STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G374		11/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	1835 MAXWELL ST BLOOMINGTON, IN 47401

(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	This visit was for a full recertification and state licensure survey. Survey Dates: November 13, 16, 17, 18, 19, 20 and 23, 2015 Facility Number: 000888 Provider Number: 15G374 AIM Number: 100239700 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/3/15.	W 0000	Additional edits are being added to the Plan of Correction (POC) in response a letter dated 12/17/15 by ISDH to Stone Belt. The primary change is to assign a Senior Director to oversee monitoring of the POC, including the SGL Director & QIDP.	
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility by failing to ensure the walls throughout the group home's common areas were repainted following repairs	W 0102	**W 102 (Condition) GOVERNING BODY AND MANAGEMENT** The facility must ensure that specific governing body and management requirements are met. **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID Q7T311 will be fully implemented, including the following specifics: 1. **A. Common Area Painting**	12/23/2015

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

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

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	and the carpets were cleaned on a regular basis. The governing body failed to monitor the Qualified Intellectual Disabilities Professional (QIDP) to ensure the QIDP integrated, coordinated and monitored the clients' program plans. The governing body failed to monitor the QIDP to ensure the QIDP conducted regular reviews of the clients' program plans to ensure the clients were meeting the criteria of their training objectives and updating/revising the program plans as needed. The governing body failed to monitor the QIDP to ensure the group home's needed repairs, repainting and cleaning were conducted as needed. The governing body failed to monitor the QIDP to ensure there was regular communication from the group home to the school. The governing body failed to monitor the QIDP to ensure issues communicated from the school were addressed. The governing body failed to monitor the QIDP to ensure visits to the schools were conducted in order to ascertain if the school was meeting the needs of clients #1, #5 and #6. The governing body failed to monitor the QIDP to ensure the clients had the right to due process in regard to the kitchen door being locked unnecessarily. The governing body failed to monitor the QIDP to ensure there was sufficient staff to manage and supervise the clients in		**-This is to include patch/repair, sanding (as needed), wall prep, and painting of all walls in the common areas (hallways, living rooms, dinning rooms, kitchen,and bathrooms) of the home. This project is to start Wednesday 12/16 and be completed by Wednesday 12/23. Joe Moore will be the one primarily responsible for this task. B. Carpet in Living Areas -We have schedule for the carpets to be replaced in the living areas on Friday 12/18. Stephen is the primary contact for this task. 2. T**he clients' programs that were not integrated, coordinated,and monitored were completed as part of this POC. Additionally, each individual's annual and quarterly meeting will be placed on calendar, and QIDP will ensure that the annual and quarterly review or update is in place by the meeting date. **A**dministrative staff on the pager**and QIDP trained to** immediately report an allegation of abuse and neglect to the administrator,conduct thorough investigations, ensure recommended corrective actions are implemented, prevent client to client abuse, ensure clients receive **appropriate** medical care following an incident of SIB such as; client using his head to break a window, contacting emergency nursing pager, document	

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	accordance with their individual program plans. The governing body failed to monitor the QIDP to ensure client #3's guardian and the specially constituted committee consented to restrictions in the home. The governing body failed to monitor the QIDP to ensure evacuation drills were conducted quarterly for each shift and the drills during the overnight shift varied in times. The governing body failed to monitor the QIDP to ensure client #2 fed himself while at the facility-operated day program and clients #1, #2, #3, #4, #5 and #6 were involved with meal preparation. Findings include: 1) Please refer to W104. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) the walls throughout the common areas of the group home were repainted following repairs and the living room carpets were regularly cleaned and 2) the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans. 2) Please refer to W122. For 6 of 6 clients living in the group home (#1, #2,		thorough pager notes, follow up with psych pager concerning PRN medication being administrated, ensuring that sufficient staff are present to implement client support plans. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** QIDP trained on completing weekly visits to facility to ensure no maintenance issues go unreported and resolved. QIDP trained on completing monthly QA checklist that will be utilized to monitor environmental issues. House staff trained on reporting maintenance issues in a timely manner. QIDP trained to ensure that clients' programs are integrated, coordinated, and monitored. Additionally, each individual's annual and quarterly meeting will be placed on calendar, and QIDP will ensure that the annual and quarterly review or update is in place by the meeting date. Director of Supported Group Living will train administrator staff on pager trained to submit pager notes each Monday for Director of Supported Group living review and monitor for concerns. **How corrective actions will be monitored to ensure no recurrence** Stone Belt has	

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	#3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Client Protections. The governing body failed to implement its policies and procedures to ensure staff immediately reported an allegation of abuse and neglect to the administrator, conduct thorough investigations, ensure recommended corrective actions were implemented, prevent client to client abuse, ensure client #1 received appropriate medical care following an incident of using his head to break a window, the administrative staff on the pager documented thorough notes, the administrative staff on the pager followed up with staff to find out who authorized the use of an as needed medication to client #1 and there was sufficient staff to implement the clients' support plans. 9-3-1(a)		assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place by 12/23/15. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than two visits per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to	W 0104	**W 104 (Standard)** Governing Body **Corrective action for resident(s) found to have been affected**All parts of the POC for the survey with event ID Q7T311	12/23/2015

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	exercise operating direction over the facility by failing to ensure: 1) the walls throughout the common areas of the group home were repainted following repairs and the living room carpets were regularly cleaned and 2) the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans. Findings include: 1) Observations were conducted at the group home on 11/16/15 from 3:18 PM to 6:24 PM and 11/17/15 from 6:03 AM to 7:38 AM. Throughout the group home's common areas (hallways, living room, dining room, kitchen and bathroom), there were several unpainted patched holes in the drywall. The common area walls were scuffed, marked, discolored and had numerous patched areas requiring sanding prior to painting as evidenced by the rough texture and non-flat surface. There was damage (gaps, missing paint and buckled areas) to the walls surrounding the doors where the trim around the doors met the door frames. The exit door window frame in the hallway where the clients' bedrooms was located had a gray, black and brown substance around the frame and window panes. The front living room area did not have a light. The		will be fully implemented, including the following specifics: **1. Common Area Painting -This is to include patch/repair, sanding (as needed), wall prep, and paintingof all walls in the common areas (hallways, living rooms, dinning rooms,kitchen, and bathrooms) of the home. This project is to start Wednesday 12/16and be completed by Wednesday 12/23. Joe Moore will be the one primarily responsible for this task. 2. Carpet in Living Areas -We have schedule for the carpets to be replaced in the living areas on Friday 12/18. Stephen is the primary contact for this task 3. Damage Around Door Frames- We will investigate and repair the areas around the doors that appear to bedamaged and showing gaps, missing paint, or buckled areas were the trim meetsthe frame. The investigation will be completed by end of day Wednesday 12/16andcorrections completed by Wednesday 12/23. Stephen will be primarily responsible fordiagnosing the issue and the assign the tasks needed to correct the issues. 4. Bedroom Hallway Door - Ifnot already completed the gray, black, and brown substance around the doorwindow frames will be inspected and cleaned in a manner appropriate to**	

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	ceiling had a round, plastic cover where the light was supposed to be. The half-bath in the main living area had a one foot by one foot area where the drywall was dented in and cracked to the right of the sink. The doorframe to the bathroom was damaged in the area where the door would latch causing the door not to latch and could not be locked. The carpets in the two living room areas was discolored in several areas. This affected clients #1, #2, #3, #4, #5 and #6. On 11/17/15 at 6:41 AM, staff #6 indicated the living room carpets needed to be cleaned. Staff #6 stated, regarding the carpets in the two rooms, "It's filthy." On 11/17/15 at 1:51 PM, the Group Home Director (GHD) indicated the front living room needed a light. The GHD stated the group home walls were "always rough looking. Needs to be painted." On 11/17/15 at 1:52 PM, the QIDP indicated the bathroom door needed to be repaired. The QIDP indicated she was not sure if a maintenance request was submitted. The QIDP indicated the group home needed to be repainted. On 11/19/15 at 3:20 PM, the Maintenance Director (MD) stated the		**theissue. Depending on what the cause is determined to be, Maintenance willprovide a recommendation to house staff on ways to clean area to prevent futureissues. The investigation will be completed by end of day Wednesday 12/16andcorrections completed by Wednesday 12/23. Stephen will be primarily responsible for diagnosingthe issue and the assign the tasks needed to correct the issues. 5. Front Living Room Light -If not already completed, we will replace the light in the front living roomwith a recessed fixture and LED bulb. This will be corrected by Wednesday 12/23.Stephen is the primary contact for this task. 6. Main Living Half Bath Wall- The wall in the half bath that has the 1 foot by 1 foot dent in the wall willbe repaired with wall paneling of the type used in the main bathrooms. Thiswill be corrected by Wednesday. 12/23 Stephen is the primary contact for this task. 7. Half Bath Lock - The latchand lock for the half bath that was noted as being damaged will berepaired/replaced. This will be corrected by Wednesday 12/23.Stephen is the primary contact for this task. 2. T**he clients' programs that were not integrated, coordinated,and monitored were completed as	

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	group home was repainted "about a year ago." The MD stated, "Trying to keep up with the holes is a chore." The MD indicated he fixed the bathroom door on 11/18/15. The MD indicated he replaced the plastic cover in the front living room with a can light on 11/18/15. The MD indicated client #1 broke the light that was in there. The MD stated he was "trying to come up with a way to protect the walls." The MD indicated the group home needed to be repainted. The MD indicated the living room carpet needed to be shampooed. 2) Please refer to W159. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to monitor the Qualified Intellectual Disabilities Professional (QIDP) to ensure the QIDP integrated, coordinated and monitored the clients' program plans. The governing body failed to monitor the QIDP to ensure the QIDP conducted regular reviews of the clients' program plans to ensure the clients were meeting the criteria of their training objectives and updating/revising the program plans as needed. The governing body failed to monitor the QIDP to ensure the group home's needed repairs, repainting and cleaning were conducted as needed. The governing body failed to monitor the QIDP to		part of this POC. Additionally, each individual's annual andquarterly meeting will be placed on calendar, and QIDP will ensure that theannual and quarterly review or update is in place by the meeting date. **How facility will identify other residentspotentially affected & what measures taken** All residents potentially are affected, andcorrective measures address the needs of all clients. **Measures or systemic changes facility putin place to ensure no recurrence** QIDP trained on completing weekly visits to facility toensure no maintenance issues go unreported and resolved. QIDP trained on completing monthly QAchecklist that will be utilized to monitor environmental issues. House staff trained on reporting maintenanceissues in a timely manner. QIDP trained to ensure that clients'programs are integrated, coordinated, and monitored. Additionally, each individual's annual andquarterly meeting will be placed on calendar, and QIDP will ensure that theannual and quarterly review or update is in place by the meeting date. **How corrective actions will be monitored toensure 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 report progress to the Chief	

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	ensure there was regular communication from the group home to the school. The governing body failed to monitor the QIDP to ensure issues communicated from the school were addressed. The governing body failed to monitor the QIDP to ensure visits to the schools were conducted in order to ascertain if the school was meeting the needs of clients #1, #5 and #6. The governing body failed to monitor the QIDP to ensure the clients had the right to due process in regard to the kitchen door being locked unnecessarily. The governing body failed to monitor the QIDP to ensure there was sufficient staff to manage and supervise the clients in accordance with their individual program plans. The governing body failed to monitor the QIDP to ensure client #3's guardian and the specially constituted committee consented to restrictions in the home. The governing body failed to monitor the QIDP to ensure evacuation drills were conducted quarterly for each shift and the drills during the overnight shift varied in times. The governing body failed to monitor the QIDP to ensure client #2 fed himself while at the facility-operated day program and clients #1, #2, #3, #4, #5 and #6 were involved with meal preparation. 9-3-1(a)		Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place by 12/23/15. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than two visits per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC.	

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W 0120 Bldg. 00	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review and interview for 3 of 3 non-sampled clients who attended school (#1, #5 and #6), the facility failed to ensure outside services met the needs of the clients. Findings include: On 11/18/15 at 9:24 AM, an interview with client #5 and #6's teacher was conducted. The teacher indicated the group home and the school had a communication book. The teacher indicated the school was not receiving communication from the group home. The teacher stated the school received communication from the group home "less than 2%" of the time. The teacher indicated client #6 came to school without needed supplies such as a belt to keep his pants from falling down. The teacher stated the school had to call the group home "at least twice a week" to "ask and plead" with them to send a belt. The teacher indicated he had not been in contact with the current Qualified Intellectual Disabilities Professional	W 0120	**W 120 (Standard) Services provided with outside sources Corrective action for resident(s)found to have been affected** All parts of the POC for the survey with event ID Q7T311 will be fully implemented, including the following specifics: House staff will communicate daily with client #1, #5, #6 utilizing communication book. Wearing a belt each day for school will be added to client #6 informal goals. A hairwashing goal introduced for Client #5. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** QIDP will conduct monthly observations at client #1, #5, #6 school(s) and document on visit form, initialed by teacher or school personnel. Training sheet will be completed with client #1, #5, #6 classroom teachers on how to communicate with house via communication book and how to contact QIDP when issues	12/23/2015

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	(QIDP). The teacher stated, "never heard of her" when asked if he knew the QIDP by name. The teacher indicated he spoke to staff #5 several times a week and had requested a belt be sent for client #6 to use at school. The teacher indicated the communication he wanted from the group home each morning was how long the clients slept, did they receive their medications and if there were any behavioral issues during the morning prior to being sent to school. The teacher indicated there were issues with client #5's hygiene, specifically client #5's hair not being washed for several days in a row. The teacher indicated there was one day this school year when client #6 did not receive his medications prior to getting on the bus in the morning (did not know a specific date). The group home did not communicate this to the teacher. The teacher indicated the group home staff reported the missed medications to the bus driver and aid on the bus. The teacher indicated there was no communication in the communication book about why client #6 did not receive his medications. The teacher indicated no one from the group home called to report client #6's missed medications which may have affected his behavior during the day at school. On 11/18/15 at 10:56 AM, a review of		arise. House staff trained on communicating effectively with client #1, #5, and #6 classrooms. Client#5 hair washing goal will be trained with facility staff. Monthly school visit form introduced and trained with QIDP.**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 report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections	

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	client #1's record was conducted for school observations being conducted and communication from the QIDP or other staff to the school. There was no documentation in client #1's record indicating the QIDP or other staff conducted observations at the school to ensure the outside services met the needs of the client. There was no documentation of communication with the school. On 11/18/15 at 10:51 AM, a review of client #5's record was conducted for school observations being conducted and communication from the QIDP or other staff to the school. There was no documentation in client #5's record indicating the QIDP or other staff conducted observations at the school to ensure the outside services met the needs of the client. There was no documentation of communication with the school. On 11/18/15 at 10:43 AM, a review of client #6's record was conducted for school observations being conducted and communication from the QIDP or other staff to the school. There was no documentation in client #6's record indicating the QIDP or other staff conducted observations at the school to ensure the outside services met the needs		are in place by 12/23/15. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than two visits per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC. The SGL Director also will meet weekly with QIDP to review plans and checklist items.	

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	of the client. There was no documentation of communication with the school. On 11/18/15 at 11:33 AM, the QIDP was asked to review the school communication notes at the group home and send documentation to the surveyor of the group home's communication with the school since August 2015 when school started. The surveyor received no documentation to review of the communication from the group home to the school. On 11/18/15 at 11:33 AM, the QIDP indicated she had not conducted observations at client #1, #5 and #6's school. The QIDP indicated she met client #5 and #6's teacher last week at a transition meeting for client #6 from the school to a community-based day program. The QIDP indicated the teacher did not communicate issues to her related to the group home. The QIDP indicated the group home needed to ensure outside services met the needs of the clients. The QIDP indicated the group home needed to ensure client #6 wore a belt to school daily. The QIDP indicated client #5 took a bath every evening but she was not sure if he washed his hair or not. The QIDP indicated the group home staff needed to ensure client #5 washed his hair daily.			

