

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2012
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
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W0000	<p>This visit was for a post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on 4/11/12.</p> <p>This visit was in conjunction with the investigation of complaint #IN00108845.</p> <p>Survey Dates: June 1, 4, 5 and 6, 2012.</p> <p>Facility Number: 001165 Provider Number: 15G650 AIM Number: 100240230</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on June 13, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 6 clients living in the group home (A and F), the governing body failed to exercise operating direction over the facility by not ensuring the staff implemented the Supervised Group Living Medical Procedures and ensuring the procedures were clear on when staff should notify the nurse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/1/12 at 1:17 PM.</p> <p>-On 5/11/12 during dinner, client A ate her food quickly and then vomited. Client A then had an episode of deep coughing; the report indicated, "She eat (sic) very fast then vomited and had an episode of deep coughing she then had her meds sat up with staff for about 30 mins (minutes) when the coughing was finished staff assisted her to bed (she had no temp)." This incident was not reported to administrative staff until 5/12/12 at 6:15 AM when client A was found to have a "shot glass" amount of blood in her bed. There was no documentation a nurse</p>	W0104	<p>W 104</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt will exercise general policy, budget, and operating direction over the group home. Specifically, the facility will ensure that medical procedures are clear for staff in regard to staff contacting the nurse.</p> <p>Date of Completion:</p> <p>July 2, 2012</p> <p>Person Responsible:</p> <p>House Coordinator</p> <p>Plan of Prevention:</p> <p>The Stone Belt Supervised Group Living Medical Procedure (Attachment # 1) was reviewed during a staff training. (Attachment # 2). The medical procedure identifies when to contact the nurse during an accident or illness.</p>	07/02/2012			

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	<p>or administrative staff pager was notified on 5/11/12. There was no incident report for the 5/11/12 eating quickly, vomiting and coughing; the incident was reported in a report dated 5/12/12 when the staff found blood in her bed. There was no documentation the incident was reviewed to ascertain whether or not staff present for dinner implemented her risk plan for aspiration. There was no documentation the Coordinator was notified until 5/12/12.</p> <p>A review of client A's record was conducted on 6/4/12 at 12:47 PM. Client A's Medication Information Sheet (MIS), dated 5/25/12, indicated client A was at risk for aspiration. The plan indicated client A had a history of choking with aspiration, first noted in July 2005. The plan indicated her choking risk was due to the fact that she takes in food at a fast rate with minimal chewing. The plan indicated the direct care staff would prompt client A with verbal and physical guidance to prevent her from eating too quickly. The plan indicated staff need to sit next to client A to prompt and cue her to take small bites of food and chew all foods well before swallowing. Staff need to check her mouth every few bites to make sure she is successfully chewing and swallowing. If food was still noted in her mouth, staff should encourage her to</p>		<p>In addition, staff were retrained on risk plan (Attachment # 3) meal time plans (Attachment # 4) for specific clients</p> <p>Quality Assurance Monitoring:</p> <p>House Coordinator and SGL Director will review incident reports to ensure that all accidents and illnesses follow the medical procedure.</p>				

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	<p>continue to chew and swallow until all food is gone. The plan indicated to prompt her to put only small bites of food on her spoon. The plan indicated, "Document in Incident Report and notify Coordinator."</p> <p>-On 4/10/12 at 7:15 AM, client F was falling asleep while at the table for breakfast. Staff #10 was trying to wake her. Staff #10 then noticed a large bruise on the right side of her forehead. Staff #10 asked staff #7 if staff #7 had observed client F fall during the night. Staff #7 indicated she was not aware of a fall. At 9:30 AM, the home manager at the time contacted the day aide to inform her of the bruise. The day aide was asked to contact client F's primary care physician and the office was closed. The day aide was instructed to pick up client F from the day program and take her to the emergency room (ER). Client F was picked up at 10:50 AM and arrived to the ER at 11:00 AM. All tests were normal. Client F had a hematoma on the right side of her forehead. In the investigation of injury of unknown origin, dated 4/10/12, the Program Coordinator described the injury as, "Softball size purple bruise - raised knot on forehead area goes up into hairline."</p> <p>There was no documentation the nurse or</p>						

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	<p>pager was notified of the injury of unknown origin.</p> <p>The inquiry into the bruise of unknown origin, dated 4/10/12, indicated, "...the fall risk plan was followed. It was determined that this was not an incident of abuse or neglect. Coordinator determined that [client F] had fallen during her incident of incontinence, possibly hitting her head on the night stand which is next to her bed. [Client F] had been seen recently for increased falls, by her PCP (primary care physician), neurologist and psychiatrist. We are still in search of the cause of [client F's] increased falls as well as her being lethargic. [Client F] will go to [name of company] to have new AFO (ankle-foot orthosis) braces fitted...."</p> <p>A review of the facility's policy on Supervised Group Living Medical Procedures was reviewed on 6/5/12 at 2:46 PM. The policy, not dated, indicated, "1. The nurse or physician must be notified as soon as possible about persistent or recurring pain, temperature elevation over 100 (degrees), vomiting, or diarrhea lasting more than 12 hours (despite the use of clear liquid diet), yellow/green or blood streaked nasal discharge or sputum, wounds or possible fracture. 2. In the event of an accident or</p>						

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	<p>injury, call the Pager. The person on call will see that the appropriate people are notified...".</p> <p>A review of the facility's policy on Health Emergency Procedures, dated 3/1/96, was conducted on 6/5/12 at 4:06 PM. The policy indicated, "The following situations require MEDICAL ADVICE IMMEDIATELY. Staff should use their best judgement to determine whether or not to call a physician, transport to a walk-in or urgent care clinic, transport to emergency room in a facility vehicle immediately, or call an ambulance. 8) If there is a change in the person's responsiveness; i.e., difficulty awakening, unusual confusion or irritability and excessive sleeping." The policy did not address when staff should contact a nurse.</p> <p>An interview with the nurse was conducted on 6/4/12 at 1:30 PM. The nurse indicated a nurse should have been contacted when client A vomited and coughed afterward due to the risk of aspiration; the nurse indicated an incident report should have been completed. The nurse indicated the staff should have contacted a nurse when client F's head injury was found on 4/10/12.</p> <p>An interview with the Manager of Health Care Services (MHCS) was conducted on</p>						

