

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2016
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4417 BLACKSTONE CT BLOOMINGTON, IN 47401
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W 0000  Bldg. 00	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: February 19, 22, 23, 24, 25 and 26, 2016</p> <p>Facility Number: 000704 Provider Number: 15G170 AIM Number: 100234540</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/3/16.</p>	W 0000		
W 0102  Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise operating direction over the facility by failing to implement its</p>	W 0102	<p><b>W102 Governing Body and Management (Condition)</b> The facility must ensure that specific governing body and management requirements are met. <b>Corrective action for resident(s) found to have been affected</b> In order to address governing body deficiencies, the following corrections will be put in place: 1)</p>	03/26/2016

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>policies and procedures to prevent client to client abuse, investigate incidents of client to client abuse, investigate an allegation of staff sleeping while on duty, investigate incidents of psychological abuse of client #7, ensure corrective actions were taken to address medication errors and staff sleeping while working at the group home, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and report the results of an investigation to the administrator within 5 working days. The facility's governing body failed to monitor the Qualified Intellectual Disabilities Professional (QIDP) to ensure the QIDP integrated, coordinated and monitored the clients' program plans. The governing body failed to ensure the QIDP: reviewed client #2, #4, #6 and #7's program plans on a regular basis, ensured client #7's outside services (school) met the needs of the client, completed client #2, #4 and #7's comprehensive functional assessment (CFA) within 30 days of admission to the group home, completed client #4's recommended assistive technology assessment, completed client #2, #4 and #7's individual program plans (IPP) within 30 days of admission, reviewed and updated client #6's CFA at least annually, reviewed and revised client #6's IPP at least annually, ensured</p>		<p>Competency-based staff training will be conducted across shifts that focuses on prevention of client-to-client aggression; 2) QIDP &amp; Coordinator training on investigations will be conducted that includes the requirement to investigate all allegations of client-to-client aggression, all instances where a staff member is found to be sleeping, and any allegation of bullying – including if the incident occurs when services are being provided with outside sources, such as a school; 3) QIDP and Coordinator will be trained on ensuring all corrective actions are taken following all incidents and investigations, including medication errors and allegations of abuse or neglect; 4) QIDP and Coordinator will be trained on timing requirements for (a) submitting incident reports to BDDS within 24 hours and (b) ensuring completion of all investigations within 5 working days; 5) The QIDP and Coordinator will be trained on ensuring integrated and coordinated program plans, including monitoring implementation of those plans; 6) The QIDP and Coordinator will be trained on ensuring that all outside services, including schools, are meeting client needs and that those services are coordinated with the IDT; 7) A tracking form will be used for all new admissions that ensures all 30-day requirements are</p>	

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	<p>quarterly evacuation drills were conducted for each shift of personnel, and ensured clients #1, #3, #4 and #5 were involved with meal preparation and serving themselves during breakfast.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's governing body failed to exercise operating direction over the facility by failing to implement its policies and procedures to prevent client to client abuse, investigate incidents of client to client abuse, investigate an allegation of staff sleeping while on duty, investigate incidents of psychological abuse of client #7, ensure corrective actions were taken to address medication errors and staff sleeping while working at the group home, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and report the results of an investigation to the administrator within 5 working days. The facility's governing body failed to monitor the Qualified Intellectual Disabilities Professional (QIDP) to ensure the QIDP integrated, coordinated and monitored the clients' program plans. The governing body failed to ensure the QIDP: reviewed client #2, #4, #6 and #7's</p>		<p>implemented, including the Comprehensive Functional Assessment (CFA) and other assessments – the QIDP and Coordinator will be trained to use this form for all new admissions; 8) The QIDP and Coordinator will be trained to ensure that each client have an annual CFA with revised Individual Program Plan (IPP) at least yearly; 9) Evacuation drills will be conducted across shifts as required, a drill schedule will be put in place, and the QIDP and Coordinator will be trained to ensure that these are properly implemented; 10) All staff, the QIDP, and the Coordinator will receive training to ensure that clients are involved in their own meal preparation. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Staff, QIDP, and Coordinator training will be conducted on a range of issues to correct deficiencies; a tracking form will be used for all new admissions to ensure 30-day requirements are met; an evacuation drill schedule will be put in place. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program</p>	

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	<p>program plans on a regular basis, ensured client #7's outside services (school) met the needs of the client, completed client #2, #4 and #7's comprehensive functional assessment (CFA) within 30 days of admission to the group home and client #4's recommended assistive technology assessment was completed, completed client #2, #4 and #7's individual program plans (IPP) within 30 days of admission, reviewed and updated client #6's CFA at least annually, reviewed and revised client #6's IPP at least annually, ensured quarterly evacuation drills were conducted for each shift of personnel, and ensured clients #1, #3, #4 and #5 were involved with meal preparation and serving themselves during breakfast.</p> <p>2) Please refer to W122. For 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to meet the Condition of Participation: Client Protections. The governing body neglected to implement its policies and procedures to prevent client to client abuse, investigate incidents of client to client abuse, investigate an allegation of staff sleeping while on duty, investigate incident of psychological abuse of client #7, ensure corrective actions were taken to address medication errors and staff sleeping while working at the group home, submit incident reports to the</p>		<p>coordination and monitoring of the facility. Until at least May 1, and longer if needed, the QIDP(or director) will conduct a minimum two documented visit to the home site per calendar week in order to monitor program implementation. The nurse coordinates health care, including monitoring medication administration procedures. Until at least May 1, and longer if medication error problems persist, the nurse will monitor a minimum of two medication pass per calendar week. These visits will be documented on a home visit form that includes a check off for observation of medication pass. Each form also includes an area for the nurse to summarize counseling/training when that is appropriate. In addition, a new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-upactions are in place. The QIDP is responsible for program implementation and monitoring of the facility, and the Coordinator assists in this role. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator.</p>				

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W 0104 Bldg. 00	<p>Bureau of Developmental Disabilities Services (BDDS) in a timely manner and report the results of an investigation to the administrator within 5 working days.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's governing body failed to exercise operating direction over the facility by failing to implement its policies and procedures to prevent client to client abuse, investigate incidents of client to client abuse, investigate an allegation of staff sleeping while on duty, investigate incidents of psychological abuse of client #7, ensure corrective actions were taken to address medication errors and staff sleeping while working at the group home, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and report the results of an investigation to the administrator within 5 working days. The facility's governing</p>	W 0104	<p>The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p><b>W104 Governing Body (Standard)</b> The governing body must exercise general policy, budget, and operating direction over the facility. <b>Corrective action for resident(s) found to have been affected</b> In order to address governing body deficiencies, the following corrections will be put in place: 1) Competency-based staff training will be conducted across shifts that focuses on prevention of client-to-client aggression; 2) QIDP &amp; Coordinator training on investigations will be conducted that includes the requirement to investigate all allegations of client-to-client aggression, all instances where a staff member is found to be sleeping, and any allegation of bullying – including if the incident occurs when services are being provided with</p>	03/26/2016

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	<p>body failed to monitor the Qualified Intellectual Disabilities Professional (QIDP) to ensure the QIDP integrated, coordinated and monitored the clients' program plans. The governing body failed to ensure the QIDP: reviewed client #2, #4, #6 and #7's program plans on a regular basis, ensured client #7's outside services (school) met the needs of the client, completed client #2, #4 and #7's comprehensive functional assessment (CFA) within 30 days of admission to the group home and client #4's recommended assistive technology assessment was completed, completed client #2, #4 and #7's individual program plans (IPP) within 30 days of admission, reviewed and updated client #6's CFA at least annually, reviewed and revised client #6's IPP at least annually, ensured quarterly evacuation drills were conducted for each shift of personnel, and ensured clients #1, #3, #4 and #5 were involved with meal preparation and serving themselves during breakfast.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 18 of 40 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the governing body neglected to implement its policies and procedures to prevent client to client abuse, investigate</p>		<p>outside sources, such as a school; 3) QIDP and Coordinator will be trained on ensuring all corrective actions are taken following all incidents and investigations, including medication errors and allegations of abuse or neglect; 4) QIDP and Coordinator will be trained on timing requirements for (a) submitting incident reports to BDDS within 24 hours and (b) ensuring completion of all investigations within 5 working days; 5) The QIDP and Coordinator will be trained on ensuring integrated and coordinated program plans, including monitoring implementation of those plans; 6) The QIDP and Coordinator will be trained on ensuring that all outside services, including schools, are meeting client needs and that those services are coordinated with the IDT; 7) A tracking form will be used for all new admissions that ensures all 30-day requirements are implemented, including the Comprehensive Functional Assessment (CFA) and other assessments –the QIDP and Coordinator will be trained to use this form for all new admissions; 8) The QIDP and Coordinator will be trained to ensure that each client have an annual CFA with revised Individual Program Plan (IPP) at least yearly; 9) Evacuation drills will be conducted across shifts as</p>	

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	<p>incidents of client to client abuse, investigate an allegation of staff sleeping while on duty, investigate incidents of psychological abuse of client #7, ensure corrective actions were taken to address medication errors and staff sleeping while working at the group home, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and report the results of an investigation to the administrator within 5 working days.</p> <p>2) Please refer to W153. For 3 of 40 incident reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the governing body failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>3) Please refer to W154. For 6 of 40 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the governing body failed to conduct thorough investigations.</p> <p>4) Please refer to W156. For 1 of 40 incident/investigative reports reviewed affecting clients #3 and #6, the governing body failed to ensure the results of an investigation were reported to the administrator within 5 working days of</p>		<p>required, a drill schedule will be put in place, and the QIDP and Coordinator will be trained to ensure that these are properly implemented; 10) All staff, the QIDP, and the Coordinator will receive training to ensure that clients are involved in their own meal preparation. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Staff, QIDP, and Coordinator training will be conducted on a range of issues to correct deficiencies; a tracking form will be used for all new admissions to ensure 30-day requirements are met; an evacuation drill schedule will be put in place. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program coordination and monitoring of the facility. Until at least May 1, and longer if needed, the QIDP or director will conduct a minimum of two documented visits to the home site per calendar week in order to monitor program implementation. The nurse coordinates health care, including monitoring medication administration procedures. Until at least May 1, and longer if medication error problems</p>	

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	<p>the incident.</p> <p>5) Please refer to W157. For 10 of 40 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the governing body failed to ensure appropriate corrective actions were implemented to address staff sleeping while working at the group home and medication errors.</p> <p>6) Please refer to W159. The governing body failed to monitor the QIDP to ensure the QIDP integrated, coordinated and monitored the clients' program plans. The governing body failed to ensure the QIDP: reviewed client #2, #4, #6 and #7's program plans on a regular basis, ensured client #7's outside services (school) met the needs of the client, completed client #2, #4 and #7's CFA within 30 days of admission to the group home and client #4's recommended assistive technology assessment was completed, completed client #2, #4 and #7's IPP within 30 days of admission, reviewed and updated client #6's CFA at least annually, reviewed and revised client #6's IPP at least annually, ensured quarterly evacuation drills were conducted for each shift of personnel, and ensured clients #1, #3, #4 and #5 were involved with meal preparation and serving themselves during breakfast.</p>		<p>persist, the nurse will monitor a minimum of two medication passes per calendar week. These visits will be documented on a home visit form that includes a check off for observation of medication pass. Each form also includes an area for the nurse to summarize counseling/training when that is appropriate. In addition, a new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility, and the Coordinator assists in this role. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		

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W 0120 Bldg. 00	<p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review and interview for 1 of 1 client in the sample (#7) who attended an outside services program (school), the facility failed to ensure the outside services met the needs of the client.</p> <p>Findings include:</p> <p>On 2/19/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 2/2/16 at 9:56 AM, the Behavior Clinician (BC) wrote in an email to client #7's support team, "Good Morning Team, it was brought to my attention that [client #7] continues to be bullied on the bus. Yesterday she was called a 'retard' by someone on her bus, which I find totally unacceptable. She reported to the bus driver and he told her to sit at the front of</p>	W 0120	<p><b>W120 Services Provided With Outside Sources (Standard)</b> The facility must assure that outside services meet the needs of each client. This includes coordinating with schools when applicable. <b>Corrective action for resident(s) found to have been affected</b> Client#7's school teacher will be contacted to reestablish a line of communication, and an inquiry will be made regarding bullying. If any continued bullying is reported, measures will be put in place to ensure that it stops. The QIDP and Coordinator will be trained on ensuring that all outside services, including schools, are meeting client needs and that those services are coordinated with the IDT. Additionally, the QIDP &amp; Coordinator training on investigations will be conducted that includes the requirement to investigate all allegations of client-to-client aggression, all instances where a staff member is found to be sleeping, and any</p>	03/26/2016

