet seat. The Coordinator indicated client #4 sat on the seat so his back was against the</p>			

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W 240 Bldg. 00	<p>back of the toilet. When client #4 had a bowel movement, the feces would get on the seat due to the way he is sitting on the seat. The Coordinator indicated client #4 needed a written plan to encourage him to sit on the toilet so his feces would go into the toilet and not on the seat.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 3 clients in the sample (#6), the facility failed to indicate in client #6's Irritation and Food Blockage Risk Plans the frequency staff were to check his ileostomy (opening in the abdomen which allows the small intestine to protrude and allows stool to pass into an ostomy pouch).</p> <p>Findings include:  On 1/15/15 at 12:40 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 1/11/15 at 6:30 AM, staff #2 arrived to the group home. Former</p>	W 240	<p><b>W240</b> Plan of correction: Client#6 high risk plan was updated to include relevant interventions including 2 hour checks and assistance with care (attachment k). Plan of prevention: Facility staff were trained on plan and a monitoring checklist (attachment l) was introduced. Weekly training will continue until staff competency is achieved (attachment h). Plan of Monitoring: House manager or associate house manager will provide dailysupervision to ensure client #6 HRP and Ostomy chart is completed every 2 hours(attachment e). Facility coordinator / QIDP-D will provide weekly supervision to ensure client #6 HRP and Ostomy chart</p>	02/01/2015

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	<p>staff #11 was asleep on the couch. Staff #2's interview in the investigation indicated, "...she woke up shortly after his arrival and laughed." Staff #11 left the group home at 7:00 AM. Staff #2 indicated when he and staff #3 checked the clients, client #6's ileostomy bag was "busted." The investigation's interview with staff #11 indicated she reported she was asleep from 4:00 AM until staff #2 arrived to the group home. The investigation indicated, "The [name of group home] Overnight Checklist details tasks and duties of the overnight staff while working at [name of group home]. This checklist was not completed on the night of 1/10/15/morning of 1/11/15. This shift was filled by [staff #11]. [Staff #11] admits to not completing tasks on the list including checking on the clients aside from one time in the night. She indicates that she doesn't even know how to change or empty [client #6's] ostomy bag. According to the [name of group home] Overnight Checklist, staff should check beds every two hours after arrival. Staff should document on a separate bed check form. The documentation on bed check form was not completed by [staff #11] on this night either."</p> <p>The investigation indicated, "Substantiated, the findings support the event as neglect." The investigation</p>		is completed every 2 hours (attachment g).	

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	<p>indicated, "In conducting the interviews and reviewing the documentation pertinent to the incident in question, the evidence examined indicates that neglect did occur. Although there are some inconsistencies in statements concerning the events on Sunday morning January 11th, 2015, the overall recollections and reports from that morning are consistent. It has been determined that [staff #11], did in fact fail to provide appropriate supervision, as well as a safe, clean, and sanitary environment for the residents of [name of group home] while working as a direct support professional on the night of January 10th, 2015 and the morning of January 11th, 2015. [Staff #11] admitted that she was sleeping through large portions of her overnight shift at Stone Belt's [name of group home]. [Staff #11] also acknowledged that she did not check on the client's (sic) consistently throughout the night...."</p> <p>Observations were conducted at the group home on 1/15/15 from 4:04 PM to 5:47 PM and 1/20/15 from 5:49 AM to 7:48 AM. During the observations, client #6 had an ileostomy bag.</p> <p>On 1/20/15 at 2:06 PM, a review of client #6's record was conducted. The Food Blockage Risk Plan, dated 7/11/14, indicated, "In December 2013, due to</p>				

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	<p>complications from Intestinal Lipomatosis (fatty deposits adhering to the wall of the large intestine resulting in tissue being destroyed/dissolved), [client #6] had an ileostomy put in place (with all of his large bowel/colon being removed). [Client #6] is at risk for food blockage (a mechanical obstruction) which is a complication unique to people with an ileostomy." The Plan indicated, "1. Staff will ensure that [client #6] consumes adequate amounts of fluids daily. 2. Staff will encourage [client #6] to chew his food thoroughly at all meal times. 3. Staff will ensure that [client #6] does not consume foods such as popcorn, peanuts, corn, coconut, celery, dried fruits, grapes, Chinese vegetables and mushrooms - all foods that put [client #6] at risk for food blockage." There was no documentation in the plan indicating the frequency staff need to check client #6's ileostomy.</p> <p>Client #6's Skin Irritation Risk Plan, dated 11/11/14, indicated, "In December 2013, due to complications from Intestinal Lipomatosis (fatty deposits adhering to the wall of the large intestine resulting in tissue being destroyed/dissolved), [client #6] had an ileostomy put in place (with all of his large bowel/colon being removed). [Client #6] is at risk for skin irritation</p>			

