

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/24/2012
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 214 E SOUTHERN DR BLOOMINGTON, IN 47401
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: August 21, 22, 23 and 24, 2012.</p> <p>Facility Number: 001210 Provider Number: 15G637 AIM Number: 100240200</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/29/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 19 incident/investigative reports affecting client #2, the facility neglected to implement its policies and procedures to report incidents to the Bureau of Developmental Disabilities Services (BDDS) and conduct thorough investigations of abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/21/12 at 1:49 PM.</p> <p>1) On 3/1/12 at 6:00 PM (documented on a facility Incident Report on 3/15/12 and not reported to BDDS), client #2 was at a local gym with her boyfriend and staff #4. The report indicated, "When getting out of the hot tub, [client #2's boyfriend] straddled a sitting [client #2]. Staff helped them both out of the hot tub. They both said good-bye. [Client #2] informed staff (#4) in the car that [initials of client #2's boyfriend] had tried to 'stick something inside of her' in the hot tub. She said that she was fine with it." The Action Taken section indicated, "Social Worker met w/ (with) [client #2] on</p>	W0149	<p>W 149</p> <p>GOVERNING BODY & MANAGEMENT</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that specific governing body and management requirements are met. Specifically, Stone Belt will ensure that policies and procedures that prohibit mistreatment, abuse and neglect are followed.</p> <p>Responsible Person:</p> <p>Southern House Coordinator & SGL Director</p> <p>Date of Completion:</p> <p>September 21, 2012</p> <p>Plan of Prevention:</p> <p>House Staff will be retrained on Stone Belt's policy of prevention of abuse and neglect, including the definition of both.(Attachment # 1).</p> <p>Client specific issues included that the nursing staff will follow the given "Protocol & Operating</p>	09/21/2012			

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	<p>3/15/12 and discussed incident. See social worker's comments on attached copy." The attached copy indicated, "This event was not reported to social worker until 3/19/12... Social worker reminded staff to report sexual acting out behavior." The facility did not provide an investigation to review regarding the incident.</p> <p>A review of client #2's record was conducted on 8/23/12 at 9:08 AM. Her Individual Support Plan (ISP), dated 5/7/12, indicated, "Currently she has a male friend with whom she talks on the phone and goes out on supervised dates. She is satisfied with the relationships and has established boundaries for the relationship which are supported by her parents. [Client #2] attended a class in 2011 on Healthy Relationships, and also participated in an Informed Consent Assessment for Sexual Activity. It was determined that although [client #2] has some information concerning decision making in sexual issues, she lacks specific information which would be necessary in order to be able to provide Informed Consent. Although, [client #2] has improve (sic) in her capacity to be assertive within her relationships, she does not have all the information necessary to be able to provide Informed Consent to Sexual Activity. [Client #2's]</p>		<p>Directions" for Milestone's Nursing Staff. This includes 1) Nurses will make on-site visits and document assessment in Client's file within 24 hours of hospital discharge or ER visit. (Attachment # 2)</p> <p>Quality Assurance Monitoring:</p> <p>Training staff on Stone Belt's policy of prevention of abuse and neglect will continue as needed with current staff and covered during initial staff orientation of new hires. Administrative staff will make unannounced visits at Maxwell House to ensure that the health and safety of the clients is being monitored.</p> <p>Nursing Manager will update and review Nursing Protocol on an on-going basis.</p>		

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	<p>Father and Mother are co-guardians."</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/23/12 at 11:09 AM. The PC indicated the incident should have been looked in to. The PC indicated client #2 was not able to consent and should not engage in sexual activity.</p> <p>An interview with the Social Worker (SW) was conducted on 8/23/12 at 11:52 AM. The SW indicated she spoke with client #2 and client #2 denied the event occurred. The SW indicated a formal investigation was not conducted. The SW indicated they are a couple. Client #2 has a guardian and can not give consent for sexual activity. The SW indicated it was her decision to not conduct an investigation. On 8/23/12 at 5:11 PM, the SW sent the following email, "I clarified this incident with [staff #4] the Southern staff that was supervising this date with the boyfriend also present at the [name of gym]. She said that [name of client #2's boyfriend] was getting out of the hot tub and went in for a kiss and was leaning over [client #2] on his exit. Later [client #2] told staff that she thought [name of client #2's boyfriend] had tried to stick something inside her during that time. However staff was present the whole time leaving no time for any unclothed</p>						