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	<p>the bus, yet there were no seats available. This has been addressed before yet continues to be an issue. I feel we need to address this further with the school or switch [client #7] to a special needs bus. Thoughts?"</p> <p>On 2/2/16 at 11:23 AM, the Assistant Group Home Director (AGHD) responded to the email, "[Coordinator], can you contact school and request front seat access for [client #7]?"</p> <p>On 2/2/16 at 1:53 PM, the Coordinator responded to the email, "Social worker at the school is on the case! She'll be talking with [client #7], the other students involved, and the bus driver. She will call me to confirm that there are measures in place to prevent this in the future."</p> <p>On 2/2/16 at 3:41 PM, the BC responded to the email, "Thanks everyone - guardian requested a special needs bus if this issue continues since our last attempt to resolve it did not work."</p> <p>On 2/2/16 at 3:45 PM, the Home Manager (HM) responded to the email, "[Client #7] has arrived home with the news that she now rides at the front of the bus in a saved seat and that the others on the bus were verbally chastised by the</p>		<p>allegation of bullying –including if the incident occurs when services are being provided with outside sources, including a client's school. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> The teacher will be contacted, and training for the QIDP and Coordinator will take place. QIDP or director will visit school, to observe client's classroom one time a month to ensure services are coordinated with the IDT. <b>How corrective actions will be monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including reports of bullying. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. In the case of bullying, an investigation would be completed, and monitoring the completion of such an investigation would be included in incident follow-up. The QIDP is responsible for program implementation and monitoring of the facility, and the Coordinator assists in this role. The QIDP and</p>		

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	<p>principal who advised them that any further bullying would be met with suspension."</p> <p>On 2/24/16 at 2:42 PM, the BC indicated she found out about the bullying on the school bus from client #7's guardian. The BC indicated the guardian wanted the BC to take care of the situation. The BC indicated client #7 was bullied on the bus one other time but she could not recall the date of the incident. The BC indicated the HM contacted the school after the first incident to report the situation. The BC indicated client #7 reported the first incident to the HM. The BC indicated the situation was resolved. The school spoke to the kids who were involved and changed client #7's seat on the bus. The BC indicated bullying was abuse but she did not think an investigation needed to be completed.</p> <p>On 2/22/16 at 2:06 PM, the AGHD indicated client #7 was bullied at school. The AGHD indicated client #7 reported the incident to the group home staff and the group home reported it to the school. The AGHD indicated some kids on the bus called her a retard. The AGHD indicated either the HM or the Coordinator spoke to the school but did not know who at the school. The AGHD indicated there were no incident reports</p>		<p>Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4417 BLACKSTONE CT BLOOMINGTON, IN 47401
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	<p>regarding the situations. The AGHD stated, "bullying with name calling is abuse." The AGHD indicated she was not sure what the school did to address the situation.</p> <p>2) On 2/25/16 at 10:46 AM, the Coordinator forwarded an email from former staff #8 regarding client #7 being bullied at school. The email from former staff #8 to client #7's support team was sent on 2/15/16 at 8:10 PM and indicated the following, "[Client #7] told me about another bully that's been harassing her, this time at school. She said the bully has been threatening to fight her and showed me a message where the bully was trying to set up a time and place to fight. I suggest (sic) [client #7] block her, but the bully simply created a new [name of social media website] account. [Client #7] said that she is scared that the bully or one of her friends will try to hurt her. I gave her generic advice (walk to classes with a friend or her phone out, talk to teachers), but I'm not sure where to go from there. Does anyone have any ideas?"</p> <p>On 2/15/16 at 8:13 PM, the Home Manager replied to the email and indicated, "Sounds a lot like what she brought to me last evening. I think it would help if [Behavior Clinician],</p>			

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	<p>[Coordinator] and if possible, [therapist] would read these messages for themselves so they get the full picture and not just our retellings."</p> <p>On 2/16/16 at 9:29 AM, the Behavior Clinician responded to the email and indicated, in part, "...This is a serious issue and social media has made it worse... I think we need to deal with it and make the school aware of what is happening, especially since they are threatening fights."</p> <p>On 2/22/16 at 2:06 PM, the AGHD indicated there was no incident report regarding the situation. The AGHD stated, "bullying with name calling is abuse." The AGHD indicated she was not sure what the school did to address the situation.</p> <p>On 2/23/16 at 1:28 PM, a review of client #7's record was conducted. There was no documentation the facility conducted regular observations and site visits to the school to ensure the school met the needs of the client.</p> <p>On 2/22/16 at 12:17 PM, the Coordinator indicated he had not conducted observations or visits at client #7's school. The Coordinator indicated he did not know who client #7's teacher was at</p>			

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	<p>the school.</p> <p>On 2/22/16 at 4:59 PM, the Home Manager indicated she did not know who client #7's teacher was at the school.</p> <p>On 2/23/16 at 2:32 PM, the Assistant Group Home Director indicated the facility should conduct monthly observations at the school.</p> <p>On 2/23/16 at 8:20 AM, client #7's Teacher of Record (TR) indicated there was an issue approximately 2-3 weeks ago when a staff at the group home spoke to client #7 about Post Traumatic Stress Disorder (PTSD). The TR indicated client #7 had several days of refusals to do anything (saying she had PTSD) at school following client #7's discussion of PTSD with the group home staff. The TR indicated there was an incident of client #7 being bullied while on the school bus by a group of junior high students. The TR indicated he found out about the incident from the junior high principal. The TR indicated the principal addressed the situation with the students and the issue was resolved. The TR indicated the students were moved to the back of the bus and client #7 was asked to sit at the front of the bus behind the driver. The TR indicated he had not seen anyone from the group home conducting</p>				

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W 0122 Bldg. 00	<p>observations at the school since client #7 moved into the group home in November 2015.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policies and procedures to prevent client to client abuse, investigate incidents of client to client abuse, investigate an allegation of staff sleeping while on duty, investigate incidents of psychological abuse of client #7, ensure corrective actions were taken to address medication errors and staff sleeping while working at the group home, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and report the results of an investigation to the administrator within 5 working days.</p> <p>Findings include:</p>	W 0122	<p><b>W122 Client Protections (Condition)</b> The facility must ensure that specific client protections requirements are met. <b>Corrective action for resident(s) found to have been affected</b> Describe In order to address client protection deficiencies, the following corrections will be put in place: 1)Competency-based staff training will be conducted across shifts that focuses on prevention of client-to-client aggression; 2) QIDP &amp; Coordinator training on investigations will be conducted that includes the requirement to investigate all allegations of client-to-client aggression, all instances where a staff member is found to be sleeping, and any allegation of bullying –including if the incident occurs when services are being provided with outside sources, such as a school; 3) QIDP and Coordinator will be trained on ensuring all corrective actions are taken following all incidents and</p>	03/26/2016

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	<p>1) Please refer to W149. For 18 of 40 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the facility neglected to implement its policies and procedures to prevent client to client abuse, investigate incidents of client to client abuse, investigate an allegation of staff sleeping while on duty, investigate incidents of psychological abuse of client #7, ensure corrective actions were taken to address medication errors and staff sleeping while working at the group home, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and report the results of an investigation to the administrator within 5 working days.</p> <p>2) Please refer to W153. For 3 of 40 incident reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the facility failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>3) Please refer to W154. For 6 of 40 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the facility failed to conduct thorough investigations.</p>		<p>investigations, including medication errors and allegations of abuse or neglect; and 4) QIDP and Coordinator will be trained on timing requirements for (a) submitting incident reports to BDDS within 24 hours and (b) ensuring completion of all investigations within 5 working days. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Staff, QIDP, and Coordinator training will be conducted on a range of issues to correct deficiencies. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program coordination and monitoring of the facility. Until at least May 1, and longer if needed, the QIDP or director will conduct a minimum of two documented visits to the home site per calendar week in order to monitor program implementation. In addition, a new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all</p>		

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W 0125 Bldg. 00	<p>4) Please refer to W156. For 1 of 40 incident/investigative reports reviewed affecting clients #3 and #6, the facility failed to ensure the results of an investigation were reported to the administrator within 5 working days of the incident.</p> <p>5) Please refer to W157. For 10 of 40 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the facility failed to ensure appropriate corrective actions were implemented to address staff sleeping while working at the group home and medication errors.</p> <p>9-3-2(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. Based on observation, record review and interview for 2 of 4 clients in the sample (#6 and #7) and one additional client</p>	W 0125	<p>follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility, and the Coordinator assists in this role. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p><b>W 125 Protection of Clients Rights (Standard)</b> The facility must ensure the rights of all clients. Therefore, the facility</p>	03/26/2016

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	<p>(#3), the facility failed to ensure the clients had the right to due process in regard to locking up snack food in the group home office.</p> <p>Findings include:</p> <p>On 2/22/16 from 3:50 PM to 6:17 PM, an observation was conducted at the group home. At 4:39 PM, the Home Manager (HM) took a package of cheese crackers from a shelf and served client #6 a serving size into a plastic bag. At 4:48 PM, the HM accessed a white plastic storage container from on top of a shelf in the group home office. The HM served client #3 a serving of mixed nuts from the container into a plastic bag.</p> <p>On 2/23/16 from 6:00 AM to 7:53 AM, an observation was conducted at the group home. At 6:21 AM, client #7 went to the office to get a Pop Tart. Client #7 took the Pop Tart with her on the bus when she left to go to school.</p> <p>On 2/23/16 at 11:55 AM, a focused review of client #3's record was conducted. There was no documentation in her record indicating mixed nuts needed to be kept in the locked office at the group home.</p> <p>On 2/23/16 at 12:56 PM, a review of</p>		<p>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. <b>Corrective action for resident(s) found to have been affected</b> Snack food will not be locked up in the office or elsewhere since this is not restricted and never was approved by the facilities human rights committee (HRC). QIDP and Coordinator will be trained on what is and is not restricted and why all restrictions must go through due process. Staff in the home will subsequently be trained on these topics as well. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Instructions will be given to staff not to lock up snack food; training will be completed QIDP, Coordinator, and staff to prevent recurrence. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility, and the Coordinator assists in this role. Until at least May 1, and longer if needed, the QIDP will conduct a minimum of</p>				

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W 0140 Bldg. 00	<p>client #6's record was conducted. There was no documentation in her record indicating her snack food was to be locked in the office.</p> <p>On 2/23/16 at 1:28 PM, a review of client #7's record was conducted. There was no documentation in her record indicating her Pop Tarts needed to be locked in the office.</p> <p>On 2/23/16 at 2:36 PM, the Assistant Group Home Director (AGHD) indicated the food being locked in the office was an unnecessary restriction. The AGHD stated, "that's a restriction. We can't do that."</p> <p>On 2/23/16 at 2:55 PM, the Coordinator indicated the food being locked in the office was an unnecessary restriction.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 3 non-sampled clients (#3), the facility failed to ensure a full and</p>	W 0140	<p>one documented visit to the home site per calendar week in order to monitor program implementation. Documentation for these home visits will include monitoring whether snack food is locked up or other unapproved restrictions are in place. If they are found to be in place, corrective action also will be documented. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p><b>W 140 Client Finances (Standard)</b> The facility must establish and maintain a system</p>	03/26/2016			

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	<p>complete accounting of client #3's personal funds entrusted to the facility.</p> <p>Findings include:</p> <p>On 2/23/16 at 7:17 AM, a review of client #3's personal funds was conducted. Client #3's February 2016 cash on hand ledger indicated she had \$23.20. When the Coordinator counted client #3's money, there was \$21.20 in her account. There was no documentation on the ledger accounting for the missing \$2.00. The Coordinator indicated he did not know where the \$2.00 was or why it was not accounted for.</p> <p>On 2/23/16 at 2:34 PM, the Assistant Group Home Director (AGHD) indicated the Home Manager (HM) took the money out and gave it to client #3 to use in the vending machines at the facility-operated workshop. The AGHD indicated the HM did not document the transaction but she should have documented it.</p> <p>On 2/23/16 at 2:48 PM, the Coordinator indicated the Home Manager removed \$2.00 from client #3's account on 2/19/16. The Coordinator indicated the HM should have immediately documented the withdrawal from client #3's account.</p>		<p>that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. <b>Corrective action for resident(s) found to have been affected</b> Gift cards will be tracked in the same manner as cash on hand is, staff are responsible to complete all accounting <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and all staff across all shifts will be trained on agency financial guidelines, including accounting for all client's funds (cash and gift cards) <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility, and the Coordinator assists in this role. Until at least May 1, and longer if needed, the QIDP will conduct a minimum of one documented visit to the home site per calendar week in order to monitor program implementation. Documentation for these home visits will include monitoring whether client finances are being documented responsibly. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will</p>				

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W 0149 Bldg. 00	<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 18 of 40 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the facility neglected to implement its policies and procedures to prevent client to client abuse, investigate incidents of client to client abuse, investigate an allegation of staff sleeping while on duty, investigate incidents of psychological abuse of client #7, ensure corrective actions were taken to address medication errors and staff sleeping while working at the group home, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and report the results of an investigation to the administrator within 5 working days.</p> <p>Findings include:</p> <p>On 2/19/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the</p>	W 0149	<p>provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p><b>W149 Staff Treatment of Clients (Standard)</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. <b>Corrective action for resident(s) found to have been affected</b> Competency-based staff training will be conducted across shifts that focuses on prevention of client-to-client aggression; the QIDP &amp; Coordinator will receive training on investigations that includes the requirement to investigate all allegations of client-to-client aggression, all instances where a staff member is found to be sleeping, and any allegation of bullying – including if the incident occurs when services are being provided with outside sources, such as a school; the QIDP and Coordinator will be trained on ensuring all corrective actions are taken following all incidents and investigations, including medication errors and allegations of abuse or neglect; and the QIDP and Coordinator</p>	03/26/2016