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W 249	<p>and breakdown around the stoma site (opening in the abdomen which allows the small intestine to protrude and allows stool to pass into an ostomy pouch) due to adhesive from his ostomy pouch.</p> <p>[Client #6] was seen at the wound center on 11/11/14 d/t (due to) excessive skin irritation and redness around the stoma site and at that time directives were given by the ostomy nurse as to how to care for [client #6's] skin." There was no documentation in the plan indicating the frequency staff need to check client #6's ileostomy.</p> <p>On 1/20/15 at 12:32 PM, the Coordinator indicated the staff should check client #6's ileostomy every two hours. After speaking with the Nurse Manager, the Coordinator indicated the staff was to check and change as needed every couple of hours. The Coordinator indicated there was nothing specific in the plan on the frequency staff was to check his ileostomy. The Coordinator indicated client #6's plans needed to indicate the frequency staff was to check his ileostomy.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p>			

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Bldg. 00	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (#1), the facility failed to ensure staff implemented client #1's program plans for mealtime as written.</p> <p>Findings include:</p> <p>On 1/15/15 from 4:04 PM to 5:47 PM, an observation was conducted at the group home. At 5:20 PM the staff prompted the clients to come to the table for dinner. Client #1 sat down at the table at 5:31 PM. Client #1 was not asked from 5:31 PM until 5:47 PM if he wanted to eat his dinner in 45 minutes or 60 minutes. Client #1 was not given reminders of how much time he had left to finish his meal.</p> <p>On 1/16/15 from 10:54 AM to 11:54 AM, an observation was conducted at the facility-operated day program (DP) where client #1 attended. At 11:30 AM, client #1 started to eat his lunch. From 11:30 AM to 11:54 AM, client #1 was not asked if he wanted 45 or 60 minutes to</p>	W 249	<p><b>W249</b> <b>483.440(d)</b> <b>(1)PROGRAMIMPLEMENTATION</b></p> <p>Planofcorrection:Client#1 highriskplanwasreviewedandwillb implemented. Planofprevention:Facilitystaffwere trainedtoimplementclient#1'sprogr amplansfor mealtime aswritten.Weeklytraining willcontinueuntilstaffcompetencyi sachieved (attachment m). PlanofMonitoring:Housemanager orassociatehousemanagerwillpro videdaily supervisiontoensureclient#1dining planisbeingimplemented(attachm ent e). Facilitycoordinator/QIDP-Dwillpro videweeklysupervisiontoensurecli ent#1dining planisbeingimplemented(attachm entg).</p>	02/01/2015	

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	<p>eat his lunch. Client #1 was not given reminders of how much time he had left to finish his meal.</p> <p>On 1/16/15 at 11:38 AM, the DP instructor indicated client #1 had until 1:00 PM to finish his lunch. The instructor indicated the DP did not use a timer. The instructor stated, "It's a good idea, though." The instructor stated, "Not sure what they do at the house" in regard to keeping track of the time it took client #1 to finish his meal.</p> <p>On 1/20/15 from 5:49 AM to 7:48 AM, an observation was conducted at the group home. At 6:59 AM, client #1 was observed to eat his breakfast. At 7:04 AM, client #1 was eating breakfast at the table unsupervised. At 7:14 AM, client #1 was prompted to go to the office area to get his medications. At 7:29 AM, client #1 returned to the dining room to finish his breakfast. During the observation, client #1 was not asked if he wanted 45 or 60 minutes to eat his breakfast. Client #1 was not given reminders of how much time he had left to finish his meal.</p> <p>On 1/20/15 at 12:38 PM, a review of client #1's record was conducted. Client #1's 9/10/14 Behavioral Support Plan (BSP) indicated he had a targeted</p>			

