

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 12/08/2015
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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 0000 Bldg. 00	<p>This visit was for a Post Certification Revisit (PCR) to the full recertification and state licensure survey completed on 10/6/15.</p> <p>Survey Dates: December 3, 4, 7 and 8, 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 12/9/15.</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.</p> <p>Based on record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility by failing to ensure the Plan of Correction</p>	W 0102	<p>per ISDH letter on 12-15-15, the following changes are being made to the POC.</p> <p>Specifically, "All tags: . . . Please amend the date of correction for all tags to December 23, 2015 and resubmit the POC. This is the date by which the facility is expected to have all corrective actions completed." W 102</p>	12/23/2015

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>for the recertification and state licensure survey was implemented as indicated.</p> <p>The governing body failed to ensure the Plan of Correction addressed the lack of thorough investigations during the annual recertification and state licensure survey completed on 10/6/15 affecting clients #2 and #5. The governing body failed to implement systemic corrections to ensure thorough investigations were conducted.</p> <p>The governing body failed to ensure the GHD (Group Home Director) conducted weekly monitoring of client #1, #2, #3, #4, #5, #6 and #7's plans to ensure the clients' safety and the clients' plans were being implemented. The governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) conducted daily monitoring of client #1, #2, #3, #4, #5, #6 and #7's plans to ensure the clients' safety and the clients' plans were being implemented. The governing body failed to ensure the facility's nurse conducted weekly mealtime monitoring of the clients' dining plans to ensure the plans were being implemented as written.</p> <p>The governing body failed to ensure the QIDP conducted daily monitoring of the clients' meals while at the facility-operated day program. The governing body failed to ensure the Home Manager (HM) or Assistant HM conducted daily monitoring of the clients' meals to ensure the clients' dining plans</p>		<p>(Condition) Governing Body and Management – Failed to ensure Plan of Correction (POC) was implemented Corrective action for resident(s) found to have been affected Each POC item from 10/6/15 Survey with Event ID O2CZ11 will be fully implemented. Implementation will be monitored by a Stone Belt Senior Director. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Stone Belt has assigned a Senior Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented. Home visit report forms will be used to document required visits to the home in order to ensure that all required monitoring takes place. How corrective actions will be monitored to ensure no recurrence Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will supervise implementation, including ensuring that monitoring visits are conducted as outlined in the</p>	

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	<p>were being implemented. The governing body failed to ensure the staff received training on client #2's new unloading from van training objective. The governing body failed to ensure the former QIDP received corrective action for failing to complete his job duties. The governing body failed to ensure the QIDP Internal Inspections were completed quarterly as indicated in the Plan of Correction. The governing body failed to ensure the facility-operated day program and group home staff received training on client #5's revised risk plan for choking. The governing body failed to ensure staff received training on client #5's refusals to participate in evacuation drills. The governing body failed to ensure the QIDP revised client #7's Individual Support Plan annually.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the governing body failed to exercise operating direction over the facility by failing to ensure the Plan of Correction for the recertification and state licensure survey was implemented as indicated.</p> <p>This deficiency was cited on 10/6/15. The facility failed to implement a</p>		<p>original POC. Each visit to the home or day program will be documented on a form, which will be reviewed and signed by the Senior Director. Visits from the SGL Director, QIDP, manager, associate manager, and nurse will be monitored to ensure full compliance with the POC. The Senior Director, SGL Director, and QIDP all meet the regulatory requirements as a QIDP. Daily QIDP monitoring visits will occur from one of these Q-qualified professionals, and these visits will continue at a minimum until all Condition level citations are lifted. Regular documented meetings will be chaired by the Senior Director to ensure ongoing compliance with the POC.</p>	

