

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/04/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Survey Dates: November 30, December 1, 2, 3 and 4, 2015</p> <p>Facility Number: 001209 Provider Number: 15G634 AIM Number: 100240160</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/11/15.</p>	W 0000	<p>Additional edits are being added to the Plan of Correction (POC) in response a letter dated 1/8/2016 by ISDH to Stone Belt. The primary change is to assign a Senior Director to oversee monitoring of the POC, including the SGL Director & QIDP.</p>	
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for 3 of 3 clients in the sample (#1, #3 and #4) and 3 additional clients (#2, #5 and former client #6), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility by failing to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated,</p>	W 0102	<p>W102 (Condition) GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID KZP911 will be fully implemented, including the following specifics: How facility will identify</p>	01/01/2016

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>coordinated and monitored the clients' program plans. The governing body failed to monitor the QIDP to ensure regular reviews of the clients' progress toward achieving their program plans were conducted. The governing body failed to monitor the QIDP to ensure client #6's final summary included developmental, social, health and nutritional status information as well as his strengths, needs, required services, social relationships and preferences. The governing body failed to monitor the QIDP to ensure the QIDP developed a plan to address client #4's recurring issues with conjunctivitis (pink eye). The governing body failed to monitor the QIDP to ensure client #4's communication training objective was updated when he obtained a new communication device. The governing body failed to monitor the QIDP to ensure staff implemented client #1's plan for restricting access to the kitchen when staff was not present as written. The governing body failed to monitor the QIDP to ensure quarterly evacuation drills for each shift of personnel were conducted. The governing body failed to monitor the QIDP to ensure staff conducted evacuation drills under varied conditions. The governing body failed to monitor the QIDP to ensure the clients were involved with grocery shopping,</p>		<p>other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP trained to ensure that clients' programs are integrated, coordinated, and monitored. Additionally, each individual's annual and quarterly meeting will be placed on calendar, and QIDP will ensure that the annual and quarterly review or update is in place by 30 days following the meeting date. How corrective actions will be monitored to ensure no recurrence Quarterly internal inspections will be completed per schedule assigned by agency. Following inspections they will be reviewed by facility director of supported group living to ensure that clients' programs are integrated and coordinated. Monthly quality assurance checklist will be completed by facility QIDP to ensure clients' programs are integrated and coordinated. These checklists will be submitted to facility director of supported group living by 10th of the each month for review. Weekly visits will be completed (at least twice weekly through February to reinforce initial compliance) and documented (online tracking) by QIDP to ensure clients' programs</p>	

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	<p>serving themselves during snack, packing their own lunches and preparing breakfast.</p> <p>Findings include:</p> <p>Please refer to W104. For 3 of 3 clients in the sample (#1, #3 and #4) and 3 additional clients (#2, #5 and former client #6), the governing body failed to exercise operating direction over the facility by failing to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans.</p> <p>9-3-1(a)</p>		<p>are being implemented. Active treatment will be monitored during these visits to ensure the clients involvement with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast. These visits are then electronically reviewed by agency Director of supported group living to monitor compliance. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p>		

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 3 of 3 clients in the sample (#1, #3 and #4) and 3 additional clients (#2, #5 and former client #6), the governing body failed to exercise operating direction over the facility by failing to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans.</p> <p>Findings include:</p> <p>Please refer to W159. For 3 of 3 clients in the sample (#1, #3 and #4) and 3 additional clients (#2, #5 and #6), the facility's governing body failed to ensure the QIDP integrated, coordinated and monitored the clients' individualized support plans. The governing body failed to monitor the QIDP to ensure regular reviews of the clients' progress toward achieving their program plans were conducted. The governing body failed to monitor the QIDP to ensure client #6's final summary included developmental, social, health and nutritional status information as well as his strengths,</p>	W 0104	<p>W104 Governing Body (Standard) The facility must ensure that specific governing body and management requirements are met. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID KZP911 will be fully implemented, including the following specifics: How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP trained to ensure that clients' programs are integrated, coordinated, and monitored. Additionally, each individual's annual and quarterly meeting will be placed on calendar, and QIDP will ensure that the annual and quarterly review or update is in place by 30 days following the meeting date. Agency final discharge summary updated to include developmental, social, health and nutritional status information as well as his strengths, needs, required services, social</p>	01/01/2016

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	<p>needs, required services, social relationships and preferences. The governing body failed to monitor the QIDP to ensure the QIDP developed a plan to address client #4's recurring issues with conjunctivitis (pink eye). The governing body failed to monitor the QIDP to ensure client #4's communication training objective was updated when he obtained a new communication device. The governing body failed to monitor the QIDP to ensure staff implemented client #1's plan for restricting access to the kitchen when staff was not present as written. The governing body failed to monitor the QIDP to ensure quarterly evacuation drills for each shift of personnel were conducted. The governing body failed to monitor the QIDP to ensure staff conducted evacuation drills under varied conditions. The governing body failed to monitor the QIDP to ensure the clients were involved with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast.</p> <p>9-3-1(a)</p>		<p>relationships and preferences. QIDP developed plan to address client #4's recurring issues with conjunctivitis (pink eye). QIDP developed objective to training client #4 to use his new tablet to replace previous communication devise training objective. QIDP, house manager, and staff trained to ensure staff are implementing client #1's plan for restricting access to the kitchen when staff was not present as written. QIDP and house manager trained to ensure quarterly evacuation drills for each shift of personnel were conducted at varied conditions and times. Successful drills completed by each shift since 12/01/15. QIDP, food management purchasing staff, and house manager trained to ensure the clients involvement with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast. How corrective actions will be monitored to ensure no recurrence Quarterly internal inspections will be completed per schedule assigned by agency. Following inspections they will be reviewed by facility director of supported group living to ensure that clients' programs are integrated, coordinated, and monitored. Internal inspections will also review that quarterly evacuation drills are completed for each shift of personnel conducted at varied conditions and times. Monthly quality</p>		