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	<p>interaction. [Client #2] was not indicating an event that actually happened she was indicating an event that she thought might happen. Ie. (that is) Nothing actually happened, she just made a statement about what she thought could happen. That's why she (client #2) did not report anything to me when I talked to her. Not that it makes a difference at this point, but I thought it was important to clarify."</p> <p>An interview with the Director of Group Homes (DGH) was conducted on 8/23/12 at 3:28 PM. The DGH indicated the incident should have been reported immediately to the administrator and the facility should have reported it to BDDS. The DGH indicated an investigation should have been conducted.</p> <p>2) A review of client #2's record was conducted on 8/23/12 at 9:08 AM. On 3/12/12, client #2 had endovenous laser ablation surgery to address venous insufficiency. The post-operative instructions, dated 3/12/12, indicated, "You will have a compression hose in place when you leave the office. Compression hose must be worn <u>CONTINUOUSLY</u> day and night until you come in for your follow up appointment." The follow-up appointment was scheduled on 3/16/12. The pre-operative instruction indicated, in</p>						

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	handwriting, "NO BATH/SHOWER UNTIL ULTRASOUND ON FRIDAY 3/16/12." On 3/13/12 and 3/14/12, the Nursing Director (ND) conducted an assessment. The assessment indicated on 3/13/12, "C/o (complained of) some discomfort to both thighs. Bandages in place. Support hose both legs. + pedal pulses noted on right and on left foot. Ambulatory with feet elevated while sitting. Pain meds as ordered." On 3/14/12, the ND conducted an assessment, "Once again, seen at workshop. Dressings intact. Support hose on. Walking around. No complaints of pain voiced to this nurse." On 3/16/12 at the follow-up appointment, client #2 had a pressure wound. A Nurse Consultation note, dated 3/19/12, from the ND indicated, "Reports received that [client #2] had a pressure wound on surgical site with accompanying cellulitis. Report received that parents questioning our ability to care properly for [client #2] based on this report and plan is to keep [client #2] home at this time. This nurse made (sic) visit to [client #2's] parents (sic) home at approximately 6:25 PM this date. [Client #2's] father, [name of father], and step-mom, [name of step-mom] was (sic) present. [Client #2] was up and walking around, in no apparent distress. With the assistance of [name of step-mom] who is an R.N., this			

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	<p>nurse examined the area in question. At the top of [client #2's] Left thigh, around the circumference, op-site had been applied by wound care center. Reddened slightly raised rash like area, approximately 2 cm (centimeters) in width around approximately 5/8th of circumference of left leg noted. No apparent drainage. Between [client #2's] thighs, in fold of top of left thigh and groin, area was larger, reddened. Appeared that support hose applied to [client #2] at time of surgery were excessively long in length and applied pressure to thigh/groin fold area, leaving raw reddened area in fold approximately 2-4 cm down thigh...". A follow-up appointment was held on 3/19/12. The diagnosis was pressure ulcer left groin.</p> <p>An email, dated 3/19/12 at 5:33 PM, sent from the DGH to the SW, client #2's co-guardians, PC, ND, client #2's workshop supervisors, Chief Operating Executive, Director of Milestones and the Director of Human Resources was reviewed on 8/23/12 at 11:13 AM. The email indicated, "...I asked [client #2's father] to see if [client #2] would provide the name of the staff she told that it was hurting so that we could continue to follow-up. This is somewhat of a concern because [client #2] always lets staff know when something is wrong, so I am</p>			

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	<p>interested in who she told so we can address it with the staff. I will stay in touch with [SW] regarding this situation and we will conduct a review to see were (sic) Stone Belt staff failed to meet the health and safety concerns of [client #2]. This is not something we take lightly and will make sure our staff did everything possible to care for [client #2] and the other clients we serve, now and in the future. [Client #2's father] advised me that they were going to keep [client #2] home with them until they can assess the care of her abrasion...".</p> <p>The facility did not provide an internal incident report, BDDS report or investigation into client #2's pressure wound and concerns of the guardian over the facility's ability to provide care following a vein procedure.</p> <p>An interview with client #2's guardian was conducted on 8/22/12 at 2:54 PM. The guardian indicated there were concerns of the lack of post-surgery care in March 2012. The guardian indicated client #2 had vein surgery and the support hose caused a rash that developed into an open wound due to not being checked. The guardian indicated client #2 was brought to his home for 3-4 weeks to ensure proper care. The guardian indicated the situation with the group</p>				