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W 0104 Bldg. 00	<p>systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the governing body failed to exercise operating direction over the facility by failing to ensure the Plan of Correction for the recertification and state licensure survey was implemented as indicated.</p> <p>Findings include:</p> <p>1) The governing body failed to ensure the Plan of Correction addressed the lack of thorough investigations during the annual recertification and state licensure survey completed on 10/6/15 affecting clients #2 and #5. The governing body failed to implement systemic corrections to ensure thorough investigations were conducted.</p> <p>On 12/3/15 at 1:56 PM, a review of the</p>	W 0104	<p>W 104 (Standard) Governing Body – Failed to ensure Plan of Correction (POC) was implemented and failed to address lack of thorough investigations Corrective action for resident(s) found to have been affected Each POC item from 10/6/15 Survey with Event ID O2CZ11 will be fully implemented. Both the QIDP and SGL Director will receive documented training by the Senior Director on the requirements to conduct thorough investigations. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Stone Belt has assigned a Senior Director to monitor implementation of the POC and</p>	12/23/2015

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	<p>facility's Plan of Correction (POC) was conducted. The plan did not address the previously cited issues of the lack of thorough investigations. The POC indicated, "...Plan of Correction: Investigation of client #5's 'choking' was investigated... Staff acted with good intentions and following client #5 (sic) choking plan...." The POC indicated, "Plan of Correction: Investigation of client #2 rolling out of back of van was investigated...." The POC indicated, "Plan of Correction: Investigation of client #5 'eloping' was investigated and was located in CIR (Confidential Incident Report) folder...." The POC indicated, "Plan of correction: Investigation of client #5 (sic) broken arm was investigated following incident and a BQIS (Bureau of Quality Improvement Services) checklist completed. It was determined that the broken bone was self inflicted and SIB (self-injurious behavior) was added to BSP (Behavior Support Plan)...."</p> <p>There was no documentation in the plan of correction addressing the lack of thorough investigations.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she was not trained on conducting thorough investigations.</p>		<p>to train the QIDP and SGL Director on thorough investigations. Training on safe unloading from the van also will be completed. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented. Home visit report forms will be used to document required visits to the home in order to ensure that all required monitoring takes place. How corrective actions will be monitored to ensure no recurrence Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will supervise implementation, including ensuring that monitoring visits are conducted as outlined in the original POC. Each visit to the home or day program will be documented on a form, which will be reviewed and signed by the Senior Director. Visits from the SGL Director, QIDP, manager, associate manager, and nurse will be monitored to ensure full compliance with the POC. The Senior Director, SGL Director, and QIDP all meet the regulatory requirements as a QIDP. Daily QIDP monitoring visits will occur from one of these Q-qualified professionals, and these visits will continue at a minimum until all Condition level citations are</p>				

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	<p>On 12/4/15 at 2:30 PM, the Group Home Director (GHD) indicated she did not address or retrain the staff on conducting thorough investigations.</p> <p>2) The governing body failed to ensure the GHD conducted weekly monitoring of client #1, #2, #3, #4, #5, #6 and #7's plans to ensure the clients' safety and the clients' plans were being implemented.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W102, W104, W159, W240, W249, W440 and W449, "DSGL (Group Home Director - GHD) will provide weekly monitoring to monitoring (sic) to ensure client plans are followed and client safety...." There was no documentation the GHD conducted weekly monitoring to ensure client safety and the clients' plans (#1, #2, #3, #4, #5, #6 and #7) were implemented as written.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated she had not conducted weekly monitoring at the group home as indicated in the POC. The GHD indicated she needed to conduct weekly monitoring as indicated in the POC.</p> <p>3) The governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) conducted daily</p>		<p>lifted. Regular documented meetings will be chaired by the Senior Director to ensure ongoing compliance with the POC.</p>	

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	<p>monitoring of client #1, #2, #3, #4, #5, #6 and #7's plans to ensure the clients' safety and the clients' plans were being implemented.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W102, W104, W159, W240, W249, W440 and W449, "...QIDP will provide daily monitoring to ensure client plans are followed and client safety...." There was no documentation the QIDP conducted daily monitoring to ensure client safety and the clients' plans (#1, #2, #3, #4, #5, #6 and #7) were implemented as written.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated the QIDP needed to conduct daily monitoring as indicated in the POC.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she did not have documentation of conducting daily monitoring at the group home. The QIDP indicated she was instructed to monitor on a weekly basis but not daily. The QIDP stated she was "not told I needed to do daily monitoring."</p> <p>4) The governing body failed to ensure the facility's nurse conducted weekly mealtime monitoring of the clients' dining plans to ensure the plans were</p>				