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	<p>6/6/12 at 8:53 AM. The MHCS indicated the policy and procedure needed to be updated to ensure the staff were aware of when to contact the nurse. The MHCS indicated the nurse should have been contacted regarding client A's vomiting and coughing on 5/11/12 due to the possibility of aspiration. The MHCS indicated the nurse should have been contacted to conduct an assessment of client F's injury of unknown origin; the staff indicated she was falling asleep at the dining room table with an unknown injury to her head. The MHCS indicated anytime a client was having medical issues, the nurse should be contacted. The MHCS indicated the nurse should have conducted an assessment of the injury for the investigation.</p> <p>This deficiency was cited on 4/11/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview for 1 of 10 incident/investigative reports reviewed affecting clients B and E, the facility failed to ensure the clients had the right to due process in regard to client E's access to soda being restricted and client B's being physically prompted to chew with her mouth closed.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/1/12 at 1:17 PM.</p> <p>On 5/20/12 (no time documented) when staff #5 returned to the group home, she found client E in the kitchen with the door shut. Client E was sitting alone with her head down. Client E told staff #5 "shh." Staff #5 asked why and client E indicated she was in trouble. Client E again said, "shh." Staff #5 told client E she was not in trouble and client E whispered, "Yes I am." Client E indicated she snuck some soda and staff #6 saw it. Staff #6 then came to the kitchen window and indicated</p>	W0125	<p>W 125</p> <p>PROTECTION OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt has written policies and procedures that ensures the rights of all clients. Stone Belt allows and encourages individual clients to exercise their right as clients of Stone Belt, and as citizens of the United States, including the right to file complaints and the right to due process.</p> <p>Date of Completion:</p> <p>July 2, 2012</p> <p>Person Responsible:</p> <p>QMRP/Coordinator</p> <p>Plan of Prevention:</p> <p>Stone Belt client rights training (Attachment # 5) was reviewed with all staff on 6/8/2012 (Attachment # 6). Client Rights Training is completed by all Stone Belt staff during initial orientation</p>	07/02/2012			

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	<p>she would tell staff #5 what happened. Staff #5 then opened the kitchen door for client E to exit the kitchen. Staff #6 told staff #5 that client E was told to wait 20 minutes for her soda and client E did not want to wait. Staff #6 told staff #5 that client E grabbed a soda and opened it so staff #6 took the soda away. Staff #6 indicated she was trying to push client E's wheelchair out of the kitchen but client E put her feet down on the ground and locked her fingers into the wheels of her wheelchair. Staff #6 then indicated to staff #5 she closed the kitchen door and told client E to stay there. Staff #6 indicated to client E she was not going to talk to her.</p> <p>Staff #5 documented in the incident report on past occasions (no dates or times), staff #6 had made comments about client B being "nasty and disgusting." Staff #5 indicated she reported this information to staff #4, her supervisor. Staff #5 indicated staff #6 had placed her fingers under client B's chin and made her mouth shut telling her she was gross and the others did not want to hear her smack her food or see it.</p> <p>The investigative report, dated 5/31/12, indicated the allegation of abuse was substantiated. The investigative report indicated, "Stone Belt's definition of</p>		<p>and then annually.</p> <p>Quality Assurance Monitoring:</p> <p>Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed.</p> <p>The Coordinator and other administrative staff will conduct random visits at the home.</p>				

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	<p>abuse states, in part: 'willful/purposeful infliction of physical or emotional pain, injury, revilement, malignment and/or otherwise disregard of an individual,' 'unauthorized restraint or confinement resulting from physical or chemical intervention; placement of a client alone and unattended in a locked room.' Stone Belt's definition of Emotional/Verbal abuse states, in part: 'intentional use of actions, words or activities where an individual suffers emotional/psychological harm or trauma.'" The report indicated, "In regards to the alleged incident with [client E], the client reports being upset by how she was treated by [staff #6]. It appears that [staff #6] attempted to move [client E] against her will, and there was no need to restrain her due to safety concerns. This is an unauthorized restraint. [Staff #6] reported that she closed the kitchen door with [client E] inside, this would meet the criteria for seclusion. She [staff #6] reported that [staff #4] was sitting at the dining table at that time. The house restriction states that the kitchen door will be closed and locked when staff are not present... It appears that [staff #6] used a hateful tone of voice with [client E] and then ignored her. [Client E] reported being upset and also concerned that [staff #6] was made at her. [Staff #6's] reported behavior displays a disregard of [client</p>			

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	<p>E's] rights as an individual and caused her emotional pain." The report indicated in regard to the abuse of client B, "In regards to the alleged incident with [client B], it is unclear if [staff #6] made derogatory comments about [client B's] meal time behavior. It appears that [staff #6] used brief physical prompts for [client B] to close her mouth while chewing. [Client B] does not have a goal of chewing with her mouth closed. [Client B] had the right to choose to chew with her mouth open. [Staff #6] used an intervention that is not written in [client B's] BSP (behavior support plan). It appears that [staff #6] had used a rough tone of voice with clients and may have been making inappropriate comments about assisting them with personal care. It appears that [staff #6's] supervisor, [staff #4], had attempted to address the issue. His attempts appear to have been unsuccessful. It appears that [staff #4's] supervisor and coordinator have now been made aware of issues and become involved to support him and [name of group home] clients."</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/6/12 at 9:16 AM. The PC indicated the facility should protect and ensure the clients' rights. The PC indicated there was no reason for the staff to try to</p>			

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	<p>restrict client E's soda. The PC indicated the staff were trained to provide client E information about healthy choices but if she wanted a soda, she could have her soda. The PC indicated staff should not redirect client E from her soda.</p> <p>9-3-2(a)</p>			

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W0149	<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.</p> <p>Based on record review and interview for 7 of 10 incident/investigative reports affecting 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/1/12 at 1:17 PM.</p> <p>-On 5/11/12 during dinner, client A ate her food quickly and then vomited. Client A then had an episode of deep coughing; the report indicated, "She eat (sic) very fast then vomited and had an episode of deep coughing she then had her meds sat up with staff for about 30 mins (minutes) when the coughing was finished staff assisted her to bed (she had no temp)." This incident was not reported to administrative staff until 5/12/12 at 6:15 AM when client A was found to have a "shot glass" amount of blood in her bed. There was no documentation a nurse was notified on 5/11/12. There was no incident report for the 5/11/12 eating</p>	W0149	<p>W 149</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt has written policies and procedures that prohibit mistreatment, neglect or abuse of a client. The policy and procedures (Attachment # 7) is presented at all orientation trainings and reviewed annually at department in-services. In addition, house staff were retrained as needed.</p> <p>Date of Completion:</p> <p>July 2, 2012</p> <p>Person Responsible:</p> <p>QMRP/Coordinator</p> <p>Plan of Prevention:</p> <p>Stone Belt Director of Group Homes will review all Incident Reports to assure possible client neglect is being reviewed appropriately. Documentation will be kept to assure all such incidents are addressed within 5 working days.</p>	07/02/2012			

