

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 04/10/2015
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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 Post Certification Revisit (PCR) to the full recertification and state licensure survey completed on 1/22/15.</p> <p>Survey Dates: April 9 and 10, 2015</p> <p>Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 8 of 29 incident/investigative reports reviewed affecting clients #1, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, implement recommendations following client #6's fall with a head injury and investigate a fracture of client #5's toe.</p>	W 149	<p>{W 149}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.</p> <p>1) Plan of Correction: Facility investigated and terminated staff #7 when it was founded that he</p>	04/17/2015

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>Findings include:</p> <p>On 4/9/15 at 1:12 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 4/4/15 at 6:35 PM, client #4 ran into client #5's bedroom. Client #4 attempted to put client #5 into a headlock. Client #4 bit client #5 on the back leaving a 2 inch round circle. The bite did not break the skin. Client #5 had a 2.5 inch red mark on his forehead. The Bureau of Developmental Disabilities Services incident report, dated 4/6/15, indicated, in part, "[Staff #7] detained client [#4] by laying on top of him for approx. (approximately) 30 seconds until [client #5] was out of the bedroom and safe."</p> <p>On 4/10/15 at 2:41 PM, the results of the investigation, dated 4/10/15, were reviewed. The investigation indicated, in part, "The allegation is substantiated. There is evidence to support the allegation that [staff #7] did not use proper CPI (Crisis Prevention Institute) technique. This is defined as physical abuse by the above policy. There is also evidence to support the allegation that [staff #7] did not maintain a safe environment when he failed to keep</p>		<p>did not implement policy and procedures that prohibit mistreatment, neglect, or abuse of clients (attachment upon request).</p> <p>Plan of Prevention: Facility DSPs trained on crisis intervention annually. Prevention of abuse and neglect trained monthly at Shiloh meeting. Client #4 behavior support plan competency based training to facility staff (attachment b).</p> <p>Plan of Monitoring: Facility coordinator / QIDP-D will provide weekly monitoring of facility. House manager and associate house manager will provide <u>daily monitoring</u> to ensure that staff are implementing policies and procedures that prohibit mistreatment, neglect or abuse of the client (attachment c)</p> <p>2) Plan of Correction: LL day program facility completed investigation and determined that staff followed fall plan. Client #6 'turned quickly and tripped'. High risk plan reviewed by support team and deemed appropriate and LL staff were following plan.</p> <p>Plan of Prevention: LL day program facility DSPs trained on client #6 fall plan (attachment d)</p> <p>Plan of Monitoring: Facility coordinator / QIDP-D will provide weekly monitoring of LL day program facility. LL day program facility coordinator will provide <u>daily</u></p>	

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	<p>[client #4] within arm's length, as defined in his Behavior Support Plan, and this resulted in injury to clients and staff. This is defined as neglect in the policy above. The admission of inappropriate physical intervention was presented by [staff #7] himself. The report of physical abuse by not using proper CPI technique is consistent in the information provided during the interviews, and is also consistent with the incident report written on 4/4/15 and reviewed by this writer. The reports of [staff #8] and [staff #3] contain contradictions from the report of [staff #7's] perspective and vantage point. The allegation of neglect by not following Behavior Support plan, in keeping [client #4] in arms length or 3 ft. (feet) at all times was evident by all parties through interview process." The Recommendations section of the investigation indicated, in part, "Due to the allegation of abuse was (sic) substantiated [staff #7] will be terminated from his substitute position with Stone Belt."</p> <p>On 4/9/15 at 2:20 PM, the Group Home Director (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. On 4/10/15 at 2:17 PM, the GHD</p>		<p><u>monitoring</u> to ensure that staff are implementing policies and procedures that prohibit mistreatment, neglect or abuse of the client(attachment e)</p> <p>3) Plan of Correction: LL day program facility completed client on client investigation and determined that staff followed fall plan. Client #5 chair being utilized outside was the causation of the fall resulting in injury. High risk plan reviewed by support team and deemed appropriate and LL staff followed plan.</p> <p>Plan of Prevention: LL day program facility DSPs trained on client #5 fall plan (attachment d) along with peers BEHAVIOR SUPPORT PLAN.</p> <p>Plan of Monitoring: Facility coordinator / QIDP-D will provide weekly monitoring of LL day program facility. LL day program facility coordinator will provide <u>daily monitoring</u> to ensure that staff are implementing policies and procedures that prohibit mistreatment, neglect or abuse of the client(attachment e).</p> <p>4) Plan of Correction: LL day program facility completed client on client investigation and determined that staff followed fall plan. Client #5 chair being utilized outside was the causation of the fall resulting in injury. High risk plan reviewed by support team and deemed appropriate and LL staff followed plan.</p>		