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	<p>home was ultimately resolved satisfactorily. They were able to work out what should have happened.</p> <p>An interview with the PC was conducted on 8/23/12 at 12:05 PM. The PC indicated the facility looked into the incident however there was no investigation for review. The PC indicated the instructions from the surgical center indicated to not remove the compression hose. The pressure wound was found at the follow-up appointment. The PC indicated the surgical center used compression hose that were too long and big for client #2. The PC indicated on 3/19/12, she was instructed by the DGH to contact staff to find out what had been done prior to the 3/19/12 follow-up appointment and if staff were aware of the pressure wound. The PC indicated the group home staff were not at fault. The PC indicated the facility would normally report an incident such as this to BDDS and investigate.</p> <p>An interview with the ND was conducted on 8/23/12 at 12:44 PM. The ND indicated client #2 had a vein procedure which was wrapped. The vein center staff told staff to leave the dressing and hose alone. The ND indicated the vein center staff put on extra long compression hose and rolled it down causing the pressure</p>						

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	<p>wound. The ND indicated this was an error of the vein center not facility staff. The ND indicated the compression hose was inappropriately sized. The ND indicated the staff of the group home followed the post-operative instructions.</p> <p>An interview with the SW was conducted on 8/23/12 at 11:55 AM. The SW indicated the incident was not investigated. The SW indicated client #2 was given the wrong size compression hose. The hose bunched up and caused the pressure wound. The SW indicated staff followed the post-op instructions.</p> <p>An interview with the DGH was conducted on 8/23/12 at 3:28 PM. The DGH indicated the facility should have documented the incident on an internal incident report, and a BDDS report. Initially the DGH indicated an investigation should not have been conducted. The DGH indicated the facility was not negligent since the doctor's office put the wrong size compression hose on client #2. The DGH indicated the facility assumed what happened. The DGH indicated an investigation or review should have been conducted.</p> <p>A review of the facility's abuse and neglect policy, dated 10/17/11, was</p>				

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	<p>conducted on 8/21/12 at 1:45 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a Client, parent/guardian, advocate, staff member, or other involved party."</p> <p>9-3-2(a)</p>						

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 2 of 19 incident/investigative reports affecting client #2, the facility failed to ensure staff reported an incident of alleged sexual contact to the administrator immediately and report incidents to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/21/12 at 1:49 PM.</p> <p>1) On 3/1/12 at 6:00 PM (documented on a facility Incident Report on 3/15/12 and not reported to BDDS), client #2 was at a local gym with her boyfriend and staff #4. The report indicated, "When getting out of the hot tub, [client #2's boyfriend] straddled a sitting [client #2]. Staff helped them both out of the hot tub. They both said good-bye. [Client #2] informed staff (#4) in the car that [initials of client #2's boyfriend] had tried to 'stick</p>	W0153	<p>W153 STAFF TREATMENT OF CLIENTS Plan of Correction Stone Belt will ensure that allegations of mistreatment, neglect or abuse are reported immediately to the Director of SGL or other administrators as designated. Date of Completion September 21, 2012 Responsible Person Southern Coordinator/SGL Director Plan of Prevention House staff will be retrained on incident reporting. (Attachment # 3) Quality Assurance Monitoring The SGL Director and House Coordinator will ensure that allegations of abuse/neglect are reported immediately. Staff received annual retraining and Incident Reporting is apart of Orientation Training for new staff.</p>	09/21/2012			

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	<p>something inside of her' in the hot tub. She said that she was fine with it." The Action Taken section indicated, "Social Worker met w/ (with) [client #2] on 3/15/12 and discussed incident. See social worker's comments on attached copy." The attached copy indicated, "This event was not reported to social worker until 3/19/12... Social worker reminded staff to report sexual acting out behavior." The facility did not report the allegation of sexual abuse to the administrator or to BDDS.</p> <p>A review of client #2's record was conducted on 8/23/12 at 9:08 AM. Her Individual Support Plan (ISP), dated 5/7/12, indicated, "Currently she has a male friend with whom she talks on the phone and goes out on supervised dates. She is satisfied with the relationships and has established boundaries for the relationship which are supported by her parents. [Client #2] attended a class in 2011 on Healthy Relationships, and also participated in an Informed Consent Assessment for Sexual Activity. It was determined that although [client #2] has some information concerning decision making in sexual issues, she lacks specific information which would be necessary in order to be able to provide Informed Consent. Although, [client #2] has improve (sic) in her capacity to be</p>			