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	behavior of unsafe eating. Unsafe eating was defined as overfilling his mouth, failing to chew and swallow adequately. The BSP indicated, in part, "Due to a history of choking episodes at [client #1's] day program and group home, [client #1's] team has recommended that he be visually supervised whenever he is eating. While [client #1] does not appear to deliberately overfill his mouth, he had reported that he wants to get all of the 'yummy-ness' out of his food which leads to trying to fit more into his mouth that he can process; therefore [client #1] does need to be monitored for accidentally overfilling his mouth and/or failing to chew properly in order to prevent choking." The plan indicated, "While eating, [client #1] will remain in line-of-sight supervision to ensure he is continuing to eat safely." The plan indicated, "At meal times, [client #1] will be given a 60-minute (1 hour) time period within which he may eat/drink his meal, and that once the stated amount of time is up, he will need to move on to the next activity. A timer may be used to remind [client #1] of the duration of his meal and the onset of the next event or transition on his schedule. [Client #1] will be given a reminder approximately five minutes before the end of the meal time. Staff may provide infrequent prompts reminding [client #1] exactly			

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W 262 Bldg. 00	<p>how much time remains before the end of the meal."</p> <p>Client #1's Individual Support Plan, dated 9/10/14, indicated he had a training objective to address his eating pace. The plan indicated, "During meal times, [client #1] will eat at a steady pace and finish his meal in specified amount of time...." The plan indicated, "[Client #1] will eat his meals in no more than 60 minutes with verbal prompts. [Client #1] will choose whether he wants 45 minutes or 60 minutes in which to complete his meal. Once he has decided how much time he will take to eat his meal, staff will keep track of the time and occasionally remind [client #1] how much time he has left...."</p> <p>On 1/20/15 at 3:03 PM, the Coordinator indicated client #1's plans should be implemented as written for giving him a choice of 45 or 60 minutes, occasional reminders of how much time he had left, and to keep him within line of sight during breakfast.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and</p>			

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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404
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	<p>monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on observation, interview and record review for 3 of 3 clients in the sample (#1, #5 and #6) and three additional clients (#2, #3 and #4), the facility's specially constituted committee (HRC - Human Rights Committee) failed to review, approve and monitor the locking of the clients' bedroom doors at night.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/20/15 from 5:49 AM to 7:48 AM. At 5:49 AM, the clients' bedrooms doors were closed and locked.</p> <p>On 1/20/15 at 6:00 AM, staff #4 indicated the clients' bedroom doors were closed and locked due to an incident when client #4 went into client #1's bedroom during the night shift months ago and injured client #1. Staff #4 indicated during the night shift, client #1, #2, #3, #5 and #6's bedroom doors were closed and locked from the inside due to the possible aggression from client #4 during the night shift.</p> <p>A review of client #1's record was</p>	W 262	<p><b>W262</b> <b>483.440(f)(3)</b> <b>(i)PROGRAMMONITORING &amp;CHANGE</b> Planofcorrection:HRApprovalwasobtainedtocontinuehouserestrictionsforlockingbedroom doors. PlanofPreventing: PlanofPreventing: Housemanagerorassociatehousemanagerwill providedailysupervisiontoensureclientsareprovidedprivacy(attachmente). PlanofMonitoring:Facilitycoordinator/QIDP-Dwillprovideweeklysupervisionto ensureprotectionofclient'srights.FacilitysocialworkerwillprovideoversightthatHRC restrictions havebeenapprovedbysupportteamanddueprocess(attachment f).</p>	02/01/2015

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	<p>conducted on 1/20/15 at 12:38 PM. Client #1's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors. Rationale: A resident entered another resident's room during the night and hit 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 should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom." The HRC approved the restriction on 5/29/13. There was no documentation the HRC reviewed, approved and monitored the restriction since 5/29/13.</p> <p>A review of client #2's record was conducted on 1/20/15 at 11:58 AM. Client #2's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors. Rationale: A resident entered another resident's room during the night and hit his peer on the back. During evening</p>				

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	<p>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 should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom." The HRC approved the restriction on 5/29/13. There was no documentation the HRC reviewed, approved and monitored the restriction since 5/29/13.</p> <p>A review of client #3's record was conducted on 1/20/15 at 11:54 AM. Client #3's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors. Rationale: A resident entered another resident's room during the night and hit 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</p>			

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	<p>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." The HRC approved the restriction on 5/29/13. There was no documentation the HRC reviewed, approved and monitored the restriction since 5/29/13.</p> <p>A review of client #4's record was conducted on 1/20/15 at 11:56 AM. Client #4's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors. Rationale: A resident entered another resident's room during the night and hit 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 should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom."</p>			

