

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: September 29, 30, October 1, 2, 5 and 6, 2015</p> <p>Facility Number: 000876 Provider Number: 15G362 AIM Number: 100249160</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/13/15.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for 2 of 4 clients in the sample (#2 and #5), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to implement its policies and procedures to conduct thorough investigations. The governing body failed to ensure an incident of client #5 choking requiring the Heimlich maneuver was investigated. The</p>	W 0102	W 102 483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. 1) Plan of correction: Investigation of client #5"choking" was investigated. Prior QIDP failed to send to Fortis data base investigation is now in Fortis. It was determined that staff acted with good intentions and followed client #5 choking	10/25/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>governing body failed to ensure a thorough investigation was conducted for an allegation of neglect of client #2 falling out of the back of the van in her wheelchair. The governing body failed to ensure a thorough investigation was conducted for a fracture of unknown origin to client #5. The governing body failed to ensure a thorough investigation was conducted for an incident of client #5 eloping from the facility-operated day program. The governing body failed to ensure the results of an investigation were reported to the administrator within 5 working days. The governing body failed to ensure recommended corrective action was implemented after client #2 fell out of the back of the van in her wheelchair causing injury.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 2 of 4 clients in the sample (#2 and #5), the facility's governing body failed to implement its policies and procedure to conduct thorough investigations. The governing body failed to ensure an incident of client #5 choking requiring the Heimlich maneuver was investigated. The governing body failed to ensure a thorough investigation was conducted for an allegation of neglect of client #2 falling out of the back of the van in her</p>		<p>plan. Client #5 choking plan revised (attachment u). Plan of prevention: Facility staff trained on preventing and reporting abuse and neglect (attachment x). QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including choking incidents (attachment a). QIDP is no longer in the QIDP/Coordinator role (attachment j). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). 2) Plan of correction: Investigation of client # 5 "eloping" was investigated and was located in CIR folder. Facility ensured that lifelong learning / day program director investigated incident and signed within 5 business days (attachment d). DSGL will sign investigations, even when another administrator has signed off, within 5 business days (attachment a). Plan of prevention: Facility staff trained on preventing and reporting abuse and neglect (attachment x). QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including elopement of clients (attachment a). Plan of</p>	

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	<p>wheelchair. The governing body failed to ensure a thorough investigation was conducted for a fracture of unknown origin to client #5. The governing body failed to ensure a thorough investigation was conducted for an incident of client #5 eloping from the facility-operated day program. The governing body failed to ensure the results of an investigation were reported to the administrator within 5 working days. The governing body failed to ensure recommended corrective action was implemented after client #2 fell out of the back of the van in her wheelchair causing injury.</p> <p>2) Please refer to W122. For 2 of 4 clients in the sample (#2 and #5), the governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to implement its policies and procedure to conduct thorough investigations. The governing body failed to investigate an incident of client #5 choking requiring the Heimlich maneuver. The governing body failed to thoroughly investigate an allegation of neglect of client #2 falling out of the back of the van in her wheelchair. The governing body failed to thoroughly investigate a fracture of unknown origin to client #5. The governing body failed to thoroughly investigate an incident of client #5</p>		<p>monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). 3) Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant failed to upload to Fortis (attachment e). Recommendation of administrator / DSGL was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). Plan of prevention: Facility staff trained on preventing and reporting abuse and neglect (attachment x). QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation /</p>	

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	<p>eloping from the facility-operated day program. The governing body failed to ensure the results of an investigation were reported to the administrator within 5 working days. The governing body failed to ensure recommended corrective action was implemented after client #2 fell out of the back of the van in her wheelchair causing injury.</p> <p>9-3-1(a)</p>		<p>wheelchair safety (attachment i). Facility staff trained on training goal for client #2 (attachment r). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). House manager / associate manager will provide daily monitoring, each shift, to ensure client plans are followed and client safety (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. 4) Plan of correction: Investigation of client #5 broken arm was investigated following incident and a bqis checklist completed. It was determined that the broken bone was self inflicted and SIB was added to BSP (attachment h). Plan of prevention: Facility staff trained on preventing and reporting abuse and neglect (attachment x). QIDP / coordinators who carry the emergency pager trained on reporting and investigating</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 2 of 4 clients in the sample (#2 and #5), the facility's governing body failed to implement its policies and procedures to conduct thorough investigations. The governing body failed to ensure an incident of client #5 choking requiring the Heimlich maneuver was investigated. The governing body failed to ensure a thorough investigation was conducted for an allegation of neglect of client #2 falling out of the back of the van in her wheelchair. The governing body failed to ensure a thorough investigation was conducted for a fracture of unknown origin to client #5. The governing body failed to ensure a thorough investigation was conducted for an incident of client #5 eloping from the facility-operated day</p>	W 0104	<p>allegation of abuse and neglect, including unknown injuries (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a).</p> <p>W 104 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. 1) A) Plan of correction: Investigation of client #5“choking” was investigated. Prior QIDP failed to send to Fortis data base (attachment b). Staff acted with good intentions and followed client #5 choking plan. Client #5 choking plan revised (attachment u). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including choking incidents (attachment a). QIDP is no longer in the QIDP/Coordinator role (attachment j). Plan of monitoring: Director of supported group living / DSGL will be</p>	10/26/2015

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	<p>program. The governing body failed to ensure the results of an investigation were reported to the administrator within 5 working days. The governing body failed to ensure recommended corrective action was implemented after client #2 fell out of the back of the van in her wheelchair causing injury.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 4 of 18 incident/investigative reports reviewed affecting clients #2 and #5, the governing body neglected to implement its policies and procedures to conduct thorough investigations, ensure the results of an investigation were reported to the administrator within 5 working days and appropriate corrective action was implemented after client #2 fell out of the back of the van in her wheelchair causing injury.</p> <p>2) Please refer to W154. For 4 of 18 investigative reports reviewed affecting clients #2 and #5, the governing body failed to conduct thorough investigations.</p> <p>3) Please refer to W156. For 1 of 18 incident/investigative reports reviewed affecting client #5, the governing body failed to ensure the results of investigations were reported to the</p>		<p>immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). b) Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant failed to upload to Fortis (attachment e). Recommendation of administrator / DSGL was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and</p>	

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	<p>administrator within 5 working days.</p> <p>4) Please refer to W157. For 1 of 18 incident/investigative reports reviewed affecting client #2, the governing body failed to implement corrective action as indicated in an investigation.</p> <p>9-3-1(a)</p>		<p>neglect, including potential neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). House manager / associate manager will provide daily monitoring , each shift, to ensure client plans are followed and client safety (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. C) Plan of correction: Investigation of client # 5 "eloping" was investigated and was located in CIR folder. Facility ensured that lifelong learning / day program director investigated incident and DSGL reviewed and signed within 5 business days (attachment d). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including elopement of clients (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign</p>		

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			<p>an investigator and review outcome and devise recommendations within 5 working days per agency policy (attachment a). D) Plan of correction: Investigation of client #5 broken arm was investigated following incident and a bqis checklist completed. It was determined that the broken bone was self inflicted and SIB was added to BSP. Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including unknown injuries (attachment a). Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents, unknown injuries, and suspected neglect of a client (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). Plan of Monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a).</p> <p>2) A) Plan of correction: Investigation of client #5 "choking" was thoroughly investigated.</p>	

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			<p>Prior QIDP failed to send to Fortis data base (attachment b). Staff acted with good intentions and followed client #5 choking plan. Client #5 choking plan revised to include date of prior "choking" incident (attachment u). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including choking incidents (attachment a). QIDP is no longer in the QIDP/Coordinator role (attachment j). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). Facility nurse will provide weekly mealtime monitoring to ensure dining plans are being followed. Facility QIDP will provide daily mealtime monitoring to ensure dining plans are being followed at day program. House manager or assistance manager will provide daily mealtime monitoring to ensure dining plans are being followed at each mealtime. This monitoring may taper off to weekly monitoring by QIDP (attachment a). b) Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant</p>	

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			<p>failed to upload to Fortis (attachment e). Recommendation of administrator / DSGL was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including potential neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). House manager / associate manager will provide daily monitoring , each shift, to ensure client plans are followed and</p>	

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			<p>client safety (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. C) Plan of correction: Investigation of client # 5 "eloping" was investigated and was located in CIR folder. Facility ensured that lifelong learning / day program director investigated incident and signed within 5 business days (attachment d). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including elopement of clients (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days per agency policy (attachment a). D) Plan of correction: Investigation of client #5 broken arm was investigated following incident and a bqis checklist completed. It was determined that the broken bone was self inflicted and SIB was added to BSP (attachment h).</p>	

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			<p>Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including unknown injuries (attachment a). Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents, unknown injuries, and suspected neglect of a client (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a).</p> <p>Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). 3)</p> <p>Plan of correction: Investigation of client # 5 "eloping" was investigated and was located in CIR folder. Facility ensured that lifelong learning / day program director investigated incident and signed within 5 business days (attachment d). Day program director was acting as administrator on behalf of the agency. Therefore, the investigation was reviewed by 5 business days by an administrator. Plan of</p>	

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			<p>prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including elopement of clients (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, elopement of clients (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days per agency policy (attachment a). 4) Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant failed to upload to Fortis (attachment e). Recommendation of administrator / DSGL was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). QIDP is no longer in that role and new one has been trained on responsibilities including following recommendations of investigation of abuse and neglect (attachment a). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal /</p>	

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 2 of 4 clients in the sample (#2 and #5),	W 0122	IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including potential neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). House manager / associate manager will provide daily monitoring , each shift, to ensure client plans are followed and client safety (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. 122 483.420 CLIENT PROTECTIONS The facility must	10/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401			
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	<p>the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to conduct thorough investigations. The facility failed to investigate an incident of client #5 choking requiring the Heimlich maneuver. The facility failed to thoroughly investigate an allegation of neglect of client #2 falling out of the back of the van in her wheelchair. The facility failed to thoroughly investigate a fracture of unknown origin to client #5. The facility failed to thoroughly investigate an incident of client #5 eloping from the facility-operated day program. The facility failed to ensure the results of an investigation were reported to the administrator within 5 working days. The facility failed to ensure recommended corrective action was implemented after client #2 fell out of the back of the van in her wheelchair causing injury.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 4 of 18 incident/investigative reports reviewed affecting clients #2 and #5, the facility neglected to implement its policies and procedures to conduct thorough investigations, ensure the results of an investigation were reported to the</p>		<p>ensure that specific client protections requirements are met.</p> <p>1) Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant failed to upload to Fortis (attachment e). Recommendation of administrator / DSGL was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). QIDP is no longer in that role and new one has been trained on responsibilities including following recommendations of investigation of abuse and neglect (attachment a). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and</p>				

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	<p>administrator within 5 working days and appropriate corrective action was implemented after client #2 fell out of the back of the van in her wheelchair causing injury.</p> <p>2) Please refer to W154. For 4 of 18 investigative reports reviewed affecting clients #2 and #5, the facility failed to conduct thorough investigations.</p> <p>3) Please refer to W156. For 1 of 18 incident/investigative reports reviewed affecting client #5, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days.</p> <p>4) Please refer to W157. For 1 of 18 incident/investigative reports reviewed affecting client #2, the facility failed to implement corrective action as indicated in an investigation.</p> <p>9-3-2(a)</p>		<p>neglect, including potential neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. 2) A) Plan of correction: Investigation of client #5 "choking" was thoroughly investigated. Prior QIDP failed to send to Fortis data base (attachment b). Staff acted with good intentions and followed client #5 choking plan. Client #5 choking plan revised (attachment u). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including choking incidents (attachment a). QIDP is no longer in the QIDP/Coordinator role (attachment j). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). B) Plan of correction: Investigation of client # 5 "eloping" was thoroughly investigated and was located in CIR folder. Facility ensured that lifelong learning / day program</p>		

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			<p>director investigated incident and signed within 5 business days (attachment d). DSGL reviewed the investigation within 5 business days (attachment d). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including elopement of clients (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). C) Plan of correction: Investigation of client #2 rolling out of back of van was thoroughly investigated. Admin assistant failed to upload to Fortis (attachment e). Recommendation of administrator / DSGL was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff</p>	

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			(attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including potential neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. D) Plan of correction: Investigation of client #5 broken arm was thoroughly investigated, following incident, and a bqis checklist completed . It was determined that the broken bone was self inflicted and SIB was added to BSP (attachment h). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including unknown injuries (attachment a). Plan of Monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents	

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			<p>(attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a).</p> <p>3) Plan of correction: Investigation of client # 5 "eloping" was thoroughly investigated and was located in CIR folder. Facility ensured that lifelong learning / day program director investigated incident and signed within 5 business days (attachment d). DSGL reviewed the investigation within 5 business days (attachment d). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including elopement of clients (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a).</p> <p>4) Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant failed to upload to Fortis (attachment e). Recommendation of administrator / DSGL was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not</p>	

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W 0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS		located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). QIDP is no longer in that role and new one has been trained on responsibilities including following recommendations of investigation of abuse and neglect (attachment a). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including potential neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). This level of monitoring may be tapered off once compliance has been met by facility.		