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	<p>assertive within her relationships, she does not have all the information necessary to be able to provide Informed Consent to Sexual Activity. [Client #2's] Father and Mother are co-guardians."</p> <p>An interview with the Director of Group Homes (DGH) was conducted on 8/23/12 at 3:28 PM. The DGH indicated the incident should have been reported immediately to the administrator and the facility should have reported it to BDDS.</p> <p>2) A review of client #2's record was conducted on 8/23/12 at 9:08 AM. On 3/12/12, client #2 had endovenous laser ablation surgery to address venous insufficiency. The post-operative instructions, dated 3/12/12, indicated, "You will have a compression hose in place when you leave the office. Compression hose must be worn <u>CONTINUOUSLY</u> day and night until you come in for your follow up appointment." The follow-up appointment was scheduled on 3/16/12. The pre-operative instruction indicated, in handwriting, "NO BATH/SHOWER UNTIL ULTRASOUND ON FRIDAY 3/16/12." On 3/13/12 and 3/14/12, the Nursing Director (ND) conducted an assessment. The assessment indicated on 3/13/12, "C/o (complained of) some discomfort to both thighs. Bandages in</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 214 E SOUTHERN DR BLOOMINGTON, IN 47401
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	<p>place. Support hose both legs. + pedal pulses noted on right and on left foot. Ambulatory with feet elevated while sitting. Pain meds as ordered." On 3/14/12, the ND conducted an assessment, "Once again, seen at workshop. Dressings intact. Support hose on. Walking around. No complaints of pain voiced to this nurse." On 3/16/12 at the follow-up appointment, client #2 had a pressure wound. A Nurse Consultation note, dated 3/19/12, from the ND indicated, "Reports received that [client #2] had a pressure wound on surgical site with accompanying cellulitis. Report received that parents questioning our ability to care properly for [client #2] based on this report and plan is to keep [client #2] home at this time. This nurse made (sic) visit to [client #2's] parents (sic) home at approximately 6:25 PM this date. [Client #2's] father, [name of father], and step-mom, [name of step-mom] was (sic) present. [Client #2] was up and walking around, in no apparent distress. With the assistance of [name of step-mom] who is an R.N., this nurse examined the area in question. At the top of [client #2's] Left thigh, around the circumference, op-site had been applied by wound care center. Reddened slightly raised rash like area, approximately 2 cm (centimeters) in width around approximately 5/8th of</p>			

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	<p>circumference of left leg noted. No apparent drainage. Between [client #2's] thighs, in fold of top of left thigh and groin, area was larger, reddened. Appeared that support hose applied to [client #2] at time of surgery were excessively long in length and applied pressure to thigh/groin fold area, leaving raw reddened area in fold approximately 2-4 cm down thigh...". A follow-up appointment was held on 3/19/12. The diagnosis was pressure ulcer left groin.</p> <p>The facility did not provide an internal incident report or BDDS report into client #2's pressure wound and concerns of the guardian over the facility's ability to provide care following a vein procedure.</p> <p>An interview with client #2's guardian was conducted on 8/22/12 at 2:54 PM. The guardian indicated there were concerns of the lack of post-surgery care in March 2012. The guardian indicated client #2 had vein surgery and the support hose caused a rash that developed into an open wound due to not being checked. The guardian indicated client #2 was brought to his home for 3-4 weeks to ensure proper care. The guardian indicated the situation with the group home was ultimately resolved satisfactorily. They were able to work out what should have happened.</p>						

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	<p>An interview with the PC was conducted on 8/23/12 at 12:05 PM. The PC indicated the instructions from the surgical center indicated to not remove the compression hose. The pressure wound was found at the follow-up appointment. The PC indicated the surgical center used compression hose that were too long and big for client #2. The PC indicated on 3/19/12, she was instructed by the DGH to contact staff to find out what had been done prior to the 3/19/12 follow-up appointment and if staff were aware of the pressure wound. The PC indicated the group home staff were not at fault. The PC indicated the facility would normally report an incident such as this to BDDS.</p> <p>An interview with the ND was conducted on 8/23/12 at 12:44 PM. The ND indicated client #2 had a vein procedure which was wrapped. The vein center staff told staff to leave the dressing and hose alone. The ND indicated the vein center staff put on extra long compression hose and rolled it down causing the pressure wound. The ND indicated it was an error of the vein center not facility staff. The ND indicated the compression hose was inappropriately sized. The ND indicated the staff of the group home followed the post-operative instructions.</p>						