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	<p>quickly, vomiting and coughing; the incident was reported in a report dated 5/12/12 when the staff found blood in her bed. There was no documentation the incident was reviewed to ascertain whether or not staff present for dinner implemented her risk plan for aspiration. There was no documentation the Coordinator was notified until 5/12/12.</p> <p>A review of client A's record was conducted on 6/4/12 at 12:47 PM. Client A's Medication Information Sheet (MIS), dated 5/25/12, indicated client A was at risk for aspiration. The plan indicated client A had a history of choking with aspiration, first noted in July 2005. The plan indicated her choking risk was due to the fact that she takes in food at a fast rate with minimal chewing. The plan indicated the direct care staff would prompt client A with verbal and physical guidance to prevent her from eating too quickly. The plan indicated staff need to sit next to client A to prompt and cue her to take small bites of food and chew all foods well before swallowing. Staff need to check her mouth every few bites to make sure she is successfully chewing and swallowing. If food was still noted in her mouth, staff should encourage her to continue to chew and swallow until all food is gone. The plan indicated to prompt her to put only small bites of food</p>		<p>All Stone Belt staff working in a group home are trained on the Stone Belt Prevention of Abuse and Neglect/Client Rights and Incident Reporting policy and procedure during orientation training and annually. House staff were retrained. (Attachment # 6)</p> <p>Quality Assurance Monitoring:</p> <p>Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed.</p> <p>The Coordinator and other administrative staff will conduct random visits at the home.</p>				

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	<p>on her spoon. The plan indicated, "Document in Incident Report and notify Coordinator."</p> <p>-On 5/24/12 at 2:00 PM, staff #5 reported allegations of abuse regarding staff #6 that had occurred at the group home on 5/19/12 and 5/20/12. On 5/19/12, staff #5 indicated staff #6 yelled at staff #4 in the presence of clients A, B, C, D, E and F due to staff #4 requesting her to go back into the group home to get the credit card. On 5/20/12 (no time documented) when staff #5 returned to the group home, she found client E in the kitchen with the door shut. Client E was sitting alone with her head down. Client E told staff #5 "shh." Staff #5 asked why and client E indicated she was in trouble. Client E again said, "shh." Staff #5 told client E she was not in trouble and client E whispered, "Yes I am." Client E indicated she snuck some soda and staff #6 saw it. Staff #6 then came to the kitchen window and indicated she would tell staff #5 what happened. Staff #5 then opened the kitchen door for client E to exit the kitchen. Staff #6 told staff #5 that client E was told to wait 20 minutes for her soda and client E did not want to wait. Staff #6 told staff #5 that client E grabbed a soda and opened it so staff #6 took the soda away. Staff #6 indicated she was trying to push client E's wheelchair out of the kitchen but client E</p>						

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	<p>put her feet down on the ground and locked her fingers into the wheels of her wheelchair. Staff #6 then indicated to staff #5 she closed the kitchen door and told client E to stay there. Staff #6 indicated to client E she was not going to talk to her.</p> <p>Staff #5 documented in the incident report on past occasions (no dates or times), staff #6 had made comments about client B being "nasty and disgusting." Staff #5 indicated she reported this information to staff #4, her supervisor. Staff #5 indicated staff #6 had placed her fingers under client B's chin and made her mouth shut telling her she was gross and the others did not want to hear her smack her food or see it.</p> <p>The investigative report, dated 5/31/12, indicated the allegation of abuse was substantiated. The investigative report indicated, "Stone Belt's definition of abuse states, in part: 'willful/purposeful infliction of physical or emotional pain, injury, revilement, malignment and/or otherwise disregard of an individual,' 'unauthorized restraint or confinement resulting from physical or chemical intervention; placement of a client alone and unattended in a locked room.' Stone Belt's definition of Emotional/Verbal abuse states, in part: 'intentional use of</p>						

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	<p>actions, words or activities where an individual suffers emotional/psychological harm or trauma." The report indicated, "In regards to the alleged incident with [client E], the client reports being upset by how she was treated by [staff #6]. It appears that [staff #6] attempted to move [client E] against her will, and there was no need to restrain her due to safety concerns. This is an unauthorized restraint. [Staff #6] reported that she closed the kitchen door with [client E] inside, this would meet the criteria for seclusion. She [staff #6] reported that [staff #4] was sitting at the dining table at that time. The house restriction states that the kitchen door will be closed and locked when staff are not present... It appears that [staff #6] used a hateful tone of voice with [client E] and then ignored her. [Client E] reported being upset and also concerned that [staff #6] was made at her. [Staff #6's] reported behavior displays a disregard of [client E's] rights as an individual and caused her emotional pain." The report indicated in regard to the abuse of client B, "In regards to the alleged incident with [client B], it is unclear if [staff #6] made derogatory comments about [client B's] meal time behavior. It appears that [staff #6] used brief physical prompts for [client B] to close her mouth while chewing. [Client B] does not have a goal of chewing with</p>			

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	<p>her mouth closed. [Client B] had the right to choose to chew with her mouth open. [Staff #6] used an intervention that is not written in [client B's] BSP (behavior support plan). It appears that [staff #6] had used a rough tone of voice with clients and may have been making inappropriate comments about assisting them with personal care. It appears that [staff #6's] supervisor, [staff #4], had attempted to address the issue. His attempts appear to have been unsuccessful. It appears that [staff #4's] supervisor and coordinator have now been made aware of issues and become involved to support him and [name of group home] clients."</p> <p>A review of client E's record was conducted on 6/4/12 at 12:59 PM. A Support Team Meeting Review Form, dated 4/25/12, indicated the following, "Drinking pop in excess is not an issue." There was no documentation in client E's record to indicate staff should try to limit her access to soda.</p> <p>A review of client B's record was conducted on 6/4/12 at 12:56 PM. There was no documentation in her record indicating there was a plan to address chewing with her mouth open.</p> <p>Client F's falls:</p>			