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	9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to ensure staff immediately reported an allegation of abuse and neglect to the administrator, conduct thorough investigations, ensure recommended corrective actions were implemented, prevent client to client abuse, ensure client #1 received appropriate medical care following an incident of using his head to break a window, the administrative staff on the pager documented thorough notes, the administrative staff on the pager followed up with staff to find out who authorized the use of an as needed medication to client #1 and there was sufficient staff to implement the clients' support plans. Findings include: 1) Please refer to W149. For 9 of 28	W 0122	**W 122 CLIENT PROTECTIONS (Condition) Corrective action forresident(s) found to have been affected A**dministrativestaff on the pager**and QIDP trained to**immediately report an allegation of abuse and neglect to the administrator,conduct thorough investigations, ensure recommended corrective actions areimplemented, prevent client to client abuse, ensure clients receive **appropriate** medical care following anincident of SIB such as; client using his head to break a window, contactingemergency nursing pager, document thorough pager notes, follow up with psychpager concerning PRN medication being administrated, ensuring that sufficientstaff are present to implement client support plans. Facility staff trained to immediately report an allegationof abuse and neglect to the administrator failure to do so in a timely mannermay result in corrective action from verbal warning to suspension. QIDP trained on completing thorough investigations. QIDP trained to follow through with	12/23/2015

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	incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to ensure staff immediately reported an allegation of abuse and neglect to the administrator, conduct thorough investigations, ensure recommended corrective actions were implemented, prevent client to client abuse, ensure client #1 received appropriate medical care following an incident of using his head to break a window, the administrative staff on the pager documented thorough notes, the administrative staff on the pager followed up with staff to find out who authorized the use of an as needed medication to client #1 and there was sufficient staff to implement the clients' support plans. 2) Please refer to W153. For 1 of 28 incident/investigative reports reviewed affecting clients #1 and #6, the facility failed to ensure staff immediately reported an allegation of abuse and neglect to the administrator, in accordance with state law. 3) Please refer to W154. For 2 of 29 incident/investigative reports reviewed affecting clients #1 and #6, the facility failed to ensure thorough investigations were conducted into an allegation of abuse and neglect involving clients #1		recommendations madefollowing an investigation of alleged abuse and neglect. **QIDP created master scheduleproviding adequate coverage to manage and support clients** inaccordance with individual program plans. **How facility will identify other residentspotentially affected & what measures taken** All residents potentially are affected, andcorrective measures address the needs of all clients. **Measures or systemic changes facility putin place to ensure no recurrence** Director of Supported Group Livingwill train administrator staff on pager to submit pager notes each Monday forDirector of Supported Group living review and monitor for concerns. House staff will train monthly ontimely reporting abuse and neglect to administrator including SIB andpreventing client on client abuse. Investigator will be assigned tocomplete a timely and thorough investigation. Recommendations will be createdand will be followed to address allegation. QIDP trained to create and followschedule unless changes are approved by an administrator. **How corrective actions will be monitored toensure no recurrence** Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The	

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	and #6 and a self-injurious behavioral incident involving client #1 breaking a window with his head. 4) Please refer to W157. For 2 of 29 incident/investigative reports reviewed affecting clients #1 and #6, the facility failed to ensure appropriate corrective action was taken to address an allegation of abuse and neglect involving clients #1 and #6 and an incident of client #1 injuring himself during an incident of self-injurious behavior. 5) Please refer to W186. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans. 9-3-2(a)		Senior Director will report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place by 12/23/15. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than two visits per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC. Monitoring by the Senior Director will continue until the CEO has determined that systems are in place sufficient to provide ongoing operations in compliance with all the conditions of participation in the Medicaid program.	
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the			

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	right to file complaints, and the right to due process. Based on observation, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients had the right to due process in regard to locking the kitchen door restricting the clients' access to the kitchen. Findings include: Observations were conducted at the group home on 11/16/15 from 3:18 PM to 6:24 PM and 11/17/15 from 6:03 AM to 7:38 AM. During the observations, when the kitchen door was closed it was locked. The staff was able to unlock the door using a key accessible to the staff. On 11/17/15 at 6:26 AM, the Qualified Intellectual Disabilities Professional used a key to unlock the kitchen door. On 11/17/15 at 6:57 AM, client #1 attempted to enter the kitchen. Client #1 stated, "the door is locked." The staff unlocked the door and client #1 entered the kitchen. This affected clients #1, #2, #3, #4, #5 and #6. On 11/17/15 at 11:03 AM, a review of client #1's record was conducted. There was no documentation in his record indicating the need for the kitchen door to be locked.	W 0125	**W125 (standard) – Client Rights** **Corrective action forresident(s) found to have been affected**IDT discussed client safety and determinedclient #1, #2, #3,#4, #5, #6 were in need of restricted access to kitchen. **How facility will identify other residentspotentially affected & what measures taken**All residents potentially are affected, andcorrective measures address the needs of all clients.**Measures or systemic changes facility putin place to ensure no recurrence**Client #1, #2, #3,#4, #5, #6 behavior supportplans revised to include restricted access to kitchen. HRC interim approval obtained forclient #1, #2, #3,#4, #5, #6 behavior support plans and restriction for kitchenaccess. Kitchen safety goals introducedfor clients #1, #2, #3,#4, #5, #6 behavior support plans. Staff trained on all plans andtraining goals. **How corrective actions will be monitored toensure no recurrence**QIDP will complete monthly monitoring toensure protection of client rights. Checklist obtaining this task will be turned into Director of SupportedGroup Living by the 10th of each month for review.	12/23/2015

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	On 11/17/15 at 11:34 AM, a review of client #2's record was conducted. There was no documentation in his record indicating the need for the kitchen door to be locked. On 11/17/15 at 12:15 PM, a review of client #3's record was conducted. There was no documentation in his record indicating the need for the kitchen door to be locked. On 11/17/15 at 12:55 PM, a review of client #4's record was conducted. There was no documentation in his record indicating the need for the kitchen door to be locked. On 11/17/15 at 11:09 AM, a review of client #5's record was conducted. There was no documentation in his record indicating the need for the kitchen door to be locked. On 11/17/15 at 11:17 AM, a review of client #6's record was conducted. Client #6's 5/3/15 Behavioral Support Plan (BSP) indicated in the Restrictions Included in this Plan section, "Restricted kitchen access." Client #6's BSP indicated he had a targeted behavior of food foraging (defined as searching for food items to eat that were either			

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	unhealthy, contaminated, or belong to another client). There was no additional information in the BSP indicating the purpose or description of this restriction. There was no proactive or reactive strategies in the BSP indicating the restricted kitchen access. On 11/17/15 at 7:17 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the kitchen door was locked due to client #4 foraging for plastic and paper from the garbage. The QIDP indicated client #4 had a plan for the door to be locked. On 11/17/15 at 2:07 PM, the QIDP indicated she was not sure when the restriction started or why the kitchen door was locked. The QIDP stated she "assumed it was for [client #4]." The QIDP indicated none of the clients had a plan to lock the kitchen door. On 11/17/15 at 2:07 PM, the Group Home Director (GHD) indicated none of the clients had a plan to lock the kitchen door. The GHD indicated the kitchen door should not be locked restricting the clients' access to the kitchen. 9-3-2(a)			

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W 0149 Bldg. 00	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 9 of 28 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to ensure staff immediately reported an allegation of abuse and neglect to the administrator, conduct thorough investigations, ensure recommended corrective actions were implemented, prevent client to client abuse, ensure client #1 received appropriate medical care following an incident of using his head to break a window, the administrative staff on the pager documented thorough notes, the administrative staff on the pager followed up with staff to find out who authorized the use of an as needed medication to client #1 and there was sufficient staff to implement the clients' support plans. Findings include: On 11/13/15 at 12:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 10/8/15 at 10:15 AM (reported to	W 0149	**W149 (standard) – Staff treatment of clients Corrective action for resident(s) found to have been affected** 1) Facility staff trained on preventing abuse and neglect and reporting alleged abuse and neglect in a timely manner. **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** Administrator staff on pager will submit pager notes each Monday for Director of Supported Group living review and monitor for concerns. Director of Supported Group Living will review monthly facility staff training. Director of Supported Group Living will review investigations to determine that thorough investigations were completed. Director of Supported Group Living will review recommendations to determine appropriate corrective action was taken to address allegation. QIDP will complete monthly monitoring to ensure protection of client rights. Area of checklist interviews staff and obtains information regarding client protections. Checklist will be	12/23/2015

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	the administrative staff on 10/9/15 at 12:30 AM), staff #6 alleged staff #9 answered client #1's questions "condescendingly" according to the Stone Belt ARC, Inc. Incident Report completed by the Qualified Intellectual Disabilities Professional (QIDP). The report indicated, "...[Client #1] was watching [client #6's] television in the living room with no issues. However, [staff #9] proceeded to tell [client #6] that '[client #1] had no right to use your TV without permission.' This seemed to agitate both clients. In the middle of the TV situation, [client #4's] alarm was going off annoying [client #1], so he turned the alarm off. [Staff #9] told [client #1], 'He cannot turn off the alarm without permission.' So [client #1] asked for permission and [staff #9] said, 'It's too late now. You should have asked for permission first.' [Client #1] walked around for a little bit after this, seeming slightly agitated. To add to it, [client #6] started getting way too close to [client #1] and was trying to follow him around. [Staff #6] stayed right with [client #6] to make sure he did not try to hit [client #1]. She tried redirecting him to give [client #1] some space. During this, [staff #9] told [staff #6] that 'You don't have to worry about [client #1] hitting [client #6] because [client #1] is afraid of [client #6].' But he told her 'not to turn her back		turned into Director of Supported Group Living by the 10th of each month for review. **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 report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place by 12/23/15. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than two visits per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC. The SGL Director also will meet weekly with QIDP to review plans and checklist items.	

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	to [client #1], because he is the one who will try and hit you.' The alarm got brought up again because [client #1] wanted to know that it was off and wouldn't bother him. He balled up his fists and started screaming 'No.' 'He went into his room and started banging his head and screaming. He even yelled, 'I'm biting my arm.' [Staff #9] was with [client #1] at this point, but did not intervene with the behavior. [Staff #6] reports hearing [staff #9] say, 'You are just doing this for attention. I am not impressed. I am going to ignore you.' Then [staff #9] walked away and started doing laundry while humming. [Client #1's] tantrum moved out into the hallway. He started banging his chin against the floor in the hallway. [Staff #6] went into the hallway and asked [staff #9] is (sic) they should direct [client #1] to the front room. [Staff #9] told [staff #6] 'to ignore him because he was just trying to get attention.' [Staff #9] even took his own head and banged it against the wall in between the bathroom and kitchen. After bannging (sic) his head he said to [staff #6], 'See...it doesn't even hurt. He's fine.' [Staff #6] went to look at [client #1's] arm and came back to ask [staff #9] what (sic) they should clean or bandage him. [Staff #9] told her again, 'He just wants attention. We should ignore him.' [Client #1] has a newer bite mark on his			

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	forearm (there are several older ones surrounding it) and bruising on his upper right arm. The underside of his chin also has a small abrasion on it from where he banged it against the ground." The Incident Report indicated staff #6 reported the incident to staff #5 on 10/8/15 at 11:30 AM, to the Home Manager on 10/8/15 at 2:00 PM and the anonymous pager on 10/9/15 at 12:30 AM. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 10/9/15, indicated, "On 10/09/2015 at 12:30 AM, pager was notified of this allegation. Director is currently conducting an investigation into this allegation and staff, [staff #9], has been suspended." The Investigation Report, dated 10/15/15, indicated the purpose of the investigation was "to determine whether staff member [staff #9] committed acts of neglect and emotional/verbal abuse by refusing to provide appropriate supervision and care when client [#1] was actively hurting himself, and by using words and actions to negatively impact [client #1] in a condescending and escalatory manner." The Statement of Findings section indicated, in part, "There were many			

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	discrepancies between the testimonies of [staff #6] and [staff #9], the two principal witnesses who were able to provide their perspectives on these incidents. [Staff #6's] testimony paints a neglectful picture of [staff #9], describing him as humming and putting away laundry while a client appears to be in distress. [Staff #6] also describes a very stern or harsh [staff #9], both in the way he speaks with clients and in his direction of her. In this way, she claims that [staff #9] was not following [client #1's] BSP (behavioral support plan), which states that 'Interactions between staff and clients should be positively framed, staff should provide ample positive reinforcement to keep [client #1] motivated in his daily activities, staff should avoid used the word 'no' when talking with [client #1].' From [staff #9's] perspective, [staff #6] was also guilty of not following [client #1's] BSP, which does stipulate that when he is in a tantrum, 'auditory input is likely to escalate him further, no eye contact should be made, and ideally staff should remain out of direct eyesight,' and is specific reference to [client #1's] calming self-talk in times of trauma, 'Try not to interrupt him if you hear him engaging in this behavior.' The report indicated, "...Finally, [staff #9] admitted that he sometimes has a difficult time preventing his frustration from entering into client			

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	interactions, and that he has used an angry tone with clients in the past." The report indicated, "The core of the neglect allegation appears to stem from the assertion that [staff #9] obstructed [staff #6] from stopping [client #1] from banging his chin on the wooden floor, which resulted in injury, and that he prevented staff from administering first aid in a timely manner. As it cannot be clearly determined that this specific mechanism of injury indeed took place ([client #1's] chin may have been injured in some other way), and as there are not clear guidelines regarding the timeline for provision of first aid (though it can be inferred from the BSP that doing so during a tantrum would be counter-productive), it does not seem that [staff #9] acted in a neglectful manner." The report indicated, "While there is testimony and circumstantial evidence that [staff #9's] tone often seems to come from a place of superiority, there is not corroborated testimony to prove that [staff #9] committed a specific act of emotional/verbal abuse on the morning of 10/8/15. However, he has admitted that he has allowed his frustration to enter into his interactions with clients, and that he has used an angry tone of voice with clients in the past. Given these admissions, it is clear that [staff #9's] use of language, while not technically			

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	abusive, may in fact be escalating negative situations and possibly causing emotional distress." The report indicated, "The allegations of both neglect and emotional/verbal abuse are not substantiated." The Recommendations section of the report indicated, "It is the recommendation of the investigator that the following corrective actions occur: Competency-based retraining for [staff #9] on the aspects of clients' BSPs that have to do with positive framing and reinforcement. In addition, guidance from supervisors regarding appropriate ways to train new staff should be provided. As [staff #9] has admitted to anger/frustration issues, and in light of his description of the challenging personal circumstances he is faced with currently, it is recommended that EAP (Employee Assistance Program) counseling be required before he returns to work. Competency-based retraining for [staff #6] on the specifics of all clients' BSPs, especially that of [client #1], so that effective support can be ensured during tantrum situations and other highly-emotional events." The facility failed to conduct a thorough investigation. The facility's investigation failed to address staff #5, staff #6 and the			

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	Home Manager failing to immediately report the allegation to the administrator. The facility failed to ensure the recommended retraining with staff #6 was completed (retraining on client #2, #3, #4, #5 and #6's BSPs). The facility failed to ensure staff #9 received the recommended EAP counseling prior to returning to work. On 11/16/15 at 1:56 PM, a review of staff #9's employee file was conducted. There was no documentation in staff #9's employee file indicating he received competency-based retraining on the clients' BSPs. There was no documentation in his employee file he received EAP counseling prior to returning to work. On 11/20/15 at 1:08 PM, the Group Home Director (GHD) indicated in an email, "It was recommended that he (staff #9) seek EAP not mandated at this time. So there is no way to verify if he did or not." On 11/20/15 at 2:47 PM, the GHD indicated in an email, "As [staff #9] has admitted to anger/frustration issues, and in light of his description of the challenging personal circumstances he is faced with currently, <u>it is recommended</u> that EAP counseling be required before he returns to work. Since we didn't mandate it we can't access the records. If			

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	after weekly supervision [staff #9's current supervisors] feels that it is needed then HR and I will require [staff #9] to seek EAP counseling." On 11/20/15 at 11:51 AM, the Human Resources Director (HRD) initially indicated staff #9 received EAP counseling as recommended. The HRD indicated if staff #9 did not receive the counseling, the facility would have been notified. On 11/20/15 at 1:51 PM, the HRD indicated she was unable to locate documentation staff #9 received EAP counseling. The HRD indicated she met with the Group Home Director (GHD) who read the investigation recommendation to herself. The GHD indicated to the HRD the EAP counseling was a recommendation, not a mandate. The HRD indicated, after the surveyor read the investigation's recommendation, she would have filled out documentation indicating staff #9 be mandated to receive EAP counseling prior to returning to work, as indicated in the investigation. On 11/16/15 at 2:07 PM, the Group Home Director (GHD) indicated the staff should have immediately reported the incident to the administrator. The GHD indicated all of the staff working at the group home needed to be retrained on reporting requirements. On 11/17/15 at 7:18 AM, staff #6 indicated she was told it was her word against staff #9's word regarding the allegation. Staff #6 stated, "not sure why his word is more important." Staff #6 indicated staff #9 was moved to another group home and received a raise. Staff #6 stated staff #9 did "many bizarre things that day" including hitting his head against the wall to show her client #1 was not injuring himself from head banging.			