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	<p>indicated the staff neglected to implement client #4's one on one supervision plan. The GHD indicated the staff's negligence led to a client to client incident which led to staff using an improper restraint. The GHD indicated the staff laid on top of client #4 which could have cause asphyxiation. The GHD indicated the staff will be terminated once the Chief Executive Officer approves the GHD's recommendation of termination.</p> <p>On 4/9/15 at 4:10 PM, the Program Coordinator (PC) indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>2) On 4/2/15 at 12:30 PM, a Stone Belt, ARC Inc. Incident Report, dated 4/2/15, indicated, in part, "[Client #6] was walking around (sic) classroom, eating bites of pudding and fruit cup. [Client #6] had not received an adequate lunch and was refusing to eat the fruit cup when he turned away quickly as a spoon of fruit was offered to him. [Client #6] turned quickly and tripped, stumbling over his feet and fell to his right side. When [client #6] fell, he hit his head on the sink corner. [Client #6] cried out, head was</p>		<p>Plan of Prevention:LL day program facility DSPs trained on client #5 fall plan (attachment d) along with peers BEHAVIOR SUPPORT PLAN.</p> <p>Plan of Monitoring:Facility coordinator / QIDP-D will provide weekly monitoring of LL day program facility. LL day program facility coordinator will provide <u>daily monitoring</u> to ensure that staff are implementing policies and procedures that prohibit mistreatment, neglect or abuse of the client(attachment e).</p> <p>5) Plan of Correction: Facility completed client on client investigation. Client #4 has history of client on incidents. Staff followed his behavior plan but he moved too quickly to prevent contact with client #5. It was determined that client slid on the floor willingly and the act may have been horseplay with no intent to cause injury.</p> <p>Plan of Prevention:Facility DSPs trained on crisis intervention annually. Prevention of abuse and neglect trained monthly at Shiloh meeting. Client #4 behavior support plan competency based training to facility staff (attachment b).</p> <p>Plan of Monitoring:Facility coordinator / QIDP-D will provide weekly monitoring of facility. House manager and associate house manager will provide <u>daily monitoring</u> to ensure that staff are implementing policies and</p>				

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	<p>bleeding; [client #6] layed (sic) down for about 2 minutes. Nurse was notified and requested that his BP (blood pressure) be taken every hour for 24 hours. Staff administered first aid."</p> <p>On 4/9/15 at 4:05 PM, a review of client #6's Medication Administration Record (MAR) for April 2015 was conducted. There was no documentation of his blood pressure being documented every hour for 24 hours after a fall with a head injury on 4/2/15 at 12:30 PM. There was no documentation the staff took his blood pressure from 8:00 PM to 6:00 AM as instructed by the nurse. The MAR indicated, "BP (blood pressure) taken every hr (hour) over the next 24 hrs (hours)." The form indicated R (refusal) at 5:00 PM and 6:00 PM. The form indicated his blood pressure was 107/66 at 7:00 PM. The form indicated his blood pressure was 141/84 at 7:00 AM.</p> <p>On 4/10/15 at 1:17 PM, the Nurse Manager (NM) indicated another nurse ordered client #6's blood pressure to be taken for 24 hours after client #6 hit his head during a fall. The NM stated, "Doesn't surprise me" when informed the staff did not record client #6's blood pressure from 8:00 PM to 6:00 AM. The NM indicated the staff should have followed the nursing order.</p>		<p>procedures that prohibit mistreatment, neglect or abuse of the client(attachment c)</p> <p>6) Plan of Correction: LL day program facility completed client on client investigation and determined that staff followed fall plan. Client #1 was scratched by a peer while dancing in the gym, no intent to harm. Behavior support plan was followed by staff. Plan of Prevention: LL day program facility DSPs trained on peers behavior support plan (attachment d). Plan of Monitoring: Facility coordinator / QIDP-D will provide weekly monitoring of LL day program facility. LL day program facility coordinator will provide <u>daily monitoring</u> to ensure that staff are implementing policies and procedures that prohibit mistreatment, neglect or abuse of the client(attachment e).</p> <p>7) Plan of Correction: LL day program facility completed client on client investigation and determined that staff followed fall plan. Client #5 was hugged by peer with no intent to cause harm. Behavior support plan was followed by staff. Plan of Prevention: LL day program facility DSPs trained on peers behavior support plan (attachment d). Plan of Monitoring: Facility coordinator / QIDP-D will provide weekly monitoring of LL day</p>	