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			assurance checklist will be completed by facility QIDP to ensure clients' programs are integrated, coordinated, and monitored. These checklist are submitted to facility director of supported group living by 10th of the each month for review. Weekly visits will be completed (at least twice weekly through February to reinforce initial compliance) and documented (online tracking) by QIDP to ensure clients' programs are being implemented. Active treatment will be monitored during these visits to ensure the clients involvement with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast. These visits are then electronically reviewed. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation	

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W 0153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 20 incident reports reviewed affecting former client #6, the facility failed to ensure staff immediately reported an allegation of abuse to the administrator.</p> <p>Findings include: On 11/30/15 at 1:45 PM, a review of the facility's incident reports indicated the following: On 1/24/15 (no time indicated), staff #9 arrived to the group home. Client #6 was in the kitchen with former staff #10. Client #6 was yelling and slamming cabinet doors. Staff #9 indicated in the Stone Belt ARC, Inc.</p>	W 0153	<p>in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for then next two months - or longer if needed - to ensure continued full implementation of the POC.</p> <p>W153 (standard) – Staff treatment of clients Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID KZP911 will be fully implemented, including the following specifics: How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measuresor systemic changes facility put in place to ensure no recurrence Facility staff will be trained monthly on immediately reporting an allegation of abuse to the administrator at SGL monthly</p>	01/01/2016	

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	<p>Incident Report, dated 3/4/15, "I had been at [name of group home] for 5-7 minutes when [staff #1], manager, walked in. Upon [client #6] seeing [staff #1], he immediately went from sitting on the floor refusing to leave to laying (sic) down, as if trying to be glued to the floor. [Staff #1 and staff #10] then assisted [client #6] to his feet, against his will, by picking (sic) up. On either side of [client #6], the two staff went under his arm pit with interior arm then exterior arm went to waist, need belt loops to stand him up. An improper two person transfer was completed by [staff #1 and staff #10]. [Client #6] was directed to his room. Once at the threshold of the door, I saw [staff #10] leaving to go to the living room/front room to retrieve the blocking pad as [client #6] was kicking, attempting to hit, and spitting. I was able to see (from the hallway) that each time [client #6] tried to get out of his room, [staff #1] was standing in the door way and would use two hands to push/shove [client #6] back into the room, at least one time landing on his bed. When he would push [client #6], [staff #1] would say things such as 'breathe, count to ten.' [Staff #1] looked back toward me and said, 'I don't need a third staff here.' I was then asked to leave... I recall this being sometime around NFL (National Football League) playoffs ([staff #10] was talking about</p>		<p>meeting. How corrective actions will be monitored to ensure no recurrence QIDP will complete monthly monitoring checklist to ensure protection of client rights. Area of checklist interviews staff and obtains information regarding client protections. Checklist will be turned into Director of Supported Group Living by the 10th of each month for review. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p>	
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W 0159 Bldg. 00	<p>who he would like to see win)... Not sure if any injuries occurred."</p> <p>Staff #10 reported the allegation to the administrator on 3/4/15. The facility failed to ensure staff immediately reported an allegation of abuse to the administrator.</p> <p>On 12/2/15 at 2:08 PM, the Qualified Intellectual Disabilities Professional indicated allegations of abuse were to be reported to the administrator immediately.</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 3 of 3 clients in the sample (#1, #3 and #4) and 3 additional clients (#2, #5 and #6), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' individualized support plans. The QIDP failed to ensure regular reviews of the clients' progress toward achieving their program plans were conducted. The</p>	W 0159	<p>W159 (standard) QIDP – failed to integrate, coordinate, and monitor client plans Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID KZP911 will be fully implemented, including the following specifics: How facility will identify other residents potentially affected & what measures taken All residents potentially are affected,</p>	01/01/2016

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	<p>QIDP failed to ensure client #6's final summary included developmental, social, health and nutritional status information as well as his strengths, needs, required services, social relationships and preferences. The QIDP failed to develop a plan to address recurring issues with conjunctivitis (pink eye). The QIDP failed to ensure client #4's communication training objective was updated when he obtained a new communication device. The QIDP failed to ensure staff implemented client #1's plan for restricting access to the kitchen when staff was not present as written. The QIDP failed to ensure quarterly evacuation drills for each shift of personnel were conducted. The QIDP failed to ensure staff conducted evacuation drills under varied conditions. The QIDP failed to ensure the clients were involved with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast.</p> <p>Findings include:</p> <p>1) On 12/1/15 at 12:27 PM, a review of client #1's record was conducted. Client #1's record did not contain documentation the QIDP reviewed his progress toward completing his training objectives since 4/18/14. On 12/1/15 at</p>		<p>and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence From this point forward, QIDP will ensure clients' progress toward achieving their program is tracked and documented. To achieve this, a new quarterly review form was developed. Using this form to track progress on goals has been trained with facility QIDP. House manager trained on ensuring monthly documentation is submitted to QIDP by 10th of following month. QIDP trained to ensure that clients' programs are integrated and coordinated. Additionally, each individual's annual and quarterly meeting will be placed on calendar, and QIDP will ensure that the annual and quarterly review or update is in place by 30 days following the meeting date. Agency final discharge summary updated to include developmental, social, health and nutritional status information as well as his strengths, needs, required services, social relationships and preferences. QIDP developed plan to address client #4's recurring issues with conjunctivitis (pink eye). QIDP developed objective to traing client #4 to use his new tablet to replace previous communication devise training objective. QIDP, house manager, and staff trained to ensure staff are implementing</p>	