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	Staff #6 indicated staff #9 did not intervene during client #1's behavior to keep client #1 safe. On 11/16/15 at 2:11 PM, the QIDP indicated staff #6 reported the incident to staff #5 and staff #5 reported the incident to the Home Manager (HM). The QIDP indicated the HM sent an email after his shift to the QIDP and another QIDP. The other QIDP contacted the administrator. The QIDP indicated the staff should have immediately reported the allegation to the administrator. The QIDP stated she went to the group home on 10/9/15 to get the "full story." The QIDP indicated at the time, the information she had was the email from the HM. The QIDP indicated she assisted staff #6 to write the incident report since staff #6 was new. The QIDP indicated she trained staff #6 on client #1's BSP. The QIDP indicated staff #6 was uncertain about what she should do. The QIDP stated staff #6 "was being passive." The QIDP indicated she trained staff #6 to step in as soon as she thought there was an issue of abuse, neglect or exploitation. The QIDP indicated the incident occurred during staff #6's first week of working at the group home so staff #6 was asking staff #9 what to do during client #1's behavior. Staff #6 reported this was the first time she saw client #1 during a behavioral incident. The QIDP indicated staff #6 reported that staff #9 told staff #6 not to intervene during client #1's behavior. The QIDP indicated she told staff #6 to follow client #1's plan and she was responsible for intervening if there was an issue. The QIDP indicated staff #9 did not return to the group home following the incident. Staff #9 was working at another group home. On 11/17/15 at 1:40 PM, the QIDP indicated she retrained staff #6 on 11/5/15 on client #1's BSP. The QIDP indicated the Behavioral Consultant was going to train staff #6 on the other clients' BSPs. The QIDP indicated the training with staff #6 on the			

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	other clients' BSPs had not been scheduled. On 11/20/15 at 1:31 PM, an interview with the Social Worker (SW) who conducted the investigation was conducted. The SW stated the investigation "basically" was one staff's word against another. The SW indicated there was not sufficient evidence to support substantiating the allegation. The SW indicated both staff reported different things. The SW stated he could not substantiate the allegation "unless absolutely clear" the evidence supported the allegation. The SW indicated he recommended that EAP be required of staff #9 prior to staff #9 returning to work. The SW indicated he expected staff #9 would get counseling prior to returning to work. The SW indicated the investigation should have addressed that staff failed to immediately report the allegation to the administrator. The SW indicated he did not notice that the allegation was not reported immediately to the administrator. 2) On 9/26/15 at 8:45 AM, client #1 woke up and left his room in a bad mood. Client #1 was agitated about the noises in the group home. Client #1 got upset about his scratched CD's and the CD's skipping. Client #1 was upset the other clients were making noise during his music time. Another client went to his room and the motion sensor alarm sounded. Client #1 slammed himself on the floor in the dining room. Staff #4 attempted to talk to client #1 but he was too upset with the noises in the group home. Client #1 ran to the window in the door by the kitchen and slammed his head into the window. The window broke and shattered. Client #1 hit himself on the wall. Staff #2 redirected client #1 to the soft room (room with padding on walls and floor). Client #1 ran into the living room and made a hole in the wall. Client #1 continued to engage in self-injurious behavior until he was bleeding from			

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	the mouth. Staff (did not indicate which staff) asked him to stop, but when he did not stop, staff put him in a baskethold for 10 seconds and released him when he agreed to stop self-injurious behavior. Client #1 bit himself on his arms. The Medical for Client section indicated, "Head was slammed into the window. He hit his face repeatedly in the carpet in the soft room. Bit his arms. 1 inch abrasion on his forehead from the window glass. Cut his lower lip. Several bite marks on his arms; some from previous tantrums...." The Chemical Restraint section indicated Zyprexa Zydis 10 milligrams was administered to client #1 at 9:15 AM after 30 minutes of maladaptive behavior. The report indicated the Central Pager (QIDP #3) gave the staff authorization to administer the PRN. At 8:50 AM, the pager was called and authorization to administer a PRN (as needed medication) was given, according to the 9/26/15 Stone Belt ARC, Inc. Incident Report. Client #1 calmed approximately 30 minutes later. Client #1 had an one inch abrasion on his forehead from the window glass which was cleaned and basic first aid was given. The incident was reported to the central pager at 9:00 AM. The incident report indicated in the PRN protocol section, "Staff are to call coordinator (QIDP) or emergency pager to receive permission to give." The Incident Report review form, no date, indicated the nurse reviewed the incident report on 9/28/15. The nurse made the following comment, "Nurse pager wasn't (sic) notified - [client #1] needs to be seen for a follow up dr (doctor) appointment for his head and arm." The Behavior Consultant added a comment, "Will review incident with team." The Social Worker and QIDP reviewed the incident report on 9/28/15. The Group Home Director reviewed the			

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	incident report on 10/20/15. On 11/20/15 at 12:48 PM, a review of QIDP #3's notes for the period of 9/25/15 to 10/2/15 titled, Epager, indicated regarding the call she received, "9/26/15...call @ (at) 9a from [name of group home] about PRN...." There was no additional information documented. QIDP #3 did not document who called her, the information provided to the pager regarding the use of a PRN (least restrictive interventions attempted prior to administering a PRN), who received a PRN, the name and dosage of the PRN and what her response to the staff included. On 11/18/15 at 12:46 PM, QIDP #3, who was the pager contact at the time of the incident, indicated the group home staff contacted her to inform her client #1 had been administered a PRN. QIDP #3 indicated she told them they needed to obtain her permission prior to administering a PRN and the staff indicated they already had permission to give the PRN. QIDP #3 indicated she did not ask who the staff received permission from. QIDP #3 indicated at the time, the staff did not report the window was broken during the incident. QIDP #3 indicated she did not document the name of the staff who contacted her. On 11/17/15 at 2:10 PM, the Group Home Director (GHD) sent an email to the Administrative Assistant (AA) indicating, "We are looking for an investigation for a head banging incident on 9/26/15 for [client #1]. We also need the electronic documentation. Can we show that he was seen by a nurse following this?" On 11/17/15 at 2:38 PM, the GHD sent an email to the AA indicating, "Thanks. [Name of former QIDP] was supposed to do an investigation of what happened." On 11/17/15 at 2:38 PM, the AA replied to the GHD, "I see nothing like that in			

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	the incident report files." On 11/17/15 at 4:07 PM, the GHD sent an email to the former QIDP indicating, "...do you have proof that you looked into it? Like a support team note or email???" On 11/18/15 at 2:54 PM, the former QIDP replied, "I couldn't find any emails. I know I spoke in person and over the phone with the weekend staff regarding the incident. We did discuss it during support team and in other conversations, and this incident was one of the reasons we decided to take any losing outings as a consequence out of his plan, and put in the bonus reinforcer." On 11/18/15 at 2:56 PM, the GHD replied to the former QIDP and current QIDP, "Ok. Unfortunately, if it wasn't documented then the investigation never happened...." On 11/20/15 at 12:56 PM, the GHD stated QIDP #3's pager notes were "vague." The GHD indicated the pager notes were sent to the GHD's administrative assistant. The GHD indicated QIDP #3 needed to be retrained. The GHD indicated QIDP #3 should have called the GHD at the time of the incident to report it to her. The GHD stated regarding the incident, "it was huge." The GHD indicated the staff needed to be given permission prior to administering a PRN medication for behavior. The GHD indicated client #1's plan needed to indicate permission must be obtained prior to administering a PRN behavioral medication. The GHD stated QIDP #3 should have known to contact her if anything "questionable" happened at the group home. The GHD indicated the incident should have been investigated. On 11/17/15 at 2:41 PM, the Group Home Director sent a Nursing Consultation note, dated 9/28/15, by email indicating, "...Over the weekend [client #1] hit his head through the window, and also bit his arm several times from the wrist down to the elbow causing bleeding.			

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	Writer instructed day aide (sic) to set an appointment up with PCP (primary care physician), to follow up for injuries. Nurse will check [client #1] out today." On 11/17/15 at 11:03 AM, a focused review of client #1's record was conducted. There was no documentation client #1 was assessed by the nurse on 9/28/15. Client #1's 10/2/15 Behavioral Support Plan indicated, in part, "If [client #1] engages in severe intentional and dangerous aggressive behavior towards himself or others, staff may call the emergency pager for PRN approval...." The facility failed to conduct a thorough investigation. The facility's Social Worker, QIDP and Group Home Director failed to identify the incident as requiring an investigation upon their review. The facility failed to ensure the nurse was notified of client #1's injury to his head. The facility failed to ensure client #1 received a medical assessment in a timely manner after he "slammed his head into the window" causing the window to break. There was no documentation QIDP #3 followed-up with the staff to see who authorized client #1 receiving a PRN. There was no documentation the facility took corrective action with QIDP #3 for failing to document thoroughly on the pager notes regarding the incident. The facility failed to ensure client #1's BSP matched the policy on PRN use. Client #1's BSP indicated the pager may be notified. The facility's policy indicated staff must receive approval from the pager prior to administering a PRN medication. The facility failed to take corrective actions to address these issues. On 11/18/15 at 12:57 PM, the facility's policy on Psychotropic PRN Medications, dated 10/3/13, indicated the following, "Before administering			

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	any PRN (as needed) medication for behavior, staff must review the individual's Behavioral Support Plan and have implemented all least restrictive techniques identified. When the individual displays behavior consistent with identified behavioral criteria, and all less restrictive procedures have been ineffective, staff will call the pager or their coordinator (QIDP)/director and get approval to administer a PRN as prescribed...." On 11/18/15 at 12:50 PM, the QIDP indicated client #1's plan should include a stipulation the staff need to obtain permission to administer a PRN prior to administering a PRN. On 11/18/15 at 12:55 PM, QIDP #2 indicated client #1's plan should indicate the staff were to receive permission to administer a PRN prior to administering a PRN. On 11/20/15 at 11:10 AM, the Nurse Manager (NM) indicated the nurse should have been notified. The NM indicated the staff have to obtain approval prior to administering a PRN medication from the Central pager or the psychiatric pager. On 11/17/15 at 1:59 PM, the Group Home Director (GHD) indicated she thought the former QIDP looked into the incident. The GHD indicated the incident should have been investigated. On 11/17/15 at 1:59 PM, the QIDP indicated the incident should have been investigated. 3) On 10/18/15 at 10:00 AM, client #1 woke up in a bad mood and yelled about clients who were already awake. Client #5 was listening to music on his tablet. Client #5 repeatedly asked a			

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	question and client #1 threw a cereal bowl at client #5 hitting his on the upper arm. At 5:00 PM, client #1 threw a remote control hitting client #5 on the torso (no description given). The Stone Belt ARC, Inc. Incident Report, dated 10/18/15, indicated there were two staff (#2 and #4) working at the group home at the time of the incidents. The incident report indicated the duration of the incident was, "7? hours on and off." On 11/13/15 at 12:41 PM, the QIDP indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. The QIDP indicated client #1 was targeting client #5 however the incidents have decreased. The QIDP indicated client #5 made high pitched noises which was a trigger for client #1 to aggress on him. The QIDP stated she was "trying to get staff to be more proactive" by moving client #5 away from client #1. The QIDP indicated client #5's noises bothered client #1 when they were in the same area of the group home. The QIDP indicated client #1's aggression was discussed with the Behavior Consultant. The QIDP indicated client #1's support team did not believe client #1 understood his actions. The QIDP stated client #1 was "taking care of the situation" when client #5 was being loud by aggressing on him getting him to stop making noises. The QIDP indicated the group home was keeping the home fully staffed on the weekends and taking client #1 out more. 4) On 9/19/15 at 4:55 PM, client #5 was listening to music on his tablet in the living room. Client #5 moved close to client #1. Client #5 began to yell. Client #1 stepped back, turned around and punched client #5 in the chest. Client #5 started			

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	to cry. On 11/13/15 at 12:41 PM, the QIDP indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. The QIDP indicated client #1 was targeting client #5 however the incidents have decreased. The QIDP indicated client #5 made high pitched noises which was a trigger for client #1 to aggress on him. The QIDP stated she was "trying to get staff to be more proactive" by moving client #5 away from client #1. The QIDP indicated client #5's noises bothered client #1 when they were in the same area of the group home. The QIDP indicated client #1's aggression was discussed with the Behavior Consultant. The QIDP indicated client #1's support team did not believe client #1 understood his actions. The QIDP stated client #1 was "taking care of the situation" when client #5 was being loud by aggressing on him getting him to stop making noises. The QIDP indicated the group home was keeping the home fully staffed on the weekends and taking client #1 out more. 5) On 9/13/15 at 4:00 PM, client #5 was listening to music on his tablet. Client #5 yelled repeatedly. Client #1 walked up to client #5 and punched him on the right side of his chest. On 11/13/15 at 12:41 PM, the QIDP indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. The QIDP indicated client #1 was targeting client #5 however the incidents have decreased. The QIDP indicated client #5 made high pitched noises which was a trigger for client			

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	#1 to aggress on him. The QIDP stated she was "trying to get staff to be more proactive" by moving client #5 away from client #1. The QIDP indicated client #5's noises bothered client #1 when they were in the same area of the group home. The QIDP indicated client #1's aggression was discussed with the Behavior Consultant. The QIDP indicated client #1's support team did not believe client #1 understood his actions. The QIDP stated client #1 was "taking care of the situation" when client #5 was being loud by aggressing on him getting him to stop making noises. The QIDP indicated the group home was keeping the home fully staffed on the weekends and taking client #1 out more. 6) On 8/30/15 at 5:00 PM, client #5 was lying on the couch listening to music on his tablet. Client #6 was asked to stop snacking since it was close to dinner. Client #6 darted across the room and hit client #5 on his neck and face. The Stone Belt ARC, Inc. Incident Report, dated 8/30/15, indicated there were two staff (#4 and #9) working at the group home at the time of the incident. On 11/13/15 at 12:41 PM, the QIDP indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. 7) On 8/29/15 at 4:00 PM, client #3 walked up the hallway, darted into the office and hit client #6 with two open hands on his shoulders. Client #3 ran back to his room. At the time of the incident, there were two staff working at the group home. On 11/13/15 at 12:41 PM, the QIDP indicated			