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	<p>3) On 4/1/15 at 2:20 PM at the facility-operated day program, client #5 was rolling in an office chair past a peer. The peer stepped into client #5's path. The peer tripped and fell. As she was falling, she grabbed client #5 to try and break her fall. Client #5 and the peer fell to the floor. Client #5 fell on his right side. At the time, no injuries were found on client #5. On 4/1/15 later in the day, client #5's foot was swollen. On 4/2/15, client #5 was taken to the doctor and found to have a fifth metatarsal (one of five long bones in the foot) fracture.</p> <p>The facility's incident report, dated 4/1/15, indicated the Regional Director of Programs reviewed the incident report on 4/3/15. The report indicated, "[Name of day program] Director completed a review of this incident on 4/3/15. Staff will be trained that [name of peer] will be asked to remain seated until she had a safe area in which to stand, given her high risk of falls. Also, as a precaution, staff will not take the rolling office chair outside, in the future." There was no documentation the facility investigated the incident.</p> <p>On 4/9/15 at 2:39 PM, the Group Home Director indicated she informed the Regional Director of Programs the</p>		<p>programfacility. LL day program facility coordinator will provide <u>daily monitoring</u>to ensure that staff are implementing policiesand procedures that prohibit mistreatment, neglect or abuse of the client(attachment e).</p> <p>8) Plan of Correction: LL day program director completed a review of incident and it was determined that follow up would be staff trainedon peer's behavior support plan and client #5 will not take chair outside.</p> <p>Plan of Prevention:LL day program facility DSPs trainedon peers behavior support plan and strategy to keep client #5 chair inside onflat surfaces (attachment d). Fracture checklist will be introduced to StoneBelt SGL program. This checklist will document that a complete investigation iscompleted (attachment k).</p> <p>Planof Monitoring:Facility coordinator / QIDP-D will provide weekly monitoring of LL day programfacility. LL day program facility coordinator will provide <u>daily monitoring</u>to ensure that staff are implementing policiesand procedures that prohibit mistreatment, neglect or abuse of the client(attachment e). Investigations will be completed by facility director ordesignee.</p>				

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	<p>incident should be investigated. The GHD indicated anytime there was a fracture involved, the facility should investigate the incident.</p> <p>4) On 4/1/15 at 12:30 PM at the facility-operated day program, client #6 was standing by the door outside of day program room 1. Client #5 was fiddling with the door handle when client #6 entered his space. Client #5 reached out and grabbed client #6 shirt. Client #6 fell to the floor in a seated position. Client #6 bumped his right shoulder on the heating unit during the fall. Client #5 reached out and pulled client #6's hair. Three staff performed hair pull release to release client #5's grip from client #6's hair.</p> <p>On 4/9/15 at 2:20 PM, the Group Home Director (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 4/9/15 at 4:10 PM, the Program Coordinator (PC) indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the</p>						

