STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G637	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	214 E SOUTHERN DR BLOOMINGTON, IN 47401

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W000000	This visit was for the investigation of complaint #IN00149539. Complaint #IN00149539 - Substantiated. Federal/state deficiency related to the allegation is cited at W149. Unrelated deficiencies cited. Survey Dates: June 5 and 6, 2014 Facility Number: 001210 Provider Number: 15G637 AIM Number: 100240200 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/12/14 by Ruth Shackelford, QIDP.	W000000		
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 16 incident/investigative reports reviewed affecting clients C, D and E, the	W000149	Plan of Correction: Item1) Staff #7 resigned from the agency rather than receive disciplinaryaction. Item 2) Staff who failed toprotect client C	06/24/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	facility neglected to implement its policies and procedures to prevent client to client abuse, investigate an incident of client to client abuse at the facility-operated workshop, investigate an incident in which a client fell off the wheelchair lift and ensure corrective actions were implemented related to a client in a wheelchair falling off the van lift. Findings include: A review of the facility's incident/investigative reports was conducted on 6/5/14 at 12:11 PM and indicated the following: 1) On 5/17/14 at 3:30 PM, the facility's Bureau of Developmental Disabilities Services report, dated 5/18/14, indicated, in part, "[Staff #7] was being trained with the ladies of [name of group home]. We were almost done with her training sheet, and she was sitting on the couch talking with staff (#8). [Staff #7] spoke liberally about other clients not at [name of group home], she spoke the same way about other staff she didn't like. She was talking this way to staff and in front of the clients here. [Staff #7] compared the clients here at [name of group home] to her dog. She was instigating fights between [client E] and [client D]. She		from client E's aggression received training on preventingclient E from injuring others in her vicinity when she is upset. Attachment #1.Item 3) Supervising staff who failed to investigate peer aggression receivedtraining on completing an investigation when there is client to client aggression.Attachment #2 Item 4) FacilityCoordinator has received training on conducting an inquiry when there is clientinjury and correcting known problems; on using an agency training roster todocument all training of staff. Facilitystaff #5 and all members of the facilitystaff were trained on the safe and appropriate use of the facility's van lift. Attachment #3 and Attachment #4. Item 5) The SGLDirector reviewed W149 regulations, the agency's investigation protocols andthe agency's client to client aggression report forms with the Life LongLearning Director. The two directorsbrought the issue of investigations to the Quality Assurance Team for reviewand revision. The agency is revising itsIncident Reporting procedure and its investigation protocols to include clearerand more inclusive guidelines about incidents that requireinvestigations/follow up/ remediation plans etc. See Attachment #5. Date of Completion6/24/2014 Plan of Prevention: The agency directors have formed a teamto review the incident reporting and investigation procedures and to	

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	was not engaging the clients in an appropriate way. Staff tried explaining things she could do to get involved with the clients. Staff specifically heard [staff #7] tell [client E] that she (staff #7) was the staff and [client E] needed to listen to her. Staff (#5) came into the room and told [staff #7] that this was [client E's] house and whether or not she liked it [client E] could do as she pleases. [Client E] told [staff #7] to leave and go home, [staff #7] said 'if I could I would.' Staff (#5) then said she could leave and that staff (#5) could handle the rest of the night without her. Staff (#5) then contacted [House Manager], the house manager for [name of group home], and told her what was happening. [House manager] said that she would contact the Pager. About 15 minutes later staff (#5) received a call from [name] (SGL (Supported Group Living) Director). Staff explained the situation to [SGL Director]. [SGL Director] asked if staff (#5) would be okay alone at the site and staff (#5) was fine with this." The investigation, dated 5/23/14, indicated, in part, "Due to the lack of firm, corroborated evidence, this investigation into allegations of verbal/emotional abuse against staff member [staff #7] must be deemed inconclusive. However, it is clear that		expand theuse of the electronic incident reporting system in order to know and respondmore timely to allegations of A/N/E, incidents involving client injury and to meetthe regulatory standards and timeframes for incidents. Quality Assurance Monitoring: The group home internal audit will be revisedto reflect all of the required elements of an incident report. The QA team process will be revised toinclude a review of all ISDH surveys; a review and report of all SGL A/N/Einvestigations by third party QA team member and the QA team will recommend andmonitor corrective actions.	