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STONE BELT ARC INC	1835 MAXWELL ST BLOOMINGTON, IN 47401

(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
	client to client aggression was considered abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. The QIDP indicated at the time of the incident there were two staff working at the group home. The QIDP indicated two staff was not sufficient to manage and supervise the clients according to their program plans. 8) On 8/19/15 at 10:10 AM at the facility-operated day program, client #2 was scooting across the gym floor in a chair. A peer was standing under the basketball goal. Client #2 hit his peer's right upper arm and scratched his arm. The peer sustained a 6 inch raised scratch. The peer cried. On 11/13/15 at 12:41 PM, the QIDP indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. 9) On 8/13/15 at 6:30 AM, client #1 shouted, "Why is he here? Why is he making these noises?" in response to client #4 standing near him. Prior to staff intervening, client #1 hit client #4's upper left arm with a closed fist. On 11/13/15 at 12:41 PM, the QIDP indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 11/13/15 at 1:23 PM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 5/14/13, indicated, in part, "Stone			

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	Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are 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... 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			

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	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 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			

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	must be interviewed to assure they have not been victimized or traumatized by the event." The policy titled, Incident Reporting Procedure, dated 7/25/13, indicated, in part, "A staff member who witnesses an incident, discovers the results of an incident, or receives the initial report of an incident from a person not on staff, immediately does the following: interrupts the inappropriate behavior, takes measures to protect, comfort and ensure treatment of the individuals involved in the incident, obtaining emergency care as needed, requests assistance as needed from immediate supervisor and/or pager, **In cases of suspected abuse/neglect or exploitation, the director of the program is to be notified immediately.** If no action is taken in response to the report, continue to report to the supervisor or next level of management." 9-3-2(a)			
W 0153 Bldg. 00	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			

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	officials in accordance with State law through established procedures. Based on record review and interview for 1 of 28 incident/investigative reports reviewed affecting clients #1 and #6, the facility failed to ensure staff immediately reported an allegation of abuse and neglect to the administrator, in accordance with state law. Findings include: On 11/13/15 at 12:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 10/8/15 at 10:15 AM (reported to the administrative staff on 10/9/15 at 12:30 AM), staff #6 alleged staff #9 answered client #1's questions "condescendingly" according to the Stone Belt ARC, Inc. Incident Report completed by the Qualified Intellectual Disabilities Professional (QIDP). The report indicated, "...[Client #1] was watching [client #6's] television in the living room with no issues. However, [staff #9] proceeded to tell [client #6] that '[client #1] had no right to use your TV without permission.' This seemed to agitate both clients. In the middle of the TV situation, [client #4's] alarm was going off annoying [client #1], so he turned the alarm off. [Staff #9] told [client #1], 'He cannot turn off the alarm	W 0153	**W153 (standard) – Staff treatment of clients** **Corrective action forresident(s) found to have been affected**1) Facility staff trained on preventing abuseand neglect and reporting alleged abuse and neglect in a timely manner. **How facility will identify other residentspotentially affected & what measures taken**All residents potentially are affected, andcorrective measures address the needs of all clients.**Measures or systemic changes facility putin place to ensure no recurrence** Administrator staff on pager willsubmit pager notes each Monday for Director of Supported Group living reviewand monitor for concerns. Director of Supported Group Livingand QIDP will be trained on thorough investigations. **How corrective actions will bemonitored to ensure no recurrence**QIDP will complete monthly monitoring toensure protection of client rights. Areaof checklist interviews staff and obtains information regarding clientprotections. Checklist will be turnedinto Director of Supported Group Living by the 10th of each monthfor review.	12/23/2015

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	without permission.' So [client #1] asked for permission and [staff #9] said, 'It's too late now. You should have asked for permission first.' [Client #1] walked around for a little bit after this, seeming slightly agitated. To add to it, [client #6] started getting way too close to [client #1] and was trying to follow him around. [Staff #6] stayed right with [client #6] to make sure he did not try to hit [client #1]. She tried redirecting him to give [client #1] some space. During this, [staff #9] told [staff #6] that 'You don't have to worry about [client #1] hitting [client #6] because [client #1] is afraid of [client #6].' But he told her 'not to turn her back to [client #1], because he is the one who will try and hit you.' The alarm got brought up again because [client #1] wanted to know that it was off and wouldn't bother him. He balled up his fists and started screaming 'No.' 'He went into his room and started banging his head and screaming. He even yelled, 'I'm biting my arm.' [Staff #9] was with [client #1] at this point, but did not intervene with the behavior. [Staff #6] reports hearing [staff #9] say, 'You are just doing this for attention. I am not impressed. I am going to ignore you.' Then [staff #9] walked away and started doing laundry while humming. [Client #1's] tantrum moved out into the hallway. He started banging his chin against the			

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	floor in the hallway. [Staff #6] went into the hallway and asked [staff #9] is (sic) they should direct [client #1] to the front room. [Staff #9] told [staff #6] 'to ignore him because he was just trying to get attention.' [Staff #9] even took his own head and banged it against the wall in between the bathroom and kitchen. After bannging (sic) his head he said to [staff #6], 'See...it doesn't even hurt. He's fine.' [Staff #6] went to look at [client #1's] arm and came back to ask [staff #9] what (sic) they should clean or bandage him. [Staff #9] told her again, 'He just wants attention. We should ignore him.' [Client #1] has a newer bite mark on his forearm (there are several older ones surrounding it) and bruising on his upper right arm. The underside of his chin also has a small abrasion on it from where he banged it against the ground." The Incident Report indicated staff #6 reported the incident to staff #5 on 10/8/15 at 11:30 AM, to the Home Manager on 10/8/15 at 2:00 PM and the anonymous pager on 10/9/15 at 12:30 AM. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 10/9/15, indicated, "On 10/09/2015 at 12:30 AM, pager was notified of this allegation. Director is			

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	currently conducting an investigation into this allegation and staff, [staff #9], has been suspended." On 11/16/15 at 2:07 PM, the Group Home Director (GHD) indicated the staff should have immediately reported the incident to the administrator. The GHD indicated all of the staff working at the group home needed to be retrained on reporting requirements. On 11/16/15 at 2:11 PM, the QIDP indicated staff #6 reported the incident to staff #5 and staff #5 reported the incident to the Home Manager (HM). The QIDP indicated the HM sent an email after his shift to the QIDP and another QIDP. The other QIDP contacted the administrator. The QIDP indicated the staff should have immediately reported the allegation to the administrator. 9-3-1(b)(5) 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for	W 0154	**W154 (standard) – Staff treatment of clients**	12/23/2015

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	2 of 28 incident/investigative reports reviewed affecting clients #1 and #6, the facility failed to ensure thorough investigations were conducted into an allegation of abuse and neglect involving clients #1 and #6 and a self-injurious behavioral incident involving client #1 breaking a window with his head. Findings include: On 11/13/15 at 12:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 10/8/15 at 10:15 AM, staff #6 alleged staff #9 answered client #1's questions "condescendingly" according to the Stone Belt ARC, Inc. Incident Report completed by the Qualified Intellectual Disabilities Professional (QIDP). The report indicated, "...[Client #1] was watching [client #6's] television in the living room with no issues. However, [staff #9] proceeded to tell [client #6] that '[client #1] had no right to use your TV without permission.' This seemed to agitate both clients. In the middle of the TV situation, [client #4's] alarm was going off annoying [client #1], so he turned the alarm off. [Staff #9] told [client #1], 'He cannot turn off the alarm without permission.' So [client #1] asked		**Corrective action forresident(s) found to have been affected**1) Facility staff trained on preventing abuseand neglect and reporting alleged abuse and neglect in a timely manner. **How facility will identify other residentspotentially affected & what measures taken**All residents potentially are affected, andcorrective measures address the needs of all clients.**Measures or systemic changes facility putin place to ensure no recurrence** Administrator staff on pager willsubmit pager notes each Monday for Director of Supported Group living reviewand monitor for concerns. **How corrective actions will bemonitored to ensure no recurrence**Director of Supported Group Living will reviewand sign investigations to determine that thorough investigations werecompleted.	

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	for permission and [staff #9] said, 'It's too late now. You should have asked for permission first.' [Client #1] walked around for a little bit after this, seeming slightly agitated. To add to it, [client #6] started getting way too close to [client #1] and was trying to follow him around. [Staff #6] stayed right with [client #6] to make sure he did not try to hit [client #1]. She tried redirecting him to give [client #1] some space. During this, [staff #9] told [staff #6] that 'You don't have to worry about [client #1] hitting [client #6] because [client #1] is afraid of [client #6].' But he told her 'not to turn her back to [client #1], because he is the one who will try and hit you.' The alarm got brought up again because [client #1] wanted to know that it was off and wouldn't bother him. He balled up his fists and started screaming 'No.' 'He went into his room and started banging his head and screaming. He even yelled, 'I'm biting my arm.' [Staff #9] was with [client #1] at this point, but did not intervene with the behavior. [Staff #6] reports hearing [staff #9] say, 'You are just doing this for attention. I am not impressed. I am going to ignore you.' Then [staff #9] walked away and started doing laundry while humming. [Client #1's] tantrum moved out into the hallway. He started banging his chin against the floor in the hallway. [Staff #6] went into			

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	the hallway and asked [staff #9] is (sic) they should direct [client #1] to the front room. [Staff #9] told [staff #6] 'to ignore him because he was just trying to get attention.' [Staff #9] even took his own head and banged it against the wall in between the bathroom and kitchen. After bannging (sic) his head he said to [staff #6], 'See...it doesn't even hurt. He's fine.' [Staff #6] went to look at [client #1's] arm and came back to ask [staff #9] what (sic) they should clean or bandage him. [Staff #9] told her again, 'He just wants attention. We should ignore him.' [Client #1] has a newer bite mark on his forearm (there are several older ones surrounding it) and bruising on his upper right arm. The underside of his chin also has a small abrasion on it from where he banged it against the ground." The Investigation Report, dated 10/15/15, indicated the purpose of the investigation was "to determine whether staff member [staff #9] committed acts of neglect and emotional/verbal abuse by refusing to provide appropriate supervision and care when client [#1] was actively hurting himself, and by using words and actions to negatively impact [client #1] in a condescending and escalatory manner." The Statement of Findings section indicated, in part, "There were many discrepancies between the testimonies of			

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	[staff #6] and [staff #9], the two principal witnesses who were able to provide their perspectives on these incidents. [Staff #6's] testimony paints a neglectful picture of [staff #9], describing him as humming and putting away laundry while a client appears to be in distress. [Staff #6] also describes a very stern or harsh [staff #9], both in the way he speaks with clients and in his direction of her. In this way, she claims that [staff #9] was not following [client #1's] BSP (behavioral support plan), which states that 'Interactions between staff and clients should be positively framed, staff should provide ample positive reinforcement to keep [client #1] motivated in his daily activities, staff should avoid used the word 'no' when talking with [client #1].' From [staff #9's] perspective, [staff #6] was also guilty of not following [client #1's] BSP, which does stipulate that when he is in a tantrum, 'auditory input is likely to escalate him further, no eye contact should be made, and ideally staff should remain out of direct eyesight,' and is specific reference to [client #1's] calming self-talk in times of trauma, 'Try not to interrupt him if you hear him engaging in this behavior.' The report indicated, "...Finally, [staff #9] admitted that he sometimes has a difficult time preventing his frustration from entering into client interactions, and that he has used an			

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	angry tone with clients in the past." The report indicated, "The core of the neglect allegation appears to stem from the assertion that [staff #9] obstructed [staff #6] from stopping [client #1] from banging his chin on the wooden floor, which resulted in injury, and that he prevented staff from administering first aid in a timely manner. As it cannot be clearly determined that this specific mechanism of injury indeed took place ([client #1's] chin may have been injured in some other way), and as there are not clear guidelines regarding the timeline for provision of first aid (though it can be inferred from the BSP that doing so during a tantrum would be counter-productive), it does not seem that [staff #9] acted in a neglectful manner." The report indicated, "While there is testimony and circumstantial evidence that [staff #9's] tone often seems to come from a place of superiority, there is not corroborated testimony to prove that [staff #9] committed a specific act of emotional/verbal abuse on the morning of 10/8/15. However, he has admitted that he has allowed his frustration to enter into his interactions with clients, and that he has used an angry tone of voice with clients in the past. Given these admissions, it is clear that [staff #9's] use of language, while not technically abusive, may in fact be escalating			

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	negative situations and possibly causing emotional distress." The report indicated, "The allegations of both neglect and emotional/verbal abuse are not substantiated." The facility failed to conduct a thorough investigation. The facility's investigation did not address staff #5, staff #6 and the Home Manager failing to immediately report the allegation to the administrator. On 11/16/15 at 2:11 PM, the QIDP stated she went to the group home on 10/9/15 to get the "full story." The QIDP indicated at the time, the information she had was the email from the HM. The QIDP indicated she assisted staff #6 to write the incident report since staff #6 was new. The QIDP indicated she trained staff #6 on client #1's BSP. The QIDP indicated staff #6 was uncertain about what she should do. The QIDP stated staff #6 "was being passive." The QIDP indicated she trained staff #6 to step in as soon as she thought there was an issue of abuse, neglect or exploitation. The QIDP indicated the incident occurred during staff #6's first week of working at the group home so staff #6 was asking staff #9 what to do during client #1's behavior. Staff #6 reported this was the first time she saw client #1 during a behavioral incident. The QIDP indicated she			

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	retrained staff #6 on 11/5/15 and she going to meet with her on 11/18/15 to train her on the other clients' BSPs. The QIDP indicated staff #6 reported that staff #9 told staff #6 not to intervene during client #1's behavior. The QIDP indicated she told staff #6 to follow client #1's plan and she was responsible for intervening if there was an issue. The QIDP indicated staff #9 did not return to the group home following the incident. Staff #9 was working at another group home. On 11/20/15 at 1:31 PM, an interview with the Social Worker (SW) who conducted the investigation was conducted. The SW stated the investigation "basically" was one staff's word against another. The SW indicated there was not sufficient evidence to support substantiating the allegation. The SW indicated both staff reported different things. The SW stated he could not substantiate the allegation "unless absolutely clear" the evidence supported the allegation. The SW indicated the investigation should have addressed that staff failed to immediately report the allegation to the administrator. The SW indicated he did not notice that the allegation was not reported immediately to the administrator and did not address it in the investigation.			