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	<p>following:</p> <p><b>Incidents of Abuse and Neglect:</b></p> <p>1) On 1/23/16 at 11:00 AM (the facility reported the incident to BDDS on 1/25/16), staff #4 was observed to be sleeping while working at the group home. The 1/23/16 Bureau of Developmental Disabilities Services incident report indicated, in part, "I (staff #7) was sitting at the dining table and facing [staff #4] and noticed that she was dozing while sitting on the couch. [Client #3] was sitting on the opposite couch, and all other clients were in their rooms. A couple of times [client #3] began talking, and [staff #4] would wake back up and try to respond, and then doze off again. I took a picture of her sleeping and walked in to (sic) kitchen. At 11:18 AM, I dialed the SGL (Supervised Group Living) pager, but after a couple of rings I hung up. Pager called back, and I asked what to do about sleeping staff. Pager suggested that I wake her up and let her know that she can't sleep. I came back in and sat down at the dining table. [Staff #4] got up and started moving around. She moved over to a chair against the wall, pulled a shirt around her which partially covered her eyes and laid back against the chair; she fell asleep. I walked over, woke her up and told her</p>		<p>will be trained on timing requirements for (a) submitting incident reports to BDDS within 24 hours and (b) ensuring completion of all investigations within 5 working days. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Staff, QIDP, and Coordinator training will be conducted on a range of issues to correct deficiencies. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program coordination and monitoring of the facility. Until at least May 1, and longer if needed, the QIDP or director will conduct a minimum of two documented visits to the home site per calendar week in order to monitor program implementation. The nurse coordinates health care, including monitoring medication administration procedures. Until at least May 1, and longer if medication error problems persist, the nurse will monitor a minimum of two medication passes per calendar week. These visits will be documented on a home visit form that includes a check off for observation of medication pass. Each form also</p>		

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	<p>she needed to stay awake. I sat on the couch and saw that she was back asleep. I went about doing some of the chores; [client #3] was watching TV in the living room; [staff #4] slept. At 12:00 PM, I administered noon med then called [name of Coordinator] and I asked what to do about [staff #4] sleeping, and [Coordinator] said to call the pager. [Coordinator] told me I could tell her to go home. I sat down on the couch again, and [Coordinator] texted for me to take a picture of staff sleeping. At 12:31 PM, [Coordinator] then texted for me to call the pager, 'We will work something out.' At 12:31 PM I sent pics of [staff #4] to SGL pager. At 12:25 PM, I called pager, got no answer and left message to call. I woke up [staff #4] and told her she needed to go home. When she woke up, she said she couldn't go home but she texted someone. I texted [Coordinator] that [staff #4] wouldn't leave. [Coordinator] responded that she needs to go home! At 12:43 PM, I called the pager and told [name of pager Coordinator] what had just transpired, [pager Coordinator] called and told [staff #4] if she can't stay awake, she needs to leave; after [pager Coordinator's] conversation, [staff #4] said, 'This is crazy.' I began making lunch; [staff #4] stayed awake the rest of the day. Staff member admitted to sleeping and was</p>		<p>includes an area for the nurse to summarize counseling/training when that is appropriate. In addition, a new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports and staff sleeping. The meeting will be chaired by SGL Director(or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility, and the Coordinator assists in this role. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>suspended." This affected clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>The 1/26/16 BDDS follow up report indicated, "There was no allegation of neglect because another staff member was providing full client supervision the entire time the other staff slept. Clients were never out of supervision, much as they would not have been if the second staff member had left the home on an errand. The staff member was suspended because sleeping is a violation of policy. This did not result in an allegation of neglect with subsequent investigation, but rather it is an HR (Human Resources) issue that will be dealt with through disciplinary action."</p> <p>On 2/22/16 at 10:09 AM, the Assistant Group Home Director (AGHD) indicated in an email to the Records Manager, "There was no investigation done, as this was reviewed and deemed NOT neglect."</p> <p>There was no documentation the facility conducted an investigation. There was no documentation staff #4 received corrective action.</p> <p>On 2/24/16 at 4:35 PM, the AGHD indicated in an email, "It sounds like [staff #4] was mentored by weekend house manager, [Associate Manager]."</p>						

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	<p>This is not documented..."</p> <p>On 2/24/16 at 2:56 PM, the AGHD sent the following 1/23/16 note from a Coordinator regarding the incident:</p> <p>"[Staff #7] called me needing an answer to a med question. While on that call she said that [staff #4] was sleeping. I asked her to send me a picture so that I could assess the situation. She indeed was sleeping. I told [staff #7] to wake her up and she said that she has woken her up a few times. I told [staff #7] I would try and get another staff in there and I called [Home Manager] and asked if she could come in and [Home Manager] stated that she could not come in and work. As I was working at my own house (another Stone Belt group home), I had to get lunch done and meds done for the rest of my clients at [name of group home]. So I did not reply to [staff #7] for about an hour while I was finishing meds and</p>			

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	<p>lunch. After that I discussed the situation with the pager [name of pager Coordinator] and he and I agreed on that she needs to go home if she cannot stay awake but because I could not get another staff in the house that I would prefer if she stays. [Staff #7] was upset with that answer of that and I told her that I would leave my house and come work with her and she told me that if I come she will go home.</p> <p>[Staff #4] admitted to dosing (sic) off and I told her that [staff #7] needs help and if she cannot stay awake she needs to go home. She said that it is not a problem and I said that as I am at my own house I cannot assess the situation and that I am allowing [staff #7] to send her home if she is to not stay awake if she falls asleep again after our discussion. I told her that we cannot sleep on the job and that if she cannot stay awake she needs to get up</p>			

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	<p>and walk around or move around. After the last text with [staff #7] around 1pm, I did not hear from her or [staff #4] for the rest of the day/night."</p> <p>On 2/25/16 at 11:58 AM, the AGHD forwarded an email from the Coordinator who was on call at the time of the incident. The email indicated, "2/25 re: 1/23, [staff #7] sub (substitute staff) at [name of group home] called to report that other staff was sleeping. She took pic (picture). I recommended that she wake her up and engage her in a task that would help her wake up. [Staff #7] was concerned that she was in an awkward rock and hard place because she was going to have to deal with the person she was reporting. Pager called [another Coordinator] to discuss. Concern that there was no staff to replace. Several back and forth conversations happened between [another Coordinator], [staff #7] and myself. At o E (sic) point [staff #7] said she tried to wake staff up, staff replied ok and then just rolled over under her blanket and went back to sleep. Also [staff #7] said that [another Coordinator] has said to send her home. Just as [staff #7] had feared, [staff #7] had to be [staff #7] (sic) to tell staff to go home. [Staff #7] called Pager again to report that staff wouldn't go home saying that she didn't have a ride. I volunteered to speak with staff and told her that if she was told to go home, she needed to leave the house and wait outside the house. Staff replied that she was told she could stay if she would wake up. As far as I know per her Coordinator, she was allowed to complete her shift. [Staff #7] was upset about the position she felt she was placed in."</p>						

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	<p>On 2/25/16 at 4:32 PM, the AGHD indicated in an email in response to the following question, "It appears this was written today by the date in the email. Did [name of Coordinator on the pager at the time of the incident] document anything regarding this situation at the time he was getting calls?" The AGHD indicated, "[Name of Coordinator on the pager at the time of the incident] does not have a pager note from that day, no."</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated one staff was nodding off and the other staff woke her up. The AGHD indicated the reason the facility did not investigate the incident was due to a second staff being at the home. The AGHD stated the staff was "trying to stay awake." The AGHD indicated she interviewed client #3 who was the client who was present during the incident. The AGHD indicated she spoke to the two staff who were involved. The AGHD indicated she did not document her interviews. The AGHD indicated the incident started as neglect however the interim Group Home Director told her it was not neglect therefore she did not conduct an investigation.</p> <p>2) On 2/2/16 at 9:56 AM, the Behavior Clinician (BC) wrote in an email to client #7's support team, "Good Morning Team, it was brought to my attention that [client #7] continues to be bullied on the bus. Yesterday she was called a 'retard' by someone on her bus, which I find totally unacceptable. She reported to the bus driver and he told her to sit at the front of the bus, yet there were no seats available. This has been addressed before yet continues to be an issue. I feel we need to address this further with the school or switch [client #7] to a special needs bus. Thoughts?"</p> <p>There was no documentation of a Stone Belt</p>			

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	<p>ARC, Inc. Incident Report, a BDDS incident report or an investigation.</p> <p>On 2/2/16 at 11:23 AM, the AGHD responded to the email, "[Coordinator], can you contact school and request front seat access for [client #7]?"</p> <p>On 2/2/16 at 1:53 PM, the Coordinator responded to the email, "Social worker at the school is on the case! She'll be talking with [client #7], the other students involved, and the bus driver. She will call me to confirm that there are measures in place to prevent this in the future."</p> <p>On 2/2/16 at 3:41 PM, the BC responded to the email, "Thanks everyone - guardian requested a special needs bus if this issue continues since our last attempt to resolve it did not work."</p> <p>On 2/2/16 at 3:45 PM, the Home Manager (HM) responded to the email, "[Client #7] has arrived home with the news that she now rides at the front of the bus in a saved seat and that the others on the bus were verbally chastised by the principal who advised them that any further bullying would be met with suspension."</p> <p>On 2/24/16 at 2:42 PM, the BC indicated she found out about the bullying on the school bus from client #7's guardian. The BC indicated the guardian wanted the BC to take care of the situation. The BC indicated client #7 was bullied on the bus one other time but she could not recall the date of the incident. The BC indicated the HM contacted the school after the first incident to report the situation. The BC indicated client #7 reported the first incident to the HM. The BC indicated the situation was resolved. The school spoke to the kids who were involved and changed client #7's seat on the bus. The BC indicated bullying was abuse but she did not think an</p>			

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	<p>investigation needed to be completed.</p> <p>On 2/22/16 at 2:06 PM, the AGHD indicated client #7 was bullied at school. The AGHD indicated client #7 reported the incident to the group home staff and the group home reported it to the school. The AGHD indicated some kids on the bus called her a retard. The AGHD indicated either the HM or the Coordinator spoke to the school but did not know who at the school. The AGHD indicated there were no incident reports regarding the situations. The AGHD stated, "bullying with name calling is abuse." The AGHD indicated she was not sure what the school did to address the situation. On 2/22/16 at 2:29 PM, the AGHD indicated BDDS reports should be submitted within 24 hours.</p> <p>3) On 2/25/16 at 10:46 AM, the Coordinator forwarded an email from former staff #8 regarding client #7 being bullied at school. The email from former staff #8 to client #7's support team was sent on 2/15/16 at 8:10 PM and indicated the following, "[Client #7] told me about another bully that's been harassing her, this time at school. She said the bully has been threatening to fight her and showed me a message where the bully was trying to set up a time and place to fight. I suggest (sic) [client #7] block her, but the bully simply created a new [name of social media website] account. [Client #7] said that she is scared that the bully or one of her friends will try to hurt her. I gave her generic advice (walk to classes with a friend or her phone out, talk to teachers), but I'm not sure where to go from there. Does anyone have any ideas?"</p> <p>On 2/15/16 at 8:13 PM, the Home Manager replied to the email and indicated, "Sounds a lot like what she brought to me last evening. I think it would help if [Behavior Clinician],</p>				

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	<p>[Coordinator] and if possible, [therapist] would read these messages for themselves so they get the full picture and not just our retellings."</p> <p>On 2/16/16 at 9:29 AM, the Behavior Clinician responded to the email and indicated, in part, "...This is a serious issue and social media has made it worse... I think we need to deal with it and make the school aware of what is happening, especially since they are threatening fights."</p> <p>There was no documentation of a Stone Belt ARC, Inc. Incident Report, a BDDS incident report or an investigation.</p> <p>On 2/24/16 at 2:42 PM, the BC indicated bullying was abuse but she did not think an investigation needed to be completed.</p> <p>On 2/22/16 at 2:06 PM, the AGHD indicated there was no incident report regarding the situation. The AGHD stated, "bullying with name calling is abuse." The AGHD indicated she was not sure what the school did to address the situation. The AGHD indicated the incident should have been reported to BDDS.</p> <p><b>Medication Errors with no Corrective/Disciplinary Action Taken:</b></p> <p>4) On 11/29/15 at 12:00 PM, client #2 was administered Lorazepam (depression/anxiety) 1 milligram (mg) instead of 0.5 mg. The 11/30/15 BDDS report indicated, in part, "No effect noticed." The 11/29/15 Medication Error Report (MER) indicated staff #2 made the error. The MER's Document Action Taken section was blank. There was no documentation staff #2 received corrective action.</p> <p>5) On 11/29/15 at 4:40 PM, client #4 returned to</p>						

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	<p>the group home from a visit to her family from 11/25/15 to 11/29/15. The 11/30/15 BDDS report indicated, "[Client #4] brought her pill bottles to staff, who found (sic) majority of packed pills still in the bottles. The missed meds were: Aripiprazole (depression) 10 mg - 1 pill; Culturelle (digestion) - 4 caps; Escitalopram (depression) 2.5 mg - 1/2 pill; Omeprazole (GERD - gastroesophageal reflux disease) 20 mg - 3 pills; Ferrous Sulfate (anemia) 325 mg - 3 pills; Lyrica (pain associated with shingles) 75 mg - 4 pills... Staff will continue to implement policies to ensure the safety of all clients."</p> <p>On 1/3/16 at 3:00 PM, the 1/4/16 BDDS report indicated, in part, "On 01/03/2016 at 3:00 PM, [client #4] returned home from her home visit; [client #4] had spent Christmas break with her family. 23 pills from each of were (sic) medications were packed for her visit. When [client #4] returned and gave staff [#2] her pill bottles, staff discovered that she hadn't taken them all. [Client #4] did not take the following medications: Omeprazole (GERD) 20 mg - 16 pills; Olive Leaf (prevention) 500 mg - 16 pills; Lyrica (pain associated with shingles) 75 mg - 16 pills were left in the travel bottles [client #4] brought back. Pager was notified. [Client #4's] mother, who signed the permission slip indicating she was responsible for administering medications to [client #4], did not administer the three different medications. Pills were packaged in order to be destroyed. There was no known effect to [client #4] due to this med error."</p> <p>There was no documentation of corrective action taken to address client #4 not receiving her medications while visiting her family.</p> <p>On 2/23/16 at 12:29 PM, a review of client #4's record was conducted. A 1/12/16 SGL</p>			