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	<p>clients.</p> <p>5) On 3/27/15 at 6:30 PM, client #4 ran from the kitchen into the living room and pulled client #5 onto the floor by his shirt. Staff blocked client #4's attempts to bite client #5. Client #5 sustained a 1 inch scratch on his shoulder where he was grabbed by client #4.</p> <p>On 4/9/15 at 2:20 PM, the Group Home Director (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 4/9/15 at 4:10 PM, the Program Coordinator (PC) indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>6) On 3/16/15 at 11:15 AM at the facility-operated day program, client #1 reported to staff that a peer accidentally scratched his left arm during a dance party. Client #1 had two parallel nail scratches on his left arm. The scratches were 2-2.5 inches long, 1/8 inch wide and 1 inch apart. There was an open cut that</p>			

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	<p>was red and irritated.</p> <p>On 4/9/15 at 2:20 PM, the Group Home Director (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 4/9/15 at 4:10 PM, the Program Coordinator (PC) indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>7) On 1/28/15 at 2:15 PM at the facility operated day program, client #5 was hugged by a peer. Client #5 reached around his peer and hugged him. Client #5 grabbed his peer's shirt and would not let go. Client #5 was punched on the arm by his peer. Client #5 was not injured.</p> <p>On 4/9/15 at 2:20 PM, the Group Home Director (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>			

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	<p>On 4/9/15 at 4:10 PM, the Program Coordinator (PC) indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>8) On 1/28/15 at 2:00 PM at the facility-operated day program, client #5 was standing next to a peer. Client #5 grabbed the peer's shirt which almost made the peer fall onto client #5. Staff assisted the peer to remove his shirt to get client #5 to release his grip on the shirt. The peer was not injured.</p> <p>On 4/9/15 at 2:20 PM, the Group Home Director (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 4/9/15 at 4:10 PM, the Program Coordinator (PC) indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 4/9/15 at 12:56 PM, a review of the</p>			

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	<p>facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law...</p> <p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The</p>			

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W 154 Bldg. 00	<p>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."</p> <p>This deficiency was cited on 1/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 29 incident reports reviewed affecting client #5, the facility failed to conduct an investigation of an incident leading to a fractured metatarsal.</p>	W 154	<p>W 154483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p>	04/27/2015

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	<p>Findings include:</p> <p>On 4/9/15 at 1:12 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/1/15 at 2:20 PM at the facility-operated day program, client #5 was rolling in an office chair past a peer. The peer stepped into client #5's path. The peer tripped and fell. As she was falling, she grabbed client #5 to try and break her fall. Client #5 and the peer fell to the floor. Client #5 fell on his right side. At the time, no injuries were found on client #5. On 4/1/15 later in the day, client #5's foot was swollen. On 4/2/15, client #5 was taken to the doctor and found to have a fifth metatarsal (one of five long bones in the foot) fracture.</p> <p>The facility's incident report, dated 4/1/15, indicated the Regional Director of Programs reviewed the incident report on 4/3/15. The report indicated, "[Name of day program] Director completed a review of this incident on 4/3/15. Staff will be trained that [name of peer] will be asked to remain seated until she had a safe area in which to stand, given her high risk of falls. Also, as a precaution, staff will not take the rolling office chair outside, in the future." There was no documentation the facility investigated</p>		<p>Plan of Correction: LL day program director completed areview of incident and it was determined that follow-up would be staff trainedon peer's behavior support plan and client #5 will not take chair outside.</p> <p>Plan of Prevention:LL day program facility DSPs trainedon peers behavior support plan and strategy to keep client #5 chair inside onflat surfaces (attachment d). Fracture checklist will be introduced to StoneBelt SGL program coordinators / QIDP and directors. This checklist willdocument that a complete investigation is completed (attachment k).</p> <p>Plan of Monitoring:Facility coordinator / QIDP-D will provide weekly monitoring of LL day programfacility. LL day program facility coordinator will provide daily monitoringto ensure that staff are implementing policiesand procedures that prohibit mistreatment, neglect or abuse of the client(attachment e). Investigations will be completed by facility director ordesignee.</p>				