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	2) On 9/26/15 at 8:45 AM, client #1 woke up and left his room in a bad mood. Client #1 was agitated about the noises in the group home. Client #1 got upset about his scratched CD's and the CD's skipping. Client #1 was upset the other clients were making noise during his music time. Another client went to his room and the motion sensor alarm sounded. Client #1 slammed himself on the floor in the dining room. Staff #4 attempted to talk to client #1 but he was too upset with the noises in the group home. Client #1 ran to the window in the door by the kitchen and slammed his head into the window. The window broke and shattered. Client #1 hit himself on the wall. Staff #2 redirected client #1 to the soft room (room with padding on walls and floor). Client #1 ran into the living room and made a hole in the wall. Client #1 continued to engage in self-injurious behavior until he was bleeding from the mouth. Staff (did not indicate which staff) asked him to stop, but when he did not stop, staff put him in a baskethold for 10 seconds and released him when he agreed to stop self-injurious behavior. Client #1 bit himself on his arms. The Medical for Client section indicated, "Head was slammed into the window. He hit his face repeatedly in the carpet in the soft			

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	room. Bit his arms. 1 inch abrasion on his forehead from the window glass. Cut his lower lip. Several bite marks on his arms; some from previous tantrums...." The Chemical Restraint section indicated Zyprexa Zydis 10 milligrams was administered to client #1 at 9:15 AM after 30 minutes of maladaptive behavior. The report indicated the Central Pager (QIDP #3) gave the staff authorization to administer the PRN. At 8:50 AM, the pager was called and authorization to administer a PRN (as needed medication) was given, according to the 9/26/15 Stone Belt ARC, Inc. Incident Report. Client #1 calmed approximately 30 minutes later. Client #1 had an one inch abrasion on his forehead from the window glass which was cleaned and basic first aid was given. The incident was reported to the central pager at 9:00 AM. The incident report indicated in the PRN protocol section, "Staff are to call coordinator (QIDP) or emergency pager to receive permission to give." On 11/17/15 at 2:10 PM, the Group Home Director (GHD) sent an email to the Administrative Assistant (AA) indicating, "We are looking for an investigation for a head banging incident on 9/26/15 for [client #1]. We also need			

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	the electronic documentation. Can we show that he was seen by a nurse following this?" On 11/17/15 at 2:38 PM, the GHD sent an email to the AA indicating, "Thanks. [Name of former QIDP] was supposed to do an investigation of what happened." On 11/17/15 at 2:38 PM, the AA replied to the GHD, "I see nothing like that in the incident report files." On 11/17/15 at 4:07 PM, the GHD sent an email to the former QIDP indicating, "...do you have proof that you looked into it? Like a support team note or email???" On 11/18/15 at 2:54 PM, the former QIDP replied, "I couldn't find any emails. I know I spoke in person and over the phone with the weekend staff regarding the incident. We did discuss it during support team and in other conversations, and this incident was one of the reasons we decided to take any losing outings as a consequence out of his plan, and put in the bonus reinforcer." On 11/18/15 at 2:56 PM, the GHD replied to the former QIDP and current QIDP, "Ok. Unfortunately, if it wasn't documented then the investigation never happened...." On 11/20/15 at 12:56 PM, the GHD stated QIDP #3's pager notes were "vague." The GHD indicated the pager notes were sent to the GHD's administrative assistant. The GHD indicated QIDP #3 needed to be			

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	retrained. The GHD indicated QIDP #3 should have called the GHD at the time of the incident to report it to her. The GHD stated regarding the incident, "it was huge." The GHD indicated the staff needed to be given permission prior to administering a PRN medication for behavior. The GHD indicated client #1's plan needed to indicate permission must be obtained prior to administering a PRN behavioral medication. The GHD stated QIDP #3 should have known to contact her if anything "questionable" happened at the group home. The GHD indicated the incident should have been investigated. The facility failed to conduct a thorough investigation. The facility's Social Worker, QIDP and Group Home Director failed to identify the incident as requiring an investigation upon their review. On 11/17/15 at 1:59 PM, the Group Home Director (GHD) indicated she thought the former QIDP looked into the incident. The GHD indicated the incident should have been investigated. On 11/17/15 at 1:59 PM, the QIDP indicated the incident should have been investigated. 9-3-2(a)			

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W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 28 incident/investigative reports reviewed affecting clients #1 and #6, the facility failed to ensure appropriate corrective action was taken to address an allegation of abuse and neglect involving clients #1 and #6 and an incident of client #1 injuring himself during an incident of self-injurious behavior. Findings include: On 11/13/15 at 12:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 10/8/15 at 10:15 AM (reported to the administrative staff on 10/9/15 at 12:30 AM), staff #6 alleged staff #9 answered client #1's questions "condescendingly" according to the Stone Belt ARC, Inc. Incident Report completed by the Qualified Intellectual Disabilities Professional (QIDP). The report indicated, "...[Client #1] was watching [client #6's] television in the	W 0157	**W157 (standard) – Staff treatment of clients Corrective action forresident(s) found to have been affected** 1) Staff #6 received training on all client's plans. Staff #6 trained on reporting concerns to administrator in a timely manner. Staff #9 Bob Wray sought EAP counseling. Staff #9 received training on all client plans. 2. **A**dministrative staff on the pager**and QIDP trained to** immediately report an allegation of abuse and neglect to the administrator, conduct thorough investigations, ensure recommended corrective actions are implemented, prevent client to client abuse, ensure clients receive **appropriate** medical care following an incident of SIB such as;client using his head to break a window, contacting emergency nursing pager,document thorough pager notes, follow up with psych pager concerning PRN medication being administrated, ensuring that sufficient staff are present to implement client support plans. **Measures or systemic changes facility putin place to ensure no recurrence** Administrator staff on pager will	12/23/2015

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	living room with no issues. However, [staff #9] proceeded to tell [client #6] that '[client #1] had no right to use your TV without permission.' This seemed to agitate both clients. In the middle of the TV situation, [client #4's] alarm was going off annoying [client #1], so he turned the alarm off. [Staff #9] told [client #1], 'He cannot turn off the alarm without permission.' So [client #1] asked for permission and [staff #9] said, 'It's too late now. You should have asked for permission first.' [Client #1] walked around for a little bit after this, seeming slightly agitated. To add to it, [client #6] started getting way too close to [client #1] and was trying to follow him around. [Staff #6] stayed right with [client #6] to make sure he did not try to hit [client #1]. She tried redirecting him to give [client #1] some space. During this, [staff #9] told [staff #6] that 'You don't have to worry about [client #1] hitting [client #6] because [client #1] is afraid of [client #6].' But he told her 'not to turn her back to [client #1], because he is the one who will try and hit you.' The alarm got brought up again because [client #1] wanted to know that it was off and wouldn't bother him. He balled up his fists and started screaming 'No.' 'He went into his room and started banging his head and screaming. He even yelled, 'I'm biting my arm.' [Staff #9] was with		submit pager notes each Monday for Director of Supported Group living review and monitor for concerns. **How corrective actions will be monitored to ensure no recurrence** Director of Supported Group Living will review and sign investigations to determine that thorough investigations were completed and recommendations were followed.	

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	[client #1] at this point, but did not intervene with the behavior. [Staff #6] reports hearing [staff #9] say, 'You are just doing this for attention. I am not impressed. I am going to ignore you.' Then [staff #9] walked away and started doing laundry while humming. [Client #1's] tantrum moved out into the hallway. He started banging his chin against the floor in the hallway. [Staff #6] went into the hallway and asked [staff #9] is (sic) they should direct [client #1] to the front room. [Staff #9] told [staff #6] 'to ignore him because he was just trying to get attention.' [Staff #9] even took his own head and banged it against the wall in between the bathroom and kitchen. After bannging (sic) his head he said to [staff #6], 'See...it doesn't even hurt. He's fine.' [Staff #6] went to look at [client #1's] arm and came back to ask [staff #9] what (sic) they should clean or bandage him. [Staff #9] told her again, 'He just wants attention. We should ignore him.' [Client #1] has a newer bite mark on his forearm (there are several older ones surrounding it) and bruising on his upper right arm. The underside of his chin also has a small abrasion on it from where he banged it against the ground." The Incident Report indicated staff #6 reported the incident to staff #5 on 10/8/15 at 11:30 AM, to the Home			

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	Manager on 10/8/15 at 2:00 PM and the anonymous pager on 10/9/15 at 12:30 AM. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 10/9/15, indicated, "On 10/09/2015 at 12:30 AM, pager was notified of this allegation. Director is currently conducting an investigation into this allegation and staff, [staff #9], has been suspended." The Investigation Report, dated 10/15/15, indicated the purpose of the investigation was "to determine whether staff member [staff #9] committed acts of neglect and emotional/verbal abuse by refusing to provide appropriate supervision and care when client [#1] was actively hurting himself, and by using words and actions to negatively impact [client #1] in a condescending and escalatory manner." The Statement of Findings section indicated, in part, "There were many discrepancies between the testimonies of [staff #6] and [staff #9], the two principal witnesses who were able to provide their perspectives on these incidents. [Staff #6's] testimony paints a neglectful picture of [staff #9], describing him as humming and putting away laundry while a client appears to be in distress. [Staff #6] also describes a very stern or harsh [staff #9],			

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	both in the way he speaks with clients and in his direction of her. In this way, she claims that [staff #9] was not following [client #1's] BSP (behavioral support plan), which states that 'Interactions between staff and clients should be positively framed, staff should provide ample positive reinforcement to keep [client #1] motivated in his daily activities, staff should avoid used the word 'no' when talking with [client #1].' From [staff #9's] perspective, [staff #6] was also guilty of not following [client #1's] BSP, which does stipulate that when he is in a tantrum, 'auditory input is likely to escalate him further, no eye contact should be made, and ideally staff should remain out of direct eyesight,' and is specific reference to [client #1's] calming self-talk in times of trauma, 'Try not to interrupt him if you hear him engaging in this behavior.' The report indicated, "...Finally, [staff #9] admitted that he sometimes has a difficult time preventing his frustration from entering into client interactions, and that he has used an angry tone with clients in the past." The report indicated, "The core of the neglect allegation appears to stem from the assertion that [staff #9] obstructed [staff #6] from stopping [client #1] from banging his chin on the wooden floor, which resulted in injury, and that he prevented staff from administering first			

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	aid in a timely manner. As it cannot be clearly determined that this specific mechanism of injury indeed took place ([client #1's] chin may have been injured in some other way), and as there are not clear guidelines regarding the timeline for provision of first aid (though it can be inferred from the BSP that doing so during a tantrum would be counter-productive), it does not seem that [staff #9] acted in a neglectful manner." The report indicated, "While there is testimony and circumstantial evidence that [staff #9's] tone often seems to come from a place of superiority, there is not corroborated testimony to prove that [staff #9] committed a specific act of emotional/verbal abuse on the morning of 10/8/15. However, he has admitted that he has allowed his frustration to enter into his interactions with clients, and that he has used an angry tone of voice with clients in the past. Given these admissions, it is clear that [staff #9's] use of language, while not technically abusive, may in fact be escalating negative situations and possibly causing emotional distress." The report indicated, "The allegations of both neglect and emotional/verbal abuse are not substantiated." The Recommendations section of the report indicated, "It is the			

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	recommendation of the investigator that the following corrective actions occur: Competency-based retraining for [staff #9] on the aspects of clients' BSPs that have to do with positive framing and reinforcement. In addition, guidance from supervisors regarding appropriate ways to train new staff should be provided. As [staff #9] has admitted to anger/frustration issues, and in light of his description of the challenging personal circumstances he is faced with currently, it is recommended that EAP (Employee Assistance Program) counseling be required before he returns to work. Competency-based retraining for [staff #6] on the specifics of all clients' BSPs, especially that of [client #1], so that effective support can be ensured during tantrum situations and other highly-emotional events." The facility failed to take appropriate corrective action to address staff #5, staff #6 and the Home Manager failing to immediately report the allegation to the administrator. The facility failed to ensure the recommended retraining with staff #6 was completed (retraining on client #2, #3, #4, #4 and #6's BSPs). The facility failed to ensure staff #9 received the recommended EAP counseling prior to returning to work.			

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	On 11/16/15 at 1:56 PM, a review of staff #9's employee file was conducted. There was no documentation in staff #9's employee file indicating he received competency-based retraining on the clients' BSPs. There was no documentation in his employee file he received EAP counseling prior to returning to work. On 11/20/15 at 1:08 PM, the Group Home Director (GHD) indicated in an email, "It was recommended that he (staff #9) seek EAP not mandated at this time. So there is no way to verify if he did or not." On 11/20/15 at 2:47 PM, the GHD indicated in an email, "As [staff #9] has admitted to anger/frustration issues, and in light of his description of the challenging personal circumstances he is faced with currently, <u>it is recommended</u> that EAP counseling be required before he returns to work. Since we didn't mandate it we can't access the records. If after weekly supervision [staff #9's current supervisors] feels that it is needed then HR and I will require [staff #9] to seek EAP counseling." On 11/20/15 at 11:51 AM, the Human Resources Director (HRD) initially indicated staff #9 received EAP counseling as recommended. The HRD indicated if staff #9 did not receive the counseling, the facility would have been notified. On 11/20/15 at 1:51 PM, the HRD indicated she			

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	was unable to locate documentation staff #9 received EAP counseling. The HRD indicated she met with the Group Home Director (GHD) who read the investigation recommendation to herself. The GHD indicated to the HRD the EAP counseling was a recommendation, not a mandate. The HRD indicated, after the surveyor read the investigation's recommendation, she would have filled out documentation indicating staff #9 be mandated to receive EAP counseling prior to returning to work, as indicated in the investigation. On 11/16/15 at 2:07 PM, the Group Home Director (GHD) indicated all of the staff working at the group home needed to be retrained on reporting requirements. On 11/16/15 at 2:11 PM, the QIDP indicated staff #6 reported the incident to staff #5 and staff #5 reported the incident to the Home Manager (HM). The QIDP indicated the HM sent an email after his shift to the QIDP and another QIDP. The other QIDP contacted the administrator. The QIDP indicated the staff should have immediately reported the allegation to the administrator. On 11/17/15 at 1:40 PM, the QIDP indicated she retrained staff #6 on 11/5/15 on client #1's BSP. The QIDP indicated the Behavioral Consultant was going to train staff #6 on the other clients' BSPs. The QIDP indicated the training with staff #6 on the other clients' BSPs had not been scheduled. On 11/20/15 at 1:31 PM, an interview with the Social Worker (SW) who conducted the investigation was conducted. The SW indicated he recommended that EAP by required of staff #9 prior to staff #9 returning to work. The SW indicated he expected staff #9 would get counseling prior to returning to work. The SW			

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	indicated the investigation should have addressed that staff failed to immediately report the allegation to the administrator. The SW indicated he did not notice that the allegation was not reported immediately to the administrator. 2) On 9/26/15 at 8:45 AM, client #1 woke up and left his room in a bad mood. Client #1 was agitated about the noises in the group home. Client #1 got upset about his scratched CD's and the CD's skipping. Client #1 was upset the other clients were making noise during his music time. Another client went to his room and the motion sensor alarm sounded. Client #1 slammed himself on the floor in the dining room. Staff #4 attempted to talk to client #1 but he was too upset with the noises in the group home. Client #1 ran to the window in the door by the kitchen and slammed his head into the window. The window broke and shattered. Client #1 hit himself on the wall. Staff #2 redirected client #1 to the soft room (room with padding on walls and floor). Client #1 ran into the living room and made a hole in the wall. Client #1 continued to engage in self-injurious behavior until he was bleeding from the mouth. Staff (did not indicate which staff) asked him to stop, but when he did not stop, staff put him in a baskethold for 10 seconds and released him when he agreed to stop self-injurious behavior. Client #1 bit himself on his arms. The Medical for Client section indicated, "Head was slammed into the window. He hit his face repeatedly in the carpet in the soft room. Bit his arms. 1 inch abrasion on his forehead from the window glass. Cut his lower lip. Several bite marks on his arms; some from previous tantrums...." The Chemical Restraint section indicated Zyprexa Zydis 10 milligrams was administered to client #1 at 9:15 AM after 30 minutes of maladaptive behavior. The report indicated the Central Pager (QIDP #3) gave the			

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	staff authorization to administer the PRN. At 8:50 AM, the pager was called and authorization to administer a PRN (as needed medication) was given, according to the 9/26/15 Stone Belt ARC, Inc. Incident Report. Client #1 calmed approximately 30 minutes later. Client #1 had an one inch abrasion on his forehead from the window glass which was cleaned and basic first aid was given. The incident was reported to the central pager at 9:00 AM. The incident report indicated in the PRN protocol section, "Staff are to call coordinator (QIDP) or emergency pager to receive permission to give." The Incident Report review form, no date, indicated the nurse reviewed the incident report on 9/28/15. The nurse made the following comment, "Nurse pager wasn't (sic) notified - [client #1] needs to be seen for a follow up dr (doctor) appointment for his head and arm." The Behavior Consultant added a comment, "Will review incident with team." The Social Worker and QIDP reviewed the incident report on 9/28/15. The Group Home Director reviewed the incident report on 10/20/15. On 11/20/15 at 12:48 PM, a review of QIDP #3's notes for the period of 9/25/15 to 10/2/15 titled, Epager, indicated regarding the call she received, "9/26/15...call @ (at) 9a from [name of group home] about PRN...." There was no additional information documented. QIDP #3 did not document who called her, the information provided to the pager regarding the use of a PRN (least restrictive interventions attempted prior to administering a PRN), who received a PRN, the name and dosage of the PRN and what her response to the staff included. On 11/18/15 at 12:46 PM, QIDP #3, who was the			