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	<p>1:37 PM, the QIDP was contacted and asked where client #1's quarterly reviews were located for review. The QIDP indicated he was working on them at the time. The surveyor requested the QIDP to bring what he had completed for review. The QIDP brought client #1's quarterly reviews dated 7/7/14, 10/7/14, 1/5/15, 4/3/15 and 7/3/15 for review. The QIDP indicated the quarterly reviews were completed. Upon review of the information, each quarterly review contained the same information for May, June and July (it was not clear if the information was for 2014 or 2015) however the information in each quarterly review was exactly the same with no changes except to the date of the review.</p> <p>On 12/1/15 at 1:34 PM, QIDP #2 indicated there was no documentation (data) in the electronic system of client #1's goals being implemented from November 2014 to April 1, 2015. QIDP #2 indicated April, May and June 2015 were the only months during since November 2014 with data. QIDP #2 indicated when she attempted to print out quarterly reviews, there was information for April, May and June 2015. There was no additional information in the system to review.</p>		<p>client #1's plan for restricting access to the kitchen when staff was not present as written. QIDP and house manager trained to ensure quarterly evacuation drills for each shift of personnel were conducted at varied conditions and times. Successful drills completed by each shift since 12/01/15. QIDP, food management purchasing staff, and house manager trained to ensure the clients involvement with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast. How corrective actions will be monitored to ensure no recurrence Quarterly internal inspections will be completed per schedule assigned by agency. Following inspections they will be reviewed by facility director of supported group living to ensure that clients' programs are integrated, coordinated, and monitored. Internal inspections will also confirm quarterly evacuation drills are completed for each shift of personnel conducted at varied conditions and times. Monthly quality assurance checklist will be completed by facility QIDP to ensure clients' programs are integrated, coordinated, and monitored. These checklist are due to facility directoro f supported group living by 10th of the each month for review. Weekly visits will be completed (at least twice weekly through</p>		

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	<p>On 12/1/15 at 2:11 PM, a review of client #3's record was conducted. Client #3's record did not contain documentation the QIDP reviewed his progress toward completing his training objectives since 12/31/14. An Active Treatment Training Summary, not dated, in client #3's record indicated, "IHP (Individual Habilitation Program) tracking for the months of November and December were (sic) lost somewhere between [name of client #3's former group home] and the QIDP-D's (QIDP designee) desk. When consulted, the manager and house staff reported that they had been sent in, but to the wrong person. The attempt to track down following this lead proved fruitless. Only one month's worth of training was recovered for one client (did not indicate the month or the client). All staff have been trained on the proper allocation of the end-of-month paperwork."</p> <p>On 12/2/15 at 12:12 PM, a review of client #4's record was conducted. Client #4's record did not contain documentation the QIDP reviewed his progress toward completing his training objectives since 4/18/14.</p> <p>On 12/1/15 at 1:36 PM, QIDP #2 indicated client #4's electronic data tracking system had no data from 7/31/14 to 4/1/15. On 12/1/15 at 1:57 PM, QIDP</p>		<p>February to reinforce initial compliance) and documented (online tracking) by QIDP to ensure clients' programs are implemented. Active treatment will be monitored during these visits to ensure the clients involvement with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast. These visits are then electronically reviewed by agency Director of supported group living to monitor compliance. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP</p>	

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	<p>#2 indicated client #4's quarterly reviews should be in his record for review.</p> <p>On 12/1/15 at 1:29 PM, the current QIDP indicated he was supposed to conduct a review on a quarterly basis, print, sign and send the information to be included in the clients' electronic records.</p> <p>On 12/1/15 at 2:27 PM, the Group Home Director (GHD) indicated she instructed the QIDPs (former and present) to conduct the quarterly reviews. The GHD indicated the facility needed to ensure the QIDPs were conducting the quarterly reviews on a quarterly basis. The GHD indicated the clients' interdisciplinary teams needed to review the clients' data and progress quarterly, discuss as a team and make changes as needed. The GHD indicated she was aware, prior to 12/1/15, the current QIDP was behind. The GHD stated she "thought he got them done." The GHD stated she needed "to have a different system so I can monitor better." The GHD indicated the QIDP needed to delegate the data entry to someone else. The GHD stated "need a system to monitor." The GHD indicated the facility needed to figure out a different way to ensure the QIDPs were conducting the clients' quarterly reviews. The GHD indicated the clients' IDTs (interdisciplinary team) needed to meet</p>		will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.				

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	<p>quarterly. The GHD stated the QIDPs "don't need monthly meetings without discussing (the clients') goals and objectives."</p> <p>2) Please refer to W203. For 1 client who was discharged from the group home (#6) since 11/30/14, the QIDP failed to ensure client #6's final summary included developmental, social, health and nutritional status information as well as his strengths, needs, required services, social relationships and preferences.</p> <p>3) Please refer to W227. For 1 of 3 clients in the sample (#4), the QIDP failed to develop a plan to address recurring issues with conjunctivitis (pink eye).</p> <p>4) Please refer to W240. For 1 of 3 clients in the sample (#4), the QIDP failed to ensure client #4's communication training objective was revised/updated when client #4 obtained a new communication device.</p> <p>5) Please refer to W249. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the QIDP to ensure staff implemented client #1's plan for restricting access to the kitchen when staff was not present as written.</p>			

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W 0189 Bldg. 00	<p>6) Please refer to W440. For 4 of 5 clients living in the group home (#1, #2, #3 and #4), the QIDP failed to ensure staff conducted quarterly evacuation drills for each shift of personnel.</p> <p>7) Please refer to W441. For 4 of 5 clients living in the group home (#1, #2, #3 and #4), the QIDP failed to ensure staff conducted evacuation drills under varied conditions.</p> <p>8) Please refer to W488. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the QIDP failed to ensure the clients were involved with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM 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. Based on record review and interview for 3 of 3 clients in the sample (#1, #3 and #4), the facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) received</p>	W 0189	W 189 STAFF TRAINING PROGRAM Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID KZP911 will be fully implemented,	01/01/2016