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W 157 Bldg. 00	<p>the incident.</p> <p>On 4/9/15 at 2:39 PM, the Group Home Director indicated she informed the Regional Director of Programs the incident should be investigated. The GHD indicated anytime there was a fracture involved, the facility should investigate the incident.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 29 incident reports reviewed affecting client #6, the facility failed to implement the nurse's instructions to take client #6's blood pressure for 24 hours following an incident involving a head injury.</p> <p>Findings include:</p> <p>On 4/9/15 at 1:12 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/2/15 at 12:30 PM, a Stone Belt, ARC Inc. Incident Report, dated 4/2/15, indicated, in part, "[Client #6] was walking around (sic) classroom,</p>	W 157	<p>W 157483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Plan of Correction: Facility house manager, associatemanager, and day aide trained to provide <u>daily</u> checks of MARs to provide immediateintervention when staff fail to follow physician orders or nursingrecommendations. They will also ensure that medication errors will be submittedalong with required training (attachment I). Plan of Prevention: Facility DSPs trained on Core A and Bannually and when a refresher is needed. Facility staff trained on importanceof following nursing recommendations and physician</p>	04/23/2015			

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	<p>eating bites of pudding and fruit cup. [Client #6] had not received an adequate lunch and was refusing to eat the fruit cup when he turned away quickly as a spoon of fruit was offered to him. [Client #6] turned quickly and tripped, stumbling over his feet and fell to his right side. When [client #6] fell, he hit his head on the sink corner. [Client #6] cried out, head was bleeding; [client #6] layed (sic) down for about 2 minutes. Nurse was notified and requested that his BP (blood pressure) be taken every hour for 24 hours. Staff administered first aid."</p> <p>On 4/9/15 at 4:05 PM, a review of client #6's Medication Administration Record (MAR) for April 2015 was conducted. There was no documentation of his blood pressure being documented every hour for 24 hours after a fall with a head injury on 4/2/15 at 12:30 PM. There was no documentation the staff took his blood pressure from 8:00 PM to 6:00 AM as instructed by the nurse. The MAR indicated, "BP (blood pressure) taken every hr (hour) over the next 24 hrs (hours)." The form indicated R (refusal) at 5:00 PM and 6:00 PM. The form indicated his blood pressure was 107/66 at 7:00 PM. The form indicated his blood pressure was 141/84 at 7:00 AM.</p> <p>On 4/10/15 at 1:17 PM, the Nurse</p>		<p>orders, including MARs. Plan of Monitoring: Facility coordinator / QIDP-D and facility nurse will provide weekly monitoring of facility. House manager and associate house manager will provide <u>daily monitoring</u> to ensure that staff are implementing policies and procedures that prohibit mistreatment, neglect or abuse of the client (attachment c)</p>	

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W 331 Bldg. 00	<p>Manager (NM) indicated another nurse ordered client #6's blood pressure to be taken for 24 hours after client #6 hit his head during a fall. The NM stated, "Doesn't surprise me" when informed the staff did not record client #6's blood pressure from 8:00 PM to 6:00 AM. The NM indicated the staff should have followed the nursing order.</p> <p>9-3-2(a)</p> <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 2 of 3 clients in the sample (#1 and #6) and 3 additional clients (#2, #3 and #4), the facility's nursing services failed to ensure staff documented the implementation of hourly blood pressure recorded after client #6's fall with injury, nail care, client #1 elevating his legs due to edema, bowel movements, physical therapy exercises, monitoring of oral hygiene, use of a mouth guard, use of glasses, hearing aids, ankle braces, weights, blood pressure, pulse, shoe inserts and fluids.</p> <p>Findings include:</p>	W 331	<p>{W 331}483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Plan of Correction: Facility house manager, associatemanager, and day aide trained to provide <u>daily</u> checks of MARs to provide immediateintervention when staff fail to follow physician orders or nursingrecommendations. They will also ensure that medication errors will be submittedalong with required training (attachment I).</p> <p>Plan of Prevention:Facility DSPs trained on Core A and Bannually and when a refresher is needed.</p>	04/23/2015