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	pager contact at the time of the incident, indicated the group home staff contacted her to inform her client #1 had been administered a PRN. QIDP #3 indicated she told them they needed to obtain her permission prior to administering a PRN and the staff indicated they already had permission to give the PRN. QIDP #3 indicated she did not ask who the staff received permission from. QIDP #3 indicated at the time, the staff did not report the window was broken during the incident. QIDP #3 indicated she did not document the name of the staff who contacted her. On 11/17/15 at 2:10 PM, the Group Home Director (GHD) sent an email to the Administrative Assistant (AA) indicating, "We are looking for an investigation for a head banging incident on 9/26/15 for [client #1]. We also need the electronic documentation. Can we show that he was seen by a nurse following this?" On 11/17/15 at 2:38 PM, the GHD sent an email to the AA indicating, "Thanks. [Name of former QIDP] was supposed to do an investigation of what happened." On 11/17/15 at 2:38 PM, the AA replied to the GHD, "I see nothing like that in the incident report files." On 11/17/15 at 4:07 PM, the GHD sent an email to the former QIDP indicating, "...do you have proof that you looked into it? Like a support team note or email???" On 11/18/15 at 2:54 PM, the former QIDP replied, "I couldn't find any emails. I know I spoke in person and over the phone with the weekend staff regarding the incident. We did discuss it during support team and in other conversations, and this incident was one of the reasons we decided to take any losing outings as a consequence out of his plan, and put in the bonus reinforcer." On 11/18/15 at 2:56 PM, the GHD replied to the former QIDP and current QIDP, "Ok. Unfortunately, if it wasn't documented then the investigation never happened...." On 11/20/15			

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	at 12:56 PM, the GHD stated QIDP #3's pager notes were "vague." The GHD indicated the pager notes were sent to the GHD's administrative assistant. The GHD indicated QIDP #3 needed to be retrained. The GHD indicated QIDP #3 should have called the GHD at the time of the incident to report it to her. The GHD stated regarding the incident, "it was huge." The GHD indicated the staff needed to be given permission prior to administering a PRN medication for behavior. The GHD indicated client #1's plan needed to indicate permission must be obtained prior to administering a PRN behavioral medication. The GHD stated QIDP #3 should have known to contact her if anything "questionable" happened at the group home. The GHD indicated the incident should have been investigated. On 11/17/15 at 2:41 PM, the Group Home Director sent a Nursing Consultation note, dated 9/28/15, by email indicating, "...Over the weekend [client #1] hit his head through the window, and also bit his arm several times from the wrist down to the elbow causing bleeding. Writer instructed day aide (sic) to set an appointment up with PCP (primary care physician), to follow up for injuries. Nurse will check [client #1] out today." On 11/17/15 at 11:03 AM, a focused review of client #1's record was conducted. There was no documentation client #1 was assessed by the nurse on 9/28/15. Client #1's 10/2/15 Behavioral Support Plan indicated, in part, "If [client #1] engages in severe intentional and dangerous aggressive behavior towards himself or others, staff may call the emergency pager for PRN approval...." The facility failed to ensure the nurse was notified			

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	of client #1's injury to his head. The facility failed to ensure client #1 received a medical assessment in a timely manner after he "slammed his head into the window" causing the window to break. There was no documentation QIDP #3 followed-up with the staff to see who authorized client #1 receiving a PRN. There was no documentation the facility took corrective action with QIDP #3 for failing to document thoroughly on the pager notes regarding the incident. The facility failed to ensure client #1's BSP matched the policy on PRN use. Client #1's BSP indicated the pager may be notified. The facility's policy indicated staff must receive approval from the pager prior to administering a PRN medication. The facility failed to take corrective actions to address these issues. On 11/18/15 at 12:57 PM, the facility's policy on Psychotropic PRN Medications, dated 10/3/13, indicated the following, "Before administering any PRN (as needed) medication for behavior, staff must review the individual's Behavioral Support Plan and have implemented all least restrictive techniques identified. When the individual displays behavior consistent with identified behavioral criteria, and all less restrictive procedures have been ineffective, staff will call the pager or their coordinator (QIDP)/director and get approval to administer a PRN as prescribed...." On 11/18/15 at 12:50 PM, the QIDP indicated client #1's plan should include a stipulation the staff need to obtain permission to administer a PRN prior to administering a PRN. On 11/18/15 at 12:55 PM, QIDP #2 indicated client #1's plan should indicate the staff were to receive permission to administer a PRN prior to administering a PRN.			

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	On 11/20/15 at 11:10 AM, the Nurse Manager (NM) indicated the nurse should have been notified. The NM indicated the staff have to obtain approval prior to administering a PRN medication from the Central pager or the psychiatric pager. 9-3-2(a)			
W 0159 Bldg. 00	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 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. The QIDP failed to conduct regular reviews of the clients' program plans to ensure the clients were meeting the criteria of their training objectives and updating/revising the program plans as needed. The QIDP failed to ensure the group home was repainted as needed following repairs being made to the walls and the living room carpet was cleaned/shampooed on a regular basis. The QIDP failed to ensure there was a light in the living room at the front of the group home. The QIDP	W 0159	**W 159 (Standard)** QIDP – failed to integrate, coordinate, and monitor client plans **Corrective action for resident(s) found to have been affected** 1) QIDP reviewed progress toward meeting training objectives for #2, #3, #4 clients. 2)W104 Maintenance issues resolved. 3) W120 - House staff will communicate daily with client #1, #5, #6 utilizing communication book. Wearing a belt each day for school will be added to client #6 informal goals. A hair washing goal introduced for Client #5. QIDP will conduct monthly observations at client #1, #5, #6 school(s) and document on visit form, initialed by teacher or school personnel. 4) W125 -IDT discussed client safety and determined client #1, #2, #3,#4, #5, #6 were in need of restricted	12/23/2015

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	failed to ensure communication from the group home to the school was being implemented regularly. The QIDP failed to ensure issues communicated from the school were addressed. The QIDP failed to conduct visits to ensure the schools were meeting the needs of clients #1, #5 and #6. The QIDP failed to ensure the clients had the right to due process in regard to the kitchen door being locked unnecessarily. The QIDP failed to ensure there was sufficient staff to manage and supervise the clients in accordance with their individual program plans. The QIDP failed to ensure client #3's dental recommendations regarding the use of a timer and an electric toothbrush were included in his program plan to increase his oral hygiene. The QIDP failed to implement a plan to address client #3's nursing recommendation to ensure client #3 completely dried off after taking a shower in response to recurrent incidents of ringworm and the showers/tubs were cleaned after each use. The QIDP failed to ensure client #3's guardian and the specially constituted committee consented to restrictions in the home. The QIDP failed to ensure evacuation drills were conducted quarterly for each shift and the drills during the overnight shift varied in times. The QIDP failed to ensure client #2 fed himself while at the facility-operated day program and clients		access to kitchen. Restriction went through due process and interim approval obtained. 5. W186 - QIDP created master schedule to provide adequate staff to client ratio. 6. W227 - goal for client #3 to dry after showering and clean tub after each use. 7. W240 - goal for #3 use of a timer during brushing with electric toothbrush. 8. W249 - client # 1 meal time goal training with staff and day program staff. 9. W262 - IDT discussed client safety and determined client #1, #2, #3,#4, #5, #6 were in need of restricted access to kitchen. Restriction went through due process and interim approval obtained. 10. W263 - #3 client hrc approval from guardian. 11. W440 – Successful drills completed for each shift. 12. W441 – Successful drills completed at varied conditions/ times. 13. W448 – Client #1, #2, #3,#4,#5, #6 are encouraged to assist with meal preparation. Client #2 feds himself a snack while at facility-owned day program. **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 putin place to ensure no recurrence** Monitoring of plan implementation and staff training will be conducted as outlined	

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	#1, #2, #3, #4, #5 and #6 were involved with meal preparation. Findings include: 1) On 11/17/15 from 11:34 AM, a review of client #2's record was conducted. There was no documentation in client #2's record indicating the QIDP reviewed the progress of meeting his training objectives in his Individualized Support Plan (ISP) since 5/31/14. Client #2's SGL (Supervised Group Living) Monthly Support Team Notes were completed monthly for the past 12 months however the notes did not include of review of his progress toward meeting his training objectives. On 11/17/15 from 12:15 PM, a review of client #3's record was conducted. There was no documentation in client #3's record indicating the QIDP reviewed the progress of meeting his training objectives in his Individualized Support Plan (ISP) since 3/31/14. Client #3's SGL (Supervised Group Living) Monthly Support Team Notes were completed monthly for the past 12 months however the notes did not include of review of his progress toward meeting his training objectives. On 11/17/15 from 12:55 PM, a review of		above. **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 report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place by 12/23/15. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than two visits per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC. The SGL Director also will meet weekly with QIDP to review plans and checklist items.	

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	client #4's record was conducted. There was no documentation in client #4's record indicating the QIDP reviewed the progress of meeting his training objectives in his Individualized Support Plan (ISP) since 4/30/14. Client #4's SGL (Supervised Group Living) Monthly Support Team Notes were completed monthly for the past 12 months however the notes did not include of review of his progress toward meeting his training objectives. On 11/18/15 at 11:22 AM, QIDP #2 indicated the clients' progress toward completing their training objectives should be reviewed quarterly. QIDP #2 indicated she accessed the clients' Personal Planning System (PPS). QIDP #2 indicated the clients' most recent quarterly reviews were conducted on 3/31/15 by the former QIDP. QIDP #2 indicated the former QIDP was supposed to print the review, sign it and turn it in for review and submission to the clients' records. QIDP #2 indicated clients #2, #3 and #4 were missing two quarterly reviews during the past year. On 11/18/15 at 10:42 AM, the Group Home Director (GHD) indicated the clients' progress toward meeting their training objectives was reviewed monthly at the support team meetings.			

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	2) Please refer to W104. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to ensure the walls throughout the common areas of the group home were repainted following repairs and the living room carpets were regularly cleaned. 3) Please refer to W120. For 3 of 3 non-sampled clients who attended school (#1, #5 and #6), the QIDP failed to ensure outside services met the needs of the clients. 4) Please refer to W125. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to ensure the clients had the right to due process in regard to locking the kitchen door restricting the clients' access to the kitchen. 5) Please refer to W186. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans. 6) Please refer to W227. For 1 of 3 clients in the sample (#3), the QIDP failed to implement a plan to address client #3's nursing recommendation to			

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	ensure client #3 completely dried off after taking a shower in response to recurrent incidents of ringworm and the showers/tubs were cleaned after each use. 7) Please refer to W240. For 1 of 3 clients in the sample (#3), the QIDP failed to ensure client #3's dental recommendations regarding the use of a timer and an electric toothbrush were included in his program plan to increase his oral hygiene. 8) Please refer to W249. For 1 of 3 clients in the sample (#3) and 1 additional client (#1), the QIDP failed to ensure staff implemented the clients' meal preparation training objectives as written. 9) Please refer to W262. For 1 of 3 clients in the sample (#3), the QIDP failed to ensure the facility's specially constituted committee (Human Rights Committee - HRC) reviewed, approved and monitored individual programs designed to manage inappropriate behavior involving risks to client protections and rights. 10) Please refer to W263. For 1 of 3 clients in the sample (#3), the QIDP failed to ensure the facility's specially constituted committee (Human Rights			

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	Committee - HRC) ensured written informed consent was obtained for restrictive interventions at the group home affecting client #3. 11) Please refer to W440. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to conduct quarterly evacuation drills for each shift of personnel. 12) Please refer to W441. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to hold evacuation drills under varied conditions. 13) Please refer to W488. For 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to ensure staff prompted and encourage the clients to assist with meal preparation and client #2 fed himself a snack while at the facility-operated day program. 9-3-3(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.			

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	Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans. Findings include: On 11/17/15 from 6:03 AM to 7:38 AM, an observation was conducted at the group home. During the observation, there were two direct care staff working at the group home. The Qualified Intellectual Disabilities Professional (QIDP) arrived to the group home at 6:03 AM. At 6:02 AM upon arrival to the group home, client #1 could be heard yelling, screaming and slamming a door from the parking lot. On 11/17/15 at 6:06 AM, staff #5 stated, "we make it work" with two staff in the mornings. Staff #5 indicated client #1 had maladaptive behaviors every morning. Staff #5 stated we, "need more staff in the morning." On 11/17/15 at 6:10 AM, staff #5 indicated the QIDP was not usually at the group home for the morning shift. On 11/17/15 at 6:13 AM,	W 0186	W 186 Direct Care Staff (standard) **Corrective action for resident(s) found tohave been affected** **QIDP created master scheduleproviding adequate coverage to manage and support clients** inaccordance with individual program plans. **How facility will identify other residentspotentially affected & what measures taken**All residents potentially are affected, andcorrective measures address the needs of all clients.**Measures or systemic changes facility putin place to ensure no recurrence** QIDP trained to create and followschedule unless changes are approved by an administrator. **How corrective actions will bemonitored to ensure no recurrence** Director of Supported Group Livingwill review master schedules to ensure adequate staffing. QIDP must obtain permission to alter approvedschedule and fill open shifts when needed. Visits and monitoring willcontinue at a minimum until all Condition level citations are lifted.	12/23/2015

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	staff #5 indicated client #6 received one on one staff supervision. Staff #5 indicated the other staff passed medications leaving four clients unsupervised for periods of time in the morning. On 11/17/15 at 6:41 AM, staff #6 indicated the group home used to have three staff in the morning. Staff #6 stated, "it's ridiculous, we need more staff." Staff #6 indicated client #6 received one on one staffing. Staff #6 stated, "It's impossible (to supervise the clients)." Staff #6 indicated client #4 had a targeted behavior of elopement. Staff #6 indicated client #4 and client #1 needed to be supervised due to client #4 making noise which irritated client #1. On 11/13/15 at 12:32 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 8/29/15 at 4:00 PM, client #3 walked up the hallway, darted into the office and hit client #6 with two open hands on his shoulders. Client #3 ran back to his room. At the time of the incident, there were two staff working at the group home. 2) On 8/30/15 at 5:00 PM, client #5 was			

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	lying on the couch listening to music on his tablet. Client #6 was asked to stop snacking since it was close to dinner. Client #6 darted across the room and hit client #5 on his neck and face. The Stone Belt ARC, Inc. Incident Report, dated 8/30/15, indicated there were two staff (#4 and #9) working at the group home at the time of the incident. 3) On 10/18/15 at 10:00 AM, client #1 woke up in a bad mood and yelled about clients who were already awake. Client #5 was listening to music on his tablet. Client #5 repeatedly asked a question and client #1 threw a cereal bowl at client #5 hitting his on the upper arm. At 5:00 PM, client #1 threw a remote control hitting client #5 on the torso (no description given). The Stone Belt ARC, Inc. Incident Report, dated 10/18/15, indicated there were two staff (#2 and #4) working at the group home at the time of the incidents. The incident report indicated the duration of the incident was, "7? hours on and off." On 11/13/15 at 12:41 PM, the QIDP indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The QIDP indicated at the time of the incident there were two staff working at the group home. The QIDP indicated two staff was			

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	not sufficient to manage and supervise the clients according to their program plans. On 11/19/15 at 11:53 AM, a review of the group home staffing schedule was reviewed from 10/1/15 to 11/19/15. On the following dates, the group home had two staff scheduled to work Monday through Friday, 6:00 to 8:00 AM: 10/6/15, 10/9/15, 10/12/15, 10/13/15, 10/14/15, 10/15/15, 10/16/15, 10/19/15, 10/20/15, 10/21/15, 10/29/15, 10/30/15, 11/3/15, 11/4/15, 11/10/15, 11/11/15, 11/12/15, 11/13/15, 11/17/15, 11/18/15 and 11/19/15. On the following dates, the group home had two staff scheduled to work on Saturdays and Sundays: 10/3/15 from 6:00 AM to 8:00 AM and 1:00 PM to 9:00 PM, 10/4/15 from 6:00 AM to 8:00 AM and 1:00 PM to 9:00 PM, 10/10/15 from 6:00 AM to 5:00 PM, 10/11/15 from 8:00 AM to 10:00 PM, 10/17/15 from 8:00 AM to 9:00 AM and 2:00 PM to 9:00 PM, 10/18/15 from 8:00 AM to 9:00 PM, 10/25/15 from 8:00 AM to 12:00 PM and 6:00 PM to 9:00 PM, 11/11/15 from 8:00 AM to 11:00 AM and 7:00 PM to 9:00 PM, and 11/15/15 from 6:00 AM to 8:00 AM. This affected clients #1, #2, #3, #4, #5 and #6. On 11/17/15 at 11:03 AM, a review of client #1's record was conducted. Client			