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	-On 4/10/12 at 7:15 AM, client F was falling asleep while at the table for breakfast. Staff #10 was trying to wake her. Staff #10 then noticed a large bruise on the right side of her forehead. Staff #10 asked staff #7 if staff #7 had observed client F fall during the night. Staff #7 indicated she was not aware of a fall. At 9:30 AM, the home manager at the time contacted the day aide to inform her of the bruise. The day aide was asked to contact client F's primary care physician and the office was closed. The day aide was instructed to pick up client F from the day program and take her to the emergency room (ER). Client F was picked up at 10:50 AM and arrived to the ER at 11:00 AM. All tests were normal. Client F had a hematoma on the right side of her forehead. In the investigation of injury of unknown origin, dated 4/10/12, the Program Coordinator described the injury as, "Softball size purple bruise - raised knot on forehead area goes up into hairline." The investigation indicated, "...the fall risk plan was followed. It was determined that this was not an incident of abuse or neglect. Coordinator determined that [client F] had fallen during her incident of incontinence, possibly hitting her head on the night stand which is next to her bed. [Client F] had been seen recently for increased falls, by her PCP (primary care physician),			

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	<p>neurologist and psychiatrist. We are still in search of the cause of [client F's] increased falls as well as her being lethargic. [Client F] will go to [name of company] to have new AFO (ankle-foot orthosis) braces fitted...".</p> <p>-On 4/11/12 at 12:00 PM (at the facility-operated day program), client F was standing in the habilitation room and began to walk toward the couch. She took about 4 steps and lost her footing. She fell to the floor. She landed on her buttocks and bumped her head on staff #10's knee. No injury noted.</p> <p>-On 4/16/12 at 11:00 AM (at the facility-operated day program), client F fell to the side and hit the right side of her head on a chair. The report indicated staff #10 was walking with her at the time. Staff #10 helped her sit up and client F began to cry. No injury was noted.</p> <p>-On 4/21/12 at 1:10 AM, client F was going to the restroom. Client F went down on her right hip, right knee and right wrist. The report indicated her knee looked red but unknown if it was an old or new red area. The report indicated staff #8 attempted to run to client F before she fell but the staff did not make it to client F in time.</p>			

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	<p>-On 4/21/12 at 4:20 AM, client F was in bed. Client E asked for staff #8's assistance. While staff was assisting client E, client F got up. The report indicated staff #8 was unable to leave client E. When staff #8 went to check on client F, client F was on the bedroom floor. No injury was noted.</p> <p>A review of the facility's Behavioral Intervention Policy, dated 10/2010, was conducted on 6/1/12 at 1:15 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over consumer support; misuse of consumer or agency goods or resources; breaches of agency policy;</p>						

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	<p>serious breaches of the employee code of conduct." The policy indicated Events Requiring Investigations included, "Situations involving suspected or alleged abuse, neglect or exploitation of consumers or any rights issue as described in agency policies will be investigated by staff designated and trained by the agency for this role."</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/1/12 at 1:31 PM. The PC indicated the facility prohibited abuse and neglect of the clients. The PC indicated the facility should try to prevent abuse and neglect. The PC indicated the staff should immediately report abuse and neglect to the administrator.</p> <p>An interview with the Manager of Health Care Services (MHCS) was conducted on 6/6/12 at 8:53 AM. The MHCS indicated the nurse should have been contacted regarding client A's vomiting and coughing on 5/11/12 due to the possibility of aspiration. The MHCS indicated the nurse should have been contacted to conduct an assessment of client F's injury of unknown origin; the staff indicated she was falling asleep at the dining room table with an unknown injury to her head. The MHCS indicated anytime a client was having medical issues, the nurse should</p>						

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	<p>be contacted. The MHCS indicated the nurse should have conducted an assessment of the injury for the investigation.</p> <p>This deficiency was cited on 4/11/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 10 incident/investigative reports reviewed affecting 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to ensure staff immediately notified the administrator of an allegation of abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/1/12 at 1:17 PM.</p> <p>On 5/24/12 at 2:00 PM, staff #5 reported allegations of abuse regarding staff #6 that had occurred at the group home on 5/19/12 and 5/20/12. On 5/19/12, staff #5 indicated staff #6 yelled at staff #4 in the presence of clients A, B, C, D, E and F due to staff #4 requesting her to go back into the group home to get the credit card. On 5/20/12 (no time documented) when staff #5 returned to the group home, she found client E in the kitchen with the door shut. Client E was sitting alone with her head down. Client E told staff #5 "shh."</p>	W0153	<p>W153</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that all allegations are reported immediately. Stone Belt Prevention of Abuse and Neglect, Client Rights and Incident Reporting policy addresses the issue of immediate reporting. (Attachment # 8)</p> <p>Date of Completion</p> <p>July 2, 2012</p> <p>Responsible Person</p> <p>QMRP Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>Retraining of house staff was completed on June 8, 2012 (Attachment # 6)</p> <p>Quality Assurance Monitoring</p>	07/02/2012			

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	<p>Staff #5 asked why and client E indicated she was in trouble. Client E again said, "shh." Staff #5 told client E she was not in trouble and client E whispered, "Yes I am." Client E indicated she snuck some soda and staff #6 saw it. Staff #6 then came to the kitchen window and indicated she would tell staff #5 what happened. Staff #5 then opened the kitchen door for client E to exit the kitchen. Staff #6 told staff #5 that client E was told to wait 20 minutes for her soda and client E did not want to wait. Staff #6 told staff #5 that client E grabbed a soda and opened it so staff #6 took the soda away. Staff #6 indicated she was trying to push client E's wheelchair out of the kitchen but client E put her feet down on the ground and locked her fingers into the wheels of her wheelchair. Staff #6 then indicated to staff #5 she closed the kitchen door and told client E to stay there. Staff #6 indicated to client E she was not going to talk to her.</p> <p>Staff #5 documented in the incident report on past occasions (no dates or times), staff #6 had made comments about client B being "nasty and disgusting." Staff #5 indicated she reported this information to staff #4, her supervisor. Staff #5 indicated staff #6 had placed her fingers under client B's chin and made her mouth shut telling her she was gross and the</p>		The SGL Director will ensure that allegations of abuse and neglect are reported immediately. Coordinator and SGL Director review all Incident Reports to assure they are reported promptly. Staff receive training annual, during initial orientation and on a as needed basis..				