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	<p>On 4/9/15 at 3:55 PM, a review of client #1's Medication Administration Record (MAR), dated April 2015, was conducted. There was no documentation client #1 wore his bilateral shoe inserts daily. The MAR was blank from 4/1/15 to 4/9/15. There was no documentation client #1 received nail care weekly. The MAR was blank from 4/1/15 to 4/9/15. There was no documentation client #1 elevated his legs when seated due to edema on 4/3/15, 4/4/15, 4/5/15 and 4/6/15. There was no documentation client #1 was offered fluids when he returned home on 4/1/15, 4/2/15, 4/3/15, 4/6/15, 4/7/15 and 4/8/15.</p> <p>On 4/9/15 at 3:56 PM, a review of client #2's MAR for April 2015 was conducted. There was no documentation of bowel movements being tracked from 4/1/15 to 4/6/15. There was no documentation client #2's oral hygiene was visually monitored on 4/5/15 in the evening. There was no documentation from 4/1/15 to 4/8/15 client #2 completed his physical therapy exercises daily. There was no documentation client #2's mouth guard was worn nightly on 4/1/15, 4/3/15, 4/4/15 and 4/5/15. There was no documentation client #2's Dental toothpaste was used on 4/5/15.</p> <p>On 4/9/15 at 3:59 PM, a review of client</p>		<p>Facility staff trained on importance of following nursing recommendations, physician orders, conducting buddy checks and ensuring MARs are completed correctly.</p> <p>Plan of Monitoring: Facility coordinator / QIDP-D and facility nurse will provide weekly monitoring of facility. House manager and associate house manager will provide <u>daily monitoring</u> to ensure that staff are implementing policies and procedures that prohibit mistreatment, neglect or abuse of the client (attachment c)</p>	

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	<p>#3's MAR for April 2015 was conducted. There was no documentation of nail care being completed in April 2015. There was no documentation client #3 wore his glasses daily. There was no documentation client #3 had his eyelids scrubbed with a warm wash cloth two times per day from 4/1/15 to 4/9/15. There was no documentation client #3 wore special diabetic with orthodic inserts in his left shoe from 4/1/15 to 4/9/15. There was no documentation client #3's hearing aids were checked for use and location three times per day on 4/4/15 and 4/5/15.</p> <p>On 4/9/15 at 4:02 PM, a review of client #4's MAR for April 2015 was conducted. There was no documentation of bowel movement tracking on 4/1/15 and 4/6/15. There was no documentation on weekly nail care in April 2015. There was no documentation of his ankle braces being worn daily on 4/4/15 and 4/5/15. There was no documentation client #4's face was washed two times a day on 4/3/15, 4/4/15, 4/5/15, 4/6/15, 4/7/15 and 4/8/15.</p> <p>On 4/9/15 at 4:05 PM, a review of client #6's MAR for April 2015 was conducted. There was no documentation of his blood pressure being documented every hour for 24 hours after a fall with a head injury on 4/2/15 at 12:30 PM. The incident</p>			

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	<p>report, dated 4/2/15, was reviewed on 4/9/15 at 1:12 PM. The report indicated, "[Client #6] was walking around (sic) classroom, eating bites of pudding and fruit cup. [Client #6] had not received an adequate lunch and was refusing to eat the fruit cup when he turned away quickly as a spoon of fruit was offered to him. [Client #6] turned quickly and tripped, stumbling over his feet and fell to his right side. When [client #6] fell, he hit his head on the sink corner. [Client #6] cried out, head was bleeding; [client #6] layed (sic) down for about 2 minutes. Nurse was notified and requested that his BP (blood pressure) be taken every hour for 24 hours. Staff administered first aid. There was no documentation the staff took his blood pressure from 8:00 PM to 6:00 AM as instructed by the nurse. There was no documentation of weekly nail care in April 2015. There was no documentation the staff tracked and recorded the emptying of his ileostomy (opening in the stomach wall) bag and tracked the contents of the stool from 4/1/15 to 4/9/15. There was no documentation the staff conducted daily body checks for skin irritation from 4/1/15 to 4/9/15. There was no documentation of a weekly weight in April 2015.</p> <p>On 4/10/15 at 1:17 PM, the Nurse</p>			

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W 368	<p>Manager (NM) indicated the staff should document the implementation of the treatments on the MAR. The NM indicated the staff should document something in the record each timeframe a treatment was to be given. The NM stated, "It's obvious they're not doing it." The NM indicated the manager and associate manager should be reviewing the MAR daily to ensure the staff were completing the orders. The NM stated there were "No excuses for holes in the documentation." The NM indicated he was not aware the issues with staff not filling out the MAR were an on-going issue. The NM indicated the facility had a buddy check system in place to avoid these documentation issues. The NM indicated the staff were either failing to implement the buddy check system or just signing the form indicating they completed the check without completing the check.</p> <p>This deficiency was cited on 1/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p>			