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	#1's 10/2/15 Behavioral Support Plan (BSP) indicated he had the following targeted behaviors: physical aggression, temper tantrums, property destruction, obsessive compulsive behavior and inappropriate sexual behavior. Client #1's BSP included the use of a two person baskethold as a reactive strategy for aggression. In the inappropriate sexual behavior portion of his BSP, the plan indicated, in part, "Due to a history of making homicidal threats and verbalizations of sexual intent towards other clients, supervision of [client #1] should increase while in the presence of another client or housemate. Staff should always be within reach of [client #1] while other clients are present...." On 11/17/15 at 11:34 AM, a review of client #2's record was conducted. Client #2's 4/28/15 BSP indicated he had the following targeted behaviors: physical aggression, self-injurious behavior (SIB), violating personal space and refusals. Client #2's BSP indicated in the self-injurious behavior section, "...At times, what [client #2] really wants is to have 1-on-1 staff. This is why staff are encouraged to remain actively engaged with [client #2] on a regular basis so that the need is not present to SIB for attention... When [client #2] is engaging in SIB, staff must keep [client #2] in			

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	line-of-sight supervision. This does not mean that staff must engage him, but he must be monitored for safety... If [client #2] attempts to hit his right ear, staff must restrain [client #2] immediately. In November, 2005, [client #2] engaged in an intense episode of SIB where he caused himself to have a major Hematoma on his right ear. [Client #2's] primary doctor [name], has said that further injury may result in permanent damage...." On 11/17/15 at 12:15 PM, a review of client #3's record was conducted. Client #3's 1/27/15 BSP indicated he had the following targeted behaviors: physical aggression, attention-seeking behavior and extended obsessive behavior. In the reactive section for physical aggression, client #3's plan indicated, in part, "If physical aggression continues, and all other interventions have been unsuccessful, staff may implement appropriate physical intervention as approved and trained per Stone Belt policy, if necessary, to prevent [client #3] from injuring himself or others...." On 11/17/15 at 12:55 PM, a review of client #4's record was conducted. Client #4's 2/3/15 BSP indicated he had the following targeted behaviors: elopement, aggression, SIB and refusals. In the			

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	aggression section of the BSP, the plan indicated, in part, "Staff may use a brief hold of [client #4's] forearm to dissuade his pinching/pulling behaviors...." On 11/17/15 at 11:09 AM, a review of client #5's record was conducted. Client #5's 9/16/15 BSP indicated he had the following targeted behaviors: darting behavior/wandering, tantrums, undressing in public and SIB. In the darting behavior/wandering section of the BSP, the plan indicated, in part, "It is very important for staff to be aware of where he is at all times in the community and at home...." On 11/17/15 at 11:17 AM, a review of client #6's record was conducted. Client #6's 5/3/15 BSP indicated he had the following targeted behaviors: physical aggression, self-injurious behavior, tantrums, elopement/out of bounds, refusals and food foraging. Client #6's plan indicated he received one on one staffing. The plan indicated, "[Client #6] has 1:1 (one on one) staffing at all times. Specifically, this means that staff is to be at arms length at all times in the home when [client #6] is awake... If [client #6] is in his room staff may wait at [client #6's] doorway. The only exceptions to this rule are when [client #6] is in the home or a community setting where there			

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	are no other people present or while [client #6] is at the [name] swimming pool...." On 11/17/15 at 7:13 AM, the QIDP indicated on Monday and Thursday mornings there were three staff working during the morning shift. The QIDP indicated two staff were not sufficient to implement the clients' program plans. On 11/17/15 at 1:41 PM, the QIDP stated two staff were not sufficient due to client #6's one on one and the "general needs of the house." The QIDP indicated client #1 was prone to have behavior issues in the morning. The QIDP indicated when there were two staff, one was passing medications and the other was one on one with client #6. The QIDP stated, "not enough staff to meet the clients' needs." On 11/17/15 at 10:58 AM, the Group Home Director (GHD) indicated the QIDP should have ensured there were three staff scheduled. The GHD indicated she did not approve the group home being staffed with two staff. The GHD indicated the group home needed three staff in the morning. The GHD indicated two staff was not a sufficient amount of staff to meet the needs of the clients. On 11/19/15 at 12:59 PM, the Behavior			

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	Support Specialist (BSS) indicated two staff were not sufficient to meet the needs of the clients. The BSS indicated client #4 had elopement issues, client #5 could wander off, client #1 had behavior issues, and client #6 received one on one staffing. The BSS indicated two staff could not implement the clients' plans to meet their needs. The BSS indicated with two staff, the staff could not be proactive with the clients. The BSS stated the group home was a "high behavioral house." The BSS stated "mornings not a good time for [client #1]." 9-3-3(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to implement a plan to address client #3's nursing recommendation to ensure client #3 completely dried off after taking a shower in response to recurrent incidents of ringworm and the showers/tubs were cleaned after each use.	W 0227	**W 227 (Standard)** Individual Program Plan**Corrective action for resident(s) found tohave been affected**As part of this POC a plan will be implementedto address nursing recommendations to ensure client #3 is completely dried offafter bathing and tub/shower is cleaned afterwards. **How facility will identify other**	12/23/2015

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	Findings include: On 11/17/15 at 12:15 PM, a review of client #3's record was conducted. A 6/22/15 Stone Belt Outside Services Report indicated client #3 was diagnosed with tinea corporis (ringworm). A 6/22/15 Nursing Consultation note indicated, "[Client #3] was seen at the walk in clinic for Ringworm with new orders for Lotrisone topically to affected area bid (twice daily)." An 8/4/15 Stone Belt Outside Services Report indicated client #3 was diagnosed with tinea corporis. An 8/4/15 Nursing Consultation note indicated, "[Client #3] was taken in to be seen due to developed ringworm on his back. Nurse instructed staff to ensure [client #3] is drying off after shower usage." An 8/4/15 Support Team Review Form indicated, "Ringworm - check (illegible) drying after showers. Clean showers/tubs after every usage - house staff." There was no documentation the Qualified Intellectual Disabilities Professional (QIDP) implemented a plan to address the nurse's recommendations. There was no documentation a plan was implemented to ensure the group home staff were cleaning the showers and tubs after every use.		**residentspotentially affected & what measures taken**All residents potentially are affected, andcorrective measures address the needs of all clients.**Measures or systemic changes facility putin place to ensure no recurrence**Training goal introduced. Staff trained on implementing plan. **How corrective actions will bemonitored to ensure no recurrence** QIDP will provide weeklymonitoring in the home to ensure plan is being implemented.	

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	On 11/20/15 at 10:22 AM, the Nurse Manager (NM) indicated ringworm could be caused by moisture and not drying off thoroughly. The NM indicated the QIDP could have developed an informal or formal plan related to hygiene. On 11/17/15 at 2:12 PM, the Group Home Director indicated a plan should have been developed and implemented. 9-3-4(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 clients in the sample (#3) and one additional client (#1), the facility failed to ensure client #3's dental recommendations regarding the use of a timer and an electric toothbrush were included in his program plan to increase his oral hygiene and client #1's Behavioral Support Plan indicated the staff must receive approval prior to administering a PRN (as needed) behavioral medication.	W 0240	**W240 Individual Program Plan (standard) Corrective action for resident(s) found to have been affected** Dental recommendations have been implemented, so an electronic tooth brush and use of a timer are in place. In addition, staff have received training on the PRN medication approval process. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected. An assessment will be conducted	12/23/2015

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	Findings include: 1) On 11/17/15 at 12:15 PM, a review of client #3's record was conducted. A 10/1/15 Stone Belt Outside Services Report (Dental) form indicated the reason for the visit was "routine cleaning." The Additional Comments section indicated, "Cont. (continue) to try to help (with) OHC (oral health care), sug (suggest) getting pt (patient) a timer to help (with) brushing 2-3 min (minutes) each time AM/PM (morning/evening) & (and) cont. (continue) to use electric toothbrush." A 10/1/15 Nursing Consultation note indicated, "[Client #3] was seen at [name of dental practice] for a routine cleaning, x-ray and fluoride varnish. Client needs to be seen again in 6 months." Client #3's 2/19/15 Individual Support Plan indicated he had a training objective to brush his teeth thoroughly. The training objective indicated in the Task Elements section, "Gets staff when he is ready to brush his teeth. Gathers supplies for toothbrushing. Properly brushes teeth, with staff watching. Rinses mouth. Rinses toothbrush and puts away supplies." Client #3's training objective was not revised to address the 10/1/15 dental recommendations. There was no documentation in client #3's record indicating the dental recommendations		to determine if other clients also need corrective action in their plans. If so, those corrections will be implemented by 12/23/15. **Measures or systemic changes facility put in place to ensure no recurrence** New plans, items purchased, and training conducted. **How corrective actions will be monitored toensure 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 report progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place by 12/23/15. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than two visits per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or longer if needed - to ensure continued full implementation of the POC. The	

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	were reviewed by the Qualified Intellectual Disabilities Professional (QIDP). The facility failed to ensure the dental recommendations were implemented. On 11/20/15 at 10:22 AM, the Nurse Manager (NM) indicated client #3's formal goal should have been updated to include the recommendations including the use of an electric toothbrush and a timer. On 11/17/15 at 2:12 PM, the Group Home Director (GHD) indicated client #3's training objective should have been updated to address the dental recommendations. 2) On 9/26/15 at 8:45 AM, client #1 woke up and left his room in a bad mood. Client #1 was agitated about the noises in the group home. Client #1 got upset about his scratched CD's and the CD's skipping. Client #1 was upset the other clients were making noise during his music time. Another client went to his room and the motion sensor alarm sounded. Client #1 slammed himself on the floor in the dining room. Staff #4 attempted to talk to client #1 but he was too upset with the noises in the group home. Client #1 ran to the window in the door by the kitchen and slammed his		SGL Director also will meet weekly with QIDP to review plans and checklist items.	

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	head into the window. The window broke and shattered. Client #1 hit himself on the wall. Staff #2 redirected client #1 to the soft room (room with padding on walls and floor). Client #1 ran into the living room and made a hole in the wall. Client #1 continued to engage in self-injurious behavior until he was bleeding from the mouth. Staff (did not indicate which staff) asked him to stop, but when he did not stop, staff put him in a baskethold for 10 seconds and released him when he agreed to stop self-injurious behavior. Client #1 bit himself on his arms. The Medical for Client section indicated, "Head was slammed into the window. He hit his face repeatedly in the carpet in the soft room. Bit his arms. 1 inch abrasion on his forehead from the window glass. Cut his lower lip. Several bite marks on his arms; some from previous tantrums...." The Chemical Restraint section indicated Zyprexa Zydis 10 milligrams was administered to client #1 at 9:15 AM after 30 minutes of maladaptive behavior. The report indicated the Central Pager (QIDP #3) gave the staff authorization to administer the PRN. At 8:50 AM, the pager was called and authorization to administer a PRN (as needed medication) was given, according to the 9/26/15 Stone Belt ARC, Inc.			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1835 MAXWELL ST BLOOMINGTON, IN 47401	

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	Incident Report. Client #1 calmed approximately 30 minutes later. Client #1 had an one inch abrasion on his forehead from the window glass which was cleaned and basic first aid was given. The incident was reported to the central pager at 9:00 AM. The incident report indicated in the PRN protocol section, "Staff are to call coordinator (QIDP) or emergency pager to receive permission to give." On 11/20/15 at 12:48 PM, a review of QIDP #3's notes for the period of 9/25/15 to 10/2/15 titled, Epager, indicated regarding the call she received, "9/26/15...call @ (at) 9a from [name of group home] about PRN...." There was no additional information documented. QIDP #3 did not document who called her, the information provided to the pager regarding the use of a PRN (least restrictive interventions attempted prior to administering a PRN), who received a PRN, the name and dosage of the PRN and what her response to the staff included. On 11/18/15 at 12:46 PM, QIDP #3, who was the pager contact at the time of the incident, indicated the group home staff contacted her to inform her client #1 had been administered a PRN. QIDP #3 indicated she told them they needed to			

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	obtain her permission prior to administering a PRN and the staff indicated they already had permission to give the PRN. QIDP #3 indicated she did not ask who the staff received permission from. On 11/17/15 at 11:03 AM, a focused review of client #1's record was conducted. Client #1's 10/2/15 Behavioral Support Plan indicated, in part, "If [client #1] engages in severe intentional and dangerous aggressive behavior towards himself or others, staff may call the emergency pager for PRN approval...." On 11/18/15 at 12:57 PM, the facility's policy on Psychotropic PRN Medications, dated 10/3/13, indicated the following, "Before administering any PRN (as needed) medication for behavior, staff must review the individual's Behavioral Support Plan and have implemented all least restrictive techniques identified. When the individual displays behavior consistent with identified behavioral criteria, and all less restrictive procedures have been ineffective, staff will call the pager or their coordinator (QIDP)/director and get approval to administer a PRN as prescribed...."			