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	<p>competency-based training on how to conduct quarterly reviews using the facility's electronic system.</p> <p>Findings include:</p> <p>On 12/1/15 at 12:27 PM, a review of client #1's record was conducted. Client #1's record did not contain documentation the QIDP reviewed his progress toward completing his training objectives since 4/18/14. On 12/1/15 at 1:37 PM, the QIDP was contacted and asked where client #1's quarterly reviews were located for review. The QIDP indicated he was working on them at the time. The surveyor requested the QIDP to bring what he had completed for review. The QIDP brought client #1's quarterly reviews dated 7/7/14, 10/7/14, 1/5/15, 4/3/15 and 7/3/15 for review. The QIDP indicated the quarterly reviews were completed. Upon review of the information, each quarterly review contained the same information for May, June and July (it was not clear if the information was for 2014 or 2015) however the information in each quarterly review was exactly the same with no changes except to the date of the review.</p> <p>On 12/1/15 at 1:34 PM, QIDP #2 indicated there was no documentation</p>		<p>including the following specifics: How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence From this point forward, QIDP will ensure clients' progress toward achieving their program is tracked and documented. To achieve this, a new quarterlyreview form was developed. Using this form to track progress on goals has been trained with facility QIDP. House manager trained on ensuring monthly documentation is submitted to QIDP by 10th of following month. Additionally, each individual's annual and quarterly meeting will be placed on calendar, and QIDP will ensure that the annual and quarterly review or update is in place by 30 days following the meeting date. How corrective actions will be monitored to ensure no recurrence Quarterly internal inspections will be completed per schedule assigned by agency. Following inspections they will be reviewed by facility director of supported group living to ensure that clients' programs are integrated, coordinated, and monitored. Internal inspections will also confirm quarterly evacuation drills are completed for each shift of personnel</p>	

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	<p>(data) in the electronic system of client #1's goals being implemented from November 2014 to April 1, 2015. QIDP #2 indicated April, May and June 2015 were the only months during since November 2014 with data. QIDP #2 indicated when she attempted to print out quarterly reviews, there was information for April, May and June 2015. There was no additional information in the system to review.</p> <p>On 12/1/15 at 2:11 PM, a review of client #3's record was conducted. Client #3's record did not contain documentation the QIDP reviewed his progress toward completing his training objectives since 12/31/14. An Active Treatment Training Summary, not dated, in client #3's record indicated, "IHP (Individual Habilitation Program) tracking for the months of November and December were (sic) lost somewhere between [name of client #3's former group home] and the QIDP-D's (QIDP designee) desk. When consulted, the manager and house staff reported that they had been sent in, but to the wrong person. The attempt to track down following this lead proved fruitless. Only one month's worth of training was recovered for one client (did not indicate the month or the client). All staff have been trained on the proper allocation of the end-of-month paperwork."</p>		<p>conducted at varied conditions and times. Monthly quality assurance checklist will be completed by facility QIDP to ensure clients' programs are integrated, coordinated, and monitored. These checklist are due to facility director of supported group living by 10th of the each month for review. Weekly visits will be completed (at least twice weekly through February to reinforce initial compliance) and documented (online tracking) by QIDP to ensure clients' programs are integrated, coordinated, and monitored. Active treatment will be monitored during these visits to ensure the clients involvement with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast. These visits are then electronically reviewed by agency Director of supported group living to monitor compliance. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include</p>	

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	<p>On 12/2/15 at 12:12 PM, a review of client #4's record was conducted. Client #4's record did not contain documentation the QIDP reviewed his progress toward completing his training objectives since 4/18/14.</p> <p>On 12/1/15 at 1:36 PM, QIDP #2 indicated client #4's electronic data tracking system had no data from 7/31/14 to 4/1/15. On 12/1/15 at 1:57 PM, QIDP #2 indicated client #4's quarterly reviews should be in his record for review.</p> <p>On 12/1/15 at 1:29 PM, the current QIDP indicated he was supposed to conduct a review on a quarterly basis, print, sign and send the information to be included in the clients' electronic records.</p> <p>On 12/1/15 at 1:57 PM, QIDP #2 indicated she had not been asked specifically by the Group Home Director to train the other QIDPs on the system. QIDP #2 indicated she had been asked to assist the QIDPs to do specific tasks but not how to use the system.</p> <p>On 12/1/15 at 2:27 PM, the Group Home Director (GHD) indicated QIDP #2 was paid to train the other QIDPs on how to use the electronic system to generate quarterly reviews. The GHD indicated</p>		<p>reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p>	

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W 0203 Bldg. 00	<p>she thought the QIDP knew how to use the system since QIDP #2 and QIDP #3 provided training to him.</p> <p>On 12/1/15 at 1:39 PM, the QIDP indicated he needed additional training on how to use the electronic system to generate the clients' quarterly reviews. On 12/1/15 at 2:00 PM, the QIDP indicated he received training from QIDP #3 on how to use the system but since the quarterly reviews he printed did not contain the information he thought should be in the reviews, he needed additional training.</p> <p>9-3-3(a)</p> <p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status. Based on record review and interview for 1 client who was discharged from the group home (#6) since 11/30/14, the facility failed to ensure client #6's final summary included developmental, social, health and nutritional status information as well as his strengths, needs, required services, social relationships and preferences.</p>	W 0203	<p>W 203 ADMISSIONS, TRANSFERS, DISCHARGE Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID KZP911 will be fully implemented, including the following specifics: How facility will identify other residents potentially affected & what measures taken Former</p>	01/01/2016

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	<p>Findings include:</p> <p>On 11/30/15 at 2:37 PM, a review of client #6's record was conducted. Client #6 was discharged from the group home on 2/18/15. The Discharge Plan Summary, dated 2/14/15, indicated client #6 was being discharged to another provider. The Reason for Discharge section indicated, "Rec'd (received) CIH (Community Integration and Habilitation) waiver - moved to be closer to family." The Present Needs of Consumer section indicated, "CIH waiver. 24 hr (hour) supports behavioral svcs (services)." The Strengths, Needs and Preferences section referred to a separate form that was unable to be located in client #6's record. The Activity recommendations to the consumer to assist him/her to maintain and/or improve skills and increase independence section was blank. The form did not include a telephone number for client #6's guardian (the section was blank). The Coordinator Discharge Summary SGL (Supported Group Living), dated 2/13/15, indicated, "[Client #6] is discharged from Stone Belt's [name of group home] on February 13, 2015. He went to reside in a new home with [name of new provider] in [name of city]. [Client #6] has been working on and showing improvement</p>		<p>client #6 potentially affected, and corrective measures address the needs of allclients. Measures or systemic changes facility put in place to ensure no recurrence Agency final discharge summary updated to include developmental, social, health and nutritional status information as well as his strengths, needs, required services, social relationships and preferences. How corrective actions will be monitored to ensure no recurrence Facility QIDP trained on completing thorough discharge summaries including developmental, social, health and nutritional status information as well as his strengths, needs, required services, social relationships and preferences. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to</p>	