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	<p>The HRC approved the restriction on 5/29/13. There was no documentation the HRC reviewed, approved and monitored the restriction since 5/29/13.</p> <p>A review of client #5's record was conducted on 1/20/15 at 1:40 PM. Client #5's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors. Rationale: A resident entered another resident's room during the night and hit 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 should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom." The HRC approved the restriction on 5/29/13. There was no documentation the HRC reviewed, approved and monitored the restriction since 5/29/13.</p> <p>A review of client #6's record was conducted on 1/20/15 at 12:00 PM.</p>			

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	<p>Client #6's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors.</p> <p>Rationale: A resident entered another resident's room during the night and hit 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 should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom." The HRC approved the restriction on 5/29/13. There was no documentation the HRC reviewed, approved and monitored the restriction since 5/29/13.</p> <p>On 1/20/15 at 11:55 AM, the Coordinator indicated the facility's HRC should review, approve and monitor the clients' restrictive plans annually.</p> <p>9-3-4(a)</p>			

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W 263  Bldg. 00	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, interview and record review for 2 of 3 clients in the sample (#1 and #5) and three additional clients (#2, #3 and #4), the facility's specially constituted committee (HRC - Human Rights Committee) failed to ensure written informed consent from the clients' guardians was obtained regarding the locking of the clients' bedroom doors at night.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/20/15 from 5:49 AM to 7:48 AM. At 5:49 AM, the clients' bedrooms doors were closed and locked.</p> <p>On 1/20/15 at 6:00 AM, staff #4 indicated the clients' bedroom doors were closed and locked due to an incident when client #4 went into client #1's bedroom during the night shift months ago and injured client #1. Staff #4 indicated during the night shift, client #1, #2, #3, #5 and #6's bedroom doors were closed and locked from the inside due to the possible aggression from client #4</p>	W 263	<p><b>W263</b> Plan of correction: HRC approval was obtained to continue house restriction for lockingbedroom doors. Plan of Preventing: Plan of Preventing: House manager or associatehouse manager will provide daily supervision to ensure clients are providedprivacy (attachment e). Plan of Monitoring: Facility coordinator / QIDP-D will provideweekly supervision to ensure protection of client's rights. Facilitysocial worker will provide oversight that HRC restrictions have been approved by support team and due process (attachment f).</p>	02/02/2015

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	<p>during the night shift.</p> <p>A review of client #1's record was conducted on 1/20/15 at 12:38 PM. Client #1's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors. Rationale: A resident entered another resident's room during the night and hit 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 should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom." The guardian gave written informed consent for the restriction on 6/17/13. There was no documentation the facility obtained written informed consent from the client's guardian since 6/17/13.</p> <p>A review of client #2's record was conducted on 1/20/15 at 11:58 AM. Client #2's Human Rights Approval, dated 4/17/13, indicated, in part, "Button</p>			

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	<p>release locks on bedroom doors.</p> <p>Rationale: A resident entered another resident's room during the night and hit 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 should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom." The guardian gave written informed consent for the restriction on 8/14/13. There was no documentation the facility obtained written informed consent from the client's guardian since 8/14/13.</p> <p>A review of client #3's record was conducted on 1/20/15 at 11:54 AM. Client #3's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors.</p> <p>Rationale: A resident entered another resident's room during the night and hit his peer on the back. During evening hours there is only one staff on duty, and should another resident need staff</p>			

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	<p>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." The guardian gave written informed consent for the restriction in June 2013. There was no documentation the facility obtained written informed consent from the client's guardian since June 2013.</p> <p>A review of client #4's record was conducted on 1/20/15 at 11:56 AM. Client #4's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors. Rationale: A resident entered another resident's room during the night and hit 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</p>			

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	<p>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." The guardian gave written informed consent for the restriction on 6/10/13. There was no documentation the facility obtained written informed consent from the client's guardian since 6/10/13.</p> <p>A review of client #5's record was conducted on 1/20/15 at 1:40 PM. Client #5's Human Rights Approval, dated 4/17/13, indicated, in part, "Button release locks on bedroom doors. Rationale: A resident entered another resident's room during the night and hit 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 should night staff be occupied with care of another resident and a resident attempts to enter another's bedroom."</p>			