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	On 11/20/15 at 11:10 AM, the Nurse Manager (NM) indicated the staff have to obtain approval prior to administering a PRN medication from the Central pager or the psychiatric pager. On 11/18/15 at 12:50 PM, the QIDP indicated client #1's plan should include a stipulation the staff need to obtain permission to administer a PRN prior to administering a PRN. The QIDP indicated the plan needed to be revised. On 11/18/15 at 12:55 PM, QIDP #2 indicated client #1's plan should indicate the staff were to receive permission to administer a PRN prior to administering a PRN. QIDP #2 indicated the plan needed to be revised. On 11/20/15 at 12:56 PM, the GHD indicated the staff needed to be given permission prior to administering a PRN medication for behavior. The GHD indicated client #1's plan needed to indicate permission must be obtained prior to administering a PRN behavioral medication. 9-3-4(a)			
W 0249	483.440(d)(1) PROGRAM IMPLEMENTATION			

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Bldg. 00	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. Based on observation, record review and interview for 1 of 3 clients in the sample (#3) and 1 additional client (#1), the facility failed to ensure staff implemented the clients' meal preparation training objectives as written. Findings include: On 11/16/15 from 3:18 PM to 6:24 PM, an observation was conducted at the group home. At 5:06 PM, staff #3 was in the kitchen preparing dinner without clients #1 and #3 being prompted to assist him. Staff #3 continued to prepare dinner from 5:06 PM to 5:53 PM without the clients being involved in preparing their dinner. On 11/17/15 from 6:03 AM to 7:38 AM, an observation was conducted at the group home. At 6:29 AM, the QIDP was in the kitchen making juice from frozen concentrate. Clients #1 and #3 were not asked to assist with breakfast preparation. At 6:36 AM, the QIDP was in the kitchen cooking sausage. At 6:41 AM, the QIDP	W 0249	**W249 Program implementation (standard) Corrective action for resident(s) found to have been affected** Client # 1 and client #3 meal time goal training completed with staff and day program staff. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Monitoring of plan implementation and staff training will be conducted as outlined above.**How corrective actions will be monitored to ensure no recurrence**Stone Belt has assigned a Senior Director with over 20 years' experience in residential services to monitor implementation of the POC. The Senior Director will report	12/23/2015

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	was cooking sausages with no client involvement. At 6:47 AM when client #1 asked the QIDP what she was making, the QIDP stated "sausage." The QIDP asked client #1 if he wanted to assist and client #1 stated, "no." Client #1 was not encouraged or prompted again to assist with breakfast preparation. Client #3 was not asked to assist to prepare breakfast or to assist with preparing breakfast. On 11/17/15 at 11:03 AM, a review of client #1's record was conducted. Client #1's 6/10/15 Individual Support Plan (ISP) indicated he had a training objective to prepare a meal. The objective indicated, "During evening meal, [client #1] will demonstrate meal preparation... Staff must stay with [client #1] while this goal is implemented. Have [client #1] find the correct day/meal on the menu. Let him do as much of the task as he can, but be sure to assist him as necessary to maintain basic safety and hygiene (which includes having him wash his hands prior)." The tasks included in the objective were, "proper kitchen safety and hygiene throughout, reads menu, gathers ingredients, prepares ingredients as needed, determines the need to set timer, sets timer and determines when food is finished cooking."		progress to the Chief Executive Officer (CEO) on a regular basis. The Senior Director will oversee POC implementation, including supervising the efforts of the Supported Group Living (SGL) Director and QIDP. The Senior Director will oversee the POC process, which will include reviewing evidence that corrections are in place by 12/23/15. The SGL Director will assist in supervising POC implementation in order to eventually re-assume the lead role in monitoring of all home activities. The QIDP will provide regular monitoring in the home, which will be no fewer than two visits per week. The Senior Director, SGL Director, and QIDP will meet regularly for the next two months - or	

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	On 11/17/15 at 12:15 PM, a review of client #3's record was conducted. Client #3's 2/19/15 ISP indicated he had a training objective to prepare a meal. The objective indicated client #3 would wash his hands, gather the needed items, measure and prepare ingredients, set the cooking temperature and cook the food. On 11/20/15 at 12:49 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients' training objectives should be implemented as written. The QIDP indicated the clients should be involved with dinner preparation. The QIDP indicated client #1 may not be successful, due to his maladaptive behaviors, with preparing breakfast. 9-3-4(a)		longer if needed - to ensure continued full implementation of the POC. The SGL Director also will meet weekly with QIDP to review plans and checklist items.	
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility's specially constituted committee (Human Rights Committee -	W 0262	**W262 Program implementation and change (standard)** **Corrective action for resident(s) found tohave been affected**Client #3 guardian provided approval for	12/23/2015

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	HRC) failed to review, approve and monitor individual programs designed to manage inappropriate behavior involving risks to client protections and rights. Findings include: Observations were conducted at the group home on 11/16/15 from 3:18 PM to 6:24 PM and 11/17/15 from 6:03 AM to 7:38 AM. During the observations at the group home, client #3's bedroom door had a motion detector to alert staff, the exterior doors had audible alarms which sounded when the door was opened and electric razors and sharps were locked up. On 11/17/15 at 12:15 PM, a review of client #3's record was conducted. Client #3's Human Rights Approval form for the restrictions at the group home was dated as reviewed and approved by the HRC on 2/24/14. There was no documentation the HRC reviewed, approved and monitored the restrictions at the group home affecting client #3 since 2/24/14. The current Human Rights Approval form (located in client #1, #2, #4, #5 and #6's records) indicated the current restrictions included, in part, "Restriction #1: Chime/alarm on all resident's doors used at night and during the day when residents are present. Rationale: A resident has a history of aggression		restrictions in the home. HRC approval was also obtained for Client #3 BSP **How facility will identify other residentspotentially affected & what measures taken**All residents potentially are affected, andcorrective measures address the needs of all clients.**Measures or systemic changes facility putin place to ensure no recurrence**Monitoring of plan implementation and stafftraining will be conducted as outlined above. **How corrective actions will be monitored toensure no recurrence** QIDP will provide weeklymonitoring in the home to ensure plan is being implemented.	

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	toward other residents, and an elopement risk. An alarm on the resident's door which is used at night and during the day to alert staff when resident exits his room. Another resident has a history of entering another resident's room for inappropriate touch. A motion detector is placed on all resident's door to alert staff... Restriction #3: Alarms on all exterior doors for three clients when those residents are present in the home. Rationale: There is an alarm placed on all exterior doors that will be used at all times when these residents are present. The residents have had events of elopement where they were able to reach the street before staff was alerted to their absence placing them at risk for injury. The use of alarms the (sic) allows staff to be immediately alerted to a resident's attempt to leave the house in order to provide protection from injury caused by wandering into the street... Restriction #5: Electric razors used in the house by all residents and electric razors kept locked in the storage cabinet in the office. Rationale: A resident has had multiple incidents of seeking out shaving razors and shaving his eye brows, which has caused cuts and scratches to his forehead. The resident has broken into sharps containers, locked storage cabinets and taken advantage of opportunities to search out razors. Another resident is			

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	preoccupied by the vibration of electric razors and had broken several razors in the past... Restriction #6: All sharps, including knives will be kept locked in the storage cabinet in the office. Rationale: A resident has been showing aggression and unstable episodes. The resident becomes aggressive to self and others...." On 11/17/15 at 2:12 PM, the Group Home Director indicated the HRC should review, approve and monitor the restrictions annually. 9-3-4(a)			
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure written informed consent was obtained for restrictive interventions at the group home affecting client #3.	W 0263	**W263 Program implementation and change (standard) Corrective action for resident(s) found tohave been affected**Client #3 guardian provided approval for restrictions in the home. **How facility will identify other residentspotentially affected &**	12/23/2015

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	Findings include: Observations were conducted at the group home on 11/16/15 from 3:18 PM to 6:24 PM and 11/17/15 from 6:03 AM to 7:38 AM. During the observations at the group home, client #3's bedroom door had a motion detector to alert staff, the exterior doors had audible alarms which sounded when the door was opened and electric razors and sharps were locked up. On 11/17/15 at 12:15 PM, a review of client #3's record was conducted. Client #3's 2/19/15 Individual Support Plan indicated client #3 had a guardian. Client #3's Human Rights Approval form for the restrictions at the group home indicated the facility obtained written informed consent on 2/21/14. There was no documentation the facility obtained written informed consent from client #3's guardian since 2/21/14. The current Human Rights Approval form (located in client #1, #2, #4, #5 and #6's records) indicated the current restrictions included, in part, "Restriction #1: Chime/alarm on all resident's doors used at night and during the day when residents are present. Rationale: A resident has a history of aggression toward other residents, and an elopement risk. An alarm on the resident's door		**what measures taken**All residents potentially are affected, andcorrective measures address the needs of all clients.**Measures or systemic changes facility putin place to ensure no recurrence**Monitoring of plan implementation and stafftraining will be conducted as outlined above.**How corrective actions will be monitored toensure no recurrence**QIDP will provide weeklymonitoring in the home to ensure plan is being implemented.	

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	which is used at night and during the day to alert staff when resident exits his room. Another resident has a history of entering another resident's room for inappropriate touch. A motion detector is placed on all resident's door to alert staff... Restriction #3: Alarms on all exterior doors for three clients when those residents are present in the home. Rationale: There is an alarm placed on all exterior doors that will be used at all times when these residents are present. The residents have had events of elopement where they were able to reach the street before staff was alerted to their absence placing them at risk for injury. The use of alarms the (sic) allows staff to be immediately alerted to a resident's attempt to leave the house in order to provide protection from injury caused by wandering into the street... Restriction #5: Electric razors used in the house by all residents and electric razors kept locked in the storage cabinet in the office. Rationale: A resident has had multiple incidents of seeking out shaving razors and shaving his eye brows, which has caused cuts and scratches to his forehead. The resident has broken into sharps containers, locked storage cabinets and taken advantage of opportunities to search out razors. Another resident is preoccupied by the vibration of electric razors and had broken several razors in			

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	the past... Restriction #6: All sharps, including knives will be kept locked in the storage cabinet in the office. Rationale: A resident has been showing aggression and unstable episodes. The resident becomes aggressive to self and others...." On 11/17/15 at 2:12 PM, the Group Home Director indicated the facility should obtain written informed consent from client #3's guardian annually. 9-3-4(a)			
W 0440 Bldg. 00	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 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: On 11/13/15 at 1:04 PM, a review of the facility's evacuation drills was conducted. During the day shift (6:00 AM to 2:00 PM), there were no evacuation drills conducted from 1/29/15 to 5/26/15.	W 0440	**W440 Evacuationdrills (standard) Corrective action for resident(s) found tohave been affected** Successful drills completed for each shift for clients #1, #2, #3, #4,#5, #6. **How facility will identify other residentspotentially affected & what measures taken** All residents potentially are affected, andcorrective measures address the needs of all clients. **Measures or systemic changes facility putin place to ensure no recurrence** Monitoring of plan implementation and stafftraining	12/23/2015

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	During the night shift (10:00 PM to 6:00 AM), there were no evacuation drills conducted from 11/13/14 to 3/28/15. This affected clients #1, #2, #3, #4, #5 and #6. On 11/17/15 at 6:41 AM, the weekday overnight staff (staff #6) indicated she had not conducted an overnight evacuation drill by herself. Staff #6 indicated she participated in one day shift evacuation drill with another staff and one overnight evacuation drill with an additional staff present. On 11/13/15 at 1:18 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility should conduct one drill per shift per quarter. On 11/17/15 at 2:03 PM, the Group Home Director indicated the facility should conduct one evacuation drill per shift per quarter. 9-3-7(a)		will be conducted as outlined above. **How corrective actions will be monitored toensure no recurrence** QIDP will review and sign off oneach drill to ensure that one evacuation drill is completed per shift perquarter.	
W 0441 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility	W 0441	**W441 Evacuationdrills (standard) Corrective action for resident(s) found tohave**	12/23/2015

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	failed to hold evacuation drills under varied conditions. Findings include: On 11/13/15 at 1:04 PM, a review of the facility's evacuation drills was conducted. The night shift drills (10:00 PM to 6:00 AM) were conducted on 3/29/15 at 11:45 PM, 6/30/15 at 11:05 PM and 9/30/15 at 11:55 PM. The facility failed to vary the drill times during the overnight shift. Two of the three evacuation drills were conducted by the former Qualified Intellectual Disabilities Professional (QIDP). The other drill was conducted by the Home Manager. This affected clients #1, #2, #3, #4, #5 and #6. On 11/18/15 at 11:50 AM, the QIDP indicated the evacuation drill times needed to be varied. 9-3-7(a)		**been affected** Successful drills completed at varied conditions #1, #2, #3, #4, #5,#6. **How facility will identify other residentspotentially affected & what measures taken** All residents potentially are affected, andcorrective measures address the needs of all clients. **Measures or systemic changes facility putin place to ensure no recurrence** Monitoring of plan implementation and stafftraining will be conducted as outlined above. **How corrective actions will bemonitored to ensure no recurrence** QIDP will review and sign off oneach drill to ensure that evacuation drills are completed in varied conditions.	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure staff prompted and encouraged	W 0488	**W488 Dining area services (standard)** **Corrective action for resident(s) found tohave been affected**Client #1, #2, #3, #4, #5, #6 will have a	12/23/2015

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	the clients to assist with meal preparation and client #2 fed himself a snack while at the facility-operated day program. Findings include: On 11/16/15 from 12:51 PM to 1:41 PM, an observation was conducted at the facility-operated day program. At 12:56 PM, day program staff #1 used a spoon to feed client #2 his snack (Jello) while standing near the refrigerator. At 1:10 PM, client #2 opened the refrigerator door. At 1:12 PM, client #2 was handed a spoon and a Jello by day program staff #1. Day program staff #1 prompted client #2 to sit down to eat his snack. Client #2 attempted to take a bite of Jello however the Jello fell off his spoon. Day program staff #2 prompted client #2 to hold his head up and then she used the spoon to put the Jello into client #2's mouth. Client #2 was not provided assistance to feed himself or taught how to use the spoon in a manner to keep the Jello from falling off. On 11/16/15 from 3:18 PM to 6:24 PM, an observation was conducted at the group home. At 5:06 PM, staff #3 was in the kitchen preparing dinner without clients #1, #2, #3, #4, #5 and #6 being prompted to assist him. Staff #3 continued to prepare dinner from 5:06		kitchen safety planimplemented. Staff will encourage clients to assist in meal preparation. Client #2 feeds himself when possible. **How facility will identify other residentspotentially affected & what measures taken**All residents potentially are affected, andcorrective measures address the needs of all clients.**Measures or systemic changes facility putin place to ensure no recurrence**Monitoring of plan implementation and stafftraining will be conducted as outlined above. **How corrective actions will bemonitored to ensure no recurrence** QIDP will provide weeklymonitoring and document on visit form that is reviewed by Director of supportedgroup living.	

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	PM to 5:53 PM without the clients being involved in preparing their dinner. At 5:47 PM, staff #5 placed a pitcher of juice on the dining room table. At 5:48 PM, staff #5 placed another pitcher on the dining room table. At 5:51 PM, staff #5 placed dinner rolls on the table. Staff #3 placed two cups with lids and straws on the table. Staff #3 placed milk on the table. At 5:58 PM, the Qualified Intellectual Disabilities Professional (QIDP) placed margarine on the table. At 6:01 PM, staff #5 placed the serving bowls on the table. At 6:03 PM, client #2 was given his plate with pureed food on it. Client #2 was not involved and was not asked to assist with pureeing his food. On 11/17/15 from 6:03 AM to 7:38 AM, an observation was conducted at the group home. At 6:29 AM, the QIDP was in the kitchen making juice from frozen concentrate. Clients #1, #2, #3, #4, #5 and #6 were not asked to assist. At 6:35 AM, the QIDP gave client #4 a drink with a mixture of coconut and almond milk. At 6:36 AM, the QIDP was in the kitchen cooking sausage. At 6:41 AM, the QIDP was cooking sausages with no client involvement. At 6:47 AM when client #1 asked the QIDP what she was making, the QIDP stated "sausage." The QIDP asked client #1 if he wanted to			

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	assist and client #1 stated, "no." At 7:02 AM, clients #2 and #4 sat down at the table to eat breakfast (puree meals). Clients #2 and #4 were not involved in preparing their meals. None of the clients ate the sausage and eggs prepared by the QIDP. At 7:03 AM, staff #6 indicated she prepared client #2 and #4's breakfast during the night shift while they slept. On 11/17/15 at 1:44 PM, the Group Home Director (GHD) indicated client #2 could and should feed himself. On 11/17/15 at 1:45 PM, the QIDP indicated client #2 could eat independently. The QIDP stated, "he can feed himself." On 11/17/15 at 1:46 PM, the Group Home Director indicated the clients should be involved with preparing their meals. On 11/17/15 at 1:46 PM, the QIDP indicated the clients should be involved with preparing their meals. 9-3-8(a)			

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W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met: 460 IAC 9-3-3 Facility Staffing (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. This state rule was not met as evidenced by: Based on record review and interview for	W 9999	**W9999 Final Observations Corrective action forresident(s) found to have been affected** Staff #5 obtained annual TB Mantoux test. **How facility will identify other residentspotentially affected & what measures taken** All residents potentially are affected, andcorrective measures address the needs of all clients. **Measures or systemic changes facility putin place to ensure no recurrence** Monitoring of plan implementation and stafftraining will be conducted as outlined above. **How corrective actions will bemonitored to ensure no recurrence** QIDP will complete monthly QAchecklist that will include HR file review and annual TB Mantouxscreening.	12/23/2015

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	1 of 3 employee (staff #5) files reviewed, the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted. Findings include: On 11/16/15 at 2:03 PM a review of the facility's employee files was conducted. Staff #5's employee file indicated her most recent Mantoux was completed on 8/27/14. There was no documentation in staff #5's employee file indicating she had a Mantoux completed since 8/27/14. On 11/16/15 at 1:52 PM, the Group Home Director indicated the staff should have an annual TB test. On 11/17/15 at 1:41 PM, the Qualified Intellectual Disabilities Professional indicated staff should have an annual TB test. 9-3-3(e)			