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	<p>with several functional living skills including staying on task, personal hygiene/teeth brushing, financial awareness and meal preparation. [Client #6] has been very helpful in meal preparation and the laundry routines at [name of group home]. [Client #6] is active and has a passion for collecting aluminum cans for recycling. All of [client #6's] personal items were removed from [name of group home] and given to [name of new provider] staff on February 13, 2015."</p> <p>The facility failed to develop a final summary to support client #6's transition to a new provider. There was no information documented on the current status of the objectives listed in client #6's Individualized Support Plan (ISP). There was no documentation provided to client #6's new provider indicating client #6's strengths, needs and preferences. There was no documentation of client #6's social relationships. There was no documentation the new provider received client #6's current dietary information. There was no documentation the new agency received client #6's current ISP, health risk plans, medical history and current medications.</p> <p>On 12/2/15 at 1:54 PM, the Qualified Intellectual Disabilities Professional</p>		<p>eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p>	

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W 0227 Bldg. 00	<p>indicated the facility should provide client #6's new agency the required information including a summary of his developmental, social, health and nutritional status information as well as his strengths, needs, required services, social relationships and preferences.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to develop a plan to address recurring issues with conjunctivitis (pink eye).</p> <p>Findings include: On 12/2/15 at 12:12 PM, a review of client #4's record was conducted. On the following dates, client #4 was diagnosed with conjunctivitis according to his Outside Services Reports: 4/2/15, 7/6/15, 11/2/15 and 11/15/15. Client #4's record did not contain a plan or specific objectives necessary to meet client #4's needs to address the recurrence of</p>	W 0227	<p>W227 Program implementation (standard) Corrective action for resident(s) found to have been affected Client #4 has a training plan for hand washing and a training plan to wash his face in the morning. How facility will identify other residents potentially affected & what measures taken Client #4 affected, and corrective measures address the needs of this client. Measures or systemic changes facility put in place to ensure no recurrence QIDP trained to ensure that clients' programs are integrated, coordinated, and monitored. Facility staff trained to ensure hand washing and face washing</p>	01/01/2016			

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	<p>conjunctivitis. On 11/23/15, client #4's Support Team Review Form indicated, in part, "Continue to encourage frequent & (and) effective hand washing." There was no documentation this recommendation was incorporated into a plan. There was no definition of frequent and effective included on the note and no plan developed to address the recommendation.</p> <p>On 12/2/15 at 2:51 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he would guess client #4 had five instances of conjunctivitis during the past year. The QIDP indicated client #4 had his hands everywhere. The QIDP indicated client #4 used hand sanitizer all the time. The QIDP indicated client #4 had his hands in his eyes all the time. The QIDP stated, "We are trying to narrow it down" in regard to the recurring issues with conjunctivitis. The QIDP stated client #4 "needs a goal for hand washing."</p> <p>On 12/2/15 at 2:41 PM, the Nurse Manager (NM) indicated the proactive plan to address conjunctivitis was proper hygiene. The NM indicated client #4 had a plan for hygiene. The NM stated client #4's current status of hygiene was "fair at best to begin with." The NM indicated client #4 needed to be washing his hands</p>		<p>plans for client effected are facilitated. How corrective actions will be monitored to ensure no recurrence QIDP will provide weekly monitoring in the home to ensure plan is being implemented. Monitoring visits entered electronically and monitored by facility director. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p>	

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W 0240 Bldg. 00	<p>frequently. The NM indicated client #4 would sneeze and then rub his face. The NM indicated client #4 needed to wash his face in the morning. The NM indicated client #4 did not need a conjunctivitis risk plan but he did need a plan to address his hygiene. The NM stated client #4's current hygiene plan to take a shower was "not going to get it."</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4's communication training objective was revised/updated when client #4 obtained a new communication device.</p> <p>Findings include: On 12/2/15 at 12:12 PM, a review of client #4's record was conducted. Client #4's 7/31/15 Individualized Support Plan included a training objective to use a communication device. The plan indicated, "[Client #4] currently has several methods through which to</p>	W 0240	<p>W240 Program implementation (standard) Corrective action for resident(s) found to have been affected Client #4 has a training plan for using his Ipad (new communication devices). How facility will identify other residents potentially affected & what measures taken Client #4 affected, and corrective measures address the needs of client. Measures or systemic changes facility put in place to ensure no recurrence QIDP trained to ensure that clients' programs are integrated, coordinated, and monitored. Facility staff trained to ensure training plans are facilitated. How corrective actions will be</p>	01/01/2016			

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	<p>communicate, including but not limited to an abbreviated sign language, a communication box and picture schedule/choice books. Encourage [client #4] to communicate his wants and needs utilizing any of the above mentioned tools... Staff should also encourage [client #4] to use his picture schedules or communication box when making choices or communicating preferences." On 2/5/15, a Support Team Review Form indicated, in part, "Discussing a change to his communication device." On 5/8/15, a Support Team Review Form indicated, in part, "Communication device needs repair - frozen." On 6/11/15, a Support Team Review Form indicated, in part, "Comm. (communication) device - needs to be reprog (reprogrammed) or replaced - iPad available sched (schedule) appt (appointment) w/ (with) speech therapist to train." On 7/30/15, a Stone Belt Outside Services Report indicated client #4 had a speech therapy appointment for an evaluation. The form indicated, "moderate communication needs. Work on motor speech communication device, signing." On 7/30/15, a Nursing Consultation note indicated, "...After a (sic) evaluation it was decided that [client #4] would do 30 minutes session on every Tuesday at 11am for 8 weeks. He will be working on motor speech, using a</p>		<p>monitored to ensure no recurrence QIDP will provide weekly monitoring (at least twice weekly through February to reinforce initial compliance) in the home to ensure plan is being implemented. Monitoring visits entered electronically and monitored by facility director. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p>	