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	<p>being implemented as written.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W104, "Facility nurse will provide weekly mealtime monitoring to ensure dining plans are being followed...." There was no documentation the facility's nurse conducted weekly monitoring of the clients' dining plans.</p> <p>On 12/4/15 at 2:30 PM, the GHD stated, "No way she could do that, can't be in there like that. She (the nurse) can't do that. There's no way." The GHD indicated the nurse could monitor the clients' dining plans monthly but she made a mistake in the POC indicating weekly monitoring. The GHD indicated the nurse should monitor the clients' plans as indicated in the POC.</p> <p>On 12/4/15 at 2:53 PM, the Nurse Manager indicated there was no documentation the nurse conducted weekly monitoring of the clients' meals to ensure the dining plans were implemented as written.</p> <p>On 12/8/15 at 11:21 AM, the nurse indicated she was not aware she needed to conduct weekly monitoring of the clients' dining plans.</p>				

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	<p>5) The governing body failed to ensure the QIDP conducted daily monitoring of the clients' meals while at the facility-operated day program.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W104, "Facility QIDP will provide daily mealtime monitoring to ensure dining plans are being followed at day program...." There was no documentation the QIDP conducted daily mealtime monitoring to ensure dining plans were being implemented as written at the facility-operated day program.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she did not have documentation of monitoring the clients' meals while at the facility-operated day program daily.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated she did not have documentation the QIDP conducted daily monitoring of the clients' meals at the facility-operated day program.</p> <p>6) The governing body failed to ensure the Home Manager (HM) or Assistant HM conducted daily monitoring of the clients' meals to ensure the clients' dining plans were being implemented.</p>			

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	<p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W102, W104, W159, W240, W249, W440 and W449, "House manager/associate manager will provide daily monitoring, each shift, to ensure client plans are followed and client safety...." There was no documentation the house manager or associate house manager conducted daily monitoring, each shift, to ensure the clients' plans were followed and client safety.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she was not aware of this recommendation in the POC. The QIDP indicated she did not instruct the manager or associate manager to conduct daily monitoring. The QIDP indicated there was no documentation of this recommendation being implemented.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated there was no documentation the house manager or associate manager conducted daily monitoring.</p> <p>7) The governing body failed to ensure the staff received training on client #2's new unloading from van training objective.</p>			

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	<p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W102, W104, W122, W149, W154, W156 and W157, "...Facility staff trained on client #2 (sic) training goal and transportation/wheelchair safety." There was no documentation the staff received training on client #2's transportation/wheelchair safety goal.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she did not have documentation the staff received training on client #2's goal for transportation/wheelchair safety.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated she did not have documentation the staff received training on client #2's goal for transportation/wheelchair safety.</p> <p>8) The governing body failed to ensure the former QIDP received corrective action for failing to complete his job duties.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W159, W240, W249, W259, W260, W322, W440, W449, "...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</p>				

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	<p>citations listed...." There was no documentation the former QIDP received corrective action to address the citations. The plan of corrective completion date for the QIDP receiving a corrective action was 10/25/15.</p> <p>On 12/4/15 at 4:09 PM, the GHD sent an email with an attachment (HR (Human Resources) Actions Self Service) indicating the former QIDP put in his two week notice on 11/12/15 and his last shift was on 11/26/15.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated the former QIDP quit working for the facility prior to receiving corrective action.</p> <p>9) The governing body failed to ensure the QIDP Internal Inspections were completed quarterly as indicated in the Plan of Correction.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W159, W240, W259, W260, W322, W440 and W449, "Plan of monitoring: Agency QIDP will complete internal audits on each other (sic) homes as assigned by DSGL... These will be reviewed by QIDP leadership team each quarter and issues will be resolved...." There was no</p>			

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	<p>documentation the QIDP conducted an internal audit(s).</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated an internal audit had not been conducted at the group home.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated the QIDP had a list of the group homes she was to audit. The GHD indicated an audit had not been conducted at the group home as indicated in the POC.</p> <p>10) The governing body failed to ensure the facility-operated day program and group home staff received training on client #5's revised risk plan for choking.</p> <p>On 12/4/15 at 12:39 PM, a review of client #5's record was conducted. Client #5's risk plan for choking was revised on 10/14/15 and 10/26/15. The group home staff was trained on client #5's risk plan on 10/23/15. There was no documentation the facility-operated day program staff was trained on either plan. There was no documentation the group home and day program staff received training on client #5's 10/26/15 risk plan for choking.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she was not sure if the group</p>			