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	[staff #7] did not adhere to the standards of practice defined by Stone Belt in the RIGHT Way training during her shifts a [name of group home], and probably also during her previous shifts at various SLP (Supported Living Program) sites. It has also been proven that [staff #7] offered false testimony at least once during this investigation." The Corrective Action section indicated, "[Staff #7] will receive a Performance Review by supervisor, [name of supervisor], 5/29/14. [Staff #7] will begin a 90 day probationary period under supervision of QIDP (Qualified Intellectual Disabilities Professional), [name of QIDP]. [Staff #7's] work schedule will be focused on QIDP's team to ensure close supervision and she will have regular supervision with site manager. [Staff #7] will receive retraining on RIGHT Way, Positive Behavior Support and Boundaries." The investigation indicated, "The staff (#7) resigned on 5/29/14, none of the above corrective action will be implemented." On 6/5/14 at 5:17 PM, staff #5 indicated client E and staff #7 did not get along. Staff #7 was inappropriate during the shift. Staff #5 indicated this was the first and only shift staff #7 worked at the group home. Staff #5 indicated staff #7 complained about other staff and other work sites all day. Staff #5 stated the			

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	staff training staff #7 were "trying to give her (staff #7) the benefit of the doubt" by continuing to work with her during the shift. Staff #5 indicated she contacted the House Manager (HM), the HM contacted the pager, and then the Director called staff #5. Staff #5 indicated she explained the situation to the Director. The Director spoke to staff #7 and sent her home. 2) On 5/25/14 at 8:00 AM, client E threw a set of keys at client C hitting client C's stomach. On 6/6/14 at 2:08 PM, the interim Director of Supported Group Living (SGL) indicated the incident would be considered abuse. The Director indicated the facility should prevent abuse. The Director indicated the facility had a policy and procedure prohibiting abuse. On 6/6/14 at 2:11 PM, the Coordinator indicated the staff indicated prior to the incident client E was upset and should not have left her keys in client E's vicinity. The Coordinator indicated client to client was considered abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy and procedure prohibiting abuse. 3) On 5/1/14 at 9:55 AM at the			

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	facility-operated workshop, client E was in the restroom with a female peer. Client E was wearing a latex glove. Her supervisor had requested she take the glove off to wash her hands. Staff heard someone yelling in the bathroom. Client E was pulling on the female peer's neck. Staff intervened. The female peer reported she asked client E to take off her glove several times which "angered" client E. Client E smacked the female peer two times. The facility failed to conduct an investigation into the incident. On 6/6/14 at 2:08 PM, the interim Director of Supported Group Living (SGL) indicated the incident would be considered abuse. The Director indicated the facility should prevent abuse. The Director indicated the facility had a policy and procedure prohibiting abuse. The Director indicated the incident should have been investigated. On 6/6/14 at 2:11 PM, the Coordinator indicated the staff indicated client to client aggression was considered abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy and procedure prohibiting abuse. The Coordinator indicated the incident should have been investigated.			

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	4) On 3/25/14 at 4:30 PM, the BDDS report, dated 3/26/14, indicated, "[Client C] began rolling back before staff prompted her to. [Client C] did not see that the list (lift) was not up. Staff prompted [client C] multiple times to stop, and she did not stop. [Client C] fell backwards off the van. She landed on top of the lift, on her back, and bumped her head. [Client C] was wearing her head gear. [Client C] had a headache, pinched her arm in her wheelchair, and reported her leg hurt, and her back was sore. [Client C] was administered 200mg (milligrams) ibuprofen for her headache and pain. [Client C] was assed (sic) by a Stone Belt nurse, and appeared fine. [Client C] went to a walk-in clinic this morning since her PCP (primary care physician) had no openings for her to be seen. She was seen in the walk in clinic by a Nurse Practitioner, [name]. The Nurse Practitioner did a thorough exam of [client C] and had no concerns. [Client C] sustained bruising to her upper thighs and right elbow from the fall. The Nurse Practitioner stated that [client C] could take over the counter pain medications (ibuprofen) if she was having any pain. There is no follow up necessary. The staff member what was with [client C] during the incident received retraining from the Program Coordinator, immediately following the			