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	<p>others did not want to hear her smack her food or see it.</p> <p>The investigative report, dated 5/31/12, indicated the allegation of abuse was substantiated. The investigative report indicated, "Stone Belt's definition of abuse states, in part: 'willful/purposeful infliction of physical or emotional pain, injury, revilement, malignment and/or otherwise disregard of an individual,' 'unauthorized restraint or confinement resulting from physical or chemical intervention; placement of a client alone and unattended in a locked room.' Stone Belt's definition of Emotional/Verbal abuse states, in part: 'intentional use of actions, words or activities where an individual suffers emotional/psychological harm or trauma.'" The report indicated, "In regards to the alleged incident with [client E], the client reports being upset by how she was treated by [staff #6]. It appears that [staff #6] attempted to move [client E] against her will, and there was no need to restrain her due to safety concerns. This is an unauthorized restraint. [Staff #6] reported that she closed the kitchen door with [client E] inside, this would meet the criteria for seclusion. She [staff #6] reported that [staff #4] was sitting at the dining table at that time. The house restriction states that the kitchen door will</p>			

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	<p>be closed and locked when staff are not present... It appears that [staff #6] used a hateful tone of voice with [client E] and then ignored her. [Client E] reported being upset and also concerned that [staff #6] was made at her. [Staff #6's] reported behavior displays a disregard of [client E's] rights as an individual and caused her emotional pain." The report indicated in regard to the abuse of client B, "In regards to the alleged incident with [client B], it is unclear if [staff #6] made derogatory comments about [client B's] meal time behavior. It appears that [staff #6] used brief physical prompts for [client B] to close her mouth while chewing. [Client B] does not have a goal of chewing with her mouth closed. [Client B] had the right to choose to chew with her mouth open. [Staff #6] used an intervention that is not written in [client B's] BSP (behavior support plan). It appears that [staff #6] had used a rough tone of voice with clients and may have been making inappropriate comments about assisting them with personal care. It appears that [staff #6's] supervisor, [staff #4], had attempted to address the issue. His attempts appear to have been unsuccessful. It appears that [staff #4's] supervisor and coordinator have now been made aware of issues and become involved to support him and [name of group home] clients."</p>			

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	<p>An interview with the Program Coordinator (PC) was conducted on 6/1/12 at 1:31 PM. The PC indicated the staff should immediately report abuse and neglect to the administrator.</p> <p>9-3-2(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 10 incident/investigative reports reviewed affecting clients A and F, the facility failed to conduct a thorough investigation of an episode of eating too fast, vomiting, deep coughing and then vomiting blood the next morning and an injury of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/1/12 at 1:17 PM.</p> <p>1) On 5/11/12 during dinner, client A ate her food quickly and then vomited. Client A then had an episode of deep coughing; the report indicated, "She eat (sic) very fast then vomited and had an episode of deep coughing she then had her meds sat up with staff for about 30 mins (minutes) when the coughing was finished staff assisted her to bed (she had no temp)." This incident was not reported to administrative staff until 5/12/12 at 6:15 AM when client A was found to have a "shot glass" amount of blood in her bed. There was no documentation a nurse was notified on 5/11/12. There was no</p>	W0154	<p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that all allegations are investigated thoroughly. Stone Belt Investigation Protocol and Procedures will be followed. (Attachment # 9)</p> <p>Date of Completion</p> <p>July 2, 2012</p> <p>Responsible Person</p> <p>QMRP Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>The Coordinators and Social Worker reviewed and completed training on Stone Belt investigation procedures. (Attachment # 10). This included how to conduct proper investigations and who should be interviewed.</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure,</p>	07/02/2012			

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	<p>incident report for the 5/11/12 eating quickly, vomiting and coughing; the incident was reported in a report dated 5/12/12 when the staff found blood in her bed. There was no documentation the incident was reviewed to ascertain whether or not staff present for dinner implemented her risk plan for aspiration. There was no documentation the Coordinator was notified until 5/12/12.</p> <p>A review of client A's record was conducted on 6/4/12 at 12:47 PM. Client A's Medication Information Sheet (MIS), dated 5/25/12, indicated client A was at risk for aspiration. The plan indicated client A had a history of choking with aspiration, first noted in July 2005. The plan indicated her choking risk was due to the fact that she takes in food at a fast rate with minimal chewing. The plan indicated the direct care staff would prompt client A with verbal and physical guidance to prevent her from eating too quickly. The plan indicated staff need to sit next to client A to prompt and cue her to take small bites of food and chew all foods well before swallowing. Staff need to check her mouth every few bites to make sure she is successfully chewing and swallowing. If food was still noted in her mouth, staff should encourage her to continue to chew and swallow until all food is gone. The plan indicated to</p>		after reviewing the incident, that investigations will be completed thoroughly.		

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	<p>prompt her to put only small bites of food on her spoon. The plan indicated, "Document in Incident Report and notify Coordinator."</p> <p>2) On 4/10/12 at 7:15 AM, client F was falling asleep while at the table for breakfast. Staff #10 was trying to wake her. Staff #10 then noticed a large bruise on the right side of her forehead. Staff #10 asked staff #7 if staff #7 had observed client F fall during the night. Staff #7 indicated she was not aware of a fall. At 9:30 AM, the home manager at the time contacted the day aide to inform her of the bruise. The day aide was asked to contact client F's primary care physician and the office was closed. The day aide was instructed to pick up client F from the day program and take her to the emergency room (ER). Client F was picked up at 10:50 AM and arrived to the ER at 11:00 AM. All tests were normal. Client F had a hematoma on the right side of her forehead. In the investigation of injury of unknown origin, dated 4/10/12, the Program Coordinator described the injury as, "Softball size purple bruise - raised knot on forehead area goes up into hairline." The investigation indicated, "...the fall risk plan was followed. It was determined that this was not an incident of abuse or neglect. Coordinator determined that [client F] had fallen</p>						