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	<p>(Supervised Group Living) Quarterly Review Form indicated in the Review incidents this quarter section, "On home visits family failed to give medications per physician's orders on two separate occasions. Where (sic) reported as med errors to state." There was no documentation indicating what corrective actions were implemented to address the medication errors.</p> <p>On 2/22/16 at 2:06 PM, the AGHD indicated either the Coordinator or the GHD should have called client #4's family to discuss the incident. The AGHD indicated there was no documentation of a call to the family.</p> <p>6) On 1/1/16 at 12:00 PM, client #2 did not receive Lorazepam (depression/anxiety) 0.5 mg from staff #3 as ordered by the physician. The 1/2/16 BDDS report indicated, in part, "This medication was not given... There was no noticeable effect to [client #2] due to this med error. Staff will be disciplined as per Stone Belt's med error policy." The 1/1/16 MER's Document Action Taken section was blank.</p> <p>There was no documentation staff #3 received disciplinary action.</p> <p>7) On 1/15/16 at 9:00 PM, client #4 was not administered Escitalopram (depression) 15 mg, Aripiprazole (depression) 10 mg, Melatonin (sleep) 3 mg and two ear drops (ear wax) in each ear. The 1/16/16 BDDS report indicated, "No negative effects noted. Staff will receive a performance review and med admin policy will be followed." The 1/16/16 MER indicated staff #1, #2 and #3 were responsible for the medication error. The 1/16/16 MER's Document Action Taken section was blank.</p> <p>There was no documentation staff #1, #2 and #3</p>						

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	<p>received performance reviews.</p> <p>8) On 1/28/16 at 4:00 PM, client #7 was not administered Aripiprazole (disruptive mood dysregulation) 15 mg by staff #1. The 1/29/16 MER's Document Action Taken section was blank.</p> <p>There was no documentation the facility reported the medication error to BDDS.</p> <p>There was no documentation staff #1 received a corrective action.</p> <p>On 2/23/16 at 2:51 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated BDDS reports should be submitted within 24 hours.</p> <p>9) On 2/1/16 at 7:00 AM (reported to BDDS on 2/3/16), staff #1 administered client #6's Meloxicam (arthritic pain) EOD (every other day) on the wrong day. Client #6 received the medication two days in a row. The 2/3/16 BDDS report indicated, in part, "Staff will be disciplined per Stone Belt's Medication Error and Progressive Disciplinary Action procedures and protocols." The 2/3/16 MER indicated there were no adverse side effects. The MER Document action taken section indicated, "Verbal Discussion/Training."</p> <p>There was no documentation staff #1 received disciplinary action.</p> <p>On 2/19/16 at 2:01 PM, the Human Resources Director (HRD) indicated the staff's employee files were reviewed and no corrective/disciplinary action was located in the staff's files.</p>			

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	<p>On 2/19/16 at 2:07 PM, the Coordinator indicated there was no corrective action taken with staff #1 for the medication errors on 1/28/16 and 2/1/16. The Coordinator stated, "I didn't do it."</p> <p>On 2/22/16 at 12:50 PM, the Organizational Effectiveness Coordinator (OEC) indicated corrective actions should be routed through the Coordinator. The OEC indicated the Home Manager could complete the corrective action with the staff and send the information to the Coordinator. The OEC stated, regarding no corrective action documentation being located, it "wasn't done right per policy."</p> <p>On 2/23/16 at 2:51 PM, the Coordinator indicated the facility was not following the medication error policy and procedure. The Coordinator indicated corrective action should have been taken with the staff. The Coordinator indicated BDDS reports should be submitted within 24 hours.</p> <p>On 2/23/16 at 2:51 PM, the AGHD indicated the facility should implement its medication error policy and procedure. The AGHD indicated corrective action should have been implemented.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated BDDS reports should be submitted within 24 hours.</p> <p><b>Incidents of client to client abuse:</b></p> <p>10) On 2/25/15 at 7:30 AM, client #3 hit client #6 on the left shoulder. Client #6 was not injured.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the</p>			

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	<p>clients.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>11) On 3/11/15 at 6:50 AM, client #3 hit former client #8 on the head and shoulders with her forearm. Client #8 was not injured.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>12) On 4/7/15 at 10:15 AM while at the facility-operated day program, client #3 hit a peer in the stomach. The peer was not injured.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the</p>			

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	<p>clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>13) On 7/27/15 at 6:40 AM, client #3 shoved former client #8 while trying to get into the refrigerator. Client #3 apologized to client #8. Client #3 lunged across the kitchen and hit client #8 three times on the upper arms and chest with a closed fist. Client #8 was upset but not injured.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>14) On 8/4/15 at 5:30 PM, client #3 hit client #6 with an open hand on her upper arm/shoulder area. Client #6 was not injured.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of</p>			

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	<p>the clients.</p> <p>15) On 9/3/15 at 10:15 AM while at the facility-operated day program, client #3 hit client #6 as she passed by her. Client #6 was not injured.</p> <p>The results of the 9/10/15 investigation were reviewed by the administrator on 9/11/15.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients. The AGHD indicated the timeframe for reporting the results of an investigation to the administrator was 5 working days.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients. The Coordinator indicated the timeframe for reported the results of an investigation to the administrator was 5 working days.</p> <p>16) On 9/21/15 at 7:00 AM, client #3 hit client #6 three or four times on the upper left arm with an open hand. Client #6 was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the</p>			

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	<p>clients. The AGHD indicated the incident should have been investigated.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients. The Coordinator indicated the incident should have been investigated.</p> <p>17) On 11/29/15 at 5:10 PM, client #1 accused client #3 of hitting her. The staff present indicated there was no incident of client to client aggression. The 11/29/15 Stone Belt ARC, Inc. Incident Report indicated, "After staff had come (sic) up to find out what was going on and 'resolved' the altercation, [client #3] went over and hit [client #1] on the legs...." Client #1 was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients. The AGHD indicated the incident should have been investigated.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients. The Coordinator indicated the incident should have been investigated.</p> <p>18) On 12/7/15 at 4:20 PM, client #3 hit client #5</p>			

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	<p>on the left side of her head and left neck/shoulder area with a closed hand. The 12/8/15 BDDS report indicated, in part, "...Client to client aggression inquiry being conducted." Client #5 was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients. The AGHD indicated the incident should have been investigated.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients. The Coordinator indicated the incident should have been investigated.</p> <p>On 2/19/16 at 11:56 AM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 5/14/13, 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</p>			

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	<p>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 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 policy indicated, "The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days." The policy indicated, in part, "Review the Incident Report to identify individuals and the nature of their participation, i.e. possible victims, perpetrators and witnesses. If there is an allegation of abuse/neglect or exploitation all staff assigned to the client(s) and present during the event, will be interviewed or asked to provide a written, signed statement. All perpetrators/alleged perpetrators will be interviewed or asked to provide a written, signed statement. All persons who saw the incident and are able to give substantial information are to be interviewed or provide written, signed statements. Those individuals who are not able to provide written or verbal statements due to disability are not required to</p>			

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	<p>provide statements. If statements can be interpreted by staff, or a 'knowledgeable other' familiar with the client's communication style, signed statements from these individuals are to be provided. In a residential setting, all residents present for the incident and able to participate in the interview process must be interviewed to assure they have not been victimized or traumatized by the event." The policy titled, Incident Reporting Procedure, dated 7/25/13, indicated, in part, "A staff member who witnesses an incident, discovers the results of an incident, or receives the initial report of an incident from a person not on staff, immediately does the following: interrupts the inappropriate behavior, takes measures to protect, comfort and ensure treatment of the individuals involved in the incident, obtaining emergency care as needed, requests assistance as needed from immediate supervisor and/or pager, in cases of suspected abuse/neglect or exploitation, the director of the program is to be notified immediately. If no action is taken in response to the report, continue to report to the supervisor or next level of management." The 9/14 Human Rights Policy defined verbal/emotional abuse as, "Emotional/Verbal abuse: Consists of the intentional use of actions, words, or activities where an individual suffers emotional/psychological harm or trauma. This includes, but is not limited to the</p>			

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W 0153	<p>following: 1. Shouting or swearing at a client. 2. Calling a client names with intent to emotionally harm. 3. Using words or actions causing the individual to experience emotional distress or humiliation. To degrade, debase, disgrace or shame clients in any manner. 4. Using words or actions causing the individual to feel harassed. To torment or irritate clients persistently in an effort to get obedience or control. 5. Using words or actions causing others to view the individual with hatred, contempt, disgrace or ridicule. 6. Actions in a client 's presence with intent to cause the individual to be placed in fear of retaliation, confinement, and/or restraint. 7. Threats of punishment (e.g. using an object that frightens a client). 8. Threats of deprivation (e.g. threatening to withhold a meal or need). 9. Intimidation/Coercion: To dominate, force or bring about by force, fear or threat behavior or compliance. 10. Pejorative or derogatory terms to describe persons with disabilities. 11. Any action or words with the intent to cause the individual to react in a negative manner."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p>			

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Bldg. 00	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 3 of 40 incident reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the facility failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 2/19/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/23/16 at 11:00 AM (the facility reported the incident to BDDS on 1/25/16), staff #4 was observed to be sleeping while working at the group home. The 1/23/16 Bureau of Developmental Disabilities Services incident report indicated, in part, "I (staff #7) was sitting at the dining table and facing [staff #4] and noticed that she was dozing while sitting on the couch. [Client #3] was sitting on the opposite couch, and all other clients were in their rooms. A couple of times [client #3]</p>	W 0153	<p><b>W 153 Staff Treatment of Clients (Standard)</b> The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p><b>Corrective action for resident(s) found to have been affected</b> The QIDP and Coordinator will be trained on timing requirements for (a) submitting incident reports to BDDS within 24 hours.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and Coordinator training will be conducted.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. Part of this meeting will</p>	03/26/2016

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	<p>began talking, and [staff #4] would wake back up and try to respond, and then doze off again. I took a picture of her sleeping and walked in to (sic) kitchen. At 11:18 AM, I dialed the SGL (Supervised Group Living) pager, but after a couple of rings I hung up. Pager called back, and I asked what to do about sleeping staff. Pager suggested that I wake her up and let her know that she can't sleep. I came back in and sat down at the dining table. [Staff #4] got up and started moving around. She moved over to a chair against the wall, pulled a shirt around her which partially covered her eyes and laid back against the chair; she fell asleep. I walked over, woke her up and told her she needed to stay awake. I sat on the couch and saw that she was back asleep. I went about doing some of the chores; [client #3] was watching TV in the living room; [staff #4] slept. At 12:00 PM, I administered noon med then called [name of Coordinator] and I asked what to do about [staff #4] sleeping, and [Coordinator] said to call the pager. [Coordinator] told me I could tell her to go home. I sat down on the couch again, and [Coordinator] texted for me to take a picture of staff sleeping. At 12:31 PM, [Coordinator] then texted for me to call the pager, 'We will work something out.' At 12:31 PM I sent pics of [staff #4] to SGL pager. At 12:25 PM, I called pager,</p>		<p>included documentation that all reportable incidents were sent to BDDS within 24 hours. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. In the case of late reporting, this would include following up to determine why the report was late and put measures in place to prevent recurrence. The QIDP is responsible for program implementation and monitoring of the facility, and reporting requirements. The Coordinator assists in this role. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>got no answer and left message to call. I woke up [staff #4] and told her she needed to go home. When she woke up, she said she couldn't go home but she texted someone. I texted [Coordinator] that [staff #4] wouldn't leave. [Coordinator] responded that she needs to go home! At 12:43 PM, I called the pager and told [name of pager Coordinator] what had just transpired, [pager Coordinator] called and told [staff #4] if she can't stay awake, she needs to leave; after [pager Coordinator's] conversation, [staff #4] said, 'This is crazy.' I began making lunch; [staff #4] stayed awake the rest of the day. Staff member admitted to sleeping and was suspended." This affected clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>On 2/22/16 at 2:29 PM, the Assistant Group Home Director (AGHD) indicated BDDS reports should be submitted within 24 hours.</p> <p>2) On 2/2/16 at 9:56 AM, the Behavior Clinician (BC) wrote in an email to client #7's support team, "Good Morning Team, it was brought to my attention that [client #7] continues to be bullied on the bus. Yesterday she was called a 'retard' by someone on her bus, which I find totally unacceptable. She reported to the bus driver and he told her to sit at the front of</p>			