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	incident, on not unlatching any wheelchair until the lift is in the upright position. All staff will be retrained on wheelchair lift safety at the next house meeting. [Client C] had no further complaints and was in a jovial mood following the incident and appointment with the Nurse Practitioner. Staff will continue to follow all plans to ensure [client C's] safety." The facility did not conduct an investigation into the incident. The facility did not have documentation indicating the staff (#5) who was supervising client C at the time received retraining. The facility did not have documentation all staff received retraining on wheelchair lift safety. A review of staff #5's employee file was conducted on 6/5/14 at 1:28 PM. There was no documentation in staff #5's employee file indicating she received retraining from the Program Coordinator. The Nursing Consultation note, dated 3/25/14 at 5:00 PM, indicated, in part, "House nurse notified this nurse that [client C], while in her wheelchair being unloaded from the van at her house, lost her balance on the van lift causing possible injury. Nurse went to [name of house] to assess [client C], assessment as			

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	follows: [Client C] noted to have a reddish/blue bruise on her right arm just above the outside of her elbow, size of bruise at the time of assessment is (approximately) 2 1/2 (inches) in circumference. [Client C] at this time has full range of motion in her right arm, is able to bend her arm at the elbow without difficulty - did state that is was 'sore.' Per staff report, [client C] was in her wheelchair on the van lift being lowered to the ground - once the lift stopped [client C] started to move the wheelchair, lost her balance causing the wheelchair to fold, which subsequently pinched her right arm. [Client C] also stated to staff that she hit the right side of her head on the van door ([client C] had her helmet on for protection). [Client C's] head was examined, no bruising or swelling was noted upon inspection, was alert/oriented x 3, PERL (pupils equal (i.e. in size & shape) and reactive to light), no signs/symptoms of concussion noted at this time." On 6/5/14 at 1:47 PM, the Coordinator indicated she retrained staff #5 at the time of the incident verbally. The Coordinator indicated she did not have documentation staff #5 was retrained. The Coordinator indicated her training consisted of telling staff #5 to ensure the lift was not down when a client's			

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	wheelchair was unstrapped. On 6/5/14 at 1:50 PM, the Human Resources Director (HRD) stated, "If it's not documented it didn't happen." The HRD indicated the Coordinator should have documented the training in writing. The HRD indicated there was a coaching and mentoring form the supervisor could fill out to address issues. The HRD stated, "Need to have documented proof." The HRD indicated it did not seem like there was documented proof the incident was addressed with training after reviewing staff #5's employee file. After searching the facility's training database on her computer, the HRD indicated there was no documentation the group home staff were retrained on wheelchair lift safety. On 6/5/14 at 4:13 PM, the Coordinator indicated she was at the group home but was inside at the time of the incident. The Coordinator indicated client B rang the doorbell to let the Coordinator know client C and staff #5 needed help. The Coordinator indicated staff #5 had unlatched the wheelchair straps in the van for clients A and C prior to the incident. Client A unloaded first. While the lift was down, client C backed up and fell out of the van. The Coordinator indicated at the time of the incident the			

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	lift was about halfway up when client C fell out. Client C's wheelchair tipped over and then fell off the lift and onto the ground. The Coordinator indicated staff #5 prompted client C to stop moving backward prior to falling out of the van. The Coordinator indicated she did not conduct an investigation but spoke with client C and staff #5. The Coordinator indicated client B witnessed the incident and the Coordinator spoke with her briefly but did not interview client B. The Coordinator indicated she did not have documentation of her interviews with staff #5 and clients B and C. The Coordinator indicated she was unable to locate documentation indicating the group home staff received training on wheelchair lift safety. On 6/5/14 at 4:27 PM, staff #5 indicated when the incident occurred, the lift was on the ground when client C backed up and fell out of the van. Staff #5 indicated client C landed on her back. Staff #5 stated the Coordinator "suggested" not unstrapping the wheelchair straps for client C until client A was out of the van and the lift was back up. Staff #5 indicated she did not receive retraining after the incident. Staff #5 could not recall if wheelchair lift safety was discussed following the incident during a house meeting.			