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	<p>An interview with the SW was conducted on 8/23/12 at 11:55 AM. The SW indicated client #2 was given the wrong size compression hose. The hose bunched up and caused the pressure wound. The SW indicated staff followed the post-op instructions.</p> <p>An interview with the DGH was conducted on 8/23/12 at 3:28 PM. The DGH indicated the facility should have documented the incident on an internal incident report and BDDS report.</p> <p>9-3-2(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 19 incident/investigative reports affecting client #2, the facility failed to conduct thorough investigations of abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/21/12 at 1:49 PM.</p> <p>1) On 3/1/12 at 6:00 PM (documented on a facility Incident Report on 3/15/12 and not reported to BDDS), client #2 was at a local gym with her boyfriend and staff #4. The report indicated, "When getting out of the hot tub, [client #2's boyfriend] straddled a sitting [client #2]. Staff helped them both out of the hot tub. They both said good-bye. [Client #2] informed staff (#4) in the car that [initials of client #2's boyfriend] had tried to 'stick something inside of her' in the hot tub. She said that she was fine with it." The Action Taken section indicated, "Social Worker met w/ (with) [client #2] on 3/15/12 and discussed incident. See social worker's comments on attached copy." The attached copy indicated, "This</p>	W0154	<p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that all allegations are investigated thoroughly.</p> <p>Date of Completion</p> <p>September 21, 2012</p> <p>Responsible Person</p> <p>Miller Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>The Coordinators reviewed and completed training on Stone Belt investigation procedures. (Attachment # 4). This included how to conduct proper investigations and who should be interviewed. (Attachment #5)</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure, after reviewing the incident, that investigations will be completed thoroughly.</p>	09/21/2012			

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	<p>event was not reported to social worker until 3/19/12... Social worker reminded staff to report sexual acting out behavior." The facility did not provide an investigation to review regarding the incident.</p> <p>A review of client #2's record was conducted on 8/23/12 at 9:08 AM. Her Individual Support Plan (ISP), dated 5/7/12, indicated, "Currently she has a male friend with whom she talks on the phone and goes out on supervised dates. She is satisfied with the relationships and has established boundaries for the relationship which are supported by her parents. [Client #2] attended a class in 2011 on Healthy Relationships, and also participated in an Informed Consent Assessment for Sexual Activity. It was determined that although [client #2] has some information concerning decision making in sexual issues, she lacks specific information which would be necessary in order to be able to provide Informed Consent. Although, [client #2] has improve (sic) in her capacity to be assertive within her relationships, she does not have all the information necessary to be able to provide Informed Consent to Sexual Activity. [Client #2's] Father and Mother are co-guardians."</p> <p>An interview with the Program</p>				

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	<p>Coordinator (PC) was conducted on 8/23/12 at 11:09 AM. The PC indicated the incident should have been looked in to. The PC indicated client #2 was not able to consent and should not engage in sexual activity.</p> <p>An interview with the Social Worker (SW) was conducted on 8/23/12 at 11:52 AM. The SW indicated she spoke with client #2 and client #2 denied the event occurred. The SW indicated a formal investigation was not conducted. The SW indicated they are a couple. Client #2 has a guardian and can not give consent for sexual activity. The SW indicated it was her decision to not conduct an investigation. On 8/23/12 at 5:11 PM, the SW sent the following email, "I clarified this incident with [staff #4] the Southern staff that was supervising this date with the boyfriend also present at the [name of gym]. She said that [name of client #2's boyfriend] was getting out of the hot tub and went in for a kiss and was leaning over [client #2] on his exit. Later [client #2] told staff that she thought [name of client #2's boyfriend] had tried to stick something inside her during that time. However staff was present the whole time leaving no time for any unclothed interaction. [Client #2] was not indicating an event that actually happened she was indicating an event that she</p>			