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	<p>home and day program staff received training on client #5's 10/26/15 risk plan for choking.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated she did not have documentation the group home and day program staff received training on client #5's 10/26/15 risk plan for choking.</p> <p>11) The governing body failed to ensure staff received training on client #5's training objective addressing his refusals to participate in evacuation drills.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W159, W240 and W449, "...Plan of Correction: Client #5 (sic) informal goal was moved to a formal goal due to refusing to participate in the safety drills... Facility staff has been trained on how to implement this goal." There was no documentation the staff was trained to implement the goal.</p> <p>On 12/4/15 at 12:39 PM, a review of client #5's record was conducted. There was no documentation in client #5's record indicating his informal goal was moved to a formal goal. On 12/7/15 at 3:28 PM, the QIDP sent an email with an attachment indicating client #5 had a training objective addressing his refusals</p>			

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	<p>to participate in evacuation drills.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she trained the staff on his evacuation drill goal but did not document the training of the staff. On 12/7/15 at 2:50 PM, the QIDP indicated client #5 had a formal goal created to address his issues with evacuation drills. The QIDP indicated she trained the Home Manager and Assistant Manager but did not document the training. The QIDP indicated she did not instruct the Home Manager or Assistant Manager to train the staff on client #5's goal.</p> <p>12) The governing body failed to ensure the QIDP revised client #7's Individual Support Plan annually.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W260, "Plan of Correction: QIDP will update client #6 and #7's individual program plans (IPP). These will be reviewed and revised if needed annually." There was no documentation client #7's program plan was revised annually.</p> <p>On 12/4/15 at 12:54 PM, a review of client #7's record was conducted. There was no documentation client #7's IPP was reviewed and revised annually. The</p>			

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W 0159 Bldg. 00	<p>current plan was dated 6/18/14.</p> <p>On 12/4/15 at 1:15 PM, the QIDP indicated she was still working on completing client #7's IPP. The QIDP indicated client #7's IPP had not been revised or updated. The QIDP indicated she needed assistance from another QIDP to complete typing the updated plan.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated client #7's IPP should have been revised and updated as needed.</p> <p>This deficiency was cited on 10/6/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(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 record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients'</p>	W 0159	<p>W 159 (Standard) QIDP – failed to integrate, coordinate, and monitor client plans Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID O2CZ12 will be fully</p>	12/23/2015			

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	<p>program plans. The QIDP failed to conduct daily monitoring of client #1, #2, #3, #4, #5, #6 and #7's plans to ensure the clients' safety and the clients' plans were being implemented. The QIDP failed to conduct daily monitoring of the clients' meals while at the facility-operated day program. The QIDP failed to ensure the Home Manager (HM) or Assistant HM conducted daily monitoring of the clients' meals to ensure the clients' dining plans were being implemented. The QIDP failed to ensure the staff received training on client #2's new unloading from van training objective. The QIDP failed to ensure the facility-operated day program and group home staff received training on client #5's revised risk plan for choking. The QIDP failed to ensure staff received training on client #5's refusals to participate in evacuation drills. The QIDP failed to revise client #7's Individual Support Plan annually.</p> <p>Findings include:</p> <p>1) The governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) conducted daily monitoring of client #1, #2, #3, #4, #5, #6 and #7's plans to ensure the clients' safety and the clients' plans were being implemented.</p>		<p>implemented, including the following specifics: The QIDP, SGL Director, or Senior Director will conduct daily monitoring of client #1, #2, #3, #4, #5, #6 and #7's plans to ensure the clients' safety and that their plans are being implemented. Daily monitoring will occur of the clients' meals while at the facility-operated day program. The QIDP will ensure the Home Manager (HM) or Assistant HM conduct daily monitoring of the clients' meals to ensure the clients' dining plans are being implemented. Staff will receive documented training on client #2's new unloading from van training objective. The facility-operated day program and group home staff will receive training on client #5's revised risk plan for choking. The staff also will receive training on client #5's refusals to participate in evacuation drills. The QIDP will revise client #7's Individual Support Plan annually.</p> <p>How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Monitoring of plan implementation and staff training will be conducted as outlined above. How corrective actions will be monitored to ensure no recurrence Stone Belt has</p>	