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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4417 BLACKSTONE CT BLOOMINGTON, IN 47401
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	<p>the bus, yet there were no seats available. This has been addressed before yet continues to be an issue. I feel we need to address this further with the school or switch [client #7] to a special needs bus. Thoughts?"</p> <p>There was no documentation of a Stone Belt ARC, Inc. Incident Report or a BDDS incident report.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated BDDS reports should be submitted within 24 hours.</p> <p>3) On 2/25/16 at 10:46 AM, the Coordinator forwarded an email from former staff #8 regarding client #7 being bullied at school. The email from former staff #8 to client #7's support team was sent on 2/15/16 at 8:10 PM and indicated the following, "[Client #7] told me about another bully that's been harassing her, this time at school. She said the bully has been threatening to fight her and showed me a message where the bully was trying to set up a time and place to fight. I suggest (sic) [client #7] block her, but the bully simply created a new [name of social media website] account. [Client #7] said that she is scared that the bully or one of her friends will try to hurt her. I gave her generic advice (walk to classes with a friend or her phone out, talk to</p>			

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	<p>teachers), but I'm not sure where to go from there. Does anyone have any ideas?"</p> <p>On 2/15/16 at 8:13 PM, the Home Manager replied to the email and indicated, "Sounds a lot like what she brought to me last evening. I think it would help if [Behavior Clinician], [Coordinator] and if possible, [therapist] would read these messages for themselves so they get the full picture and not just our retellings."</p> <p>On 2/16/16 at 9:29 AM, the Behavior Clinician responded to the email and indicated, in part, "...This is a serious issue and social media has made it worse... I think we need to deal with it and make the school aware of what is happening, especially since they are threatening fights."</p> <p>There was no documentation of a Stone Belt ARC, Inc. Incident Report or a BDDS incident report.</p> <p>On 2/22/16 at 2:06 PM, the AGHD indicated there was no incident report regarding the situation. The AGHD stated, "bullying with name calling is abuse." The AGHD indicated she was not sure what the school did not address the situation. The AGHD indicated the</p>						

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W 0154 Bldg. 00	<p>incident should have been reported to BDDS.</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 6 of 40 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>On 2/19/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/23/16 at 11:00 AM, staff #4 was observed to be sleeping while working at the group home. The 1/23/16 Bureau of Developmental Disabilities Services incident report indicated, in part, "I (staff #7) was sitting at the dining table and facing [staff #4] and noticed that she was dozing while sitting on the couch. [Client #3] was sitting on the opposite</p>			W 0154	<p><b>W154 Staff Treatment of Clients (Standard)</b> The facility must have evidence that all alleged violations are thoroughly investigated. <b>Corrective action for resident(s) found to have been affected</b> The QIDP &amp; Coordinator will receive training on conducting thorough investigations, which includes ensuring follow-up all corrective actions. In addition, both the QIDP and Coordinator will be trained on timing requirements for ensuring completion of all investigations within 5 working days. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and Coordinator</p>		03/26/2016

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	couch, and all other clients were in their rooms. A couple of times [client #3] began talking, and [staff #4] would wake back up and try to respond, and then doze off again. I took a picture of her sleeping and walked in to (sic) kitchen. At 11:18 AM, I dialed the SGL (Supervised Group Living) pager, but after a couple of rings I hung up. Pager called back, and I asked what to do about sleeping staff. Pager suggested that I wake her up and let her know that she can't sleep. I came back in and sat down at the dining table. [Staff #4] got up and started moving around. She moved over to a chair against the wall, pulled a shirt around her which partially covered her eyes and laid back against the chair; she fell asleep. I walked over, woke her up and told her she needed to stay awake. I sat on the couch and saw that she was back asleep. I went about doing some of the chores; [client #3] was watching TV in the living room; [staff #4] slept. At 12:00 PM, I administered noon med then called [name of Coordinator] and I asked what to do about [staff #4] sleeping, and [Coordinator] said to call the pager. [Coordinator] told me I could tell her to go home. I sat down on the couch again, and [Coordinator] texted for me to take a picture of staff sleeping. At 12:31 PM, [Coordinator] then texted for me to call the pager, 'We will work something out.'		training will be conducted on the full process of investigations, including thoroughness, timeliness, and follow-up requirements.  <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP, with assistance from the Coordinator, is responsible to ensure that all reportable incidents that need investigations are thoroughly investigated. The SGL Director supervises the QIDP and Coordinator and monitors their performance through a variety of means. One of these is through a new Incident Oversight meeting that will take place on a regular basis to ensure that all corrective action has been completed for incident reports and investigations. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. For incidents requiring an investigation, this will include timeliness (complete within 5 business days) and follow-up for the investigation. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.				

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	<p>At 12:31 PM I sent pics of [staff #4] to SGL pager. At 12:25 PM, I called pager, got no answer and left message to call. I woke up [staff #4] and told her she needed to go home. When she woke up, she said she couldn't go home but she texted someone. I texted [Coordinator] that [staff #4] wouldn't leave. [Coordinator] responded that she needs to go home! At 12:43 PM, I called the pager and told [name of pager Coordinator] what had just transpired, [pager Coordinator] called and told [staff #4] if she can't stay awake, she needs to leave; after [pager Coordinator's] conversation, [staff #4] said, 'This is crazy.' I began making lunch; [staff #4] stayed awake the rest of the day. Staff member admitted to sleeping and was suspended." This affected clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>The 1/26/16 BDDS follow up report indicated, "There was no allegation of neglect because another staff member was providing full client supervision the entire time the other staff slept. Clients were never out of supervision, much as they would not have been if the second staff member had left the home on an errand. The staff member was suspended because sleeping is a violation of policy. This did not result in an allegation of neglect with subsequent investigation,</p>			

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	<p>but rather it is an HR (Human Resources) issue that will be dealt with through disciplinary action."</p> <p>On 2/22/16 at 10:09 AM, the Assistant Group Home Director (AGHD) indicated in an email to the Records Manager, "There was no investigation done, as this was reviewed and deemed NOT neglect."</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/24/16 at 2:56 PM, the AGHD sent the following 1/23/16 note from the Coordinator regarding the incident:</p> <p>"[Staff #7] called me needing an answer to a med question. While on that call she said that [staff #4] was sleeping. I asked her to send me a picture so that I could assess the situation. She indeed was sleeping. I told [staff #7] to wake her up and she said that she has woken her up a few times. I told [staff #7] I would try and get another staff in there and I called [Home Manager] and asked if she could come in and [Home Manager] stated that</p>			
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	<p>she could not come in and work. As I was working at my own house (another Stone Belt group home), I had to get lunch done and meds done for the rest of my clients at [name of group home]. So I did not reply to [staff #7] for about an hour while I was finishing meds and lunch. After that I discussed the situation with the pager [name of pager Coordinator] and he and I agreed on that she needs to go home if she cannot stay awake but because I could not get another staff in the house that I would prefer if she stays. [Staff #7] was upset with that answer of that and I told her that I would leave my house and come work with her and she told me that if I come she will go home.</p> <p>[Staff #4] admitted to dosing (sic) off and I told her that [staff #7] needs help and if she cannot stay awake she needs to go home. She said that it is not a problem</p>			

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	<p>and I said that as I am at my own house I cannot assess the situation and that I am allowing [staff #7] to send her home if she is to not stay awake if she falls asleep again after our discussion . I told her that we cannot sleep on the job and that if she cannot stay awake she needs to get up and walk around or move around. After the last text with [staff #7] around 1pm, I did not hear from her or [staff #4] for the rest of the day/night."</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated one staff was nodding off and the other staff woke her up. The AGHD indicated the reason the facility did not investigate the incident was due to a second staff being at the home. The AGHD stated the staff was "trying to stay awake." The AGHD indicated she interviewed client #3 who was the client who was present during the incident. The AGHD indicated she spoke to the two staff who were involved. The AGHD indicated she did not document her interviews. The AGHD indicated the incident started as neglect however the interim Group Home Director told her it was not neglect therefore she did not conduct an investigation.</p> <p>2) On 2/2/16 at 9:56 AM, the Behavior Clinician (BC) wrote in an email to client #7's support team, "Good Morning Team, it was brought to my attention that [client #7] continues to be bullied</p>			

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	<p>on the bus. Yesterday she was called a 'retard' by someone on her bus, which I find totally unacceptable. She reported to the bus driver and he told her to sit at the front of the bus, yet there were no seats available. This has been addressed before yet continues to be an issue. I feel we need to address this further with the school or switch [client #7] to a special needs bus. Thoughts?"</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/2/16 at 11:23 AM, the AGHD responded to the email, "[Coordinator], can you contact school and request front seat access for [client #7]?"</p> <p>On 2/2/16 at 1:53 PM, the Coordinator responded to the email, "Social worker at the school is on the case! She'll be talking with [client #7], the other students involved, and the bus driver. She will call me to confirm that there are measures in place to prevent this in the future."</p> <p>On 2/2/16 at 3:41 PM, the BC responded to the email, "Thanks everyone - guardian requested a special needs bus if this issue continues since our last attempt to resolve it did not work."</p> <p>On 2/2/16 at 3:45 PM, the Home Manager (HM) responded to the email, "[Client #7] has arrived home with the news that she now rides at the front of the bus in a saved seat and that the others on the bus were verbally chastised by the principal who advised them that any further bullying would be met with suspension."</p> <p>On 2/24/16 at 2:42 PM, the BC indicated she found out about the bullying on the school bus from client #7's guardian. The BC indicated the guardian wanted the BC to take care of the situation. The BC indicated client #7 was bullied</p>			

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	<p>on the bus one other time but she could not recall the date of the incident. The BC indicated the HM contacted the school after the first incident to report the situation. The BC indicated client #7 reported the first incident to the HM. The BC indicated the situation was resolved. The school spoke to the kids who were involved and changed client #7's seat on the bus. The BC indicated bullying was abuse but she did not think an investigation needed to be completed.</p> <p>On 2/22/16 at 2:06 PM, the AGHD indicated client #7 was bullied at school. The AGHD indicated client #7 reported the incident to the group home staff and the group home reported it to the school. The AGHD indicated some kids on the bus called her a retard. The AGHD indicated either the HM or the Coordinator spoke to the school but did not know who at the school. The AGHD indicated there were no incident reports regarding the situations. The AGHD stated, "bullying with name calling is abuse." The AGHD indicated she was not sure what the school did not address the situation. The AGHD indicated there was no documentation of an investigation.</p> <p>3) On 2/25/16 at 10:46 AM, the Coordinator forwarded an email from former staff #8 regarding client #7 being bullied at school. The email from former staff #8 to client #7's support team was sent on 2/15/16 at 8:10 PM and indicated the following, "[Client #7] told me about another bully that's been harassing her, this time at school. She said the bully has been threatening to fight her and showed me a message where the bully was trying to set up a time and place to fight. I suggest (sic) [client #7] block her, but the bully simply created a new [name of social media website] account. [Client #7] said that she is scared that the bully or one of her</p>			

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	<p>friends will try to hurt her. I gave her generic advice (walk to classes with a friend or her phone out, talk to teachers), but I'm not sure where to go from there. Does anyone have any ideas?"</p> <p>On 2/15/16 at 8:13 PM, the Home Manager replied to the email and indicated, "Sounds a lot like what she brought to me last evening. I think it would help if [Behavior Clinician], [Coordinator] and if possible, [therapist] would read these messages for themselves so they get the full picture and not just our retellings."</p> <p>On 2/16/16 at 9:29 AM, the Behavior Clinician responded to the email and indicated, in part, "...This is a serious issue and social media has made it worse... I think we need to deal with it and make the school aware of what is happening, especially since they are threatening fights."</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/24/16 at 2:42 PM, the BC indicated bullying was abuse but she did not think an investigation needed to be completed.</p> <p>On 2/22/16 at 2:06 PM, the AGHD indicated there was no incident report regarding the situation. The AGHD stated, "bullying with name calling is abuse." The AGHD indicated she was not sure what the school did not address the situation. The AGHD indicated the incident should have been reported to BDDS. The AGHD indicated there was no documentation of an investigation.</p> <p>4) On 9/21/15 at 7:00 AM, client #3 hit client #6 three or four times on the upper left arm with an open hand. Client #6 was not injured.</p>			

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	<p>There was no documentation the facility conducted an investigation.</p> <p>On 2/22/16 at 2:29 PM, the Assistant Group Home Director (AGHD) indicated the incident should have been investigated.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated the incident should have been investigated.</p> <p>5) On 11/29/15 at 5:10 PM, client #1 accused client #3 of hitting her. The staff present indicated there was no incident of client to client aggression. The 11/29/15 Stone Belt ARC, Inc. Incident Report indicated, "After staff had come (sic) up to find out what was going on and 'resolved' the altercation, [client #3] went over and hit [client #1] on the legs...." Client #1 was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated the incident should have been investigated.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated the incident should have been investigated.</p> <p>6) On 12/7/15 at 4:20 PM, client #3 hit client #5 on the left side of her head and left neck/shoulder area with a closed hand. The 12/8/15 BDDS report indicated, in part, "...Client to client aggression inquiry being conducted." Client #5 was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/22/16 at 2:29 PM, the AGHD indicated the incident should have been investigated.</p>				