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	<p>communication device (Ipad), and signing. She was very impressed with the skill he has now." A 11/11/15 Nursing Consultation note indicated, in part, "Correspondence received by nurse from social worker (sent to entire support team as well) regarding communication device which reads as follows: 'Hi team, having gotten the right cord for [client #4's] iPad and downloaded an assistive communication app (name of app), I worked with [client #4] briefly yesterday. He allowed me to show him some of the features of the app, and entered some text in for the device to speak out loud. While he stuck to his normal computer repertoire ('[Client #4] is pizza mommy. '), it was encouraging that he used the keyboard to express himself and seemed interested in using (and keeping) the device itself. He doesn't seem embarrassed by it, as has been the case with previous devices. That said, he was also not interested in many aspects of the app, such as using pre-loaded words and phrases to more quickly communicate his needs. He was also quite easily distracted, and seemed to recognize the slower speed of communicating with the device as a hindrance. This could change with time, but it looks like it will take focused one-on-one work. So this brings me to the idea of implementation. Would we want house staff to work with him</p>			

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	<p>daily on this, would it be better for me or [name of Behavior Consultant] to do this work, or some combination of these approaches? What steps would need to happen to put a plan in place for the device? I'd like to get the team's input on this endeavor as a whole." A 11/23/15 Support Team Review Form indicated, "Discussed usefulness of iPad device as comm (communication) tool. Going to put in house as an elective activity."</p> <p>There was no documentation in client #4's record indicating the facility revised client #4's plan to include the use of his new communication device.</p> <p>On 12/2/15 at 12:56 PM, the Nurse Manager (NM) indicated he was not sure if client #4's training objective was updated to include his new device. The NM indicated the social worker had been working with client #4. The NM indicated if there was a program on the device for client #4 to use, his training objective needed to be updated to reflect the change.</p> <p>On 12/1/15 at 2:36 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the team was trying to decide if the device was going to work for client #4. The QIDP indicated client #4 did not have a goal for his new device.</p>			

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W 0249 Bldg. 00	<p>The QIDP indicated a new goal should have been developed</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to implement client #1's plan for restricting access to the kitchen when staff was not present as written.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/30/15 from 3:41 PM to 6:22 PM and 12/1/15 from 6:03 AM to 8:07 AM. On 11/30/15 at 4:37 PM while staff #3 and client #3 were in the kitchen preparing dinner, the kitchen door was closed and locked. At 4:46 PM, staff #3 and client #3 were in the kitchen preparing dinner with the kitchen door closed and locked. At 4:52 PM, staff #3</p>	W 0249	<p>W 249 PROGRAM IMPLEMENTATION (standard)</p> <p>Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID KZP911 will be fully implemented, including the following specifics: How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Facility staff trained to implement client #1's plan for restricting access to the kitchen when staff was not present as written. Additionally staff trained to keep door unlocked when staff were in the kitchen. Client #5</p>	01/01/2016

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	<p>and client #3 were in the kitchen preparing dinner with the kitchen door closed and locked. On 12/1/15 at 7:52 AM with the Qualified Intellectual Disabilities Professional (QIDP) and staff #8 present in the dining room and kitchen, the kitchen door was closed and locked. Client #5 attempted to enter the kitchen however the door was locked. The QIDP stated to client #5, "Here's the secret code to the door" and the QIDP reached through the opening to the kitchen and opened the locked door. At 7:53 AM, client #5 attempted to open the kitchen door by reaching through the window however he could not open the kitchen door. The QIDP reached through the opening into the kitchen and opened the door for client #5. This affected clients #1, #2, #3, #4 and #5.</p> <p>On 11/30/15 at 4:52 PM, staff #3 indicated she was not sure why the kitchen door was locked. Staff #3 stated, "It's always been like that." Staff #3 indicated she did not know the purpose of the kitchen door being locked.</p> <p>On 12/1/15 at 12:27 PM, a review of client #1's record was conducted. Client #1's Human Rights Approval form, dated 8/17/15, indicated the kitchen door was locked when staff was not in the kitchen. The form indicated the restriction was in</p>		<p>was assessed (documented on weekly visit) by QIDP and determined capable of accessing kitchen when door was locked when staff were not present in kitchen. How corrective actions will be monitored to ensure no recurrence Weekly visits will be completed (at least twice weekly through February to reinforce initial compliance) and documented (online tracking) by QIDP to ensure clients' programs are implemented. Active treatment will be monitored during these visits to ensure the clients involvement with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast. These visits are then electronically reviewed by agency Director of supported group living to monitor compliance. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The</p>	

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	<p>place for client #1. The Rationale section indicated, "One [name of group home] resident displays unsafe behavior in the kitchen, including touching hot stove or oven, putting hand in garbage disposal, using knives and other appliances inappropriately, etc. This behavior could result in serious burns, cuts, and dismemberment to the resident if he is allowed in the kitchen without supervision. This resident also demonstrates PICA (ingesting non-nutritive items) behavior. This client needs to be directly supervised in the kitchen. Therefore, for the safety of residents, the kitchen door is locked when staff are not in the kitchen and at-risk clients are present... All the other residents of [name of group home] are able to open the door when they want to be in the kitchen. Residents will have supervised access to the kitchen when they want food, drink or the ability to cook, and will be able to access the kitchen with a key provided by staff... Progress: This resident has not made significant progress toward the goal of kitchen safety. This restriction will remain in place at this time and will be reviewed in 1 year."</p> <p>On 12/2/15 at 2:27 PM, the QIDP indicated client #1's plan should be implemented as written. The QIDP</p>		<p>SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p>	