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	<p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W102, W104, W159, W240, W249, W440 and W449, "...QIDP will provide daily monitoring to ensure client plans are followed and client safety...." There was no documentation the QIDP conducted daily monitoring to ensure client safety and the clients' plans (#1, #2, #3, #4, #5, #6 and #7) were implemented as written.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated the QIDP needed to conduct daily monitoring as indicated in the POC.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she did not have documentation of conducting daily monitoring at the group home. The QIDP indicated she was instructed to monitor on a weekly basis but not daily. The QIDP stated she was "not told I needed to do daily monitoring."</p> <p>2) The QIDP failed to conduct daily monitoring of the clients' meals while at the facility-operated day program.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W104, "Facility QIDP will provide daily mealtime monitoring to ensure dining</p>		<p>assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will supervise implementation, including ensuring that monitoring visits are conducted as outlined in the original POC. Each visit to the home or day program will be documented on a form, which will be reviewed and signed by the Senior Director. Visits from the SGL Director, QIDP, manager, associate manager, and nurse will be monitored to ensure full compliance with the POC. The Senior Director, SGL Director, and QIDP all meet the regulatory requirements as a QIDP. Daily QIDP monitoring visits will occur from one of these Q-qualified professionals, and these visits will continue at a minimum until all Condition level citations are lifted. Regular documented meetings will be chaired by the Senior Director to ensure ongoing compliance with the POC.</p>		

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	<p>plans are being followed at day program...." There was no documentation the QIDP conducted daily mealtime monitoring to ensure dining plans were being implemented as written at the facility-operated day program.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she did not have documentation of monitoring the clients' meals while at the facility-operated day program daily.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated she did not have documentation the QIDP conducted daily monitoring of the clients' meals at the facility-operated day program.</p> <p>3) The QIDP failed to ensure the Home Manager (HM) or Assistant HM conducted daily monitoring of the clients' meals to ensure the clients' dining plans were being implemented.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W102, W104, W159, W240, W249, W440 and W449, "House manager/associate manager will provide daily monitoring, each shift, to ensure client plans are followed and client safety...." There was no documentation the house manager or associate house manager conducted daily</p>				

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	<p>monitoring, each shift, to ensure the clients' plans were followed and client safety.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she was not aware of this recommendation in the POC. The QIDP indicated she did not instruct the manager or associate manager to conduct daily monitoring. The QIDP indicated there was no documentation of this recommendation being implemented.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated there was no documentation the house manager or associate manager conducted daily monitoring.</p> <p>4) The QIDP failed to ensure the staff received training on client #2's new unloading from van training objective.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W102, W104, W122, W149, W154, W156 and W157, "...Facility staff trained on client #2 (sic) training goal and transportation/wheelchair safety." There was no documentation the staff received training on client #2's transportation/wheelchair safety goal.</p> <p>On 12/4/15 at 12:44 PM, the QIDP</p>						

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	<p>indicated she did not have documentation the staff received training on client #2's goal for transportation/wheelchair safety.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated she did not have documentation the staff received training on client #2's goal for transportation/wheelchair safety.</p> <p>5) The governing body failed to ensure the facility-operated day program and group home staff received training on client #5's revised risk plan for choking.</p> <p>On 12/4/15 at 12:39 PM, a review of client #5's record was conducted. Client #5's risk plan for choking was revised on 10/14/15 and 10/26/15. The group home staff was trained on client #5's risk plan on 10/23/15. There was no documentation the facility-operated day program staff was trained on either plan. There was no documentation the group home and day program staff received training on client #5's 10/26/15 risk plan for choking.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she was not sure if the group home and day program staff received training on client #5's 10/26/15 risk plan for choking.</p> <p>On 12/4/15 at 2:30 PM, the GHD</p>			