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Bldg. 00	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 4 of 18 incident/investigative reports reviewed affecting clients #2 and #5, the facility neglected to implement its policies and procedures to conduct thorough investigations, ensure the results of an investigation were reported to the administrator within 5 working days and appropriate corrective action was implemented after client #2 fell out of the back of the van in her wheelchair causing injury.</p> <p>Findings include:</p> <p>On 9/29/15 at 1:49 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 4/16/15 at 6:00 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 4/17/15, indicated client #5 was eating dinner which included boneless porkchops, gravy, rice and green beans. Staff (BDDS report did not indicate who the staff was) heard client #5 making gurgling noises with his drink and initially thought client #5 was blowing air</p>	W 0149	<p>W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>1) Plan of correction: Investigation of client #5 "choking" was thoroughly investigated. Prior QIDP failed to send to Fortis data base (attachment b). Staff acted with good intentions and followed client #5 choking plan. Client #5 choking plan revised (attachment u). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including choking incidents (attachment a). QIDP is no longer in the QIDP/Coordinator role (attachment j). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a).</p> <p>2) Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin. Assistant failed to upload to Fortis (attachment e).</p>	10/25/2015			

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	<p>into his glass "making bubbles" to be silly. When client #5 did not stop, staff looked at him and the noise continued. Client #5 removed the glass from his mouth and staff observed liquid coming from his nose. Staff stood up and asked, "[Client #5], are you OK?" Client #5 did not respond. Staff went over to his chair and asked, "Are you choking?" Client #5 did not respond. Staff performed the Heimlich maneuver. Client #5 coughed with each thrust and staff felt something dislodge. Client #5 spoke and said he was OK. Client #5 went to change his shirt as there was a lot of thin mucus discharge on his shirt. The follow-up BDDS report indicated the item dislodged was a large piece of porkchop. There was no documentation the facility conducted an investigation to ensure staff implemented client #5's Dining and risk plans for choking.</p> <p>On 9/30/15 from 10:55 AM to 12:30 PM, an observation was conducted at the facility-operated day program. At 11:28 AM, client #5 entered a conference room to eat his lunch. Client #5 entered the room and told staff #11 he wanted to eat by himself. Client #5 closed the door and started to eat his lunch without staff supervision. Client #5 indicated he enjoyed eating by himself without staff present. Client #5 was in the conference</p>		<p>Recommendation of administrator / DSGL was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). QIDP is no longer in that role and new one has been trained on responsibilities including following recommendations of investigation of abuse and neglect (attachment a). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including potential neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). This level of monitoring may be</p>		

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	<p>room with the door closed throughout his meal. Staff #11 opened the door several times throughout the meal but did not provide constant supervision of client #5 during his meal.</p> <p>On 9/30/15 at 11:28 AM, staff #11 indicated client #5 ate his lunch in private daily. Staff #11 indicated client #5 did not want staff in the same room with him while he ate.</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's risk plan for choking, dated 6/19/14, indicated, "On 5/13/11 [client #5] was observed to be choking at lunch time in the workshop. [Client #5] has a tendency to eat fast and puts too much food in his mouth at once. He also does not chew his food fully before taking additional bites, and he does not follow bites with liquid to ensure that the food is properly swallowed." The plan indicated, "[Client #5] will eat meals and snacks in area with other consumers and staff so he can be monitored." The plan indicated, in part, "Staff will encourage [client #5] to take sips of fluid after every other bite to make sure food is clear and swallowed completely." The plan, revised on 6/22/15, indicated, "[Client #5] has had no further incidents of choking at this time." The risk plan failed to indicate</p>		<p>tapered off once compliance has been met by facility. 3) Plan of correction: Investigation of client #5 broken arm was thoroughly investigated, following incident, and a bqis checklist completed. It was determined that the broken bone was self inflicted and SIB was added to BSP (attachment h). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including unknown injuries (attachment a). Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). 4) Plan of correction: Investigation of client # 5 "eloping" was thoroughly investigated and was located in CIR folder. Facility ensured that lifelong learning / day program director investigated incident and</p>		

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	<p>client #5 choked on 4/16/15.</p> <p>Client #5's Dining Plan, dated 4/24/15, indicated, in part, "[Client #5] has had one incident in the last month of choking." The plan indicated, "[Client #5] eats independently. Staff should ensure food is cut up appropriately (not defined). Staff should be in the area to monitor...." The Dining Plan did not indicate staff would encourage client #5 to take sips of liquid after every other bite to make sure food is clear and swallowed completely.</p> <p>Client #5's Dining Plan and risk plan for choking did not include the same information regarding the steps staff were to implement to ensure client #5 did not choke.</p> <p>On 9/30/15 at 2:26 PM, the Group Home Director (GHD) indicated she instructed the former Coordinator to conduct an investigation. The GHD indicated an investigation was not conducted.</p> <p>On 10/1/15 at 2:15 PM, the interim Coordinator indicated the Dining Plan did not match the risk plan for choking. The interim Coordinator indicated the plans needed to include the same information. On 10/5/15 at 11:01 AM, the interim Coordinator indicated the</p>		<p>signed within 5 business days (attachment d). DSGL reviewed the investigation within 5 business days (attachment d). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including elopement of clients (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. 1) A) Plan of correction: Investigation of client #5"choking" was investigated. Prior QIDP failed to send to Fortis data base (attachment b). Staff acted with good intentions and followed client #5 choking plan. Client #5 choking plan revised (attachment u). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including choking incidents (attachment a). QIDP is no longer in the QIDP/Coordinator role (attachment j). Plan of monitoring: Director of supported group living / DSGL will be immediately</p>	

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	<p>facility should have ensured the staff implemented client #5's Dining plan and risk plan for choking. The interim Coordinator indicated an investigation should have been conducted. The interim Coordinator stated, "if someone chokes you have to investigate it." The interim Coordinator indicated the facility should have conducted an investigation.</p> <p>2) On 4/26/15 at 6:00 PM, client #2 was in the group home van after a trip into the community. Staff #6 was assisting her to exit the van. Staff #6 removed the safety straps from the bottom of her wheelchair. Prior to staff #6 raising the lift into place, client #2 moved her wheelchair backward and rolled out of the back of the van. Staff #6 called to the other staff in the house (#2) for assistance. Both staff noted there was blood on the ground. Staff noted client #2 was bleeding from the back of her head. Staff contacted the pager and 911. Client #2 was transported to the hospital. Client #2 had three lacerations less than 1/2 inch on the back of her head. The BDDS incident report, dated 4/27/15, indicated, in part, "A form of skin adhesive was applied to assist with healing by the attending physician." The BDDS report indicated, "Staff was retrained that evening on proper van unloading procedures. A new procedure was put into place, which is as follows:</p>		<p>notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). b) Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant failed to upload to Fortis (attachment e). Recommendation of administrator / DSGL was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including potential</p>	

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	<p>The four safety straps used to secure the wheel chair will be left in place until the lift is in its full and upright position. These straps will make it not possible to disembark the van while the lift is not in its full and upright position. All staff will be trained on this new procedure prior to assisting with transportation duties."</p> <p>The investigation, dated 4/28/15, indicated, in part, "The [name of group home] residents were returning from going out to eat in the community. Other [name of group home] clients had already disembarked the van, except for [client #2]. [Staff #2] was assisting other clients into the house. [Staff #6] was assisting [client #2] getting out of the van. The following is a narrative of the incident as written by [staff #6]: [Staff #6] was unstrapping the bottom hooks of the clients (sic) chair inside of the van from the back entrance. The ramp was down on the ground at the time. [Staff #6] then stepped off the back of the van on to the ground. The client then moved towards the back of the van but was asked by [staff #6] to stop so that he could remove the back hook that would have been in the way of the client moving on to the ramp. [Staff #6] was trying to remove the hook in the back of the van from the attachment bar so the client could move her chair back. The hook he was trying</p>		<p>neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. C) Plan of correction: Investigation of client # 5 "eloping" was investigated and was located in CIR folder. Facility ensured that lifelong learning / day program director investigated incident and signed within 5 business days (attachment d). Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including elopement of clients (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days per agency policy (attachment a). D) Plan of correction: Investigation of client #5 broken arm was investigated following incident and a bqis checklist completed. It was determined that the broken bone was self inflicted and SIB was added to BSP (attachment h). Plan of prevention: QIDP / coordinators who carry the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401		
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	to remove was not an attachment for [client #2's] chair but it was the attachment for the client whom sits in the back on the van, [client #1] whom had been removed form (sic) the van first. The client [#2] was unhooked at the time from the bottom. [Staff #6] removed the back hook and was reaching to garb (sic) the controller so that he could lift the ramp up for the client to move back on to. Before [staff #6] could grab the controller, the client moved her chair backwards and rolled off of the back of the van. [Staff #6] then called for [staff #2] to help him. [Staff #2] carried [client #2] into the house and laid her in her bed. [Staff #2 and staff #6] noticed there was some blood on the ground. [Staff #6 and staff #2] checked [client #2's] body for injuries. Staff then moved [client #2] to her bed. When [staff #6 and staff #2] discovered [client #2] was bleeding on the back of her head, [staff #2] contacted 911 for medical assistance and reported the incident to the emergency pager... [Staff #2] confirms that this narrative of the incident is accurate. [Client #2] was interviewed, and she also confirmed that this is an accurate portrayal of the incident." The Statement of Findings section indicated, "Policy and procedure were not followed. Staff failed to ensure client's safe exit from the vehicle. Staff then moved client when a possible		emergency pager trained on reporting and investigating allegation of abuse and neglect, including unknown injuries (attachment a). Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents, unknown injuries, and suspected neglect of a client (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a).		

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	<p>head/neck/spinal injury could have taken place." The investigation indicated, "Not substantiated. This appears to be an honest mistake." The Recommendations section indicated, "Staff will be trained on how to deal with suspteced (sic) head/neck/spinal injuries. [Staff #6] was trained on proper exiting procedures for assisting with transportation. All staff have been instructed to leave the safety straps in for both [client #1's] chair and [client #2's] chair until the ramp is in its upright position. This will prevent any client from falling of (sic) the van while the lift is not in its upright position. [Staff #6] will also receive a performance review regarding this incident."</p> <p>The investigation was not thorough. The investigation did not include interviews with staff #2 and client #2. There were no interviews with clients #1, #3, #4, #5, #6 and #7. The investigation indicated the allegation to be not substantiated but further indicated, "Policy and procedure were not followed. Staff failed to ensure client's safe exit from the vehicle. Staff then moved client when a possible head/neck/spinal injury could have taken place." There was no documentation staff #6 received a performance review as evidenced by the Group Home Director not being able to locate the documentation.</p>			