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W 0156 Bldg. 00	<p>On 2/23/16 at 2:50 PM, the Coordinator indicated the incident should have been investigated.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 40 incident/investigative reports reviewed affecting clients #3 and #6, the facility failed to ensure the results of an investigation were reported to the administrator within 5 working days of the incident.</p> <p>Findings include:</p> <p>On 2/19/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 9/3/15 at 10:15 AM while at the facility-operated day program, client #3 hit client #6 as she passed by her. Client #6 was not injured.</p> <p>The results of the 9/10/15 investigation were reviewed by the administrator on</p>	W 0156	<p><b>W156 Staff Treatment of Clients (Standard)</b> The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. <b>Corrective action for resident(s) found to have been affected</b> The QIDP &amp; Coordinator will receive training on conducting thorough investigations, which includes ensuring that it is reported to the administrator/SGL Director within 5 working days. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and Coordinator training will be conducted on the full process</p>	03/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G170	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2016
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W 0157	<p>9/11/15.</p> <p>On 2/22/16 at 2:29 PM, the Assistant Group Home Director indicated the timeframe for reporting the results of an investigation to the administrator was 5 working days.</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated the timeframe for reported the results of an investigation to the administrator was 5 working days.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p>		<p>of investigations, including thoroughness, timeliness, and follow-up requirements. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP, with assistance from the Coordinator, is responsible to ensure that all reportable incidents that need investigations are thoroughly investigated. The SGL Director supervises the QIDP and Coordinator and monitors their performance through a variety of means. One of these is through a new Incident Oversight meeting that will take place on a regular basis to ensure that all corrective action has been completed for incident reports and investigations. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. For incidents requiring an investigation, this will include timeliness (complete within 5 business days) and follow-up for the investigation. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		

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Bldg. 00	<p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 10 of 40 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6 and #7, the facility failed to ensure appropriate corrective actions were implemented to address staff sleeping while working at the group home and medication errors.</p> <p>Findings include:</p> <p>On 2/19/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/23/16 at 11:00 AM, staff #4 was observed to be sleeping while working at the group home. The 1/23/16 Bureau of Developmental Disabilities Services incident report indicated, in part, "I (staff #7) was sitting at the dining table and facing [staff #4] and noticed that she was dozing while sitting on the couch. [Client #3] was sitting on the opposite couch, and all other clients were in their rooms. A couple of times [client #3] began talking, and [staff #4] would wake back up and try to respond, and then doze off again. I took a picture of her sleeping and walked in to (sic) kitchen. At 11:18 AM, I dialed the SGL (Supervised Group</p>	W 0157	<p><b>W157 Staff Treatment of Clients (Standard)</b> If the alleged violation is verified, appropriate corrective action must be taken.</p> <p><b>Corrective action for resident(s) found to have been affected</b> The QIDP &amp; Coordinator will receive training on conducting thorough investigations, which includes ensuring follow-up all corrective actions. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and Coordinator training will be conducted on the full process of investigations, including thoroughness, timeliness, and follow-up requirements. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP, with assistance from the Coordinator, is responsible to ensure that all reportable incidents that need investigations are thoroughly investigated. The SGL Director supervises the QIDP and Coordinator and monitors their performance through a variety of means. One of these is through a new Incident Oversight meeting that will take place on a regular basis to ensure that all corrective action has been completed for</p>	03/26/2016			

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	<p>Living) pager, but after a couple of rings I hung up. Pager called back, and I asked what to do about sleeping staff. Pager suggested that I wake her up and let her know that she can't sleep. I came back in and sat down at the dining table. [Staff #4] got up and started moving around. She moved over to a chair against the wall, pulled a shirt around her which partially covered her eyes and laid back against the chair; she fell asleep. I walked over, woke her up and told her she needed to stay awake. I sat on the couch and saw that she was back asleep. I went about doing some of the chores; [client #3] was watching TV in the living room; [staff #4] slept. At 12:00 PM, I administered noon med then called [name of Coordinator] and I asked what to do about [staff #4] sleeping, and [Coordinator] said to call the pager. [Coordinator] told me I could tell her to go home. I sat down on the couch again, and [Coordinator] texted for me to take a picture of staff sleeping. At 12:31 PM, [Coordinator] then texted for me to call the pager, 'We will work something out.' At 12:31 PM I sent pics of [staff #4] to SGL pager. At 12:25 PM, I called pager, got no answer and left message to call. I woke up [staff #4] and told her she needed to go home. When she woke up, she said she couldn't go home but she texted someone. I texted [Coordinator]</p>		<p>incident reports and investigations. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. For incidents requiring an investigation, this will include timeliness (complete within 5 business days) and follow-up for the investigation. The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>that [staff #4] wouldn't leave. [Coordinator] responded that she needs to go home! At 12:43 PM, I called the pager and told [name of pager Coordinator] what had just transpired, [pager Coordinator] called and told [staff #4] if she can't stay awake, she needs to leave; after [pager Coordinator's] conversation, [staff #4] said, 'This is crazy.' I began making lunch; [staff #4] stayed awake the rest of the day. Staff member admitted to sleeping and was suspended." This affected clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>The 1/26/16 BDDS follow up report indicated, "There was no allegation of neglect because another staff member was providing full client supervision the entire time the other staff slept. Clients were never out of supervision, much as they would not have been if the second staff member had left the home on an errand. The staff member was suspended because sleeping is a violation of policy. This did not result in an allegation of neglect with subsequent investigation, but rather it is an HR (Human Resources) issue that will be dealt with through disciplinary action."</p> <p>There was no documentation staff #4 received corrective action.</p>			

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	<p>On 2/24/16 at 4:35 PM, the AGHD indicated in an email, "It sounds like [staff #4] was mentored by weekend house manager, [Associate Manager]. This is not documented..."</p> <p>2) On 11/29/15 at 12:00 PM, client #2 was administered Lorazepam (depression/anxiety) 1 milligram (mg) instead of 0.5 mg. The 11/30/15 BDDS report indicated, in part, "No effect noticed." The 11/29/15 Medication Error Report (MER) indicated staff #2 made the error. The MER's Document Action Taken section was blank. There was no documentation staff #2 received corrective action.</p> <p>3) On 11/29/15 at 4:40 PM, client #4 returned to the group home from a visit to her family from 11/25/15 to 11/29/15. The 11/30/15 BDDS report indicated, "[Client #4] brought her pill bottles to staff, who found (sic) majority of packed pills still in the bottles. The missed meds were: Aripiprazole (depression) 10 mg - 1 pill; Culturelle (digestion) - 4 caps; Escitalopram (depression) 2.5 mg - 1/2 pill; Omeprazole (GERD - gastroesophageal reflux disease) 20 mg - 3 pills; Ferrous Sulfate (anemia) 325 mg - 3 pills; Lyrica (pain associated with shingles) 75 mg - 4 pills... Staff will continue to implement policies to ensure</p>						

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	<p>the safety of all clients."</p> <p>On 1/3/16 at 3:00 PM, the 1/4/16 BDDS report indicated, in part, "On 01/03/2016 at 3:00 PM, [client #4] returned home from her home visit; [client #4] had spent Christmas break with her family. 23 pills from each of were (sic) medications were packed for her visit. When [client #4] returned and gave staff [#2] her pill bottles, staff discovered that she hadn't taken them all. [Client #4] did not take the following medications: Omeprazole (GERD) 20 mg - 16 pills; Olive Leaf (prevention) 500 mg - 16 pills; Lyrica (pain associated with shingles) 75 mg - 16 pills were left in the travel bottles [client #4] brought back. Pager was notified. [Client #4's] mother, who signed the permission slip indicating she was responsible for administering medications to [client #4], did not administer the three different medications. Pills were packaged in order to be destroyed. There was no known effect to [client #4] due to this med error."</p> <p>There was no documentation of corrective action taken to address client #4 not receiving her medications while visiting her family.</p> <p>On 2/23/16 at 12:29 PM, a review of</p>			

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	<p>client #4's record was conducted. A 1/12/16 SGL (Supervised Group Living) Quarterly Review Form indicated in the Review incidents this quarter section, "On home visits family failed to give medications per physician's orders on two separate occasions. Where (sic) reported as med errors to state." There was no documentation indicating what corrective actions were implemented to address the medication errors.</p> <p>On 2/22/16 at 2:06 PM, the AGHD indicated either the Coordinator or the GHD should have called client #4's family to discuss the incident. The AGHD indicated there was no documentation of a call to the family.</p> <p>4) On 1/1/16 at 12:00 PM, client #2 did not receive Lorazepam (depression/anxiety) 0.5 mg from staff #3 as ordered by the physician. The 1/2/16 BDDS report indicated, in part, "This medication was not given... There was no noticeable effect to [client #2] due to this med error. Staff will be disciplined as per Stone Belt's med error policy." The 1/1/16 MER's Document Action Taken section was blank.</p> <p>There was no documentation staff #3 received disciplinary action.</p>			

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	<p>5) On 1/15/16 at 9:00 PM, client #4 was not administered Escitalopram (depression) 15 mg, Aripiprazole (depression) 10 mg, Melatonin (sleep) 3 mg and two ear drops (ear wax) in each ear. The 1/16/16 BDDS report indicated, "No negative effects noted. Staff will receive a performance review and med admin policy will be followed." The 1/16/16 MER indicated staff #1, #2 and #3 were responsible for the medication error. The 1/16/16 MER's Document Action Taken section was blank.</p> <p>There was no documentation staff #1, #2 and #3 received performance reviews.</p> <p>6) On 1/28/16 at 4:00 PM, client #7 was not administered Aripiprazole (disruptive mood dysregulation) 15 mg by staff #1. The 1/29/16 MER's Document Action Taken section was blank.</p> <p>There was no documentation staff #1 received a corrective action.</p> <p>7) On 2/1/16 at 7:00 AM, staff #1 administered client #6's Meloxicam (arthritic pain) EOD (every other day) on the wrong day. Client #6 received the medication two days in a row. The 2/3/16 BDDS report indicated, in part, "Staff will be disciplined per Stone Belt's Medication Error and Progressive</p>			

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	<p>Disciplinary Action procedures and protocols." The 2/3/16 MER indicated there were no adverse side effects. The MER Document action taken section indicated, "Verbal Discussion/Training."</p> <p>There was no documentation staff #1 received disciplinary action.</p> <p>On 2/19/16 at 2:01 PM, the Human Resources Director (HRD) indicated the staff's employee files were reviewed and no corrective/disciplinary action was located in the staff's files.</p> <p>On 2/19/16 at 2:07 PM, the Coordinator indicated there was no corrective action taken with staff #1 for the medication errors on 1/28/16 and 2/1/16. The Coordinator stated, "I didn't do it."</p> <p>On 2/22/16 at 12:50 PM, the Organizational Effectiveness Coordinator (OEC) indicated corrective actions should be routed through the Coordinator. The OEC indicated the Home Manager could complete the corrective action with the staff and send the information to the Coordinator. The OEC stated, regarding no corrective action documentation being located, it "wasn't done right per policy."</p> <p>On 2/23/16 at 2:51 PM, the Coordinator</p>			

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W 0159 Bldg. 00	<p>indicated the facility was not following the medication error policy and procedure. The Coordinator indicated corrective action should have been taken with the staff.</p> <p>On 2/23/16 at 2:51 PM, the AGHD indicated the facility should implement its medication error policy and procedure. The AGHD indicated corrective action should have been implemented.</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 observation, record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's Qualified Intellectual Disabilities Professional (QIDP - called Coordinator at the facility) failed to integrate, coordinate and monitor the individuals' program plans. The QIDP failed to ensure client #2, #4, #6 and #7's program plans were reviewed on a regular basis. The QIDP failed to ensure client #7's outside services (school) met the needs of the client. The QIDP failed to ensure clients #2, #4 and #7 had a</p>	W 0159	<p><b>W 159 QIDP (Standard)</b> Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. <b>Corrective action for resident(s) found to have been affected</b> The QIDP will be trained on active treatment programming, development and implementation. The QIDP will be trained on quarterly reports, meetings and documentation of ISP progress towards goals set by the IST. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected,</p>	03/26/2016

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	<p>comprehensive functional assessment (CFA) completed within 30 days of admission to the group home and client #4's recommended assistive technology assessment was completed. The QIDP failed to ensure for 3 of 3 clients in the sample (#2, #4 and #7) who were admitted to the group home since February 2015, individual program plans (IPP) were completed within 30 days of admission. The QIDP failed to ensure client #6's comprehensive functional assessment (CFA) was reviewed and updated at least annually. The QIDP failed to ensure client #6's IPP was revised at least annually. The QIDP failed to ensure quarterly evacuation drills were conducted for each shift of personnel affecting clients #1, #2, #3, #4, #5, #6 and #7. The QIDP failed to ensure clients #1, #3, #4 and #5 were involved with meal preparation and serving themselves during breakfast.</p> <p>Findings include:</p> <p>1) On 2/23/16 at 12:01 PM, a review of client #2's record was conducted. There was no documentation in her record indicating the QIDP reviewed, revised and monitored her program plans on a regular basis from 2/22/15 (date of admission) to 2/23/16.</p>		<p>and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>On 2/23/16 at 12:29 PM, a review of client #4's record was conducted. There was no documentation in her record indicating the QIDP reviewed, revised and monitored her program plans on a regular basis from 8/24/15 (date of admission) to 2/23/16. Client #4's record contained one SGL (Supervised Group Living) Quarterly Review Form dated 1/12/16. The form indicated client #4 had the following goals that were not achieved: Medication training, cycle fill, use of debit card, meal prep/kitchen safety, brushing teeth and general hygiene. The form was blank in the Month section for data. The form was blank in the Quarterly Average percent section. The form did not indicate the percentages client #4 met her goals. The form indicated "continue" for all goals. There was no documentation indicating whether or not client #4 made progress toward meeting her training goals. There were no additional Quarterly Review Forms in client #4's record for review. The form was signed by a Coordinator assigned to another Stone Belt group home and not the Coordinator assigned to this group home.</p> <p>On 2/23/16 at 12:56 PM, a review of client #6's record was conducted. There was no documentation in her record indicating the QIDP reviewed, revised</p>						