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	<p>during her incident of incontinence, possibly hitting her head on the night stand which is next to her bed. [Client F] had been seen recently for increased falls, by her PCP (primary care physician), neurologist and psychiatrist. We are still in search of the cause of [client F's] increased falls as well as her being lethargic. [Client F] will go to [name of company] to have new AFO (ankle-foot orthosis) braces fitted...". The investigation did not include an assessment of the injury by the nurse.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/6/12 at 9:16 AM. The PC indicated she did not think the incident of client A's vomiting and then coughing needed to be investigated since it was not an incident of choking. The PC indicated she interviewed the staff and determined the staff followed the risk plan however she was unable to locate the documentation.</p> <p>An interview with the Manager of Health Care Services (MHCS) was conducted on 6/6/12 at 8:53 AM. The MHCS indicated the nurse should have been contacted to conduct an assessment of client F's injury of unknown origin; the staff indicated she was falling asleep at the dining room table with an unknown injury to her head. The MHCS indicated anytime a client was</p>				

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	<p>having medical issues, the nurse should be contacted. The MHCS indicated the nurse should have conducted an assessment of the injury for the investigation.</p> <p>9-3-2(a)</p>			

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 1 of 10 incident/investigative reports reviewed affecting 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to ensure corrective action was taken in regard to a substantiated allegation of abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/1/12 at 1:17 PM.</p> <p>On 5/24/12 at 2:00 PM, staff #5 reported allegations of abuse regarding staff #6 that had occurred at the group home on 5/19/12 and 5/20/12. On 5/19/12, staff #5 indicated staff #6 yelled at staff #4 in the presence of clients A, B, C, D, E and F due to staff #4 requesting her to go back into the group home to get the credit card. On 5/20/12 (no time documented) when staff #5 returned to the group home, she found client E in the kitchen with the door shut. Client E was sitting alone with her head down. Client E told staff #5 "shh." Staff #5 asked why and client E indicated she was in trouble. Client E again said, "shh." Staff #5 told client E she was not</p>	W0157	<p>W157</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that proper corrective action is taken if allegations are verified. The corrective action must be implemented within 5 business days.</p> <p>Date of Completion</p> <p>July 2, 2012</p> <p>Responsible Person</p> <p>QMRP Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>Recommendations (Attachment # 11) occurred on the 6 th day following the incident. Due to the absence of the SGL Director, the Senior Director of Human Resources completed the recommendations. He is now aware of the 5 day time frame.</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure,</p>	07/02/2012			

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	<p>in trouble and client E whispered, "Yes I am." Client E indicated she snuck some soda and staff #6 saw it. Staff #6 then came to the kitchen window and indicated she would tell staff #5 what happened. Staff #5 then opened the kitchen door for client E to exit the kitchen. Staff #6 told staff #5 that client E was told to wait 20 minutes for her soda and client E did not want to wait. Staff #6 told staff #5 that client E grabbed a soda and opened it so staff #6 took the soda away. Staff #6 indicated she was trying to push client E's wheelchair out of the kitchen but client E put her feet down on the ground and locked her fingers into the wheels of her wheelchair. Staff #6 then indicated to staff #5 she closed the kitchen door and told client E to stay there. Staff #6 indicated to client E she was not going to talk to her.</p> <p>Staff #5 documented in the incident report on past occasions (no dates or times), staff #6 had made comments about client B being "nasty and disgusting." Staff #5 indicated she reported this information to staff #4, her supervisor. Staff #5 indicated staff #6 had placed her fingers under client B's chin and made her mouth shut telling her she was gross and the others did not want to hear her smack her food or see it.</p>		<p>after reviewing the incident, that the corrective action is implemented within 5 business days</p>				

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	<p>The investigative report, dated 5/31/12, indicated the allegation of abuse was substantiated. The investigative report indicated, "Stone Belt's definition of abuse states, in part: 'willful/purposeful infliction of physical or emotional pain, injury, revilement, malignment and/or otherwise disregard of an individual,' 'unauthorized restraint or confinement resulting from physical or chemical intervention; placement of a client alone and unattended in a locked room.' Stone Belt's definition of Emotional/Verbal abuse states, in part: 'intentional use of actions, words or activities where an individual suffers emotional/psychological harm or trauma.'" The report indicated, "In regards to the alleged incident with [client E], the client reports being upset by how she was treated by [staff #6]. It appears that [staff #6] attempted to move [client E] against her will, and there was no need to restrain her due to safety concerns. This is an unauthorized restraint. [Staff #6] reported that she closed the kitchen door with [client E] inside, this would meet the criteria for seclusion. She [staff #6] reported that [staff #4] was sitting at the dining table at that time. The house restriction states that the kitchen door will be closed and locked when staff are not present... It appears that [staff #6] used a hateful tone of voice with [client E] and</p>			

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	<p>then ignored her. [Client E] reported being upset and also concerned that [staff #6] was made at her. [Staff #6's] reported behavior displays a disregard of [client E's] rights as an individual and caused her emotional pain." The report indicated in regard to the abuse of client B, "In regards to the alleged incident with [client B], it is unclear if [staff #6] made derogatory comments about [client B's] meal time behavior. It appears that [staff #6] used brief physical prompts for [client B] to close her mouth while chewing. [Client B] does not have a goal of chewing with her mouth closed. [Client B] had the right to choose to chew with her mouth open. [Staff #6] used an intervention that is not written in [client B's] BSP (behavior support plan). It appears that [staff #6] had used a rough tone of voice with clients and may have been making inappropriate comments about assisting them with personal care. It appears that [staff #6's] supervisor, [staff #4], had attempted to address the issue. His attempts appear to have been unsuccessful. It appears that [staff #4's] supervisor and coordinator have now been made aware of issues and become involved to support him and [name of group home] clients."</p> <p>The investigative report, dated 5/31/12, did not contain documentation of</p>			

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	<p>corrective action addressing the substantiated abuse of clients B and E. On 6/5/12 at 2:16 PM, an email was received from the Director of Human Resources. The email indicated the following recommendations for the investigation, "1. Termination of [staff #6] (due to substantiated allegation of abuse by staff against a client of Stone Belt) Staff remains suspended and will be terminated as soon as possible. 2. Training of [staff #4] on proper way to document issues occurring with staff so that manager and coordinator are aware of issues and can provide support. This will take place by June 11, 2012. 3. Advisement of client rights to affected client(s) in incident. This was completed during the investigation by [social worker].</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/1/12 at 1:31 PM. The PC she thought as long as the investigation was finished within 5 business days the recommendations could be completed at a later date. The PC indicated the recommendations should be part of the investigation. The PC indicated she received notification of the recommendations from the investigation on 6/5/12.</p>						