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	<p>On 10/1/15 at 1:34 PM, client #2 indicated the lift was down and she backed up her wheelchair. Client #2 indicated she fell out of the back of the van in her wheelchair and hurt her head. Client #2 indicated she should have asked the staff if the lift was up. Client #2 indicated she had never fallen out of the wheelchair prior to this incident. Client #2 stated she was "sorry it happened."</p> <p>On 10/1/15 at 2:06 PM, the interim Coordinator indicated everyone present at the time of the incident should have been interviewed. The interim Coordinator stated, "it was neglect" whether or not it was intentional. The interim Coordinator indicated the facility should conduct thorough investigations. The Coordinator indicated client #2 and staff #2 should have been interviewed. The interim Coordinator indicated staff #6's performance review should have been in his employee file for review. The interim Coordinator indicated the procedure documented as new in the BDDS report was not new. The interim Coordinator indicated it was the facility's policy and procedure on how to unload clients from the van.</p> <p>On 9/30/15 at 3:30 PM, the GHD</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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	<p>indicated after reviewing staff #6's employee file she was unable to locate the documentation staff #6 received corrective action following the incident.</p> <p>3) On 7/12/15 at 8:00 AM, client #5 exited his room to eat breakfast. Staff #2 noticed client #5's right arm was swollen. Staff #2 contacted the pager for advice. The nurse instructed staff #2 to take client #5 to the walk-in clinic. The clinic ordered an x-ray. Client #5 was given a splint to wear. Once client #5 was home, client #5 took off the splint and threw it on the floor. The incident report, dated 7/13/15, indicated, "It is unknown how [client #5] injured himself, but [client #5] self-reports he hit it." A handwritten note on the report, not signed or dated indicated, "Believed [client #5] hit his wrist when he was upset." The Resolution section of the incident report indicated, "Coordinator completing an injury of unknown origin inquiry. On 07/13/2015, [client #5] was taken to walk-in clinic for the x-ray. X-ray determined an old fracture to [client #5's] right wrist." The BDDS report, dated 7/13/15, indicated, in part, "It is unknown how [client #5] injured his arm, but [client #5] self-reports he hit it." The Plan to Resolve section indicated, "On 07/13/2015 in the morning, [client #5] was taken to the walk-in clinic for the</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
--------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>X-ray. X-ray determined that [client #5] fractured his right wrist. Coordinator completing an injury of unknown origin inquiry. Coordinator has determined that [client #5] hit his wrist when he was upset."</p> <p>The Injuries of Unknown Origin Inquiry, dated 7/16/15, indicated client #5 was interviewed (no date or time of the interview in the investigation). The interview indicated, "I hit my hand on the picnic table on Friday (7/10/15)." The investigation did not include interviews with all of the facility-operated day program staff who worked with client #5 on 7/10/15. The investigation did not indicate who worked with client #5 on 7/10/15 at the facility-operated day program. The investigation section for Persons having contact with client in past 24 hours section indicated, "[name of group home] staff." The investigation indicated client #5 did not have a history of self-abuse.</p> <p>A 7/15/15 Fracture Checklist indicated, in part, "[Client #5] has reported that on Friday, the 12th of July (incorrect date - 7/12/15 was a Sunday), he hit his left wrist on a picnic table outside of [facility-operated day program]. The action he performed of hitting his wrist on the table is consistent with the break.</p>			

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--------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>On Wednesday, the 8th, [client #5] was refusing to go to day program. [Client #5] had reported to staff, and to the coordinator, that his arm was broken. When the coordinator asked [client #5] about his arm, [client #5] reported that is was fine, and that he did not want to go to day program. This was consistent with the behavior he had been showing and relaying to staff in an attempt to not go to day program, get dressed when leaving his room, or doing chores. At this time, there was no swelling, bruising, and [client #5] did not report any pain. When discussing this with the coordinator, [client #5] was able to ambulate and move his wrist without any issue. When asked where it hurts, [client #5] reported that his arm was fine, that he just didn't want to go to day program. [Client #5] was able to put pressure on his arm, raising and lowering himself on and off the counter, as well as doing several push ups...."</p> <p>The investigation was not thorough. The investigation did not indicate who worked with client #5. The investigation included interviews with staff #2, staff #10 and staff #11. The investigation did not include interviews with the staff who worked with client #5 on 7/10/15 (day program and group home staff), 7/11/15 (group home staff) and 7/12/15 (group</p>			

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	<p>home staff). There was no documentation of a review of client #5's daily documentation for any length of time preceding when the injury was discovered. There was no documentation client #5's peers at his group home were interviewed.</p> <p>On 10/2/15 at 2:31 PM, the Human Resources Director (HRD) indicated the following staff worked at client #5's group home on 7/10/15: staff #1, #2, #3, #5, #12 and #13. The HRD indicated the following staff worked at client #5's group home on 7/11/15: staff #1, #2, #4, #7 and #8. The HRD indicated the following staff worked at client #5's group home on 7/12/15: #2, #4, #7, #8 and #9.</p> <p>On 10/5/15 at 11:10 AM, the interim Coordinator indicated the facility should have interviewed all staff and clients to determine the origin of the fracture. The interim Coordinator indicated the investigation was not thorough. The interim Coordinator indicated the investigation should have indicated and included interviews with the staff who worked with client #5 on 7/10/15 to 7/12/15.</p> <p>4) On 8/28/15, the facility conducted an investigation to determine if the</p>			

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	<p>facility-operated day program staff was negligent due to client #5's elopement from the building. On 8/27/15 (no time indicated), maintenance staff observed client #5 going up the ramp into the maintenance area in the back of the building without staff. The maintenance staff asked client #5 where his staff was located. Client #5 indicated he did not know. The investigation indicated, in part, "[Maintenance staff] asked him (client #5) if he'd sneaked away from his staff and [client #5] said yes. [Client #5] didn't seem upset and was willing to walk with him to the front of the building where they ran into [name of former Coordinator]." The interview with day program staff #14 indicated, in part, "[Client #5] had been to the restroom dozens of times during the day (upstairs RR (restroom) near staff breakroom) and was very restless and frustrated during the day. She thought it was because the conference rooms he normally likes to spend time, were in use. She stated that she thought about the situation, over the evening, and thinks [client #5] was not in the restroom (upstairs near the employee breakroom), but was in the training room. He was in the training room and had the door closed, and refused to allow staff into the room. [Staff #14] checked on him every minute, or so, and asked him if he was OK and had everything he</p>			

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	needed. [Staff #14] stated [client #5] will become very angry if interrupted too often. [Client #5] seemed to realize he'd missed his community experience at about 2:15, when he asked where [name of another day program staff] was, who would have been his staff for that. He was also distraught about losing his hat and asked about it repeatedly. [Staff #14] couldn't imagine how he got past her, and wondered if he went out the training room door to the outside stairs. She did talk to a new staff briefly in the hallway, but doesn't think he could have gotten past her without being seen. She asked if the door was alarmed. The interviewer checked the exterior/emergency door in the training room and found that the door alarm was not functioning. [Maintenance Director] indicated it had been disarmed, as (sic) some point in the past, and apparently had not been re-armed. It appears [client #5] left the training room through the emergency door and went straight to the maintenance area behind the building, which would have taken 30-60 seconds, which is the period of time estimated he was missing." The investigation's Statement of Findings indicated, "The allegation of neglect is substantiated due to the safety issues that were involved in his exit from the building without staff support. The hallway outside the upstairs training			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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--------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>room is where the staff was stationed and when interviewed she could not imagine how he'd gotten past her either out of the training room or from the restroom even though she'd answered a question for another staff. Also, had [client #5] left the restroom and gone down the stairs through Room 100 and out the side door, the likelihood of him being intercepted by another staff would be high. He ended up at the back of the building very near the maintenance exit, which makes sense given the location of the exit from the Training Room. Also, during the investigation the emergency door alarm was found to be unarmed and [staff #14] would not have been aware of that. The door is well marked as being alarmed."</p> <p>The investigation was not thorough. There was no documentation the facility interviewed the staff that staff #14 indicated she spoke to during the incident. There was no documentation the facility interviewed the staff who worked in the area where client #5 was located (staff in the records department). There was no documentation the facility interviewed the staff in Room 100 to ensure client #5 did not exit the building through the room. There was no documentation the administrator received the results of the investigation within 5 working days.</p>			

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	<p>On 9/30/15 at 2:03 PM, the interim Coordinator indicated the results of investigations should be reported to the administrator within 5 working days. On 10/5/15 at 11:07 AM, the interim Coordinator indicated the investigation should have included interviews with the staff who worked in the area as well as the staff in Room 100. The interim Coordinator indicated the facility should have interviewed the staff who spoke with staff #14 in the hallway.</p> <p>On 9/29/15 at 1:58 PM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 5/14/13, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems,</p>			

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	<p>procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law...</p> <p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events." The policy indicated, "The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days." The policy indicated, in part, "Review the Incident Report to identify individuals and the nature of</p>			

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W 0154 Bldg. 00	<p>their participation, i.e. possible victims, perpetrators and witnesses. If there is an allegation of abuse/neglect or exploitation all staff assigned to the client(s) and present during the event, will be interviewed or asked to provide a written, signed statement. All perpetrators/alleged perpetrators will be interviewed or asked to provide a written, signed statement. All persons who saw the incident and are able to give substantial information are to be interviewed or provide written, signed statements. Those individuals who are not able to provide written or verbal statements due to disability are not required to provide statements. If statements can be interpreted by staff, or a 'knowledgeable other' familiar with the client's communication style, signed statements from these individuals are to be provided. In a residential setting, all residents present for the incident and able to participate in the interview process must be interviewed to assure they have not been victimized or traumatized by the event."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>				

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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	<p>alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 4 of 18 investigative reports reviewed affecting clients #2 and #5, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>On 9/29/15 at 1:49 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 4/16/15 at 6:00 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 4/17/15, indicated client #5 was eating dinner which included boneless pork chops, gravy, rice and green beans. Staff (BDDS report did not indicate who the staff was) heard client #5 making gurgling noises with his drink and initially thought client #5 was blowing air into his glass "making bubbles" to be silly. When client #5 did not stop, staff looked at him and the noise continued. Client #5 removed the glass from his mouth and staff observed liquid coming from his nose. Staff stood up and asked, "[Client #5], are you OK?" Client #5 did not respond. Staff went over to his chair and asked, "Are you choking?" Client #5 did not respond. Staff performed the</p>	W 0154	<p>W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>1.A) Plan of correction: Investigation of client #5 "choking" was investigated. Prior QIDP failed to send to Fortis data base (attachment b). Staff acted with good intentions and followed client #5 choking plan. Client #5 choking plan revised (attachment u).</p> <p>Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including choking incidents (attachment a). QIDP is no longer in the QIDP/Coordinator role (attachment j). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a).</p> <p>b) Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant failed to upload to Fortis (attachment e).</p> <p>Recommendation of administrator / DSGL was to present DSP responsible a</p>	10/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015	
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	<p>Heimlich maneuver. Client #5 coughed with each thrust and staff felt something dislodge. Client #5 spoke and said he was OK. Client #5 went to change his shirt as there was a lot of thin mucus discharge on his shirt. The follow-up BDDS report indicated the item dislodged was a large piece of pork chop. There was no documentation the facility conducted an investigation to ensure staff implemented client #5's Dining and risk plans for choking.</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's risk plan for choking, dated 6/19/14, indicated, "On 5/13/11 [client #5] was observed to be choking at lunch time in the workshop. [Client #5] has a tendency to eat fast and puts too much food in his mouth at once. He also does not chew his food fully before taking additional bites, and he does not follow bites with liquid to ensure that the food is properly swallowed." The plan indicated, "[Client #5] will eat meals and snacks in area with other consumers and staff so he can be monitored." The plan indicated, in part, "Staff will encourage [client #5] to take sips of fluid after every other bite to make sure food is clear and swallowed completely." The plan, revised on 6/22/15, indicated, "[Client #5] has had no further incidents of choking at this</p>		<p>corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident(attachment f). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including potential neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. C) Plan of correction: Investigation of client # 5 "eloping" was investigated and was located in CIR folder. Facility ensured that lifelong learning / day program</p>				

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	<p>time." The risk plan failed to indicate client #5 choked on 4/16/15.</p> <p>Client #5's Dining Plan, dated 4/24/15, indicated, in part, "[Client #5] has had one incident in the last month of choking." The plan indicated, "[Client #5] eats independently. Staff should ensure food is cut up appropriately (not defined). Staff should be in the area to monitor..." The Dining Plan did not indicate staff would encourage client #5 to take sips of liquid after every other bite to make sure food is clear and swallowed completely.</p> <p>Client #5's Dining Plan and risk plan for choking did not include the same information regarding the steps staff were to implement to ensure client #5 did not choke.</p> <p>On 9/30/15 at 2:26 PM, the Group Home Director (GHD) indicated she instructed the former Coordinator to conduct an investigation. The GHD indicated an investigation was not conducted.</p> <p>On 10/1/15 at 2:15 PM, the interim Coordinator indicated the Dining Plan did not match the risk plan for choking. The interim Coordinator indicated the plans needed to include the same information. On 10/5/15 at 11:01 AM,</p>		<p>director investigated incident and signed within 5business days (attachment d). Planof prevention: QIDP / coordinatorstrained on reporting and investigating allegation of abuse and neglect,including elopement of clients (attachment a). Plan of monitoring:Director of supported group living / DSGL will be immediately notifiedfollowing any allegation of abuse and neglect, including choking incidents(attachment a). DSGL will assign aninvestigator and review outcome and devise recommendations within 5 workingdays per agency policy (attachment a). D) Plan of correction: Investigation of client#5 broken arm was investigated following incident and a bqis checklistcompleted. It was determined that thebroken bone was self inflicted and SIB was added to BSP (attachment h). Plan ofprevention: QIDP / coordinators whocarry the emergency pager trained on reporting and investigating allegation ofabuse and neglect, including unknown injuries (attachment a). Director of supported group living / DSGLwill be immediately notified following any allegation of abuse and neglect,including choking incidents, unknown injuries, and suspected neglect of acient (attachment a). DSGL will assignan investigator and review outcome and devise</p>	