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W 0322 Bldg. 00	<p>indicated the kitchen door should not be locked when staff was in the kitchen.</p> <p>On 12/1/15 at 11:14 AM, the Social Worker (SW) indicated the kitchen door should only be locked when staff was not present. The SW indicated if the staff was locking the door when staff was in the kitchen, the plan was not implemented as written.</p> <p>9-3-4(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure client #3 had an annual physical.</p> <p>Findings include:</p> <p>On 12/1/15 at 2:11 PM, a review of client #3's record was conducted. Client #3's most recent annual physical was conducted on 11/6/14. The Stone Belt Outside Services Report indicated in the Follow-up for this problem section, "1 year." There was no documentation in</p>	W 0322	<p>W 322 PHYSICIAN SERVICES (standard) Corrective action for resident(s) found to have been affected Client#3 obtained annual physical. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP trained to ensure that facility obtains preventive and general medical care. Day aide (medical coordinator) trained to</p>	01/01/2016

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	<p>client #3's record indicating client #3 had an annual physical since 11/6/14.</p> <p>On 12/2/15 at 1:04 PM, the Nurse Manager (NM) stated client #3's annual physical was "out of date." The NM indicated he spoke to the group home's Medical Coordinator to schedule client #3's annual physical. The NM stated client #3's annual physical "fell through the cracks."</p> <p>On 12/2/15 at 2:33 PM, the Qualified Intellectual Disabilities Professional indicated client #3 should have a physical annually.</p> <p>9-3-6(a)</p>		<p>ensure annual physicals are scheduled within 365 days of the previous annual physical. How corrective actions will be monitored to ensure no recurrence Quarterly internal inspections will be completed per schedule assigned by agency. Following inspections they will be reviewed by facility director of supported group living to ensure that clients' programs are integrated and coordinated. Internal inspections will include a review of quarterly evacuation drills to ensure that they are completed for each shift and are conducted at varied conditions and times. Additionally, checklist will monitor each client received annual physicals or as recommended by physician. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to</p>	

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W 0323 Bldg. 00	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure client #3 had a vision evaluation in the timeframe recommended by the optometrist.</p> <p>Findings include:</p> <p>On 12/1/15 at 2:11 PM, a review of client #3's record was conducted. On 11/11/14, client #3 had a vision appointment. The Diagnosis/Results section of the Stone Belt Outside Services Report indicated, in part, "Hyperopia (farsighted)." The Treatment/Tests Ordered section indicated, "Wear glasses F/T (full time)." The Follow-up for this problems section indicated, "1 yr (year)." There was no documentation in client #3's record</p>	W 0323	<p>eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p> <p>W 323 PHYSICIAN SERVICES Correctiveaction for resident(s) found to have been affected Client#3 physical and necessary vison and dental appointments completed or scheduled for next available appointment. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measuresor systemic changes facility put in place to ensure no recurrence Annual appointments for client #3 have been completed. QIDP trained to ensure that facility obtains preventive and general medical care. Day aide (medical coordinator) trained to ensure annual physicals including an evaluation of vision and hearing,</p>	01/01/2016

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	<p>indicating he had a follow-up appointment since the appointment on 11/11/14.</p> <p>On 12/2/15 at 2:34 PM, the Qualified Intellectual Disabilities Professional indicated client #3 should have had a follow-up appointment in the timeframe indicated by the optometrist.</p> <p>On 12/2/15 at 1:01 PM, the Nurse Manager indicated client #3 should have had a follow-up appointment in the timeframe indicated by the optometrist.</p> <p>9-3-6(a)</p>		<p>unless stated otherwise by physician, are scheduled within 365 days of previous annual physical. How corrective actions will be monitored to ensure no recurrence</p> <p>Quarterly internal inspections will be completed per schedule assigned by agency. Following inspections they will be reviewed by facility director of supported group living to ensure that clients' programs are integrated, coordinated, and monitored. Internal inspections will also review that quarterly evacuation drills are completed for each shift of personnel conducted at varied conditions and times. Additionally checklist will monitor each client received annual physicals, including evaluation of vision and hearing, or as recommended by physician. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation</p>		

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W 0440 Bldg. 00	<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 4 of 5 clients living in the group home (#1, #2, #3 and #4), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p> <p>On 11/30/15 at 11:29 AM, a review of the facility's evacuation drills was conducted and indicated the following: During the day shift (6:00 AM to 2:00 PM), the facility failed to conduct evacuation drills from 11/30/14 to 4/13/15. During the evening shift (2:00 PM to 10:00 PM), the facility failed to conduct evacuation drills from 5/18/15 to 10/28/15. This affected clients #1, #2, #3 and #4 (client #5 was admitted to the group home on 11/30/15).</p>	W 0440	<p>in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p> <p>W440 Evacuation drills (standard) Corrective action for resident(s) found to have been affected Successful drills completed for each shift, at varied conditions, with scheduled staff. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Monitoring of plan implementation and staff training will be conducted as outlined above. How corrective actions will be monitored to ensure no recurrence QIDP will review and sign off on each drill to ensure that one evacuation drill is completed per shift per quarter, at varied conditions, with scheduled staff. Stone Belt has assigned</p>	01/01/2016

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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W 0441 Bldg. 00	<p>On 11/30/15 at 1:33 PM, the Qualified Intellectual Disabilities Professional indicated the facility should conduct one evacuation per shift per quarter.</p> <p>On 11/30/15 at 2:28 PM, the Organizational Effectiveness Coordinator indicated the facility should conduct one evacuation per shift per quarter.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview for 4 of 5 clients living in the group home (#1, #2, #3 and #4), the facility failed to conduct evacuation drills under varied conditions.</p>	W 0441	<p>a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p> <p>W441 Evacuation drills (standard) Corrective action for resident(s) found to have been affected Successful drills completed for each shift, at varied conditions, with scheduled staff. How facility will identify other</p>	01/01/2016