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 2 of 6 clients living in the group home (A and F), the facility failed to ensure staff receive adequate training on when to notify the nurse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/1/12 at 1:17 PM.</p> <p>-On 5/11/12 during dinner, client A ate her food quickly and then vomited. Client A then had an episode of deep coughing; the report indicated, "She eat (sic) very fast then vomited and had an episode of deep coughing she then had her meds sat up with staff for about 30 mins (minutes) when the coughing was finished staff assisted her to bed (she had no temp)." This incident was not reported to administrative staff until 5/12/12 at 6:15 AM when client A was found to have a "shot glass" amount of blood in her bed. There was no documentation a nurse was notified on 5/11/12. There was no incident report for the 5/11/12 eating quickly, vomiting and coughing; the</p>	W0189	<p>W189</p> <p>DIRECT CARE STAFF</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will provide each employee with initial and continuing training that enables the employee to perform their duties effectively, efficiently and competently.</p> <p>Person Responsible:</p> <p>QMRP Coordinator</p> <p>Date of Completion:</p> <p>July 2, 2012</p> <p>Plan of Prevention:</p> <p>House staff were retrained on Stone Belt Medical Procedures (Attachment # 1 and # 2), client high risk plan(Attachment # 3) and client specific meal time plan (Attachment # 4).</p> <p>Quality Assurance Monitoring:</p> <p>QMRP Coordinator during announced and unannounced visits, will ensure that staff are following plans as written.</p>	07/02/2012			

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	<p>incident was reported in a report dated 5/12/12 when the staff found blood in her bed. There was no documentation the incident was reviewed to ascertain whether or not staff present for dinner implemented her risk plan for aspiration. There was no documentation the Coordinator was notified until 5/12/12. There was no documentation the nurse was notified or reviewed the incident report.</p> <p>A review of client A's record was conducted on 6/4/12 at 12:47 PM. Client A's Medication Information Sheet (MIS), dated 5/25/12, indicated client A was at risk for aspiration. The plan indicated client A had a history of choking with aspiration, first noted in July 2005. The plan indicated her choking risk was due to the fact that she takes in food at a fast rate with minimal chewing. The plan indicated the direct care staff would prompt client A with verbal and physical guidance to prevent her from eating too quickly. The plan indicated staff need to sit next to client A to prompt and cue her to take small bites of food and chew all foods well before swallowing. Staff need to check her mouth every few bites to make sure she is successfully chewing and swallowing. If food was still noted in her mouth, staff should encourage her to continue to chew and swallow until all</p>		Additional training will be scheduled as needed.				

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	<p>food is gone. The plan indicated to prompt her to put only small bites of food on her spoon. The plan indicated, "Document in Incident Report and notify Coordinator."</p> <p>-On 4/10/12 at 7:15 AM, client F was falling asleep while at the table for breakfast. Staff #10 was trying to wake her. Staff #10 then noticed a large bruise on the right side of her forehead. Staff #10 asked staff #7 if staff #7 had observed client F fall during the night. Staff #7 indicated she was not aware of a fall. At 9:30 AM, the home manager at the time contacted the day aide to inform her of the bruise. The day aide was asked to contact client F's primary care physician and the office was closed. The day aide was instructed to pick up client F from the day program and take her to the emergency room (ER). Client F was picked up at 10:50 AM and arrived to the ER at 11:00 AM. All tests were normal. Client F had a hematoma on the right side of her forehead. In the investigation of injury of unknown origin, dated 4/10/12, the Program Coordinator described the injury as, "Softball size purple bruise - raised knot on forehead area goes up into hairline." The investigation indicated, "...the fall risk plan was followed. It was determined that this was not an incident of abuse or neglect. Coordinator</p>				

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	<p>determined that [client F] had fallen during her incident of incontinence, possibly hitting her head on the night stand which is next to her bed. [Client F] had been seen recently for increased falls, by her PCP (primary care physician), neurologist and psychiatrist. We are still in search of the cause of [client F's] increased falls as well as her being lethargic. [Client F] will go to [name of company] to have new AFO (ankle-foot orthosis) braces fitted...." There was no documentation the nurse was notified of the injury of unknown origin or reviewed the incident report.</p> <p>An interview with the Manager of Health Care Services (MHCS) was conducted on 6/6/12 at 8:53 AM. The MHCS indicated the nurse should have been contacted regarding client A's vomiting and coughing on 5/11/12 due to the possibility of aspiration. The MHCS indicated the nurse should have been contacted to conduct an assessment of client F's injury of unknown origin; the staff indicated she was falling asleep at the dining room table with an unknown injury to her head. The MHCS indicated anytime a client was having medical issues, the nurse should be contacted. The MHCS indicated the staff need retraining on when to contact the nurse.</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
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	9-3-3(a)			

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview for 1 of 3 non-sampled clients (A), the facility failed to ensure staff implemented her risk plan for aspiration in regard to documenting on an incident report and notifying the Program Coordinator (PC).</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/1/12 at 1:17 PM.</p> <p>On 5/11/12 during dinner, client A ate her food quickly and then vomited. Client A then had an episode of deep coughing; the report indicated, "She eat (sic) very fast then vomited and had an episode of deep coughing she then had her meds sat up with staff for about 30 mins (minutes) when the coughing was finished staff assisted her to bed (she had no temp)." This incident was not reported to administrative staff until 5/12/12 at 6:15 AM when client A was found to have a "shot glass" amount of blood in her bed.</p>	W0249	<p>W249</p> <p>PROGRAM IMPLEMENTATION</p> <p>Plan of Correction</p> <p>Stone Belt will ensures that once the interdisciplinary team has formulated a clients individual program plan, each client must receive continuous active treatment.</p> <p>Date of Completion</p> <p>July 2, 2012</p> <p>Responsible Person</p> <p>QMRP Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>House staff were retrained on Stone Belt Medical Procedures (Attachment # 1 and # 2), client high risk plan(Attachment # 3) and client specific meal time plan (Attachment # 4).</p>	07/02/2012			