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	<p>the interim Coordinator indicated the facility should have ensured the staff implemented client #5's Dining plan and risk plan for choking. The interim Coordinator indicated an investigation should have been conducted. The interim Coordinator stated, "if someone chokes you have to investigate it." The interim Coordinator indicated the facility should have conducted an investigation.</p> <p>2) On 4/26/15 at 6:00 PM, client #2 was in the group home van after a trip into the community. Staff #6 was assisting her to exit the van. Staff #6 removed the safety straps from the bottom of her wheelchair. Prior to staff #6 raising the lift into place, client #2 moved her wheelchair backward and rolled out of the back of the van. Staff #6 called to the other staff in the house (#2) for assistance. Both staff noted there was blood on the ground. Staff noted client #2 was bleeding from the back of her head. Staff contacted the pager and 911. Client #2 was transported to the hospital. Client #2 had three lacerations less than 1/2 inch on the back of her head. The BDDS incident report, dated 4/27/15, indicated, in part, "A form of skin adhesive was applied to assist with healing by the attending physician." The BDDS report indicated, "Staff was retrained that evening on proper van unloading procedures. A new procedure</p>		<p>recommendations within 5 workingdays (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents(attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 workingdays (attachment a).</p>	

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	<p>was put into place, which is as follows: The four safety straps used to secure the wheel chair will be left in place until the lift is in its full and upright position. These straps will make it not possible to disembark the van while the lift is not in its full and upright position. All staff will be trained on this new procedure prior to assisting with transportation duties."</p> <p>The investigation, dated 4/28/15, indicated, in part, "The [name of group home] residents were returning from going out to eat in the community. Other [name of group home] clients had already disembarked the van, except for [client #2]. [Staff #2] was assisting other clients into the house. [Staff #6] was assisting [client #2] getting out of the van. The following is a narrative of the incident as written by [staff #6]: [Staff #6] was unstrapping the bottom hooks of the clients (sic) chair inside of the van from the back entrance. The ramp was down on the ground at the time. [Staff #6] then stepped off the back of the van on to the ground. The client then moved towards the back of the van but was asked by [staff #6] to stop so that he could remove the back hook that would have been in the way of the client moving on to the ramp. [Staff #6] was trying to remove the hook in the back of the van from the attachment bar so the client could move</p>				

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	<p>her chair back. The hook he was trying to remove was not an attachment for [client #2's] chair but it was the attachment for the client whom sits in the back on the van, [client #1] whom had been removed form (sic) the van first. The client [#2] was unhooked at the time from the bottom. [Staff #6] removed the back hook and was reaching to garb (sic) the controller so that he could lift the ramp up for the client to move back on to. Before [staff #6] could grab the controller, the client moved her chair backwards and rolled off of the back of the van. [Staff #6] then called for [staff #2] to help him. [Staff #2] carried [client #2] into the house and laid her in her bed. [Staff #2 and staff #6] noticed there was some blood on the ground. [Staff #6 and staff #2] checked [client #2's] body for injuries. Staff then moved [client #2] to her bed. When [staff #6 and staff #2] discovered [client #2] was bleeding on the back of her head, [staff #2] contacted 911 for medical assistance and reported the incident to the emergency pager... [Staff #2] confirms that this narrative of the incident is accurate. [Client #2] was interviewed, and she also confirmed that this is an accurate portrayal of the incident." The Statement of Findings section indicated, "Policy and procedure were not followed. Staff failed to ensure client's safe exit from the vehicle. Staff</p>			

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	<p>then moved client when a possible head/neck/spinal injury could have taken place." The investigation indicated, "Not substantiated. This appears to be an honest mistake." The Recommendations section indicated, "Staff will be trained on how to deal with suspected (sic) head/neck/spinal injuries. [Staff #6] was trained on proper exiting procedures for assisting with transportation. All staff have been instructed to leave the safety straps in for both [client #1's] chair and [client #2's] chair until the ramp is in its upright position. This will prevent any client from falling of (sic) the van while the lift is not in its upright position. [Staff #6] will also receive a performance review regarding this incident."</p> <p>The investigation was not thorough. The investigation did not include interviews with staff #2 and client #2. There were no interviews with clients #1, #3, #4, #5, #6 and #7. The investigation indicated the allegation to be not substantiated but further indicated, "Policy and procedure were not followed. Staff failed to ensure client's safe exit from the vehicle. Staff then moved client when a possible head/neck/spinal injury could have taken place."</p> <p>On 10/1/15 at 2:06 PM, the Coordinator indicated everyone present at the time of</p>						

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	<p>the incident should have been interviewed. The Coordinator stated, "it was neglect" whether or not it was intentional. The Coordinator indicated the facility should conduct thorough investigations. The Coordinator indicated client #2 and staff #2 should have been interviewed.</p> <p>3) On 7/12/15 at 8:00 AM, client #5 exited his room to eat breakfast. Staff #2 noticed client #5's right arm was swollen. Staff #2 contacted the pager for advice. The nurse instructed staff #2 to take client #5 to the walk-in clinic. The clinic ordered an x-ray. Client #5 was given a splint to wear. Once client #5 was home, client #5 took off the splint and threw it on the floor. The incident report, dated 7/13/15, indicated, "It is unknown how [client #5] injured himself, but [client #5] self-reports he hit it." A handwritten note on the report, not signed or dated indicated, "Believed [client #5] hit his wrist when he was upset." The Resolution section of the incident report indicated, "Coordinator completing an injury of unknown origin inquiry. On 07/13/2015, [client #5] was taken to walk-in clinic for the x-ray. X-ray determined an old fracture to [client #5's] right wrist." The BDDS report, dated 7/13/15, indicated, in part, "It is unknown how [client #5] injured his arm, but</p>			

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	<p>[client #5] self-reports he hit it." The Plan to Resolve section indicated, "On 07/13/2015 in the morning, [client #5] was taken to the walk-in clinic for the X-ray. X-ray determined that [client #5] fractured his right wrist. Coordinator completing an injury of unknown origin inquiry. Coordinator has determined that [client #5] hit his wrist when he was upset."</p> <p>The Injuries of Unknown Origin Inquiry, dated 7/16/15, indicated client #5 was interviewed (no date or time of the interview in the investigation). The interview indicated, "I hit my hand on the picnic table on Friday (7/10/15)." The investigation did not include interviews with all of the facility-operated day program staff who worked with client #5 on 7/10/15. The investigation did not indicate who worked with client #5 on 7/10/15 at the facility-operated day program. The investigation section for Persons having contact with client in past 24 hours section indicated, "[name of group home] staff." The investigation indicated client #5 did not have a history of self-abuse.</p> <p>A 7/15/15 Fracture Checklist indicated, in part, "[Client #5] has reported that on Friday, the 12th of July (incorrect date - 7/12/15 was a Sunday), he hit his left</p>			

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	<p>wrist on a picnic table outside of [facility-operated day program]. The action he performed of hitting his wrist on the table is consistent with the break. On Wednesday, the 8th, [client #5] was refusing to go to day program. [Client #5] had reported to staff, and to the coordinator, that his arm was broken. When the coordinator asked [client #5] about his arm, [client #5] reported that is was fine, and that he did not want to go to day program. This was consistent with the behavior he had been showing and relaying to staff in an attempt to not go to day program, get dressed when leaving his room, or doing chores. At this time, there was no swelling, bruising, and [client #5] did not report any pain. When discussing this with the coordinator, [client #5] was able to ambulate and move his wrist without any issue. When asked where it hurts, [client #5] reported that his arm was fine, that he just didn't want to go to day program. [Client #5] was able to put pressure on his arm, raising and lowering himself on and off the counter, as well as doing several push ups...."</p> <p>The investigation was not thorough. The investigation did not indicate who worked with client #5. The investigation included interviews with staff #2, staff #10 and staff #11. The investigation did</p>			

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	<p>not include interviews with the staff who worked with client #5 on 7/10/15 (day program and group home staff), 7/11/15 (group home staff) and 7/12/15 (group home staff). There was no documentation of a review of client #5's daily documentation for any length of time preceding when the injury was discovered. There was no documentation client #5's peers at his group home were interviewed.</p> <p>On 10/2/15 at 2:31 PM, the Human Resources Director (HRD) indicated the following staff worked at client #5's group home on 7/10/15: staff #1, #2, #3, #5, #12 and #13. The HRD indicated the following staff worked at client #5's group home on 7/11/15: staff #1, #2, #4, #7 and #8. The HRD indicated the following staff worked at client #5's group home on 7/12/15: #2, #4, #7, #8 and #9.</p> <p>On 10/5/15 at 11:10 AM, the interim Coordinator indicated the facility should have interviewed all staff and clients to determine the origin of the fracture. The interim Coordinator indicated the investigation was not thorough. The interim Coordinator indicated the investigation should have indicated and included interviews with the staff who worked with client #5 on 7/10/15 to</p>			

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	<p>7/12/15.</p> <p>4) On 8/28/15, the facility conducted an investigation to determine if the facility-operated day program staff was negligent due to client #5's elopement from the building. On 8/27/15 (no time indicated), maintenance staff observed client #5 going up the ramp into the maintenance area in the back of the building without staff. The maintenance staff asked client #5 where his staff was located. Client #5 indicated he did not know. The investigation indicated, in part, "[Maintenance staff] asked him (client #5) if he'd sneaked away from his staff and [client #5] said yes. [Client #5] didn't seem upset and was willing to walk with him to the front of the building where they ran into [name of former Coordinator]." The interview with day program staff #14 indicated, in part, "[Client #5] had been to the restroom dozens of times during the day (upstairs RR (restroom) near staff breakroom) and was very restless and frustrated during the day. She thought it was because the conference rooms he normally likes to spend time, were in use. She stated that she thought about the situation, over the evening, and thinks [client #5] was not in the restroom (upstairs near the employee breakroom), but was in the training room. He was in the training room and had the</p>			

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	door closed, and refused to allow staff into the room. [Staff #14] checked on him every minute, or so, and asked him if he was OK and had everything he needed. [Staff #14] stated [client #5] will become very angry if interrupted too often. [Client #5] seemed to realize he'd missed his community experience at about 2:15, when he asked where [name of another day program staff] was, who would have been his staff for that. He was also distraught about losing his hat and asked about it repeatedly. [Staff #14] couldn't imagine how he got past her, and wondered if he went out the training room door to the outside stairs. She did talk to a new staff briefly in the hallway, but doesn't think he could have gotten past her without being seen. She asked if the door was alarmed. The interviewer checked the exterior/emergency door in the training room and found that the door alarm was not functioning. [Maintenance Director] indicated it had been disarmed, as (sic) some point in the past, and apparently had not been re-armed. It appears [client #5] left the training room through the emergency door and went straight to the maintenance area behind the building, which would have taken 30-60 seconds, which is the period of time estimated he was missing." The investigation's Statement of Findings indicated, "The allegation of neglect is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401		
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	<p>substantiated due to the safety issues that were involved in his exit from the building without staff support. The hallway outside the upstairs training room is where the staff was stationed and when interviewed she could not imagine how he'd gotten past her either out of the training room or from the restroom even though she'd answered a question for another staff. Also, had [client #5] left the restroom and gone down the stairs through Room 100 and out the side door, the likelihood of him being intercepted by another staff would be high. He ended up at the back of the building very near the maintenance exit, which makes sense given the location of the exit from the Training Room. Also, during the investigation the emergency door alarm was found to be unarmed and [staff #14] would not have been aware of that. The door is well marked as being alarmed."</p> <p>The investigation was not thorough. There was no documentation the facility interviewed the staff that staff #14 indicated she spoke to during the incident. There was no documentation the facility interviewed the staff who worked in the area where client #5 was located (staff in the records department). There was no documentation the facility interviewed the staff in Room 100 to ensure client #5 did not exit the building</p>				