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	<p>and monitored her program plans on a regular basis from 2/19/15 to 2/23/16.</p> <p>On 2/23/16 at 1:28 PM, a review of client #7's record was conducted. There was no documentation in her record indicating the QIDP reviewed, revised and monitored her program plans on a regular basis from 11/4/15 (date of admission) to 2/23/16.</p> <p>On 2/23/16 at 3:01 PM, the Coordinator indicated the clients' quarterly reviews had not been done. The Coordinator stated, "they are a mess."</p> <p>2) Please refer to W120. For 1 of 1 client in the sample (#7) who attended an outside services program (school), the facility failed to ensure the outside services met the needs of the client.</p> <p>3) Please refer to W210. For 3 of 4 clients in the sample (#2, #4 and #7), the facility failed to ensure: 1) clients #2, #4 and #7 had a comprehensive functional assessment (CFA) completed within 30 days of admission to the group home and 2) a recommended assistive technology assessment was completed as recommended during her a meeting for Supported Employment.</p> <p>4) Please refer to W226. For 3 of 3</p>						

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	<p>clients in the sample (#2, #4 and #7) who were admitted to the group home since February 2015, the facility failed to prepare, within 30 days after admission, an individual program plan (IPP).</p> <p>5) Please refer to W259. For 1 of 4 clients in the sample (#6), the facility failed to review and update client #6's comprehensive functional assessment (CFA) at least annually.</p> <p>6) Please refer to W260. For 1 of 4 clients in the sample (#6), the facility failed to ensure client #6's individual program plan (IPP) was revised at least annually.</p> <p>7) Please refer to W440. For 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>8) Please refer to W488. For 4 of 7 clients living in the group home (#1, #3, #4 and #5), the facility failed to ensure the clients were involved with meal preparation and serving themselves during breakfast.</p> <p>9-3-3(a)</p>			

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W 0210  Bldg. 00	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 3 of 4 clients in the sample (#2, #4 and #7), the facility failed to ensure: 1) clients #2, #4 and #7 had a comprehensive functional assessment (CFA) completed within 30 days of admission to the group home and 2) a recommended assistive technology assessment was completed as recommended during client #4's meeting for Supported Employment.</p> <p>Findings include:</p> <p>1) On 2/23/16 at 12:01 PM, a review of client #2's record was conducted. Client #2 was admitted to the group home on 2/22/15. There was no documentation in her record indicating within 30 days of her admission, the facility completed a CFA.</p> <p>On 2/23/16 at 12:29 PM, a review of client #4's record was conducted. Client #4 was admitted to the group home on 8/24/15. There was no documentation in her record indicating within 30 days of her admission, the facility completed a CFA. Client #4's 9/11/15 SGL</p>	W 0210	<p><b>W 210 Individual Program Plan (Standard)</b> Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. <b>Corrective action for resident(s) found to have been affected</b> The QIDP and support team will be trained on active treatment programing, development and implementation, including all assessments needed 30 days after assessment. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and support team training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and</p>	03/26/2016

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	<p>(Supervised Group Living) Support Team Review Form indicated, in part, "Team is still learning about [client #4]. Program assessment is being completed."</p> <p>On 2/23/16 at 1:28 PM, a review of client #7's record was conducted. Client #7 was admitted to the group home on 11/4/15. There was no documentation in her record indicating within 30 days of her admission, the facility completed a CFA.</p> <p>On 2/23/16 at 3:01 PM, the Coordinator indicated he completed the clients' assessments. The Coordinator indicated he did not know why the assessments were not in the clients' records for review. The Coordinator did not provide documentation of the assessments being completed within 30 days of the clients being admitted to the group home during the survey.</p> <p>2) On 2/23/16 at 12:29 PM, a review of client #4's record was conducted. A 11/13/15 Case Conference Summary indicated, in part, "Current Barriers: Vision is limited. Needs to complete an Assistive Technology Assessment. [Employment Specialist's name] will assist her w/ (with) this." There was no documentation an assistive technology assessment was conducted in client #4's record.</p>		that documentation is available at resurvey.				

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W 0226 Bldg. 00	<p>On 2/23/16 at 2:24 PM, the nurse indicated she was not sure if an assessment was completed. The nurse indicated an assessment should have been completed.</p> <p>On 2/23/16 at 3:04 PM, the Coordinator indicated the assessment was completed through client #4's supported employment provider. The Coordinator indicated he could obtain of copy of the assessment. The Coordinator failed to provide a copy of the assessment during the survey.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 3 of 3 clients in the sample (#2, #4 and #7) who were admitted to the group home since February 2015, the facility failed to prepare, within 30 days after admission, an individual program plan (IPP).</p> <p>Findings include:  On 2/23/16 at 12:01 PM, a review of</p>	W 0226	<p><b>W 226 Individual Program Plan (Standard)</b> Within 30 days after admission, the interdisciplinary team must prepare, for each client,an individual program plan. <b>Corrective action for resident(s) found to have been affected</b> The QIDP and support team will be trained on active treatment programing, development and implementation, including all assessments needed 30 days after assessment. <b>How facility will identify other</b></p>	03/26/2016

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	<p>client #2's record was conducted. Client #2 was admitted to the group home on 2/22/15. There was no documentation in her record indicating within 30 days after admission the facility prepared an IPP. Client #2's 3/10/15 SGL (Supervised Group Living) Support Team Review Form indicated, in part, "QIDP-D (Qualified Intellectual Disabilities Professional - Designee) in process of developing ISP (individual support plan) and IHP (individual habilitation program) goals (and) objectives." The form indicated, "QIDP-D will have goals in place (and) will train staff." The 4/14/15 SGL Support Team Review Form indicated in the IHP section, "In development." The 5/12/15 SGL Support Team Review Form indicated in the IHP section, "IHPs beginning this month." There was no documentation in client #2's record of an IPP being developed and implemented.</p> <p>On 2/23/16 at 12:29 PM, a review of client #4's record was conducted. Client #4 was admitted to the group home on 8/24/15. There was no documentation in her record indicating within 30 days after admission the facility prepared an IPP. Client #4's 8/13/15 SGL Support Team Review Form indicated, "IHPs will address: cooking, meds, finances, general hygiene, oral hygiene, (and) appropriate</p>		<p><b>residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and support team training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>behavior." There was no documentation in client #4's record of an IPP being developed and implemented.</p> <p>On 2/23/16 at 1:28 PM, a review of client #7's record was conducted. Client #7 was admitted to the group home on 11/4/15. There was no documentation in her record indicating within 30 days after admission the facility prepared an IPP. Client #7's 11/2/15 Individual Support Plan indicated "Temporary" at the top of the form. There was no documentation of another plan being developed and implemented. The 11/3/15 Case Conference Summary - Admission Only form indicated in the Recommendations section, "[Coordinator] to complete ISP, IHPs, and informal goals." There was no documentation the Coordinator completed the ISP, IHPs and informal goals as indicated on 11/3/15.</p> <p>On 2/23/16 at 2:41 PM, the Assistant Group Home Director (AGHD) indicated the clients should have IPPs.</p> <p>On 2/23/16 at 2:56 PM, the Coordinator indicated the clients had IPP meetings. The Coordinator indicated the IPPs should be in the clients' records. The Coordinator indicated he did not know where the clients' IPPs were located.</p>			

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W 0259 Bldg. 00	<p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 4 clients in the sample (#6), the facility failed to review and update client #6's comprehensive functional assessment (CFA) at least annually.</p> <p>Findings include:</p> <p>On 2/23/16 at 12:56 PM, a review of client #6's record was conducted. Client #6's most recent CFA was dated 2/9/15. There was no documentation in client #6's record indicating her CFA was reviewed for relevancy and updated at least annually.</p> <p>On 2/23/16 at 2:41 PM, the Assistant Group Home Director indicated the CFA should be reviewed annually.</p> <p>On 2/23/16 at 3:01 PM, the Coordinator indicated he completed the CFA. The Coordinator indicated he did not know where the CFA was located.</p> <p>9-3-4(a)</p>	W 0259	<p><b>W 259 Program Monitoring &amp; Change (Standard)</b> At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. <b>Corrective action for resident(s) found to have been affected</b> The QIDP will be trained on active treatment programming, development and implementation. The QIDP will be trained on quarterly reports, meetings and documentation of ISP progress towards goals set by the IST. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented</p>	03/26/2016

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W 0260 Bldg. 00	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 1 of 4 clients in the sample (#6), the facility failed to ensure client #6's individual program plan (IPP) was revised at least annually.</p> <p>Findings include:</p> <p>On 2/23/16 at 12:56 PM, a review of client #6's record was conducted. Client #6's most recent IPP was dated 2/9/15. Client #6's record did not contain an IPP completed since 2/9/15. A 3/10/15 SGL (Supervised Group Living) Support Team Review Form indicated, in part, "IHP (individual habilitation program) Quarterly Review: Very little progress. Goals will be reassessed (at) her annual in June." There was no documentation in client #6's record of an annual being conducted in June 2015.</p> <p>On 2/23/16 at 2:41 PM, the Assistant Group Home Director (AGHD) indicated</p>	W 0260	<p>training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p><b>W 260 Program Monitoring &amp; Change (Standard)</b> At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. <b>Corrective action for resident(s) found to have been affected</b> The QIDP will be trained on active treatment programming, development and implementation. The QIDP will be trained on quarterly reports, meetings and documentation of ISP progress towards goals set by the ISP. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director</p>	03/26/2016

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W 0312 Bldg. 00	<p>client #6's IPP should have reviewed at least annually. The AGHD indicated client #6 should have a current IPP in her record.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 4 of 4 clients in the sample (#2, #4, #6 and #7), the facility failed to ensure the clients' psychotropic medication reduction plans were attainable.</p> <p>Findings include:</p> <p>On 2/23/16 at 12:01 PM, a review of client #2's record was conducted. Client #2's 10/25/15 Behavioral Support Plan (BSP) included the use of psychotropic medications. The plan indicated she was prescribed Prozac for mild recurrent major depression and Ativan for generalized anxiety and depression. The Medication Reduction Plan section of the BSP indicated, in part, "...Psychotropic medications Prozac and Ativan are administered as one component of [client</p>	W 0312	<p>will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p><b>W 312 Drug Usage (Standard)</b> Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. <b>Corrective action for resident(s) found to have been affected</b> Behavior plans will be updated to include obtainable goals for drug reduction or therapeutic level. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and Behavior Clinicians will</p>	03/26/2016

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	<p>#2's] treatment plan for her depression and anxiety. When symptoms of depression and anxiety have decreased to zero episodes per quarter for four consecutive quarters, the team will assess the appropriateness of medication reduction and consult with [client #2's] psychiatrist to determine the appropriateness of a medication reduction."</p> <p>On 2/23/16 at 12:29 PM, a review of client #4's record was conducted. Client #4's 1/8/16 BSP included the use of psychotropic medications. The plan indicated she was prescribed Abilify and Lexapro for depression. The Medication Reduction Plan section of the BSP indicated, in part, "Psychotropic medications Abilify and Lexapro are administered as one component of [client #4's] treatment plan for her depression. When symptoms of depression have decreased to zero episodes per quarter for four consecutive quarters, the team will assess the appropriateness of medication reduction and consult with [client #4's] psychiatrist to determine the appropriateness of a medication reduction."</p> <p>On 2/23/16 at 12:56 PM, a review of client #6's record was conducted. Client #6's 1/27/15 BSP included the use of</p>		<p>be trained to identify and implement obtainable goals for drug reduction and/or establishing a therapeutic level. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>psychotropic medications. The plan indicated she was prescribed Lexapro for mood and Risperdal for psychosis. The Medication Reduction Plan section of the BSP indicated, in part, "Lexapro is administered as one component of [client #6's] treatment plan for depression. When incidences of agitation/aggression are tracked at a rate of one or fewer for 6 consecutive months, and/or incidences of psychotic ideation are tracked at a rate of 'low' for 6 consecutive months, and/or incidents of depressive symptoms are tracked at a rate of 1 or fewer per month for 6 consecutive months, then the support team will assess the appropriateness of a medication reduction with [client #6's] psychiatrist. Risperdal is administered as one component of [client #6's] treatment plan for Post Traumatic Stress Disorder and Presumptive Atypical Psychosis. When there have been 0 incidents of aggressive or agitated behavior for 10 consecutive months, [client #6's] team will assess the appropriateness of a medication reduction with [client #6's] psychiatrist."</p> <p>On 2/23/16 at 1:28 PM, a review of client #7's record was conducted. Client #7's 12/6/15 BSP included the use of psychotropic medications. The plan indicated she was prescribed Abilify for disruptive mood dysregulation, Prozac</p>			