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	On 6/5/14 at 4:31 PM, client B indicated she observed client C fall out of the van. Client B indicated client C did not know the lift was on the ground. Client C backed up when the lift was down and fell out backwards. Client B indicated staff #5 told client C not to back up but client C backed up anyway. Client B indicated the lift was on the ground when client C fell out. Client B indicated she was not sure how client C landed. Client B indicated she ran for help. On 6/6/14 at 2:08 PM, the interim Director of Supported Group Living (SGL) indicated the incident should have been investigated. The Director indicated there should be documentation indicating staff #5 as well as the group home staff received retraining. The Director indicated the Coordinator should document every time teaching and training was provided to staff. 5) On 2/4/14 at 9:10 AM at the facility-operated day program, client E was yelling at a male peer. The male peer yelled back. Client E hit the male peer who then hit client E. Client E threw a water bottle hitting a female peer in the head. On 6/6/14 at 2:08 PM, the interim Director of Supported Group Living			

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	(SGL) indicated the incident would be considered abuse. The Director indicated the facility should prevent abuse. The Director indicated the facility had a policy and procedure prohibiting abuse. On 6/6/14 at 2:11 PM, the Coordinator indicated the staff indicated client to client aggression was considered abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy and procedure prohibiting abuse. On 6/5/14 at 12:20 PM, a review of the facility's policies and procedures was conducted. The policy, dated 9/2014, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt ' s emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are			

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	detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law. Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over client support; misuse of client or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct. This does not replace the obligation of employees to report immediately to supervisors, directors or to write incident reports. This provides for another level of notification beyond, and in addition to, incident reporting. The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR (Intermediate Care Facilities/Mental Retardation) regulations including completion of all investigations within 5 working days. Investigations involving clients in SLP (Supported Living Program) residences are to be completed within 10 days. Investigations			

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	must be started within 24 hours. There are several types of Inquiries: CLIENT TO CLIENT AGGRESSION - The director or designee will complete a Client to Client Aggression Inquiry for any incidents of client to client aggression. In the event that the information gathered in the report indicates the possibility of abuse or neglect the director will be notified immediately. The director will assure that a referral for an investigation is made to the social worker." This federal tag relates to complaint #IN00149539. 9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 16 incident/investigative reports reviewed affecting clients C and E, the facility failed to investigate an incident of client to client abuse at the facility-operated workshop affecting client E and an incident in which a client C fell off the wheelchair lift. Findings include:	W000154	See W 149 and attachments	06/24/2014

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	A review of the facility's incident/investigative reports was conducted on 6/5/14 at 12:11 PM and indicated the following: 1) On 5/1/14 at 9:55 AM at the facility-operated workshop, client E was in the restroom with a female peer. Client E was wearing a latex glove. Her supervisor had requested she take the glove off to wash her hands. Staff heard someone yelling in the bathroom. Client E was pulling on the female peer's neck. Staff intervened. The female peer reported she asked client E to take off her glove several times which "angered" client E. Client E smacked the female peer two times. The facility failed to conduct an investigation into the incident. On 6/6/14 at 2:08 PM, the interim Director of Supported Group Living (SGL) indicated the incident would be considered abuse. The Director indicated the facility should prevent abuse. The Director indicated the facility had a policy and procedure prohibiting abuse. The Director indicated the incident should have been investigated. On 6/6/14 at 2:11 PM, the Coordinator indicated the staff indicated client to			

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	client aggression was considered abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy and procedure prohibiting abuse. The Coordinator indicated the incident should have been investigated. 2) On 3/25/14 at 4:30 PM, the BDDS report, dated 3/26/14, indicated, "[Client C] began rolling back before staff prompted her to. [Client C] did not see that the list (lift) was not up. Staff prompted [client C] multiple times to stop, and she did not stop. [Client C] fell backwards off the van. She landed on top of the lift, on her back, and bumped her head. [Client C] was wearing her head gear. [Client C] had a headache, pinched her arm in her wheelchair, and reported her leg hurt, and her back was sore. [Client C] was administered 200mg (milligrams) ibuprofen for her headache and pain. [Client C] was assed (sic) by a Stone Belt nurse, and appeared fine. [Client C] went to a walk-in clinic this morning since her PCP (primary care physician) had no openings for her to be seen. She was seen in the walk in clinic by a Nurse Practitioner, [name]. The Nurse Practitioner did a thorough exam of [client C] and had no concerns. [Client C] sustained bruising to her upper thighs and right elbow from the fall. The Nurse Practitioner stated that [client C]			