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W 0156 Bldg. 00	<p>through the room.</p> <p>On 10/5/15 at 11:07 AM, the interim Coordinator indicated the investigation should have included interviews with the staff who worked in the area as well as the staff in Room 100. The interim Coordinator indicated the facility should have interviewed the staff who spoke with staff #14 in the hallway.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 18 incident/investigative reports reviewed affecting client #5, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days.</p> <p>Findings include:</p> <p>On 9/29/15 at 1:49 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/28/15, the facility conducted an investigation to determine</p>	W 0156	W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Plan of correction: Investigation of client # 5 "eloping" was investigated and was located in CIR folder. Facility ensured that lifelong learning / day program director investigated incident and signed within 5 business days (attachment d). The DSGL reviewed investigation after	10/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401		
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	if the facility-operated day program staff was negligent due to client #5's elopement from the building. On 8/27/15 (no time indicated), maintenance staff observed client #5 going up the ramp into the maintenance area in the back of the building without staff. The maintenance staff asked client #5 where his staff was located. Client #5 indicated he did not know. The investigation indicated, in part, "[Maintenance staff] asked him (client #5) if he'd sneaked away from his staff and [client #5] said yes. [Client #5] didn't seem upset and was willing to walk with him to the front of the building where they ran into [name of former Coordinator]." The interview with day program staff #14 indicated, in part, "[Client #5] had been to the restroom dozens of times during the day (upstairs RR (restroom) near staff breakroom) and was very restless and frustrated during the day. She thought it was because the conference rooms he normally likes to spend time, were in use. She stated that she thought about the situation, over the evening, and thinks [client #5] was not in the restroom (upstairs near the employee breakroom), but was in the training room. He was in the training room and had the door closed, and refused to allow staff into the room. [Staff #14] checked on him every minute, or so, and asked him if he was OK and had everything he		completion within 5 business days. Plan of prevention: QIDP / coordinators trained on reporting and investigating allegation of abuse and neglect, including elopement of clients (attachment a). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days per agency policy (attachment a). W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant failed to upload to Fortis (attachment e). Recommendation of administrator / DSGL was to present DSP resvan\ possible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f). Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client		

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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	needed. [Staff #14] stated [client #5] will become very angry if interrupted too often. [Client #5] seemed to realize he'd missed his community experience at about 2:15, when he asked where [name of another day program staff] was, who would have been his staff for that. He was also distraught about losing his hat and asked about it repeatedly. [Staff #14] couldn't imagine how he got past her, and wondered if he went out the training room door to the outside stairs. She did talk to a new staff briefly in the hallway, but doesn't think he could have gotten past her without being seen. She asked if the door was alarmed. The interviewer checked the exterior/emergency door in the training room and found that the door alarm was not functioning. [Maintenance Director] indicated it had been disarmed, as (sic) some point in the past, and apparently had not been re-armed. It appears [client #5] left the training room through the emergency door and went straight to the maintenance area behind the building, which would have taken 30-60 seconds, which is the period of time estimated he was missing." The investigation's Statement of Findings indicated, "The allegation of neglect is substantiated due to the safety issues that were involved in his exit from the building without staff support. The hallway outside the upstairs training		injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i). Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including potential neglect to follow plans (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a). This level of monitoring may be tapered off once compliance has been met by facility.	

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W 0157 Bldg. 00	<p>room is where the staff was stationed and when interviewed she could not imagine how he'd gotten past her either out of the training room or from the restroom even though she'd answered a question for another staff. Also, had [client #5] left the restroom and gone down the stairs through Room 100 and out the side door, the likelihood of him being intercepted by another staff would be high. He ended up at the back of the building very near the maintenance exit, which makes sense given the location of the exit from the Training Room. Also, during the investigation the emergency door alarm was found to be unarmed and [staff #14] would not have been aware of that. The door is well marked as being alarmed."</p> <p>There was no documentation the administrator received the results of the investigation within 5 working days.</p> <p>On 9/30/15 at 2:03 PM, the interim Coordinator indicated the results of investigations should be reported to the administrator within 5 working days.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate</p>				

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401			
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	<p>corrective action must be taken.</p> <p>Based on record review and interview for 1 of 18 incident/investigative reports reviewed affecting client #2, the facility failed to implement corrective action as indicated in an investigation.</p> <p>Findings include:</p> <p>On 9/29/15 at 1:49 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/26/15 at 6:00 PM, client #2 was in the group home van after a trip into the community. Staff #6 was assisting her to exit the van. Staff #6 removed the safety straps from the bottom of her wheelchair. Prior to staff #6 raising the lift into place, client #2 moved her wheelchair backward and rolled out of the back of the van. Staff #6 called to the other staff in the house (#2) for assistance. Both staff noted there was blood on the ground. Staff noted client #2 was bleeding from the back of her head. Staff contacted the pager and 911. Client #2 was transported to the hospital. Client #2 had three lacerations less than 1/2 inch on the back of her head. The BDDS incident report, dated 4/27/15, indicated, in part, "A form of skin adhesive was applied to assist with healing by the attending physician." The BDDS report indicated, "Staff was</p>	W 0157	<p>W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Plan of correction: Investigation of client #2 rolling out of back of van was investigated. Admin assistant failed to upload to Fortis (attachment e).</p> <p>Recommendation of administrator / DSGI was to present DSP responsible a corrective action. This was completed the day the incident occurred but was not located in HR file. This corrective action was completed a second time and a copy placed in HR file and with incident (attachment f).</p> <p>Plan of prevention: QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including client injuries that may be due to neglect of staff (attachment a). Client #2 goal / IPP introduced to train her to check her wheelchair brake and to not engage reverse control unless staff is present to assist her down ramp (attachment h). Facility staff trained on client #2 training goal and transportation / wheelchair safety (attachment i).</p>	10/25/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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	<p>retrained that evening on proper van unloading procedures. A new procedure was put into place, which is as follows: The four safety straps used to secure the wheel chair will be left in place until the lift is in its full and upright position. These straps will make it not possible to disembark the van while the lift is not in its full and upright position. All staff will be trained on this new procedure prior to assisting with transportation duties."</p> <p>The investigation, dated 4/28/15, indicated, in part, "The [name of group home] residents were returning from going out to eat in the community. Other [name of group home] clients had already disembarked the van, except for [client #2]. [Staff #2] was assisting other clients into the house. [Staff #6] was assisting [client #2] getting out of the van. The following is a narrative of the incident as written by [staff #6]: [Staff #6] was unstrapping the bottom hooks of the clients (sic) chair inside of the van from the back entrance. The ramp was down on the ground at the time. [Staff #6] then stepped off the back of the van on to the ground. The client then moved towards the back of the van but was asked by [staff #6] to stop so that he could remove the back hook that would have been in the way of the client moving on to the ramp. [Staff #6] was trying to remove</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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	<p>the hook in the back of the van from the attachment bar so the client could move her chair back. The hook he was trying to remove was not an attachment for [client #2's] chair but it was the attachment for the client whom sits in the back on the van, [client #1] whom had been removed form (sic) the van first. The client [#2] was unhooked at the time from the bottom. [Staff #6] removed the back hook and was reaching to garb (sic) the controller so that he could lift the ramp up for the client to move back on to. Before [staff #6] could grab the controller, the client moved her chair backwards and rolled off of the back of the van. [Staff #6] then called for [staff #2] to help him. [Staff #2] carried [client #2] into the house and laid her in her bed. [Staff #2 and staff #6] noticed there was some blood on the ground. [Staff #6 and staff #2] checked [client #2's] body for injuries. Staff then moved [client #2] to her bed. When [staff #6 and staff #2] discovered [client #2] was bleeding on the back of her head, [staff #2] contacted 911 for medical assistance and reported the incident to the emergency pager... [Staff #2] confirms that this narrative of the incident is accurate. [Client #2] was interviewed, and she also confirmed that this is an accurate portrayal of the incident." The Statement of Findings section indicated, "Policy and procedure</p>			

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	<p>were not followed. Staff failed to ensure client's safe exit from the vehicle. Staff then moved client when a possible head/neck/spinal injury could have taken place." The investigation indicated, "Not substantiated. This appears to be an honest mistake." The Recommendations section indicated, "Staff will be trained on how to deal with suspteced (sic) head/neck/spinal injuries. [Staff #6] was trained on proper exiting procedures for assisting with transportation. All staff have been instructed to leave the safety straps in for both [client #1's] chair and [client #2's] chair until the ramp is in its upright position. This will prevent any client from falling of (sic) the van while the lift is not in its upright position. [Staff #6] will also receive a performance review regarding this incident."</p> <p>There was no documentation staff #6 received a performance review as evidenced by the Group Home Director (GHD) not being able to locate the documentation.</p> <p>On 10/1/15 at 2:06 PM, the interim Coordinator indicated staff #6's performance review should have been in his employee file for review. The Coordinator indicated the procedure documented as new in the BDDS report was not new. The Coordinator indicated</p>			

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W 0159 Bldg. 00	<p>it was the facility's policy and procedure on how to unload clients from the van.</p> <p>On 9/30/15 at 3:30 PM, the GHD indicated after reviewing staff #6's employee file she was unable to locate the documentation staff #6 received corrective action following the incident.</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 5 of 7 clients living in the group home (#2, #4, #5, #6 and #7), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans as evidenced by: 1) failing to monitor client #6 and #7's program plans from September 2014 to September 2015, 2) failing to ensure client #5's audiologist's recommendation for hearing aids was reviewed by the interdisciplinary team (IDT), 3) failing to ensure client #2 purchased a computer in a timely manner, 4) failing to ensure client #2's request to be moved from the</p>	W 0159	<p>W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>1) Plan of correction: QIDP and support team have updated client #6 and client #7 program plans (attachment l and m). Quarterly reviews were completed on client #6 and #7 (attachment b). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a).</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401			
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	<p>workshop to the day program was implemented, 5) failing to ensure the day program had client #5's Dining and risk plans for choking to ensure the plans were implemented as written, 6) failing to ensure client #6 and #7's comprehensive functional assessments were reviewed by the interdisciplinary team (IDT) for relevancy and updated at least annually, 7) failing to ensure client #6 and #7's individual program plans (IPP) were revised at least annually, 8) failing to ensure staff implemented client #5's informal goal to review fire escape procedures, failing to ensure the informal goal indicated the frequency the goal was to be implemented and failed to move the informal goal to a formal goal when client #5 refused to participate in the drills and 9) failing to obtain written informed consent for the implementation of client #2 and #4's Individual Support Plans.</p> <p>Findings include:</p> <p>1) On 10/1/15 at 12:42 PM, a review of client #6's record was conducted. There was no documentation in client #6's record indicating the QIDP reviewed his progress toward completing his program plan training objectives (quarterly reviews) from September 2014 to September 2015. The most recent</p>		<p>2) Plan of correction: QIDP and IDT / support team met and determined that client #5 not wearing hearing aides do not hinder his ability to function. Client #5 made the informed decision to not wear hearing aides team will review quarterly by IDT (attachment m). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a).</p> <p>3) Plan of correction: Computer was purchased for client #2 prior to the survey completion. Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed</p>				

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	<p>quarterly reviewed in client #6's record was dated 6/30/14.</p> <p>On 10/1/15 at 1:23 PM, a focused review of client #7's record was conducted. There was no documentation in client #7's record indicating the QIDP reviewed his progress toward completing his program plan training objectives (quarterly reviews) from September 2014 to September 2015. The most recent quarterly reviewed in client #7's record was dated 6/30/14.</p> <p>On 10/1/15 at 2:17 PM, the interim Coordinator (QIDP) indicated the former QIDP failed to conduct quarterly reviews of the clients' program plans.</p> <p>2) On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's most recent hearing examination, dated 10/13/14, indicated, "Moderate to severe hearing loss, bilaterally. Continue monitoring hearing loss. Amplification rec'd (recommended)." There was no documentation in client #5's Support Team Review Forms, dated October 2014 to September 2015, the IDT reviewed the recommendation for client #5 to have amplification for his hearing loss. There were no notes or documentation the QIDP addressed the recommendation.</p>		<p>(attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). 4) Plan of correction: Client #2 was transitioned from workshop and placed in LL as decided by support team / IDT. Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). 5) Plan of correction: Day program and facility staff have been trained on client #5's revised Dining and risk plans for choking to ensure the plans were implemented as written (attachment o). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo</p>		