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Bldg. 00	<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 2 of 3 clients in the sample (#1 and #5) and one additional client (#4), the facility failed to ensure staff documented the administration of the clients' medications as ordered the their physicians.</p> <p>Findings include:</p> <p>On 4/9/15 at 3:55 PM, a review of client #1's Medication Administration Record (MAR), dated April 2015, was conducted. On 4/4/15 and 4/5/15 in the morning and evening, the MAR was blank for the administration of client #1's Chlorhexidine mouthwash for gingivitis. On 4/3/15 at 9:00 PM, the MAR was blank for the administration of Benztropine 1 milligram for EPS (Extrapyramidal symptoms). On 4/4/15 at 9:00 PM, client #1's MAR was blank for Refresh eye drops.</p> <p>On 4/10/15 at 1:58 PM, a review of client #1's Physician's Orders, dated 3/31/15, indicated Chlorhexidine was to be administered twice a day for gingivitis. A review on 4/10/15 at 2:09 PM of client #1's Psychiatric Clinic Visit, dated 1/21/15, indicated Benztropine was prescribed twice a day for excessive</p>	W 368	<p>{W 368}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.</p> <p>Plan of Correction: Facility house manager, associatemanager, and day aide trained to provide <u>daily</u> checks of MARs to provide immediateintervention when staff fail to follow physician orders or nursingrecommendations. They will also ensure that medication errors will be submittedalong with required training (attachment I).</p> <p>Plan of Prevention:Facility DSPs trained on Core A and Bannually and when a refresher is needed. Facility staff trained on importanceof following nursing recommendations, physician orders, conducting buddy checks andensuring MARs are completed correctly.</p> <p>Planof Monitoring:Facility coordinator / QIDP-D and facility nurse will provide weekly monitoringof facility. House manager and associate house manager will provide <u>daily</u>monitoring to ensure that staff are implementing policies and procedures that prohibitmistreatment, neglect or abuse of the client (attachment c)</p>	04/23/2015			

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	<p>drooling.</p> <p>On 4/9/15 at 4:02 PM, a review of client #4's MAR for April 2015 was conducted. There was no documentation Miracle foot cream was applied to his feet daily on 4/4/15. There was no documentation client #4's Chlorhexidine mouth wash was applied to his teeth and gums prior to brushing twice daily on 4/4/15.</p> <p>On 4/10/15 at 1:59 PM, a review of client #4's Physician's Orders, dated 3/31/15, indicated Miracle foot cream was to be applied to his feet daily. The orders indicated client #4 was to receive Chlorhexidine to his teeth and gums prior to brushing twice daily for gingivitis.</p> <p>On 4/9/15 at 4:05 PM, a review of client #5's MAR for April 2015 was conducted. There was no documentation client #5 received Chlorhexidine mouth wash for gingivitis twice a day on 4/5/15.</p> <p>On 4/10/15 at 2:03 PM, a review of client #5's Physician's Orders, dated 3/31/15, indicated he was to receive Chlorhexidine twice a day for gingivitis.</p> <p>On 4/10/15 at 1:17 PM, the Nurse Manager (NM) indicated the staff failing to document on the MAR was a medication error. The NM indicated the</p>			

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W 999 Bldg. 00	<p>staff should document the implementation of the medications on the MAR. The NM stated, "It's obvious they're not doing it." The NM indicated the manager and associate manager should be reviewing the MAR daily to ensure the staff were completing the orders. The NM stated there were "No excuses for holes in the documentation." The NM indicated he was not aware the issues with staff not filling out the MAR were an on-going issue. The NM indicated the facility had a buddy check system in place to avoid these documentation issues. The NM indicated the staff were either failing to implement the buddy check system or just signing the form indicating they completed the check without completing the check.</p> <p>This deficiency was cited on 1/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		W 999	W-9999 was not listed on H03Q12 survey	04/27/2015	