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	<p>There was no documentation a nurse was notified on 5/11/12. There was no incident report for the 5/11/12 eating quickly, vomiting and coughing; the incident was reported in a report dated 5/12/12 when the staff found blood in her bed. There was no documentation the incident was reviewed to ascertain whether or not staff present for dinner implemented her risk plan for aspiration. There was no documentation the Coordinator was notified until 5/12/12.</p> <p>A review of client A's record was conducted on 6/4/12 at 12:47 PM. Client A's Medication Information Sheet (MIS), dated 5/25/12, indicated client A was at risk for aspiration. The plan, dated 5/25/12, indicated client A had a history of choking with aspiration, first noted in July 2005. The plan indicated her choking risk was due to the fact that she takes in food at a fast rate with minimal chewing. The plan indicated the direct care staff would prompt client A with verbal and physical guidance to prevent her from eating too quickly. The plan indicated staff need to sit next to client A to prompt and cue her to take small bites of food and chew all foods well before swallowing. Staff need to check her mouth every few bites to make sure she is successfully chewing and swallowing. If food was still noted in her mouth, staff</p>		<p>Quality Assurance Monitoring</p> <p>Coordinator and SGL Director will review incidents for proper reporting and the Coordinator will make announced and unannounced visits to ensure that the risk plans and meal plans are being practiced.</p>				

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	<p>should encourage her to continue to chew and swallow until all food is gone. The plan indicated to prompt her to put only small bites of food on her spoon. The plan indicated, "Document in Incident Report and notify Coordinator." There was no documentation of an incident report and notification of the Coordinator.</p> <p>An interview with the PC was conducted on 6/6/12 at 9:16 AM. The PC indicated the staff did not follow client A's risk plan for documenting the 5/11/12 episode of vomiting and coughing in an incident report and notifying her of the incident.</p> <p>9-3-4(a)</p>			

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W0356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (D), the facility failed to ensure client D received the dental treatment recommended by the dentist.</p> <p>Findings include:</p> <p>A review of client D's record was conducted on 6/4/12 at 3:17 PM. On 4/14/11, client D was seen by his pediatric dentist. The reason for the visit was indicated as, "Eval before cleaning in OR [operating room]." The form indicated future treatments as, "Pt [patient] will have xrays, deep cleaning and fillings done in the operating room." Client D was seen by a dentist again on 2/8/12. The Outside Services Report form indicated, "unable to do exam today. Needs referral to pediatric dentist for treatment." There was no documentation in client D's record indicating client D received the x-rays, deep cleaning and fillings recommended on 4/14/11. Client D's Nurse Quarterly Physical, dated 3/2/12, indicated the following, "No health concerns at this time. Trying to get</p>	W0356	<p>W356</p> <p>COMPREHENSIVE DENTAL TREATMENT</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that a comprehensive dental treatment service that includes dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health will be implemented.</p> <p>Date of Completion</p> <p>July 5, 2012</p> <p>Responsible Person</p> <p>QMRP Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>The Coordinator will review documentation and annual appointments on a monthly basis to ensure that appointments are not overlooked. The appointment for the specific client is Thursday, July 5, 2012. (Attachment # 12)</p> <p>Quality Assurance Monitoring</p>	07/05/2012			

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	<p>into dentist due to bad front teeth. [Name of dentist] nor [name of dentist] will see [client D] due to having seizure during anesthetic last time. Will continue to try to solve this problem." An appointment with client D's primary care physician (PCP), dated 3/13/12, indicated the appointment was to discuss anesthesia for dental extraction. The physician documented on a prescription pad the following, "I do not recommend general anesthesia for [client D] without clearance by anesthesiologist with respect to his reaction and hospitalization in 2009." There was no documentation client D had a consultation with an anesthesiologist.</p> <p>A review of client D's Behavioral Intervention Plan (BIP), dated 3/19/11, indicated the targeted behaviors of physical aggression and non-compliance to dental procedures were removed from the plan. There was no documentation of a dental desensitization plan. A review of his Individual Support Plan (ISP), dated 2/29/12, indicated the following, "He will have a dental desense objective due to difficulties during dental services which will be addressing during oral hygiene." The ISP indicated, "When asked, [client D] will participate in oral hygiene process." The ISP indicated, "[Client D] requires heavy sedation for dental exams and treatment due to his fear and inability</p>		Coordinator and SGL Director will review documentation with house staff on a monthly basis to ensure that all appointments are being met.		

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	<p>to relax during the exams. He sees [name of dentist] in [name of city] for dental tx (treatment). He is past due for tx at this time. Has an appt (appointment) to see GP (general practitioner) for cardiac work up before next appt with [name of dentist]."</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/4/12 at 3:17 PM. The PC indicated there had been no dental appointment for client D since the annual survey. The PC indicated an appointment was scheduled for client D's dental appointment on 7/5/12.</p> <p>This deficiency was cited on 4/11/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met:</p> <p>460 IAC 9-3-1 Governing Body</p> <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>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 10 incident/investigative reports reviewed affecting client B, the facility failed to ensure incidents were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with State law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/1/12 at 1:17 PM. -On 4/12/12 at 7:00 AM (reported to BDDS on 4/16/12), client B did not</p>	W9999	<p>W9999</p> <p>FINAL OBSERVATIONS</p> <p>Plan of Correction</p> <p>Stone Belt will ensures 1) Incidents will be reported to BDDS within 24 hours and 2) All staff will have Mantoux tuberculosis skin test or chest x-ray.</p> <p>Date of Completion</p> <p>July 2, 2012</p> <p>Responsible Person</p> <p>QMRP Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>Social Worker and QMRP Coordinator reviewed 24 hour reporting (Attachment # 10) and staff completed chest x-ray verification (Attachment # 13)</p> <p>Quality Assurance Monitoring</p> <p>Coordinator and SGL Director will review incident reports to ensure they are reported to BDDS within 24 hours. HR Department and Coordinator will ensure all staff have Mantoux test or chest x-ray</p>	07/02/2012	

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	<p>receive Levors (birth control). -On 4/12/12 at 7:00 AM (reported to BDDS on 4/24/12), client B did not receive Senna Lax (laxative).</p> <p>An interview with the PC was conducted on 6/4/12 at 1:01 PM. The PC indicated incidents should be reported to BDDS within 24 hours.</p> <p>9-3-1(b)</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p>						

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	<p>Based on record review and interview for 1 of 3 employee files reviewed (Direct Care Staff #4), the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis screening was conducted.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 6/4/12 at 12:34 PM. Direct Care Staff #4 had a negative chest x-ray on 2/22/10. Direct Care Staff #4 had a screening on 2/20/11. There was no documentation Direct Care Staff #4 had a screening conducted since 2/20/11.</p> <p>An interview was conducted with the Program Coordinator (PC) on 6/4/12 at 2:32 PM. The PC indicated the staff should have annual screenings.</p> <p>This deficiency was cited on 4/11/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(e)</p>				