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	<p>On 10/1/15 at 2:15 PM, the interim Coordinator indicated the former QIDP should have discussed the audiologist's recommendations and addressed them in some way in the record. The interim Coordinator indicated there was no documentation in client #5's record indicating the QIDP addressed the recommendations.</p> <p>3) On 9/29/15 at 3:45 PM, client #2 asked the surveyor if he wanted to see her new computer. Client #2 stated she just received the new computer and "loved it."</p> <p>On 9/30/15 at 1:26 PM, a review of client #2's record was conducted. Client #2's Support Team Review Form, dated 5/12/15, indicated, "Search for a laptop." There was no additional information on the form. The Support Team Review Form dated 7/14/15 indicated, in part, "Buying a laptop - [name of former QIDP]." The Support Team Review Form dated 8/11/15 indicated, in part, "Laptop shopping - [name of former QIDP], 8/14/15." The Support Team Review Form dated 9/8/15 indicated, "Computer!"</p> <p>On 9/30/15 at 2:17 PM, the Group Home Director (GHD) indicated she did not attend the support team meetings. The</p>		<p>extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: House manager / associate manager will provide daily monitoring , each shift, to ensure client plans are followed and client safety and plans are followed (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. 6) Plan of correction: Client #6 and client #7 comprehensive functional assessments were reviewed by the QIDP and interdisciplinary team (attachment o). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with</p>				

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	<p>GHD indicated client #2's request for a new computer should have been addressed sooner. The GHD stated, "Don't just write it down, need to follow through."</p> <p>On 9/30/15 at 10:55 AM, staff #5 indicated the former QIDP failed to assist client #2 with purchasing a new laptop in a timely manner. Staff #5 indicated the delay in client #2 purchasing her laptop put client #2 behind with her tutoring for her GED (General Education Degree).</p> <p>On 9/30/15 at 1:47 PM, the interim Coordinator indicated client #2 should have purchased a new computer much sooner than she did. The interim Coordinator indicated she did not know why it took so long for client #2 to get the computer. The interim Coordinator indicated client #2 should have been assisted by the former QIDP to purchase the computer. The interim Coordinator indicated client #2's computer was to assist her with completing her GED.</p> <p>On 10/5/15 at 1:32 PM, the Fiscal Coordinator (FC) indicated she received the request for client #2's purchase of a new computer from the former QIDP in August 2015. The FC indicated she remembered the former QIDP telling her that client #2 was interested in</p>		<p>the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). 7) Plan of correction: QIDP will update client #6 and #7's individual program plans (IPP) these will be reviewed and revised if needed annually (attachment p). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Reviewing and updating IPPs annually will be trained with agency QIDP. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). 8) Plan of correction: Client #5 informal goal was moved to a formal goal due to refusing to participate in the safety drills (attachment R). Facility staff has been trained on how to implement this goal (attachment R). Plan of</p>		

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	<p>purchasing a new computer. The FC indicated she told the former QIDP the documentation she needed to process the request. The FC indicated several weeks later, the former QIDP asked her again about what he needed to do to purchase a computer for client #2. The FC indicated she told the former QIDP what documentation he needed to submit. The FC indicated the former QIDP told her that client #2 was upset due to not having her new computer. The FC indicated the former QIDP did not submit the paperwork until August 21, 2015. The FC indicated client #2 purchased her new computer on 9/3/15.</p> <p>4) On 9/30/15 at 1:26 PM, a review of client #2's record was conducted. Client #2's Support Team Review Form dated 2/10/15 indicated, "(Unhappy) at workshop - contact [name of day program coordinator]. Client #2's 3/10/15 Support Team Review Form indicated, "Eventual transition to day program, out of workshop." Client #2's April to September 2015 Support Team Review Forms did not address transitioning client #2 from the workshop to the day program.</p> <p>On 9/30/15 at 12:01 PM, client #2 indicated she told the former QIDP she wanted to move out of the workshop and</p>		<p>prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Reviewing and updating IPPs annually will be trained with agency QIDP. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). (9) Plan of correction: QIDP and IDT obtained written informed consent for the implementation of client #2 and #4's Individual Support Plans (attachment s), . Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Reviewing and updating IPPs annually will be trained with agency QIDP. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will</p>	

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	<p>into the day program. Client #2 stated, "He didn't help me."</p> <p>On 9/30/15 at 1:27 PM, the interim Coordinator indicated she was working to get client #2 out of the workshop and into the day program. The interim Coordinator indicated she contacted the workshop coordinator and the day program coordinator to get the process started during the survey. The interim Coordinator indicated the workshop coordinator told her that client #2 wanted to get out of the workshop for awhile. The interim Coordinator indicated, after reviewing client #2's Support Team Review Forms, the notes first mentioned client #2 leaving the workshop was in February 2015. The interim Coordinator indicated it should not take longer than two weeks to transition someone. The interim Coordinator indicated she spoke to the Social Worker who indicated the former QIDP told him the transition from the workshop to the day program was a long process and took a long time to coordinate.</p> <p>5) On 9/30/15 from 10:55 AM to 12:30 PM, an observation was conducted at the facility-operated day program. At 11:28 AM, client #5 entered a conference room to eat his lunch. Client #5 entered the room and told staff #11 he wanted to eat</p>		<p>be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). W 240 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. 1) Plan of correction: Client #5 informal goal was moved to a formal goal due to participation in the safety drills (attachment R). Facility staff has been trained on how to implement this goal (attachment R). Plan of prevention: Facility staff trained on fire drill policy and alerting the coordinator when issues arise (attachment s). Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Reviewing and updating IPPs annually will be trained with agency QIDP. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). House manager / associate manager will provide daily monitoring, each shift, to ensure</p>				

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	<p>by himself. Client #5 closed the door and started to eat his lunch without staff supervision. Client #5 indicated he enjoyed eating by himself without staff present. Client #5 was in the conference room with the door closed throughout his meal. Staff #11 opened the door several times throughout the meal but did not provide constant supervision of client #5 during his meal.</p> <p>On 9/30/15 at 11:28 AM, staff #11 indicated client #5 ate his lunch in private daily. Staff #11 indicated client #5 did not want staff in the same room with him while he ate.</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's risk plan for choking, dated 6/19/14, indicated, "On 5/13/11 [client #5] was observed to be choking at lunch time in the workshop. [Client #5] has a tendency to eat fast and puts too much food in his mouth at once. He also does not chew his food fully before taking additional bites, and he does not follow bites with liquid to ensure that the food is properly swallowed." The plan indicated, "[Client #5] will eat meals and snacks in area with other consumers and staff so he can be monitored." The plan indicated, in part, "Staff will encourage [client #5] to take sips of fluid after every other bite to</p>		<p>client plans are followed and client safety and plans are followed (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. 2) Plan of correction: Day program and facility staff have been trained on client #5's revised Dining and risk plans for choking to ensure the plans were implemented as written (attachment o). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: House manager / associate manager will provide daily monitoring, each shift, to ensure client plans are followed and client safety and plans are followed (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly</p>				

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	<p>make sure food is clear and swallowed completely." The plan, revised on 6/22/15, indicated, "[Client #5] has had no further incidents of choking at this time." The risk plan failed to indicate client #5 choked on 4/16/15.</p> <p>Client #5's Dining Plan, dated 4/24/15, indicated, in part, "[Client #5] has had one incident in the last month of choking." The plan indicated, "[Client #5] eats independently. Staff should ensure food is cut up appropriately (not defined). Staff should be in the area to monitor...." The Dining Plan did not indicate staff would encourage client #5 to take sips of liquid after every other bite to make sure food is clear and swallowed completely.</p> <p>Client #5's Dining Plan and risk plan for choking did not include the same information regarding the steps staff were to implement to ensure client #5 did not choke.</p> <p>On 10/1/15 at 2:15 PM, the interim Coordinator indicated the Dining Plan did not match the risk plan for choking. The interim Coordinator indicated the plans needed to include the same information. The interim Coordinator indicated the plan given to the day program by the former QIDP did not</p>		<p>monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. W 249 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program 1) Plan of correction: Day program and facility staff have been trained on client #5's revised Dining and risk plans for choking to ensure the plans were implemented as written (attachment o). High risk plan has been updated to match dining plan and vice versa (attachment u). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: House manager / associate manager will provide</p>				

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	<p>indicate client #5 needed constant supervision during meals. On 10/5/15 at 11:01 AM, the interim Coordinator indicated the staff should implement the plans as written for supervision.</p> <p>6) On 10/1/15 at 12:42 PM, a review of client #6's record was conducted. Client #6's most recent update to his comprehensive functional assessment (CFA) was conducted on 7/30/14. There was no documentation in client #6's record indicating his IDT reviewed his CFA for relevancy and updated his CFA at least annually.</p> <p>On 10/1/15 at 1:23 PM, a focused review of client #7's record was conducted. Client #7's most recent update to his CFA was conducted on 6/18/14. There was no documentation in client #7's record indicating his IDT reviewed his CFA for relevancy and updated his CFA at least annually.</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's most recent update to his CFA was conducted on 6/22/15.</p> <p>On 10/1/15 at 1:37 PM, the interim Coordinator indicated client #5's CFA was not updated following client #5 being diagnosed with dementia. The</p>		<p>daily monitoring, each shift, to ensure client plans are followed and client safety and plans are followed (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. W 259 483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. 1) Plan of correction: Client #5, #6 and client #7 comprehensive functional assessments were reviewed by the QIDP and interdisciplinary team (attachment o). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will</p>		

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	<p>interim Coordinator indicated the previous Coordinator should have updated client #5's CFA to reflect the changes in client #5's mental status and functioning level. The interim Coordinator indicated client #6 and #7's CFAs should have been reviewed and updated at least annually.</p> <p>7) On 10/1/15 at 12:42 PM, a review of client #6's record was conducted. Client #6's current IPP was dated 7/30/14. There was no documentation in client #6's record indicating his IPP was revised since 7/30/14.</p> <p>On 10/1/15 at 1:23 PM, a focused review of client #7's record was conducted. Client #7's current IPP was dated 6/18/14. There was no documentation in client #7's record indicating his IPP was revised since 6/18/14.</p> <p>On 10/1/15 at 2:17 PM, the interim Coordinator indicated the former Coordinator held the clients' IPP meetings however there was no documentation for review. The interim Coordinator indicated the clients' new plans had not been implemented. The interim Coordinator indicated the clients' IPPs should be revised at least annually.</p> <p>8) On 9/29/15 at 3:47 PM, a review of</p>		<p>complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). W 260 483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. 1) Plan of correction: QIDP will update client #6 and #7's individual program plans (IPP) these will be reviewed and revised if needed annually (attachment p). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Reviewing and updating IPPs annually will be trained with agency QIDP. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a).</p>	

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	<p>the facility's evacuation drills was conducted. On 6/21/15 at 10:15 PM, the facility conducted a fire drill. The drill took 3 minutes and 40 seconds to complete. The evaluation of the drill indicated, "Only problem I had was getting [client #5] to listen to me and to touch the van." The Plan of Correction indicated, "Try to help him more even knowing there are 6 others I have to help." There was no documentation the former Coordinator reviewed the drill. There was no documentation indicating how the facility was going to assist client #5 with completing evacuation drills. On 9/13/15 at 10:20 PM, the facility conducted a fire drill. The drill took 6 minutes and 21 seconds to complete. The evaluation of the drill indicated, "Client (#5) refused to evacuate the house, it took him 6 minutes to step over the front door threshold (sic)." The Plan of Correction section indicated, "N/A."</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's 6/18/15 Individual Support Plan did not include a training objective to increase his participation in evacuation drills. Client #5's monthly interdisciplinary team (IDT) meeting notes indicated the facility did not discuss client #5's refusals to participate in evacuation drills. Client #5's had an</p>				