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W 323 Bldg. 00	<p>The guardian gave written informed consent for the restriction on 8/8/13. There was no documentation the facility obtained written informed consent from the client's guardian since 8/8/13.</p> <p>On 1/20/15 at 11:55 AM, the Coordinator indicated the facility's HRC should ensure annual written informed consent was obtained from the clients' guardians.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5's vision and hearing were evaluated annually.</p> <p>Findings include:</p> <p>On 1/20/15 at 1:40 PM, a review of client #5's record indicated he had a hearing assessment attempted on 10/27/14. The Outside Services Report form, dated 10/27/14 indicated, in part, "Unable to test. Patient could not understand</p>	W 323	<p><b>W323</b> <b>483.460(a)(3)</b> <b>(i)PHYSICIANSERVICES</b></p> <p>Planofcorrection:Clientannualphy sicalwascompleted2/15/15(attach mentn).</p> <p>Planofprevention:Dayaidewillensu reannualphysicalexaminationsofe achclientare completed (attachment q).</p> <p>PlanofMonitoring:Housemanager orassociatehousemanagerwillmo nitortoensure clientsannualphysicalappointment sarecompleted(attachment e). Facilitycoordinator/QIDP-Dandfac ilitynursewillmonitortoensureclient</p>	02/01/2015

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	<p>instructions. If specific hearing ability is needed, sedated ABR (auditory brainstem response) is recommended." An Outside Services Report, dated 11/15/10, indicated, "Could not assess today... Return only if new concerns arise." Client #5's most recent annual physical exam, dated 6/12/14, did not include an assessment of his hearing. The section on the form was blank for hearing.</p> <p>Client #5's most recent vision evaluation, dated 11/6/14, indicated, "He would not cooperate today for me to look at him." Client #5's most recent annual physical exam, dated 6/12/14, did not include an assessment of his vision. The section on the form was blank for vision.</p> <p>On 1/20/15 at 3:11 PM, the Coordinator indicated client #5 was going to have general anesthesia in February 2015. The Coordinator indicated client #5's vision assessment will be completed in February. The Coordinator indicated client #5's hearing appointment was not successful. The Coordinator indicated she went to the appointment but client #5 was unable to respond to the instructions.</p> <p>9-3-6(a)</p>		<p>sannual physicalappointmentsarecomplet edimplemented(attachment g).</p>				

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W 331  Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 3 of 3 clients in the sample (#1, #5 and #6), the facility's nursing services failed to ensure staff documented the implementation of nail care, weights, blood pressure, pulse, shoe inserts and fluids.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 1/20/15 at 12:38 PM. Client #1's November 2014 Routine Treatments documentation indicated the staff did not document weighing client #1 weekly, the use of bilateral shoe inserts daily, weekly nail care and offering fluids (full glass of water) when client #1 returned home for the day and with meals and snacks. Client #1's December 2014 Routine Treatments documentation indicated the staff documented 3 of 5 weekly weights, no documentation for the use of bilateral shoe inserts daily, no documentation for weekly nail care, and no documentation for offering fluids (full glass of water) when client #1 returned home for the day and with meals and snacks. A 1/8/15 Nursing Consultation note indicated, "Documentation for the</p>	W 331	<p><b>W331</b> <b>483.460(c)NURSINGSERVICES</b> Planofcorrection:Facilitystafftraîne dondocumentingtheimplementatio nofnailcare, weights,bloodpressure,pulse,sho einsertsandfluidintake. (attachment o) Planofprevention:Dayaidewillensu rethatstaffaredocumentingtheimpl ementationofnailcare,weights,blo odpressure,pulse,shoeinsertsandf luidintake(attachment q). PlanofMonitoring:Housemanager orassociatehousemanagerwillmo nitortoensure staffsdocumentingtheimplementa tionofnailcare,weights,bloodpress ure,pulse, shoeinsertsandfluidintake. (attachment e).Facilitycoordinator/QIDP-Dand facility nursewillmonitor toensurestaffisd ocumentingtheimplementationofn ailcare, weights,bloodpressure,pulse,sho einsertsandfluidintake(attachment g).</p>	02/01/2015