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	<p>thought might happen. Ie. (that is) Nothing actually happened, she just made a statement about what she thought could happen. That's why she (client #2) did not report anything to me when I talked to her. Not that it makes a difference at this point, but I thought it was important to clarify."</p> <p>An interview with the Director of Group Homes (DGH) was conducted on 8/23/12 at 3:28 PM. The DGH indicated an investigation should have been conducted.</p> <p>2) A review of client #2's record was conducted on 8/23/12 at 9:08 AM. On 3/12/12, client #2 had endovenous laser ablation surgery to address venous insufficiency. The post-operative instructions, dated 3/12/12, indicated, "You will have a compression hose in place when you leave the office. Compression hose must be worn <u>CONTINUOUSLY</u> day and night until you come in for your follow up appointment." The follow-up appointment was scheduled on 3/16/12. The pre-operative instruction indicated, in handwriting, "NO BATH/SHOWER UNTIL ULTRASOUND ON FRIDAY 3/16/12." On 3/13/12 and 3/14/12, the Nursing Director (ND) conducted an assessment. The assessment indicated on 3/13/12, "C/o (complained of) some discomfort to both thighs. Bandages in</p>						

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	<p>place. Support hose both legs. + pedal pulses noted on right and on left foot. Ambulatory with feet elevated while sitting. Pain meds as ordered." On 3/14/12, the ND conducted an assessment, "Once again, seen at workshop. Dressings intact. Support hose on. Walking around. No complaints of pain voiced to this nurse." On 3/16/12 at the follow-up appointment, client #2 had a pressure wound. A Nurse Consultation note, dated 3/19/12, from the ND indicated, "Reports received that [client #2] had a pressure wound on surgical site with accompanying cellulitis. Report received that parents questioning our ability to care properly for [client #2] based on this report and plan is to keep [client #2] home at this time. This nurse made (sic) visit to [client #2's] parents (sic) home at approximately 6:25 PM this date. [Client #2's] father, [name of father], and step-mom, [name of step-mom] was (sic) present. [Client #2] was up and walking around, in no apparent distress. With the assistance of [name of step-mom] who is an R.N., this nurse examined the area in question. At the top of [client #2's] Left thigh, around the circumference, op-site had been applied by wound care center. Reddened slightly raised rash like area, approximately 2 cm (centimeters) in width around approximately 5/8th of</p>			

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	<p>circumference of left leg noted. No apparent drainage. Between [client #2's] thighs, in fold of top of left thigh and groin, area was larger, reddened. Appeared that support hose applied to [client #2] at time of surgery were excessively long in length and applied pressure to thigh/groin fold area, leaving raw reddened area in fold approximately 2-4 cm down thigh...". A follow-up appointment was held on 3/19/12. The diagnosis was pressure ulcer left groin.</p> <p>An email, dated 3/19/12 at 5:33 PM, sent from the DGH to the SW, client #2's co-guardians, PC, ND, client #2's workshop supervisors, Chief Operating Executive, Director of Milestones and the Director of Human Resources was reviewed on 8/23/12 at 11:13 AM. The email indicated, "...I asked [client #2's father] to see if [client #2] would provide the name of the staff she told that it was hurting so that we could continue to follow-up. This is somewhat of a concern because [client #2] always lets staff know when something is wrong, so I am interested in who she told so we can address it with the staff. I will stay in touch with [SW] regarding this situation and we will conduct a review to see were (sic) Stone Belt staff failed to meet the health and safety concerns of [client #2]. This is not something we take lightly and</p>			

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	<p>will make sure our staff did everything possible to care for [client #2] and the other clients we serve, now and in the future. [Client #2's father] advised me that they were going to keep [client #2] home with them until they can assess the care of her abrasion...".</p> <p>The facility did not provide an internal incident report, BDDS report or investigation into client #2's pressure wound and concerns of the guardian over the facility's ability to provide care following a vein procedure.</p> <p>An interview with client #2's guardian was conducted on 8/22/12 at 2:54 PM. The guardian indicated there were concerns of the lack of post-surgery care in March 2012. The guardian indicated client #2 had vein surgery and the support hose caused a rash that developed into an open wound due to not being checked. The guardian indicated client #2 was brought to his home for 3-4 weeks to ensure proper care. The guardian indicated the situation with the group home was ultimately resolved satisfactorily. They were able to work out what should have happened.</p> <p>An interview with the PC was conducted on 8/23/12 at 12:05 PM. The PC indicated the facility looked into the</p>				