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	<p>informal goal to review fire escape procedures. The informal goal did not indicate how often the staff was to review the fire escape procedures with client #5. The informal goal was implemented two times from September 2014 to September 2015.</p> <p>On 9/29/15 at 4:17 PM, the Home Manager indicated the facility was having issues with getting client #5 to participate in drills.</p> <p>On 10/5/15 at 11:12 AM, the interim Coordinator indicated client #5's informal goal should indicate the frequency staff was to implement the training. The interim Coordinator indicated client #5's IDT needed to discuss his refusals to participate in drills. The interim Coordinator indicated client #5 may need a formal goal or social story to increase his participation in drills. The interim Coordinator indicated client #5's refusals should have been addressed.</p> <p>On 9/29/15 at 2:44 PM, the Group Home Director (GHD) indicated client #5 needed a plan to address his refusals to participate in evacuation drills. The GHD indicated the targeted time for the completion of drills was 3 minutes. The GHD indicated client #5 had an informal goal for staff to implement regarding</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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	<p>evacuation drills however the goal should have been moved to his formal goals when he started refusing to participate regularly. The GHD indicated client #5's refusals to participate should have been addressed by the IDT.</p> <p>9) On 9/30/15 at 1:26 PM, a review of client #2's record was conducted. Client #2's record indicated she was an emancipated adult. Client #2's 7/20/15 Individual Support Plan (ISP) did not include a signature from client #2 indicating she consented to the plan. The QIDP failed to obtain client #2's signature for the implementation of her ISP.</p> <p>On 9/30/15 at 2:58 PM, a review of client #4's record was conducted. Client #4's record indicated she had a guardian. Client #4's 2/12/15 ISP did not include a signature from client #4's guardian indicated the guardian consented to the plan. The QIDP failed to obtain a signature from client #4's guardian for the implementation of her ISP.</p> <p>On 10/1/15 at 2:12 PM, the interim Coordinator indicated the former QIDP should have obtained client #2's signature for the implementation of her ISP during the annual meeting. The interim Coordinator indicated the former QIDP</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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W 0240 Bldg. 00	<p>should have obtained client #4's guardian's signature for the implementation of her ISP during the annual meeting.</p> <p>9-3-3(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 observation, record review and interview for 1 of 4 clients in the sample (#5), the facility failed to ensure the written instructions to staff regarding client #5's refusals to participate in evacuation drills included the frequency the goal was to be implemented and what information the staff were to review with client #5, and client #5's Dining Plan and risk plan for choking included the same information.</p> <p>Findings include:</p> <p>1) On 9/29/15 at 3:47 PM, a review of the facility's evacuation drills was conducted. On 6/21/15 at 10:15 PM, the facility conducted a fire drill. The drill took 3 minutes and 40 seconds to complete. The evaluation of the drill indicated, "Only problem I had was</p>	W 0240	<p>W 240 483.440(c)(6)(i) INDIVIDUALPROGRAM PLAN The individual program plan mustdescribe relevant interventions to supportthe individual toward independence. 1) Planof correction: Client #5 informal goal was moved to a formal goal due to participationin the safety drills (attachment R). Facility staff has been trained on how toimplement this goal (attachment R). Planof prevention: Facility staff trained onfire drill policy and alerting the coordinator when issues arise (attachments). Agency QIDPs have been trained on duties as defined by W159 and willundergo extensive training in the next 14 days (attachment a). Reviewing and updating IPPs annually will betrained with agency QIDP. Prior QIDP offacility was demoted on 10/28/15 he received a negative annual review and willalso receive a corrective</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401		
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	<p>getting [client #5] to listen to me and to touch the van." The Plan of Correction indicated, "Try to help him more even knowing there are 6 others I have to help." There was no documentation the former Coordinator reviewed the drill. There was no documentation indicating how the facility was going to assist client #5 with completing evacuation drills. On 9/13/15 at 10:20 PM, the facility conducted a fire drill. The drill took 6 minutes and 21 seconds to complete. The evaluation of the drill indicated, "Client (#5) refused to evacuate the house, it took him 6 minutes to step over the front door threshold (sic)." The Plan of Correction section indicated, "N/A."</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's 6/18/15 Individual Support Plan did not include a training objective to increase his participation in evacuation drills. Client #5's monthly interdisciplinary team (IDT) meeting notes indicated the facility did not discuss client #5's refusals to participate in evacuation drills. Client #5's had an informal goal to review fire escape procedures. The informal goal did not indicate how often the staff was to review the fire escape procedures with client #5. The informal goal was implemented two times from September 2014 to September</p>		<p>action with the above citations listed (attachmentn). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). House manager /associate manager will provide daily monitoring, each shift, to ensure client plans are followed and client safety and plans are followed (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility. 2) Plan of correction: Day program and facility staff have been trained on client #5's revised Dining and risk plans for choking to ensure the plans were implemented as written (attachment o). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action</p>		

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401			
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	<p>2015.</p> <p>On 9/29/15 at 4:17 PM, the Home Manager indicated the facility was having issues with getting client #5 to participate in drills.</p> <p>On 10/5/15 at 11:12 AM, the interim Coordinator indicated client #5's informal goal should indicate the frequency staff was to implement the training. The interim Coordinator indicated client #5's IDT needed to discuss his refusals to participate in drills. The interim Coordinator indicated client #5 may need a formal goal or social story to increase his participation in drills. The interim Coordinator indicated client #5's refusals should have been addressed.</p> <p>On 9/29/15 at 2:44 PM, the Group Home Director (GHD) indicated client #5 needed a plan to address his refusals to participate in evacuation drills. The GHD indicated the targeted time for the completion of drills was 3 minutes. The GHD indicated client #5 had an informal goal for staff to implement regarding evacuation drills however the goal should have been moved to his formal goals when he started refusing to participate regularly. The GHD indicated client #5's refusals to participate should have been addressed by the IDT.</p>		<p>with the above citations listed (attachment n). Plan of monitoring: House manager / associate manager will provide daily monitoring, each shift, to ensure client plans are followed and client safety and plans are followed (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401		
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	<p>2) On 9/30/15 from 10:55 AM to 12:30 PM, an observation was conducted at the facility-operated day program. At 11:28 AM, client #5 entered a conference room to eat his lunch. Client #5 entered the room and told staff #11 he wanted to eat by himself. Client #5 closed the door and started to eat his lunch without staff supervision. Client #5 indicated he enjoyed eating by himself without staff present. Client #5 was in the conference room with the door closed throughout his meal. Staff #11 opened the door several times throughout the meal but did not provide constant supervision of client #5 during his meal.</p> <p>On 9/30/15 at 11:28 AM, staff #11 indicated client #5 ate his lunch in private daily. Staff #11 indicated client #5 did not want staff in the same room with him while he ate.</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's risk plan for choking, dated 6/19/14, indicated, "On 5/13/11 [client #5] was observed to be choking at lunch time in the workshop. [Client #5] has a tendency to eat fast and puts too much food in his mouth at once. He also does not chew his food fully before taking additional bites, and he does not follow bites with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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	<p>liquid to ensure that the food is properly swallowed." The plan indicated, "[Client #5] will eat meals and snacks in area with other consumers and staff so he can be monitored." The plan indicated, in part, "Staff will encourage [client #5] to take sips of fluid after every other bite to make sure food is clear and swallowed completely." The plan, revised on 6/22/15, indicated, "[Client #5] has had no further incidents of choking at this time." The risk plan failed to indicate client #5 choked on 4/16/15.</p> <p>Client #5's Dining Plan, dated 4/24/15, indicated, in part, "[Client #5] has had one incident in the last month of choking." The plan indicated, "[Client #5] eats independently. Staff should ensure food is cut up appropriately (not defined). Staff should be in the area to monitor...." The Dining Plan did not indicate staff would encourage client #5 to take sips of liquid after every other bite to make sure food is clear and swallowed completely.</p> <p>Client #5's Dining Plan and risk plan for choking did not include the same information regarding the steps staff were to implement to ensure client #5 did not choke.</p> <p>On 10/1/15 at 2:15 PM, the interim</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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W 0249 Bldg. 00	<p>Coordinator indicated the Dining Plan did not match the risk plan for choking. The interim Coordinator indicated the plans needed to include the same information. The interim Coordinator indicated the plan given to the day program by the former QIDP did not indicate client #5 needed constant supervision during meals.</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, record review and interview for 1 of 4 clients in the sample (#5), the facility failed to ensure client #5's plans for supervision were implemented as written at the facility-operated day program and client #5's plan to take a sip of fluids after every other bite was implemented at the group home and the facility-operated day program.</p> <p>Findings include:</p>	W 0249	<p>W 249 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program</p> <p>1. Plan of correction: Day program and facility staff have</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401			
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	<p>On 9/29/15 from 3:45 PM to 6:12 PM, an observation was conducted at the group home. At 5:56 PM, client #5 started to eat his dinner. During client #5's meal, staff #1 and #3 did not encourage client #5 to take sips of fluid after every other bite to make sure food is clear and swallowed completely.</p> <p>On 9/30/15 from 10:55 AM to 12:30 PM, an observation was conducted at the facility-operated day program. At 11:28 AM, client #5 entered a conference room to eat his lunch. Client #5 entered the room and told staff #11 he wanted to eat by himself. Client #5 closed the door and started to eat his lunch without staff supervision. Client #5 indicated he enjoyed eating by himself without staff present. Client #5 was in the conference room with the door closed throughout his meal. Staff #11 opened the door several times throughout the meal but did not provide constant supervision of client #5 during his meal. Staff #11 did not prompt client #5 to take sips of fluid after every other bite to make sure his food was cleared and swallowed completely.</p> <p>On 9/30/15 at 11:28 AM, staff #11 indicated client #5 ate his lunch in private daily at the facility-operated day program. Staff #11 indicated client #5 did not want</p>		<p>been trained on client #5's revised Dining and risk plans for choking to ensure the plans were implemented as written (attachment o). High risk plan has been updated to match dining plan and vice versa (attachment u). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: House manager / associate manager will provide daily monitoring, each shift, to ensure client plans are followed and client safety and plans are followed (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
--------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>staff in the same room with him while he ate.</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's risk plan for choking, dated 6/19/14, indicated, "On 5/13/11 [client #5] was observed to be choking at lunch time in the workshop. [Client #5] has a tendency to eat fast and puts too much food in his mouth at once. He also does not chew his food fully before taking additional bites, and he does not follow bites with liquid to ensure that the food is properly swallowed." The plan indicated, "[Client #5] will eat meals and snacks in area with other consumers and staff so he can be monitored." The plan indicated, in part, "Staff will encourage [client #5] to take sips of fluid after every other bite to make sure food is clear and swallowed completely." The plan, revised on 6/22/15, indicated, "[Client #5] has had no further incidents of choking at this time." The risk plan failed to indicate client #5 choked on 4/16/15.</p> <p>Client #5's Dining Plan, dated 4/24/15, indicated, in part, "[Client #5] has had one incident in the last month of choking." The plan indicated, "[Client #5] eats independently. Staff should ensure food is cut up appropriately (not defined). Staff should be in the area to</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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W 0259 Bldg. 00	<p>monitor..." The Dining Plan did not indicate staff would encourage client #5 to take sips of liquid after every other bite to make sure food is clear and swallowed completely.</p> <p>Client #5's Dining Plan and risk plan for choking did not include the same information regarding the steps staff were to implement to ensure client #5 did not choke.</p> <p>On 10/5/15 at 11:01 AM, the interim Coordinator indicated the staff should implement the plans as written.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 4 clients in the sample (#5 and #6) and one additional client (#7), the facility failed to ensure client #6 and #7's comprehensive functional assessments were reviewed by the interdisciplinary team (IDT) for relevancy and updated at least annually. The facility failed to ensure client #5's comprehensive</p>	W 0259	<p>W 259 483.440(f)(2) PROGRAMMONITORING & CHANGE At least annually, thecomprehensive functional assessment of each client must bereviewed by the interdisciplinary team forrelevancy and updated as needed. 1.Planof correction: Client #5, #6 and client#7 comprehensive functional assessments were reviewed by the QIDP</p>	10/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401		
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	<p>functional assessment was reviewed and updated when he was diagnosed with dementia and changes were noted with his mental status and functioning level.</p> <p>Findings include:</p> <p>On 10/1/15 at 12:42 PM, a review of client #6's record was conducted. Client #6's most recent update to his comprehensive functional assessment (CFA) was conducted on 7/30/14. There was no documentation in client #6's record indicating his IDT reviewed his CFA for relevancy and updated his CFA at least annually.</p> <p>On 10/1/15 at 1:23 PM, a focused review of client #7's record was conducted. Client #7's most recent update to his CFA was conducted on 6/18/14. There was no documentation in client #7's record indicating his IDT reviewed his CFA for relevancy and updated his CFA at least annually.</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's most recent update to his CFA was conducted on 6/22/15. Client #5's Dementia Screen Review, dated 1/12/15, indicated, in part, "According to the information obtained, it appears that [client #5] shows many features which</p>		<p>and interdisciplinary team (attachment o). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Implementing team decisions was trained with agency QIDPs. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGI (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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W 0260 Bldg. 00	<p>may be associated with the early stages of dementia...."</p> <p>On 10/1/15 at 1:37 PM, the interim Coordinator indicated client #5's CFA was not updated following client #5 being diagnosed with dementia. The interim Coordinator indicated the former Coordinator should have updated client #5's CFA to reflect the changes in client #5's mental status and functioning level. The interim Coordinator indicated client #6 and #7's CFAs should have been reviewed and updated at least annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (#6) and one additional client (#7), the facility failed to ensure the clients' individual program plans (IPP) were revised at least annually.</p> <p>Findings include:</p> <p>On 10/1/15 at 12:42 PM, a review of client #6's record was conducted. Client</p>	W 0260	<p>W 260 483.440(f)(2) PROGRAMMONITORING & CHANGE At least annually, the individualprogram plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>1. Planof correction: QIDP will update client#6 and #7's individual program plans (IPP) these will be reviewed and revisedif needed annually (attachment p). Planof</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401			
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W 0322 Bldg. 00	<p>#6's current IPP was dated 7/30/14. There was no documentation in client #6's record indicating his IPP was revised since 7/30/14.</p> <p>On 10/1/15 at 1:23 PM, a focused review of client #7's record was conducted. Client #7's current IPP was dated 6/18/14. There was no documentation in client #7's record indicating his IPP was revised since 6/18/14.</p> <p>On 10/1/15 at 2:17 PM, the interim Coordinator indicated the former Coordinator held the clients' IPP meetings however there was no documentation for review. The interim Coordinator indicated the clients' new plans had not been implemented. The interim Coordinator indicated the clients' IPPs should be revised at least annually.</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 4 clients in the sample (#4), the facility failed to ensure client #4 had an annual physical since 9/16/14.</p>	W 0322	<p>prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Reviewing and updating IPPs annually will be trained with agency QIDP. Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a).</p> <p>W 322 483.460(a)(3) PHYSICIANS SERVICES The facility must provide or obtain preventive and general medical care. Plan of correction: Client #4 has</p>	10/30/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401		
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W 0440 Bldg. 00	<p>Findings include:</p> <p>On 9/30/15 at 2:58 PM, a review of client #4's record was conducted. Client #4's most recent annual physical was conducted on 9/16/14. There was no documentation in her record indicating client #4 had an annual physical completed since 9/16/14.</p> <p>On 10/1/15 at 2:12 PM, the Coordinator indicated client #4 should have an annual physical. The Coordinator indicated client #4's annual physical was scheduled on 10/12/15.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p>	W 0440	<p>a physical exam scheduled and will be obtained in next 30 days (attachment w). Plan of prevention: Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days (attachment a). Reviewing and ensuring day aid follows annual physical schedule was trained to new QIDP (attachment v). This was also trained to agency QIDPs (attachment a). Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a).</p> <p>W 440 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Plan of correction: Prior house manager and QIDP of facility was demoted on 10/28/15. QIDP received a negative annual review and will also receive a corrective action</p>	10/25/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015	
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	<p>On 9/29/15 at 2:36 PM and 3:47 PM, reviews of the facility's evacuation drills were conducted. During the day shift (6:00 AM to 2:00 PM), the facility failed to conduct evacuation drills from 9/29/14 to 4/26/15. During the evening shift (2:00 PM to 10:00 PM), the facility failed to conduct evacuation drills from 9/29/14 to 2/25/15. During the night shift (10:00 PM to 6:00 AM), the facility failed to conduct evacuation drills from 9/29/14 to 3/12/15. This affected clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>On 9/29/15 at 4:22 PM, the Coordinator indicated the facility should conduct one drill per shift per quarter.</p> <p>On 9/29/15 at 2:44 PM, the Group Home Director indicated the facility should conduct one drill per shift per quarter.</p> <p>9-3-7(a)</p>		<p>with the above citations listed (attachment n). Plan of prevention: Facility staff trained on fire drill policy and alerting the coordinator when issues arise (attachment s). Agency QIDPs have been trained on duties as defined by W159 and will undergo extensive training in the next 14 days including reviewing drills (attachment a). Prior QIDP of facility was demoted on 10/28/15 he received a negative annual review and will also receive a corrective action with the above citations listed (attachment n). Plan of monitoring: Agency QIDP will complete internal audits on each other homes as assigned by DSGL to ensure drills are completed each quarter for each shift (attachment n). These will be reviewed by QIDP leadership team each quarter and issues will be resolved (attachment a). House manager / associate manager will provide daily monitoring, each shift, to ensure client plans are followed and client safety and plans are followed (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility.</p>				