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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404
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	<p>month of Dec. '14 reviewed by nurse - documentation continues to be incomplete, coordinator and staff notified. At house meeting scheduled for 1/16/15 this ongoing issue will be addressed by nurse and coordinator with definitive parameters set going forward which will include disciplinary actions when appropriate."</p> <p>A review of client #5's record was conducted on 1/20/15 at 1:40 PM. Client #5's June, September, October and November 2014 Routine Treatments documentation indicated the staff did not document nail care and a monthly weight. A 10/23/14 Dietician note indicated, "No weight recorded as of yet this month. Continues to receive high cal (calorie) HS (bedtime) snack and Ensure supp. (supplement) BID (twice a day). Recommend to keep monthly weight log in chart to access previous month weights. Goal: maintain wt (weight) 115 - 120 (pounds)." A Nursing Consultation note, dated 7/10/14, indicated, "When reviewing end of the month paperwork (June '14 MARS (medication administration record)/TX (treatment) sheets nurse noted items that had not been documented completely or accurately - coordinator notified of missed documentation and asked to addressed (sic) this issue with staff</p>			

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	<p>(trainings have taken place in the past on same issue)."</p> <p>A review of client #6's record was conducted on 1/20/15 at 2:06 PM. Client #6's October and November 2014 Routine Treatments documentation indicated staff did not document weekly nail care, weekly blood pressure, weekly pulse and weekly weights. Client #6's December 2014 Routine Treatments documentation indicated staff did not document weekly nail care, weekly blood pressure, 4 of 5 weekly pulse, and 3 of 5 weekly weights. A Nursing Consultation note, dated 1/8/15, indicated, "Documentation for the month of Dec. '14 reviewed by nurse - documentation continues to be incomplete, coordinator and staff notified. At house meeting scheduled for 1/16/15 this ongoing issue will be addressed by nurse and coordinator with definitive parameters set going forward which will include disciplinary actions when appropriate." The Nutritional Recommendations Worksheet, dated 10/23/14, for client #6 indicated, "No weight recorded... Obtain weekly weights, maintain weight log in chart to access previous month's weight."</p> <p>On 1/15/15 at 2:33 PM, the Nurse Manager (NM) indicated the staff were failing to document weekly weights,</p>			

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W 340 Bldg. 00	<p>weekly blood pressure, nail care and other treatments for the clients. The NM indicated he was aware and had made notes in the clients' records. The NM indicated he was recently informed he was able to take disciplinary action with the staff for failing to document these items. The NM indicated he informed the Coordinator and staff of the expectations. The NM indicated the issue would be addressed again at the next group home meeting with the staff.</p> <p>9-3-6(a)</p> <p>483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on observation and interview for 1 of 1 client (#6) in the sample observed to have his medication crushed with a pill crusher, the facility failed to ensure the pill crusher was cleaned after each use.</p> <p>Findings include:  On 1/20/15 at 6:43 AM, client #6 received Levothyroxine (thyroid) from staff #7. Staff #7 used a pill crusher to</p>	W 340	<p><b>W340</b> <b>483.460(c)(S)(i)</b> <b>NURSINGSERVICES</b> Planofcorrection:Facilitystafftraine d oncleaningpillcrusherfollowingeach medication administration(attachmentR). Planofprevention:Dayaidewillensu rethatstaffsarecleaningpillcrusherf ollowing eachmedication administration(attachment q).. PlanofMonitoring:Housemanager</p>	02/01/2015

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	<p>crush the medication prior to administering the medication. The pill crusher was caked with residue prior to staff #7 using the crusher. The bottom and sides of the pill crusher had residue from previous medications being crushed. The sides and bottom were white in color with medications from previous medication passes stuck to the sides and bottom.</p> <p>On 1/20/15 at 6:43 AM, staff #7 indicated she tried to wash the pill crusher and some of the residue came out. Staff #7 stated she tried to "rinse" the pill crusher daily. Staff #7 indicated she needed to speak to the Coordinator about getting new pill crushers. Staff #7 stated, "Every time I open it there's something in there."</p> <p>On 1/20/15 at 12:16 PM, the Coordinator indicated the pill crusher should be washed every each use. The Coordinator indicated the task was on the overnight staff's checklist to complete daily. The Coordinator indicated the pill crusher should not be full of residue.</p> <p>On 1/20/15 at 12:43 PM, the Nurse Manager indicated the pill crusher should be washed after each use.</p> <p>9-3-6(a)</p>		<p>orassociatehousemanagerwillcleaningpill crusherfollowingeachmedication administration(attachmente).Facility coordinator/ QIDP-Dandfacilitynursewillmonitortoensurecleaningpillcrusherfollow ingeach medicationadministration(attachm entg).</p>		