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	<p>incident however there was no investigation for review. The PC indicated the instructions from the surgical center indicated to not remove the compression hose. The pressure wound was found at the follow-up appointment. The PC indicated the surgical center used compression hose that were too long and big for client #2. The PC indicated on 3/19/12, she was instructed by the DGH to contact staff to find out what had been done prior to the 3/19/12 follow-up appointment and if staff were aware of the pressure wound. The PC indicated the group home staff were not at fault. The PC indicated the facility would normally investigate an incident such as this.</p> <p>An interview with the ND was conducted on 8/23/12 at 12:44 PM. The ND indicated client #2 had a vein procedure which was wrapped. The vein center staff told staff to leave the dressing and hose alone. The ND indicated the vein center staff put on extra long compression hose and rolled it down causing the pressure wound. The ND indicated this was an error of the vein center not facility staff. The ND indicated the compression hose was inappropriately sized. The ND indicated the staff of the group home followed the post-operative instructions.</p>						

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	<p>An interview with the SW was conducted on 8/23/12 at 11:55 AM. The SW indicated the incident was not investigated. The SW indicated client #2 was given the wrong size compression hose. The hose bunched up and caused the pressure wound. The SW indicated staff followed the post-op instructions.</p> <p>An interview with the DGH was conducted on 8/23/12 at 3:28 PM. Initially the DGH indicated an investigation should not have been conducted. The DGH indicated the facility was not negligent since the doctor's office put the wrong size compression hose on client #2. The DGH indicated the facility assumed what happened. The DGH indicated an investigation or review should have been conducted.</p> <p>9-3-2(a)</p>				

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W0159	<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, interview and record review for 2 of 6 clients living in the group home (#3 and #5), the Qualified Mental Retardation Professional (QMRP) failed to monitor the clients' plans to ensure their program plans were updated as needed with the clients' current status.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 8/21/12 from 4:26 PM to 6:21 PM and 8/22/12 from 6:02 AM to 7:40 AM. An observation was conducted at the facility-operated workshop on 8/22/12 from 9:32 AM to 10:24 AM. During the observations, client #3 was wearing a gait belt. Client #3 did not receive staff assistance (holding onto gait belt) while ambulating.</p> <p>A review of client #3's record was conducted on 8/23/12 at 9:55 AM. Client #3's Behavior Support Plan (BSP), dated 9/2/11, indicated, "[Client #3] will wear, and staff will hold onto a gate (sic) belt when [client #3] is ambulatory to reduce risk of injury during a seizure."</p>	W0159	<p>W159 QUALIFIED DD PROFESSIONAL Plan of Correction Stone Belt will ensure that each clients plan is integrated, coordinated and monitored by a qualified developmental disability professional. The Coordinator/QMRP will monitor client's plans to ensure program plans are updated as needed with current client status. Date of Completion September 14, 2012 Responsible Person Southern Coordinator/SGL Director Plan of Prevention The Coordinator and Support Team review plans during the monthly support team meetings to assure all in current and accurate. Specifically, the Behaviorist updated both client's plans identified during the survey. (Attachment # 6). Quality Assurance Monitoring Monthly Support Team meetings are conducted to ensure that Behavior Plans are updated and trained on upon and additions or deletions from the BSP. Coordinator and SGL Director will monitor.</p>	09/14/2012			

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	<p>An interview with the Nursing Director (ND) was conducted on 8/23/12 at 12:56 PM. The ND indicated at one time client #3 had an order for staff to hold onto her gait belt however this was changed when her seizure activity decreased. The ND indicated staff did not need to hold onto client #3's gait belt while she ambulated.</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/23/12 at 11:12 AM. The PC indicated client #3 did not need staff to hold onto her gait belt while ambulating. The PC indicated client #3 could ambulate independently. The PC indicated the plan for staff to hold onto her gait belt should have been removed from the BSP when her seizure activity decreased.</p> <p>An interview with the Director of Group Homes (DGH) was conducted on 8/23/12 at 3:28 PM. The DGH indicated the BSP was outdated. The DGH indicated the plan for staff to hold onto the gait belt should have been updated and removed. The DGH stated, "That's not accurate."</p> <p>An interview with the Behavior Clinician (BC) was conducted on 8/24/12 at 9:24 AM. The BC indicated she was not sure if the plan was current or not. The BC indicated she needed to check on it and remove from the plan, if needed. The BC</p>						