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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W 0449 Bldg. 00	<p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills and take corrective action.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (#5), the facility failed to investigate all problems with evacuation drills and take corrective action.</p> <p>Findings include:</p> <p>On 9/29/15 at 3:47 PM, a review of the facility's evacuation drills was conducted. On 6/21/15 at 10:15 PM, the facility conducted a fire drill. The drill took 3 minutes and 40 seconds to complete. The evaluation of the drill indicated, "Only problem I had was getting [client #5] to listen to me and to touch the van." The Plan of Correction indicated, "Try to help him more even knowing there are 6 others I have to help." There was no documentation the former Coordinator reviewed the drill. There was no documentation indicating how the facility was going to assist client #5 with completing evacuation drills. On 9/13/15 at 10:20 PM, the facility conducted a fire drill. The drill took 6 minutes and 21 seconds to complete. The evaluation of the drill indicated, "Client (#5) refused to evacuate the house, it took him 6 minutes to step over the front door threshold (sic)."</p>	W 0449	<p>W 449 483.470(i)(2)(iv) EVACUATIONDRILLS The facility must investigate all problems with evacuationdrills and take corrective action. Planof correction: Client #5 informal goal was moved to a formal goal due toparticipation in the safety drills (attachment R). Facility staff hasbeen trained on how to implement this goal (attachment R). Planof prevention: Facility staff trained onfire drill policy and alerting the coordinator when issues arise (attachments). Agency QIDPs have been trained on duties as defined by W159 and willundergo extensive training in the next 14 days (attachment a). Reviewing and updating IPPs annually will betrained with agency QIDP. Prior QIDP offacility was demoted on 10/28/15 he received a negative annual review and willalso receive a corrective action with the above citations listed (attachmentn). Plan ofmonitoring: Agency QIDP will completeinternal audits on each other homes as assigned by DSGL (attachment n). These will be reviewed by QIDP leadershipteam each quarter and issues will be resolved (attachment a). House manager /associate manager will provide daily monitoring, each shift, to</p>	10/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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	<p>The Plan of Correction section indicated, "N/A."</p> <p>On 10/1/15 at 11:40 AM, a review of client #5's record was conducted. Client #5's 6/18/15 Individual Support Plan did not include a training objective to increase his participation in evacuation drills. Client #5's monthly interdisciplinary team (IDT) meeting notes indicated the facility did not discuss client #5's refusals to participate in evacuation drills. Client #5's had an informal goal to review fire escape procedures. The informal goal did not indicate how often the staff was to review the fire escape procedures with client #5. The informal goal was implemented two times from September 2014 to September 2015.</p> <p>On 9/29/15 at 4:17 PM, the Home Manager indicated the facility was having issues with getting client #5 to participate in drills.</p> <p>On 10/5/15 at 11:12 AM, the interim Coordinator indicated client #5's informal goal should indicate the frequency staff was to implement the training. The interim Coordinator indicated client #5's IDT needed to discuss his refusals to participate in drills. The interim Coordinator indicated client #5 may need</p>		<p>ensure client plans are followed and client safety and plans are followed (attachment k). QIDP will provide daily monitoring to ensure client plans are followed and client safety (attachment a). DSGL will provide weekly monitoring to ensure client plans are followed and client safety (attachment a). This level of monitoring may be tapered off once compliance has been met by facility.</p>	

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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W 9999 Bldg. 00	<p>a formal goal or social story to increase his participation in drills. The interim Coordinator indicated client #5's refusals should have been addressed.</p> <p>On 9/29/15 at 2:44 PM, the Group Home Director (GHD) indicated client #5 needed a plan to address his refusals to participate in evacuation drills. The GHD indicated the targeted time for the completion of drills was 3 minutes. The GHD indicated client #5 had an informal goal for staff to implement regarding evacuation drills however the goal should have been moved to his formal goals when he started refusing to participate regularly. The GHD indicated client #5's refusals to participate should have been addressed by the IDT.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>1) 460 IAC 9-3-1(a) Governing Body</p>	W 9999	W9999 FINAL OBSERVATIONS W9999 State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 1) 460 IAC 9-3-1(a) Governing Body Plan of correction: Client #2 the occurrence of skin breakdown related to a decubitus ulcer,	10/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
--------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>14. A significant injury to an individual that includes but is not limited to: f. any occurrence of skin breakdown related to a decubitus ulcer, regardless of severity....</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 18 incident reports reviewed affecting client #2, the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law, an occurrence of skin breakdown related to a decubitus ulcer, regardless of the severity.</p> <p>Findings include</p> <p>On 9/29/15 at 1:49 PM, a review of the facility's incident reports was conducted and indicated the following: On 7/30/15 at 12:00 PM, a BDDS incident report indicated, in part, "On 07/30/2015 at 12:00 PM, [client #2] had a follow up appointment with her dermatologist. [Client #2] has had a sore on her right ankle for several weeks now, and it has</p>		<p>regardless of the severity was reported when DSGL was notified.</p> <p>Plan of prevention: Facility staff trained on preventing and reporting abuse and neglect (attachment x). QIDP / coordinators who carry the emergency pager trained on reporting and investigating allegation of abuse and neglect, including unknown injuries (attachment a).</p> <p>Plan of monitoring: Director of supported group living / DSGL will be immediately notified following any allegation of abuse and neglect, including choking incidents (attachment a). DSGL will assign an investigator and review outcome and devise recommendations within 5 working days (attachment a).</p>	

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	<p>been undergoing treatment for the same length of time. However, because the wound wasn't healing as fast as the dermatologist would like, [client #2] was referred to a Wound Care Specialist. [Client #2] was seen, and a new treatment of iodine and a special inflatable boot to wear while sleeping was prescribed. In this appointment, the wound was referred to as a pressure ulcer. [Client #2] is undergoing treatment for the sore. At no time has the pressure ulcer been open or infected...."</p> <p>On 9/30/15 at 1:26 PM, a review of client #2's record was conducted. Client #2's Outside Services Report (OSR) with the dermatologist, dated 5/19/15, indicated, in part, in the Diagnosis/Results section, "Early ulcer (R) lateral malliol (sic)... Needs 3-4 (inch) thick foam pillow to support the ankle during sleep...." On 7/22/15, the OSR from the dermatologist indicated the Reason for the Visit was "Follow-up on right ankle ulcer." The Treatment/Tests Ordered section indicated, "Referral to Wound Care Center for evaluation (and) treatment...."</p> <p>On 9/30/15 at 2:34 PM, the Group Home Director indicated the ulcer should have been reported to BDDS when it was first noted in May 2015. The GHD indicated as soon as she saw the report she reported</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
--------------------------------------------------------	-----------------------------------------------------------------------------------

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	<p>it to BDDS. The GHD indicated BDDS reports should be submitted within 24 hours.</p> <p>2) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (staff #5), the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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	<p>On 9/29/15 at 3:02 PM a review of the facility's employee files was conducted. Staff #5's employee file indicated her most recent Mantoux was completed on 9/1/14. There was no documentation in staff #5's employee file indicating she had a Mantoux completed since 9/1/14.</p> <p>On 9/29/15 at 3:09 PM, the Group Home Director indicated the staff should have an annual TB test.</p> <p>On 9/30/15 at 2:15 PM, the Coordinator indicated the staff should have an annual TB test.</p> <p>9-3-1(b) 9-3-3(e)</p>			