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W 368  Bldg. 00	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 4 of 6 clients (#2, #3, #4 and #6) living in the group home, the facility failed to ensure the staff administered the clients' medications according to the physician's orders.</p> <p>Findings include:</p> <p>On 1/15/15 at 12:40 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/7/15 at 7:00 AM, staff #4 did not administer client #3's Lexapro (anxiety). The Medication Error Report, dated 1/7/15, indicated, "Staff did not administer 7A Lexapro (Escitalopram) 10 mg (milligrams) on 1/7/15 as the pill was found on the floor and was not there the previous day."</p> <p>2) On 1/2/15 at 7:00 AM, staff #4 administered the wrong dose of Methylpredisolone (synthetic glucocorticoid or corticosteroid drug) to</p>	W 368	<p><b>W368 483.460(k)(1) DRUG ADMINISTRATION</b> Plan of correction: Facility staff trained drug administration in compliance with the physician's orders. (attachment s). Plan of prevention: Day aide will review MARs and pill packs to ensure that staff are completing drug administration in compliance with the physician's orders (attachment q) Plan of Monitoring: House manager or associate house manager will review MARs and pillpacks daily to ensure that staff are completing drug administration in compliance with the physician's orders (attachment g). <b>Facility Nurse will provide weekly review of MARs and pill packs to ensure that staff are completing drug administration in compliance with the physician's order (attachment yy).</b></p>	02/01/2015

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	<p>client #3. Staff #4 administered two tabs instead of one tab.</p> <p>3) On 12/28/14 at HS (hour of sleep), staff #2 failed to administer client #4's Miralax (constipation). The Medication Error Report, dated 12/29/14, indicated, "After two days without a BM (bowel movement) administer 17 gm (grams) of Miralax. Miralax wasn't administered... Keep better attention on the number of days it has been since [client #4] bm'ed." The report indicated, "Failure to follow high risk plan."</p> <p>4) On 12/6/14 at 8:00 PM, staff #3 administered one capsule instead of two capsules of Tamsulosin (enlarged prostate) to client #3.</p> <p>5) On 11/18/14 and 11/19/14 at HS, staff #9 administered client #2 another client's Quetiapine (antipsychotic) 400 mg (milligrams). The Medication Error Report, dated 11/19/14, indicated, "The last two day quetiapine 400 mg was accidentally passed to [client #2]."</p> <p>6) On 11/13/14 at 11:15 PM, staff #9 administered one tablet of Mapap (acetaminophen) instead of two tablets to client #6.</p> <p>7) On 10/25/14 at 8:00 PM, staff #10</p>			

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W 382 Bldg. 00	<p>administered one capsule instead of two capsules of Tamsulosin (enlarged prostate) to client #3.</p> <p>On 1/21/15 at 1:37 PM, the Nurse Manager (NM) indicated the medication errors were due to carelessness of the staff. The NM indicated the staff did not do the checks during the medication pass as he/she was taught. The NM stated, "People get lazy." The NM indicated the staff was not paying attention and not doing the checks.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) <b>DRUG STORAGE AND RECORDKEEPING</b> The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation 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 secured the clients' medications.</p> <p>Findings include:</p> <p>On 1/20/15 at 6:07 AM, staff #7 left the medication cabinet and office door unlocked and open when she exited the</p>	W 382	<p><b>W382</b> <b>483.460(1)</b> <b>(2)DRUGSTORAGEANDRECORDKEEPING</b> Planofcorrection:Facilitystafftraîne donkeepingalldrugsandbiologicals locked exceptwhenbeingpreparedforadm inistration(attachmentT). Planofprevention:Dayaidewillensu restaffarekeepingalldrugsandbiologicalslocked exceptwhenbeingpreparedforadm inistration(attachment q)..</p>	02/01/2015

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W 440 Bldg. 00	<p>medication room to assist client #1 to go to the restroom. Staff #7 left the medication room unattended and the medications unsecured for 15 seconds. At 6:41 AM, staff #7 left the medication cabinet and office door unlocked when client #6 walked out of the medication room and she followed him. Staff #7 closed the office door however the door was not locked and the medication cabinet was unlocked. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 1/20/15 at 12:07 PM, the Coordinator indicated when the staff leave the office, the medications should be secured. The Coordinator indicated the medications should be unlocked when staff was present in the office.</p> <p>On 1/20/15 at 12:42 PM, the Nurse Manager indicated the medications should be locked at all times unless the staff were administering medications.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for</p>	W 440	Plan of Monitoring: House manager or associate house manager will ensure staff are keeping all drugs and biologicals locked except when being prepared for administration (attachmentg).	02/01/2015