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	<p>indicated she did not have documentation the group home and day program staff received training on client #5's 10/26/15 risk plan for choking.</p> <p>6) The QIDP failed to ensure staff received training on client #5's training objective addressing his refusals to participate in evacuation drills.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W159, W240 and W449, "...Plan of Correction: Client #5 (sic) informal goal was moved to a formal goal due to refusing to participate in the safety drills... Facility staff has been trained on how to implement this goal." There was no documentation the staff was trained to implement the goal.</p> <p>On 12/4/15 at 12:39 PM, a review of client #5's record was conducted. There was no documentation in client #5's record indicating his informal goal was moved to a formal goal. On 12/7/15 at 3:28 PM, the QIDP sent an email with an attachment indicating client #5 had a training objective addressing his refusals to participate in evacuation drills.</p> <p>On 12/4/15 at 12:44 PM, the QIDP indicated she trained the staff on his evacuation drill goal but did not</p>						

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	<p>document the training of the staff. On 12/7/15 at 2:50 PM, the QIDP indicated client #5 had a formal goal created to address his issues with evacuation drills. The QIDP indicated she trained the Home Manager and Assistant Manager but did not document the training. The QIDP indicated she did not instruct the Home Manager or Assistant Manager to train the staff on client #5's goal.</p> <p>7) The QIDP failed to revise client #7's Individual Support Plan annually.</p> <p>On 12/3/15 at 1:56 PM, a review of the facility's POC was conducted. The POC indicated the following in W260, "Plan of Correction: QIDP will update client #6 and #7's individual program plans (IPP). These will be reviewed and revised if needed annually." There was no documentation client #7's program plan was revised annually.</p> <p>On 12/4/15 at 12:54 PM, a review of client #7's record was conducted. There was no documentation client #7's IPP was reviewed and revised annually. The current plan was dated 6/18/14.</p> <p>On 12/4/15 at 1:15 PM, the QIDP indicated she was still working on completing client #7's IPP. The QIDP indicated client #7's IPP had not been</p>			

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W 0260 Bldg. 00	<p>revised or updated. The QIDP indicated she needed assistance from another QIDP to complete typing the updated plan.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated client #7's IPP should have been revised and updated as needed.</p> <p>This deficiency was cited on 10/6/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(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 (#7), the facility failed to revise client #7's individual program plan at least annually.</p> <p>Findings include:</p> <p>On 12/4/15 at 12:54 PM, a review of client #7's record was conducted. There was no documentation client #7's IPP was reviewed and revised annually. The current plan was dated 6/18/14.</p>	W 0260	<p>W 260 (Standard) Program Monitoring and Change – failed to update individual's program plan on annual basis Corrective action for resident(s) found to have been affected The IPP that was not updated annually will be updated as part of this POC. Additionally, each individual's annual meeting will be placed on calendar, and QIDP will ensure that the annual update is in place by the annual meeting date. How facility will identify other residents potentially</p>	12/23/2015

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	<p>On 12/4/15 at 1:15 PM, the QIDP indicated she was still working on completing client #7's IPP. The QIDP indicated client #7's IPP had not been revised or updated. The QIDP indicated she needed assistance from another QIDP to complete typing the updated plan.</p> <p>On 12/4/15 at 2:30 PM, the GHD indicated client #7's IPP should have been revised and updated as needed.</p> <p>This deficiency was cited on 10/6/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>		<p>affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence IPP update and scheduled updates for the rest of the clients in the home. How corrective actions will be monitored to ensure no recurrence Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will supervise implementation, including ensuring that monitoring visits are conducted as outlined in the original POC. Each visit to the home or day program will be documented on a form, which will be reviewed and signed by the Senior Director. Visits from the SGL Director, QIDP, manager, associate manager, and nurse will be monitored to ensure full compliance with the POC. The Senior Director, SGL Director, and QIDP all meet the regulatory requirements as a QIDP. Daily QIDP monitoring visits will occur from one of these Q-qualified professionals, and these visits will continue at a minimum until all Condition level citations are lifted. Regular documented meetings will be chaired by the Senior Director to ensure ongoing compliance with the POC.</p>	

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W 9999 Bldg. 00		W 9999	W9999 was not included in the survey and no text is included above, so no correction is being written to address it	12/23/2015	