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	could take over the counter pain medications (ibuprofen) if she was having any pain. There is no follow up necessary. The staff member what was with [client C] during the incident received retraining from the Program Coordinator, immediately following the incident, on not unlatching any wheelchair until the lift is in the upright position. All staff will be retrained on wheelchair lift safety at the next house meeting. [Client C] had no further complaints and was in a jovial mood following the incident and appointment with the Nurse Practitioner. Staff will continue to follow all plans to ensure [client C's] safety." The facility did not conduct an investigation into the incident. The Nursing Consultation note, dated 3/25/14 at 5:00 PM, indicated, in part, "House nurse notified this nurse that [client C], while in her wheelchair being unloaded from the van at her house, lost her balance on the van lift causing possible injury. Nurse went to [name of house] to assess [client C], assessment as follows: [Client C] noted to have a reddish/blue bruise on her right arm just above the outside of her elbow, size of bruise at the time of assessment is (approximately) 2 1/2 (inches) in circumference. [Client C] at this time			

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	has full range of motion in her right arm, is able to bend her arm at the elbow without difficulty - did state that is was 'sore.' Per staff report, [client C] was in her wheelchair on the van lift being lowered to the ground - once the lift stopped [client C] started to move the wheelchair, lost her balance causing the wheelchair to fold, which subsequently pinched her right arm. [Client C] also stated to staff that she hit the right side of her head on the van door ([client C] had her helmet on for protection). [Client C's] head was examined, no bruising or swelling was noted upon inspection, was alert/oriented x 3, PERL (pupils equal (i.e. in size & shape) and reactive to light), no signs/symptoms of concussion noted at this time." On 6/5/14 at 1:47 PM, the Coordinator indicated she retrained staff #5 at the time of the incident verbally. The Coordinator indicated she did not have documentation staff #5 was retrained. The Coordinator indicated her training consisted of telling staff #5 to ensure the lift was not down when a client's wheelchair was unstrapped. On 6/5/14 at 1:50 PM, the Human Resources Director (HRD) stated, "If it's not documented it didn't happen." The HRD indicated the Coordinator should			

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	have documented the training in writing. The HRD indicated there was a coaching and mentoring form the supervisor could fill out to address issues. The HRD stated, "Need to have documented proof." The HRD indicated it did not seem like there was documented proof the incident was addressed with training after reviewing staff #5's employee file. After searching the facility's training database on her computer, the HRD indicated there was no documentation the group home staff were retrained on wheelchair lift safety. On 6/5/14 at 4:13 PM, the Coordinator indicated she was at the group home but was inside at the time of the incident. The Coordinator indicated client B rang the doorbell to let the Coordinator know client C and staff #5 needed help. The Coordinator indicated staff #5 had unlatched the wheelchair straps in the van for clients A and C prior to the incident. Client A unloaded first. While the lift was down, client C backed up and fell out of the van. The Coordinator indicated at the time of the incident the lift was about halfway up when client C fell out. Client C's wheelchair tipped over and then fell off the lift and onto the ground. The Coordinator indicated staff #5 prompted client C to stop moving backward prior to falling out of the van.			

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	The Coordinator indicated she did not conduct an investigation but spoke with client C and staff #5. The Coordinator indicated client B witnessed the incident and the Coordinator spoke with her briefly but did not interview client B. The Coordinator indicated she did not have documentation of her interviews with staff #5 and clients B and C. The Coordinator indicated she was unable to locate documentation indicating the group home staff received training on wheelchair lift safety. On 6/5/14 at 4:27 PM, staff #5 indicated when the incident occurred, the lift was on the ground when client C backed up and fell out of the van. Staff #5 indicated client C landed on her back. Staff #5 stated the Coordinator "suggested" not unstrapping the wheelchair straps for client C until client A was out of the van and the lift was back up. Staff #5 indicated she did not receive retraining after the incident. Staff #5 could not recall if wheelchair lift safety was discussed following the incident during a house meeting. On 6/5/14 at 4:31 PM, client B indicated she observed client C fall out of the van. Client B indicated client C did not know the lift was on the ground. Client C backed up when the lift was down and			