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W 460 Bldg. 00	<p>6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>On 1/15/15 at 3:50 PM a review of the facility's evacuation drills was conducted. During the day shift (6:00 AM to 2:00 PM) there were no drills conducted from 6/6/14 to 10/30/14. During the evening shift (2:00 PM to 10:00 PM) there were no drills conducted from 8/11/14 to 12/11/14. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 1/15/15 at 4:03 PM, the Coordinator stated the facility should conduct evacuation drills "one per shift per quarter."</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, 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</p>	W 460	<p>have been trained to complete quarterly evacuation drills for each shift (attachment w)</p> <p>Plan of prevention: Facility house manager will ensure that drills are scheduled and have been completed per the drill schedule form (attachment x)</p> <p>Plan of monitoring: Email alerts are sent out to the coordinator each month notifying that drills are still outstanding</p> <p><b>W460</b> <b>483.480(a)</b> <b>(1)FOODANDNUTRITIONSERVICES</b> Planofcorrection:Facilitystafftraîne</p>	02/01/2015

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	<p>encouraged and prompted the clients to receive a nourishing, well-balanced diet during breakfast.</p> <p>Findings include:</p> <p>On 1/20/15 from 5:49 AM to 7:48 AM, an observation was conducted at the group home. At 6:37 AM, client #4 was observed at the dining room table eating waffles and drinking milk. At 6:47 AM, client #5 was eating a bowl of cereal. Client #5 did not have a drink. At 6:59 AM, client #1 was eating a breakfast bar broken up into pieces in a bowl with raisins and coffee. At 7:12 AM, client #5 was at the table with an empty bowl and no drink. At 7:13 AM, client #3 had a bowl of cereal and a glass of milk. At 7:19 AM, client #2 ate a waffle with peanut butter on it in the living room. Client #2 had a cup of coffee. At 7:26 AM, client #5 poured a second bowl of cereal. Client #5 did not have a drink. At 7:41 AM, client #6 ate a banana. Client #6 was not offered a drink or any additional food during the observation. During breakfast, none of the clients was offered or provided orange juice or a bacon and egg sandwich.</p> <p>On 1/20/15 at 6:02 AM, a review of the menu, dated Week 2, 9/15/14, for breakfast on Tuesday indicated: 4 ounces</p>		<p>d ensuring that each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets (attachment U). Plan of prevention: FMPS will ensure that staff are providing each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Plan of Monitoring: House manager or associate house manager will ensure staff are ensuring that each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets (attachment g).</p>	

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W 999 Bldg. 00	<p>of orange juice, bacon and egg sandwich, and 8 ounces of milk and coffee.</p> <p>On 1/20/15 at 12:19 PM, the Coordinator indicated the clients should be offered the items from the menu. The Coordinator indicated cereal was not a nutritional equivalent substitution for a bacon and egg sandwich.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met:</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the</p>	W 999	<p><b>W999</b></p> <p>460IAC9-3-3FacilityStaffing Planofcorrection:Facilitystaffwasa dministeredaPPDscreening1/16/15 anditwas read1/19/15byfacilitynurse(attach mentv}.</p> <p>Planofprevention:Facilityhumanre sourcedepartmentwillensurethatst afffilesare current andifitemsareexpiredanal ertwillbeemailedtothestaffandcoor dinator.Planofmonitoring: Facilitycoordinatorwillassistwithm onitoringstaffhumanresource recordstoensurethisdocumentatio niscurrent.</p>	02/01/2015

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	<p>skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee (staff #5) files reviewed, the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>On 1/15/15 at 2:14 PM, a review of the facility's employee files was conducted. Staff #5's most recent Mantoux was completed on 1/8/14. There was no documentation in staff #5's employee file indicating staff #5 had an annual Mantoux since 1/8/14.</p> <p>On 1/16/15 at 12:56 PM, the Nurse Manager indicated in an email, "[Group Home Director] wanted me to send you a copy of a staff's tb (tuberculosis) test - was just given this morning so won't be able to read until Sunday/Monday."</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G643	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2015
NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	On 1/15/15 at 2:26 PM, the Group Home Director indicated staff #5 should have an annual Mantoux.  9-3-3(e)				