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	<p>Findings include:</p> <p>On 11/30/15 at 11:29 AM, a review of the facility's evacuation drills was conducted and indicated the following:</p> <ul style="list-style-type: none"> -On 6/21/15 at 10:15 PM, the group home had an evacuation drill (fire) with 2 staff present. -On 6/29/15 at 11:30 PM, the group home had an evacuation drill (fire) with 2 staff present. -On 9/23/15 at 5:50 AM, the group home had an evacuation drill (fire) with 2 staff present. <p>This affected clients #1, #2, #3 and #4.</p> <p>On 12/2/15 at 2:19 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the group home had one overnight staff (10:00 PM to 6:00 AM) since February 2015 after a former client moved out of the group home. The QIDP indicated the facility should conduct overnight evacuation drills (10:00 PM to 6:00 AM) with one staff.</p> <p>9-3-7(a)</p>		<p>residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Monitoring of plan implementation and staff training will be conducted as outlined above. How corrective actions will be monitored to ensure no recurrence QIDP will review and sign off on each drill to ensure that one evacuation drill is completed per shift per quarter, at varied conditions, with scheduled staff.</p> <p>Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home,</p>		

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W 0488 Bldg. 00	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure the clients were involved with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/30/15 from 3:41 PM to 6:22 PM and 12/1/15 from 6:03 AM to 8:07 AM. On 11/30/15 at 4:00 PM, staff #3 returned to the group home after going grocery shopping. Clients #1, #2 and #5 were at the group home when she returned from shopping and were available to go grocery shopping. Staff #3 carried the groceries into the group home without requesting assistance from clients #1, #2 and #5. At 4:07 PM, staff #3 put away the groceries without clients</p>	W 0488	<p>which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p> <p>W488 Dining area services (standard) Corrective action for resident(s) found to have been affected Staff will encourage clients to be involved with grocery shopping, serving themselves during snack, packing their own lunches, and preparing breakfast. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Monitoring of plan implementation and staff training will be conducted as outlined above. How corrective actions will be monitored to ensure no recurrence Monthly quality assurance checklist will be completed by facility QIDP to ensure clients' programs are implemented. These checklist are due to facility director of supported group living by 10th of</p>	01/01/2016	

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	<p>#1, #2 and #5 being asked to assist. At 4:10 PM, staff #3 put animal crackers into 5 bowls for clients #1, #2, #3, #4 and #5. None of the clients was asked to assist staff #3. At 4:37 PM, staff #3 asked client #4 if he wanted a drink. Staff #3 poured client #4's drink for him. On 12/1/15 at 6:03 AM upon arrival to the group home, there were 4 plates on the kitchen counter with a waffle and egg. Client #2 was sitting at the dining room table eating his breakfast. At 7:28 AM, staff #8 told staff #6 he made the clients' lunches during the overnight shift. Staff #8 indicated he did not make a lunch for client #5 due to forgetting to make one for client #5 since client #5 just moved in (on 11/30/15). At 7:32 AM, staff #8 gave client #1 a plate with the egg and waffle from the counter. Client #1 refused to eat.</p> <p>On 12/1/15 at 7:43 AM, staff #8 indicated he made the clients' breakfast. Staff #8 stated it was "hard to cook breakfast with 2 staff and [client #1] being staffed 1:1 (one on one)."</p> <p>On 12/2/15 at 1:58 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients should be involved with grocery shopping. The QIDP stated, "They go periodically but need to be more involved." At 2:03 PM,</p>		<p>the each month for review. Weekly visits will be completed (at least twice weekly through February to reinforce initial compliance) and documented (online tracking) by QIDP to ensure clients' programs are integrated, coordinated, and monitored. Active treatment will be monitored during these visits to ensure the clients involvement with grocery shopping, serving themselves during snack, packing their own lunches and preparing breakfast. These visits are then electronically reviewed by agency Director of supported group living to monitor compliance. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home,</p>	

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W 9999 Bldg. 00	<p>the QIDP indicated the clients needed to be involved with breakfast preparation. The QIDP indicated none of the clients was involved with preparing their breakfast. At 2:07 PM, the QIDP indicated the clients should prepare their own lunches the night before during the evening shift (2:00 PM to 10:00 PM).</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met:</p> <p>1) 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)</p>	W 9999	<p>which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p> <p>W9999 Final Observations Corrective action for resident(s) found to have been affected Staff #3 obtained annual TB Mantoux test. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Monitoring of plan implementation and staff training will be conducted as outlined above. How corrective actions will be monitored to ensure no recurrence Monthly quality assurance checklist will be completed by facility QIDP that will include HR file review and annual TB Mantoux screening.</p>	01/01/2016			

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	<p>millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (staff #3), the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>On 11/30/15 at 1:34 PM a review of the facility's employee files was conducted. Staff #3's employee file did not contain documentation of a TB test being conducted since she was hired on 7/14/14.</p> <p>On 11/30/15 at 3:08 PM, the Nurse Manager (NM) sent the following information in an email to the surveyor, "I don't have a copy of [staff #3's] tb test (recent or new hire). Unless one of the other nurses who no longer work here gave her one, I don't have her's on file."</p>		<p>These checklists are due to facility director of supported group living by 10th of the each month for review. Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than one visit per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.</p>	

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	<p>On 11/30/15 at 2:34 PM, the Organizational Effectiveness Coordinator (OEC) indicated staff #3 should have an annual TB test. The OEC indicated there was no documentation staff #3 had a TB test since she was hired.</p> <p>On 12/2/15 at 1:04 PM, the NM indicated he was unable to locate documentation staff #3 had a TB test since she was hired. The NM indicated he gave staff #3 a TB test on 11/30/15. The NM indicated staff #3 told him she had a TB test when she was hired however he could not locate the documentation. The NM indicated staff was to have a TB upon hire and annually thereafter.</p> <p>On 12/2/15 at 1:56 PM, the Qualified Intellectual Disabilities Professional indicated staff should have an annual TB test.</p> <p>9-3-3(e)</p>				