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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4417 BLACKSTONE CT BLOOMINGTON, IN 47401
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	<p>for obsessive compulsive disorder and Hydroxyzine HCL for anxiety. The Medication Reduction Plan section of the BSP indicated, in part, "The psychotropic medication of Abilify is used as one component in [client #7's] treatment for Disruptive Mood Dysregulation Disorder. The team will review the possibility of psychotropic medication reduction and consider making recommendation to [client #7's] psychiatrist for such when [client #7] displays no symptoms of Disruptive Mood Dysregulation for four consecutive quarters. The psychotropic medication Prozac is administered as one component of [client #7's] treatment plan for her Obsessive Compulsive Disorder. When symptoms of [client #7's] Obsessive Compulsive Disorder have decreased to zero episodes per quarter for four consecutive quarters, the team will assess the appropriateness of medication reduction and consult with [client #7's] psychiatrist to determine the appropriateness of a medication reduction. Hydroxyzine HCL is one component of [client #7's] treatment for her psychiatric illness of Anxiety disorder that can result in agitation and sleeplessness. When [client #7] has zero episodes of agitation and aggression for four consecutive quarters, the team will discuss the appropriateness of discussing a possible medication reduction trial with</p>			

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W 0368 Bldg. 00	<p>[client #7's] psychiatrist."</p> <p>On 2/23/16 at 3:10 PM, the Coordinator stated the medication reduction plans were "setting them up for failure." The Coordinator indicated the medication reduction plans were not attainable.</p> <p>On 2/23/16 at 3:10 PM, the Assistant Group Home Director indicated the clients' medication reduction plans were not attainable.</p> <p>9-3-5(a)</p> <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 4 clients in the sample (#2, #4, #6 and #7), the facility failed to ensure staff administered the clients' medications in accordance with their physician's orders.</p> <p>Findings include:</p> <p>On 2/19/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 11/29/15 at 12:00 PM, client #2</p>	W 0368	<p><b>W 368 Drug Administration (Standard)</b> The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. <b>Corrective action for resident(s) found to have been affected QIDP</b> and all staff will be trained in medication administration, including reviewing Medication Information Sheets that are in compliance with the physician's orders. Added oversight and training, including medication administration monitoring and training for staff who make</p>	03/26/2016

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	<p>was administered Lorazepam (depression/anxiety) 1 milligram (mg) instead of 0.5 mg. The 11/30/15 BDDS report indicated, in part, "No effect noticed."</p> <p>2) On 1/1/16 at 12:00 PM, client #2 did not receive Lorazepam (depression/anxiety) 0.5 mg from staff #3 as ordered by the physician. The 1/2/16 BDDS report indicated, in part, "This medication was not given... There was no noticeable effect to [client #2] due to this med error...."</p> <p>3) On 1/15/16 at 9:00 PM, client #4 was not administered Escitalopram (depression) 15 mg, Aripiprazole (depression) 10 mg, Melatonin (sleep) 3 mg and two ear drops (ear wax) in each ear. The 1/16/16 BDDS report indicated, "No negative effects noted...."</p> <p>4) On 1/28/16 at 4:00 PM, client #7 was not administered Aripiprazole (disruptive mood dysregulation) 15 mg by staff #1.</p> <p>5) On 2/1/16 at 7:00 AM, staff #1 administered client #6's Meloxicam (arthritic pain) EOD (every other day) on the wrong day. Client #6 received the medication two days in a row.</p> <p>On 2/25/16 at 11:29 AM, the Nurse</p>		<p>medication errors after each error, will be implemented and documented by nursing staff and QIDP. Staff that make medication errors will be monitored, following medication error, during medication passes until competence is achieved. Monitoring will be completed and documented by nursing staff, coordinator and QIDP All medication errors will reviewed in the incident oversight meeting on a regular basis by the director and coordinator <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and all staff will be trained in medication administration, including reviewing Medication Information Sheets(MIS) that are in compliance with the physician's orders. QIDP will check MIS and medication administration logs to ensure staff are following doctor's orders. Added oversight, including medication administration monitoring three times a week and documented by nursing staff and QIDP All medication errors will reviewed in the incident oversight meeting on a regular basis by the director and coordinator <b>How corrective actions will be</b></p>	

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W 0369 Bldg. 00	<p>Manager indicated the clients' medications should be administered as indicated in their physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 1 medication administered to client #4 during the evening medication pass, the facility failed to ensure there was a physician's order for the medication being administered to client #4.</p> <p>Findings include:  On 2/22/16 from 3:50 PM to 6:17 PM, an observation was conducted at the group home. At 4:47 PM, client #4 requested medication for her migraine headache. Client #4 went to the group home office where she was administered two</p>	W 0369	<p><b>monitored to ensure no recurrence</b> The QIDP and Coordinator are supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey. All medication errors will reviewed in the incident oversight meeting on a regular basis by the director and coordinator</p> <p><b>W 369 Drug Administration (Standard)</b> The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. <b>Corrective action for resident(s) found to have been affected</b>QIDP and all staff will be trained in medication administration, including reviewing Medication Information Sheets that are in compliance with the physician's orders.Added oversight and training, including medication administration monitoring and training for staff who make medication errors after each error, will be implemented and</p>	03/26/2016	

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	<p>Excedrin Migraine 250 milligrams from staff #1. Client #4 indicated she was not supposed to take more than two pills of the Excedrin in a 24 hour period. Staff #1 documented administering the medication on the back of client #4's February 2016 Medication Administration Record.</p> <p>On 2/23/16 at 12:29 PM, a review of client #4's record was conducted. The Excedrin Migraine medication was not listed on client #4's 11/30/15 Physician's Orders. There was no documentation of a physician's order in client #4's record indicating she was prescribed the Excedrin.</p> <p>On 2/23/16 at 2:06 PM, the nurse stated, when told staff administered the Excedrin Migraine medication, "Staff passed it to her?" The nurse indicated there was no order for the medication. The nurse indicated client #4 should not have received the medication. The nurse indicated it was a medication error. The nurse indicated she did not know where the medication came from.</p> <p>On 2/23/16 at 2:47 PM, the Coordinator indicated there was no physician's order for the medication. The Coordinator stated, "It's a med error."</p>		<p>documented by nursing staff and QIDP. Staff that make medication errors will be monitored, following medication error, during medication passes until competence is achieved. Monitoring will be completed and documented by nursing staff, coordinator and QIDP All medication errors will reviewed in the incident oversight meeting on a regular basis by the director and coordinator <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and all staff will be trained in medication administration, including reviewing Medication Information Sheets(MIS) that are in compliance with the physician's orders. QIDP will check MIS and medication administration logs to ensure staff are following doctor's orders. Added oversight, including medication administration monitoring three times a week and documented by nursing staff and QIDP All medication errors will reviewed in the incident oversight meeting on a regular basis by the director and coordinator <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP and Coordinator are supervised by the</p>				

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W 0440 Bldg. 00	<p>On 2/25/16 at 11:30 AM, the Nurse Manager indicated if there was no order for the medication and staff administered the medication, it was a medication error.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p> <p>On 2/22/16 at 12:31 PM, a review of the facility's evacuation drills was conducted. During the night shift (10:00 PM to 6:00 AM), there were no evacuation drills conducted from 2/19/15 to 6/24/15 and 7/6/15 to 12/24/15. This affected clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>On 2/22/16 at 12:43 PM, the Organizational Effectiveness Coordinator indicated the group home was scheduled</p>	W 0440	<p>SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey. All medication errors will reviewed in the incident oversight meeting on a regular basis by the director and coordinator</p> <p><b>W 440 Evacuation Drills (Standard)</b> The facility must hold evacuation drills at least quarterly for each shift of personnel. <b>Corrective action for resident(s) found to have been affected</b> Overnight staff will be retrained on the importance of conducting evacuation drills once per quarter and the drill binder will be updated to provide guidance and reminders for overnight staff. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Retraining of staff on the importance of conducting evacuation drills and implementation and regular review by QIDP of the drill binder</p>	03/26/2016

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W 0488 Bldg. 00	<p>to conduct one evacuation drill per shift per quarter during the weekdays and weekends.</p> <p>On 2/22/16 at 2:30 PM, the Assistant Group Home Director (AGHD) indicated the group home should conduct one drill per shift per quarter.</p> <p>On 2/23/16 at 6:02 AM, staff #6 indicated she worked the weekday overnight shifts at the group home for 1.5 years. Staff #6 indicated she had not conducted an evacuation drill during the overnight shift.</p> <p>On 2/23/16 at 2:53 PM, the Coordinator indicated the group home should conduct one drill per shift per quarter. The Coordinator indicated he was unsure why the drills were not conducted.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 4 of 7 clients living in the group home (#1, #3, #4 and #5), the facility failed to ensure the clients were involved with meal preparation and serving themselves</p>	W 0488	<p>will ensure that mandated drills are performed each quarter. <b>How corrective actions will be monitored to ensure no recurrence</b> QIDP,DSGL and ADSGL will be responsible for quarterly monitoring of drill binder to ensure mandated drills are performed.</p> <p><b>W 488 Dining Areas and Service (Standard)</b> The facility must assure that each client eats in a manner consistent with his or her developmental level. <b>Corrective action for</b></p>	03/26/2016			

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	<p>during breakfast.</p> <p>Findings include:</p> <p>On 2/23/16 from 6:00 AM to 7:53 AM, an observation was conducted at the group home. At 6:30 AM, client #4 sat down to eat her breakfast (English muffin, egg, milk and juice). Client #4 was not involved with preparing her meal. Staff #6 cooked the egg and made the toast. At 6:38 AM, client #3 poured too much milk into a cup while sitting at the table. Staff #6 cleaned up the spill. Client #3 was not involved with cleaning up the milk. Staff #6 mopped the floor. At 6:41 AM, client #3 sat down to eat her breakfast. Client #3 was not involved with preparing her egg or English muffin. At 6:48 AM, client #5 was sitting at the table when staff #6 brought her plate with an egg and English muffin to her. Client #5 was not involved with preparing her breakfast. At 7:00 AM, staff #6 went into the kitchen and brought client #3 an apple to eat during breakfast. At 7:03 AM, staff #6 told client #1 she was going to make client #1's toast. Staff #6 went into the kitchen to make client #1's toast. At 7:09 AM, staff #6 placed client #1's plate with toast and jelly on the table. Client #1 was not involved in preparing her breakfast. Staff #6 asked client #1 what she wanted to drink. Client #1</p>		<p><b>resident(s) found to have been affected</b> Staff will be retrained on the importance of encouraging clients to prepare their own meals and serve themselves at mealtimes to the best of their abilities. Clients will be reminded of their own abilities and encouraged to prepare and serve as much of their own meals as possible. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Retraining for staff on the importance of promoting and encouraging clients to prepare and serve their own meals. Regular review of this standard in group home staff meetings. <b>How corrective actions will be monitored to ensure no recurrence</b> QIDP and house manager will regularly observe levels of client engagement in meal preparation and food serving at mealtimes for the next two months.</p>	

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W 9999 Bldg. 00	<p>indicated she wanted juice. Staff #6 put client #1's cup with juice on the table. At 7:14 AM, staff #6 mopped the dining room floor a second time.</p> <p>On 2/23/16 at 2:43 PM, the Assistant Group Home Director (AGHD) indicated the clients should be involved with preparing their meals and serving themselves. The AGHD indicated the issue was addressed in the past with the staff. The AGHD stated the clients "should definitely be doing it."</p> <p>On 2/23/16 at 2:50 PM, the Coordinator indicated the clients should be involved with meal preparation and serving themselves.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p>	W 9999	<p>W 9999 460 IAC 9-3-1(a) Governing Body <b>Staff Treatment of Clients (Standard)</b></p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p><b>Correctiveaction for resident(s)</b></p>	03/26/2016

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	<p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>16. A medication error or medical treatment error as follows: a. wrong medication given; b. wrong medication dosage given; c. missed medication - not given; d. medication given wrong route; or e. medication error that jeopardizes an individual's health and welfare and requires medical attention.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 40 incident reports reviewed affecting clients #6 and #7, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law.</p> <p>Findings include:</p> <p>On 2/19/16 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/28/16 at 4:00 PM, client #7 was not administered Aripiprazole (disruptive</p>		<p><b>found to have been affected</b></p> <p>The QIDP and Coordinator will be trained on timing requirements for submitting incident reports to BDDS within 24 hours. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and Coordinator training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. Part of this meeting will include documentation that all reportable incidents were sent to BDDS within 24hours. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. In the case of late reporting, this would include following up to determine why the report was late and put measures inplace to prevent recurrence. The QIDP is responsible for program implementation and monitoring of the facility, and reporting requirements. The Coordinator assists in this role. The QIDP and Coordinator are</p>		

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	<p>mood dysregulation) 15 mg by staff #1.</p> <p>There was no documentation the facility reported the medication error to BDDS.</p> <p>On 2/23/16 at 2:51 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours.</p> <p>On 2/22/16 at 2:29 PM, the Assistant Group Home Director (AGHD) indicated BDDS reports should be submitted within 24 hours.</p> <p>2) On 2/1/16 at 7:00 AM (reported to BDDS on 2/3/16), staff #1 administered client #6's Meloxicam (arthritic pain) EOD (every other day) on the wrong day. Client #6 received the medication two days in a row. The 2/3/16 BDDS report indicated, in part, "Staff will be disciplined per Stone Belt's Medication Error and Progressive Disciplinary Action procedures and protocols." The 2/3/16 MER indicated there were no adverse side effects. The MER Document action taken section indicated, "Verbal Discussion/Training."</p> <p>On 2/23/16 at 2:51 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours.</p> <p>On 2/22/16 at 2:29 PM, the AGHD</p>		<p>supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP and the Coordinator. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G170	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016
NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4417 BLACKSTONE CT BLOOMINGTON, IN 47401		
(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	
	indicated BDDS reports should be submitted within 24 hours.  9-3-1(b)				