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	fell out backwards. Client B indicated staff #5 told client C not to back up but client C backed up anyway. Client B indicated the lift was on the ground when client C fell out. Client B indicated she was not sure how client C landed. Client B indicated she ran for help. On 6/6/14 at 2:08 PM, the interim Director of Supported Group Living (SGL) indicated the incident should have been investigated. 9-3-2(a)			
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 16 incident reports reviewed affecting client C, the facility failed to implement corrective actions to address an incident involving client C falling out of the back of the van in her wheelchair. Findings include: A review of the facility's incident/investigative reports was conducted on 6/5/14 at 12:11 PM and indicated the following: On 3/25/14 at	W000157	Plan of Correction: FacilityCoordinator has received training on conducting an inquiry when there is clientinjury and correcting known problems; on using an agency training roster todocument all training of staff. Facilitystaff #5 and all members of the facilitystaff were trained on the safe and appropriate use of the facility's van lift. Attachment #3 and Attachment #4. Plan of Prevention: The agency directors haveformed a team to review the incident reporting and investigation procedures andto expand the use of the electronic	06/24/2014

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	4:30 PM, the BDDS report, dated 3/26/14, indicated, "[Client C] began rolling back before staff prompted her to. [Client C] did not see that the list (lift) was not up. Staff prompted [client C] multiple times to stop, and she did not stop. [Client C] fell backwards off the van. She landed on top of the lift, on her back, and bumped her head. [Client C] was wearing her head gear. [Client C] had a headache, pinched her arm in her wheelchair, and reported her leg hurt, and her back was sore. [Client C] was administered 200mg (milligrams) ibuprofen for her headache and pain. [Client C] was assed (sic) by a Stone Belt nurse, and appeared fine. [Client C] went to a walk-in clinic this morning since her PCP (primary care physician) had no openings for her to be seen. She was seen in the walk in clinic by a Nurse Practitioner, [name]. The Nurse Practitioner did a thorough exam of [client C] and had no concerns. [Client C] sustained bruising to her upper thighs and right elbow from the fall. The Nurse Practitioner stated that [client C] could take over the counter pain medications (ibuprofen) if she was having any pain. There is no follow up necessary. The staff member what was with [client C] during the incident received retraining from the Program Coordinator, immediately following the incident, on		incident reporting system in order to knowand respond more timely to allegations of A/N/E, incidents involving clientinjury and to meet the regulatory standards and timeframes for incidents. Thefacility coordinator will be trained on all aspects of the agency's revised andexpanded incident reporting procedure. Quality Assurance Monitoring: The group home internal audit will be revisedto reflect all of the required elements of the revised incident reportingprocess. The SGL Director will monitorall facility incidents and follow up reports.	

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	not unlatching any wheelchair until the lift is in the upright position. All staff will be retrained on wheelchair lift safety at the next house meeting. [Client C] had no further complaints and was in a jovial mood following the incident and appointment with the Nurse Practitioner. Staff will continue to follow all plans to ensure [client C's] safety." The facility did not have documentation indicating the staff (#5) who was supervising client C at the time received retraining. The facility did not have documentation all staff received retraining on wheelchair lift safety. A review of staff #5's employee file was conducted on 6/5/14 at 1:28 PM. There was no documentation in staff #5's employee file indicating she received retraining from the Program Coordinator. On 6/5/14 at 1:47 PM, the Coordinator indicated she retrained staff #5 at the time of the incident verbally. The Coordinator indicated she did not have documentation staff #5 was retrained. The Coordinator indicated her training consisted of telling staff #5 to ensure the lift was not down when a client's wheelchair was unstrapped. On 6/5/14 at 1:50 PM, the Human			

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	Resources Director (HRD) stated, "If it's not documented it didn't happen." The HRD indicated the Coordinator should have documented the training in writing. The HRD indicated there was a coaching and mentoring form the supervisor could fill out to address issues. The HRD stated, "Need to have documented proof." The HRD indicated it did not seem like there was documented proof the incident was addressed with training after reviewing staff #5's employee file. After searching the facility's training database on her computer, the HRD indicated there was no documentation the group home staff were retrained on wheelchair lift safety. On 6/5/14 at 4:13 PM, the Coordinator indicated she was unable to locate documentation indicating the group home staff received training on wheelchair lift safety. On 6/6/14 at 2:08 PM, the interim Director of Supported Group Living (SGL) indicated there should be documentation indicating staff #5 as well as the group home staff received retraining. The Director indicated the Coordinator should document every time teaching and training was provided to staff.			

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