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	<p>stated, "I'm pretty sure that may have been changed."</p> <p>2) A review of client #5's record was conducted on 8/23/12 at 10:33 AM. A Support Team Review Form, dated 5/14/12, indicated, "BSP to be revised regarding pop tabs instead of cans." The BSP, dated 4/16/12, had not been revised since 4/16/12. The plan indicated in the General Proactive Strategies section, "In addition to verbal praise, [client #5] will have the daily opportunity to earn one donated aluminum can per positive demonstration of target tasks and/or behavior... [Client #5] may choose to receive these cans daily or all on the day of recycling. Staff should remind [client #5] of what she did to earn her cans and stickers."</p> <p>An interview with the Director of Group Homes (DGH) was conducted on 8/23/12 at 3:28 PM. The DGH indicated the BSP should have been revised.</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/23/12 at 11:12 AM. The PC indicated the BSP should have been revised.</p> <p>An interview with the Behavior Clinician (BC) was conducted on 8/24/12 at 9:24 AM. The BC indicated she revised the</p>						

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	<p>plan however the plan was not in client #5's record. She indicated client #5's guardian recommended the change from cans to tabs however she was not sure of the reason.</p> <p>9-3-3(a)</p>			

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W0371	<p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on record review and interview for 2 of 6 clients living in the group home (#1 and #3), the facility failed to ensure the clients had medication training objectives addressing identified needs from the functional assessment.</p> <p>Findings include:</p> <p>1) A review of client #1's record was conducted on 8/23/12 at 11:34 AM. Client #1's Program Assessment, dated 12/30/11, indicated client #1 needed reminders for the following: name dosage for each medication, name side effects of medication, notify staff if there is a concern, and write out own medication log. The assessment indicated client #1 had no knowledge in the following areas for medication training: fill one week's worth of medication, administer one weeks worth of medication, contact pharmacy for a refill, obtain medications from pharmacy and check medications to make sure they are correct. Client #1's Individual Support Plan (ISP), dated 12/7/11, indicated, "[Client #1] says</p>	W0371	<p>W371</p> <p>DRUG ADMINISTRATION</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that each is taught to administer their own medications if the interdisciplinary team determines that self administration of medications is an appropriate objective.</p> <p>Date of Completion</p> <p>September 14, 2012</p> <p>Responsible Person</p> <p>Southern Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>The Coordinator developed medication administration goals for each client specifically identified in the survey. The Coordinator will continue to monitor all clients goals and objectives to assure all have medication administration if</p>	09/14/2012			

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	<p>[client #1] indicated that she would like to continue to progress in the area of medication administration. People close to [client #1] say [client #1's] team feel that [client #1] could become more independent in the area of medications administration and following physician's orders." The ISP indicated this would be addressed with a residential habilitation service training objective #3. The ISP did not contain a training objective #3 addressing medication training.</p> <p>An interview with direct care staff #6 was conducted on 8/21/12 at 6:38 AM. Staff #6 indicated she (staff #6) pops the medications into client #1's weekly med dispenser. Staff #6 indicated she did not know the purpose of client #1's pill box. Staff #6 indicated the staff remove the pills from the pill box and place into a cup during med administration for client #1.</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/23/12 at 11:27 AM. The PC indicated although client #1 did not have a training objective in her ISP, client #1 assisted staff on Sundays with filling up a weeks worth of medications in a dispenser. The PC indicated client #1 should have a med training objective in her ISP.</p>		<p>applicable. (Attachment # 7 and # 8)</p> <p>Quality Assurance Monitoring</p> <p>Coordinator and Support Team will monitor goals on a annual basis to assure that are appropriate and meet the needs of the individual client. This includes each client having a medication goal.</p>		

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	<p>2) A review of client #3's record was conducted on 8/23/12 at 9:55 AM. Client #3's Program Assessment, dated 1/19/12, indicated she had no knowledge in the following areas for medication training: sign off on own med log, fill one week's worth of medications, maintain one week's worth of medication in a locked area, administer one week's worth of medications, write out own med log, contact pharmacy for a refill, contact physician for an appointment, make follow-up appointments with the physician, obtain meds from pharmacy, and check meds to make sure they are correct. The assessment indicated client #3 needed verbal prompts to state the side effects of medication. The assessment indicated client #3 needed reminders to do the following: name own meds, name dose of each med, and name time to take each medication. Client #3's ISP, dated 1/19/12, indicated, "she continues to make progress in medication identification." The ISP indicated medication administration was addressed with residential habilitation service training objective #8. The ISP did not contain a training objective #8 or a training objective addressing medication administration training.</p> <p>An interview with the PC was conducted on 8/23/12 at 11:12 AM. The PC</p>			

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	indicated client #3 should have a medication administration training objective. 9-3-6(a)			