

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/26/2012
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: October 23, 24, 25 and 26, 2012.</p> <p>Facility Number: 000744 Provider Number: 15G220 AIM Number: 100234860</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/1/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to ensure: 1) the walls of the group home were repainted, 2) the carpet on the stairs and in the upstairs hallway was cleaned or replaced, 3) the carpet in client #6's bedroom was cleaned or replaced, 4) the staff ensured the dining room floors were cleaned after dinner, and 5) the utensil drawer was repaired.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/23/12 from 4:05 PM to 6:08 PM and 10/24/12 from 5:51 AM to 7:45 AM.</p> <p>1) During the observations at the group home, the walls throughout the home were scuffed, stained, marked, and chipped. Throughout the home, there were numerous holes patched and repaired and unpainted. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated</p>	W0104	<p>W 104 GOVERNING BODY</p> <p>Plan of Correction:</p> <p>Stone Belt exercises general policy, budget, and operating direction over the facility. Specifically, the facility will ensure that 1) the interior walls of the home are painted and in good repair, 2) carpet on the stairs and in the upstairs area is cleaned, 3) carpet in specific clients room is cleaned or replaced, 4) floors are cleaned after meals and 5) utensil drawer is repaired.</p> <p>Date of Completion:</p> <p>November 25, 2012</p> <p>Person Responsible:</p>	11/25/2012			

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	<p>the home needed to be repainted.</p> <p>2) The carpet in the common areas of the group home (two sets of stairs and in the upstairs hallway) was stained, matted, discolored and had dried drops of paint on it. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with the PC was conducted on 10/24/12 at 11:01 AM. The PC indicated the carpet was matted and stained and needed to be cleaned or replaced.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 10/26/12 at 11:16 AM. The BC indicated the carpet in the hallway and stairs needed to be replaced.</p> <p>3) The carpet in client #6's bedroom was stained and discolored. There was an area one foot by one foot in front of his closet with a stain. Staff #10 indicated on 10/23/12 at 6:03 AM the stain was feces. Client #6's room also smelled of feces and urine.</p> <p>A review of an email sent from the PC to maintenance staff, dated 10/18/12, was conducted on 10/26/12 at 12:29 PM. The email indicated, "We need the carpets in [client #6's] room removed. The</p>		<p>Hite Program Coordinator</p> <p>Plan of Prevention:</p> <p>Stone Belt Maintenance Manager has been notified of the need to complete the various maintenance tasks described. House staff have been reminded about the need to assure floors are cleaned after meals.</p> <p>Quality Assurance Monitoring:</p> <p>Program Coordinator and House Manager will conduct a Quarterly Internal Inspection of the home which will identify environmental needs. (Attachment # 1). Program Coordinator and SGL Director will review and prioritize various repairs.</p>	
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	<p>incontinence issues are extreme."</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated the carpet in client #6's room was going to be replaced with some type of flooring besides carpeting due to incontinence issues.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 10/26/12 at 11:16 AM. The BC indicated the carpet in client #6's room needed to be replaced. The BC indicated client #6 may not be sleeping in his room due to the smell.</p> <p>4) On 10/24/12 at 5:51 AM until 7:22 AM, there was a 2 feet by 2 feet area under the dining room table with spaghetti on it from dinner on 10/23/12. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>At 6:10 AM, staff #8 indicated the spaghetti was still on the floor from dinner on 10/23/12.</p> <p>At 7:02 AM, client #1 indicated the spaghetti was on the floor from dinner last night. At 7:22 AM, client #1 indicated he cleaned up the spaghetti on the floor.</p>						

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	<p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated staff #8 should have cleaned the spaghetti during the overnight shift.</p> <p>5) On 10/24/12 at 7:03 AM client #2 opened the kitchen drawer where the utensils were stored. The drawer hung down toward the floor, almost spilling the utensils onto the floor. Client #2 stated on 10/24/12 at 7:03 AM, the drawer had been broken for "a long time."</p> <p>An interview with client #3 was conducted on 10/26/12 at 11:53 AM. Client #3 indicated the drawer had been broken for years. Client #3 indicated the drawer had attempted to be repaired in the past however the drawer was not fixed.</p> <p>An interview with the Director of Supported Group Living was conducted on 10/26/12 at 12:02 PM. The Director indicated the drawer should be fixed. The Director indicated he did not recall seeing a work order for the drawer.</p> <p>9-3-1(a)</p>				

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 10 of 100 incident/investigative reports reviewed affecting clients #1, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, and to conduct investigations of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/23/12 at 11:03 AM.</p> <p>1) On 8/25/12 at 5:00 AM, client #1 was eating a salad at the table. Client #6 was walking around the home. Client #6 attempted to take client #1's salad and client #1 poked client #6's hand with his fork causing an injury to client #6's thumb. The facility did not conduct an investigation of client to client abuse.</p> <p>2) On 8/9/12 at 10:00 PM, client #1 threw wads of paper at client #6 who was asleep on the couch. One of the wads his client #6 in the face. The facility did not conduct an investigation of client to client abuse.</p>	W0149	<p>W149</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will ensure any incidents of Abuse, Neglect, and/or mistreatment of the consumers will be reported immediately.</p> <p>Person Responsible:</p> <p>Hite Program Coordinator</p> <p>Date of Completion:</p> <p>November 25, 2012</p>	11/25/2012			

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	<p>3) On 8/9/12 at 10:00 PM, client #4 was hit in the head by client #1. The facility did not conduct an investigation into client to client abuse.</p> <p>4) On 8/9/12 at 1:30 PM, client #1 was hit by a bag and binder thrown by a peer while at the facility-operated day program. The facility did not conduct an investigation into client to client abuse.</p> <p>5) On 7/23/12 at 8:30 AM while at the facility-operated day program, client #1 was following client #3 around. Client #3 asked client #1 to stop however client #1 did not stop following client #3. Client #3 pushed client #1 into the wall causing him to fall to the floor.</p> <p>6) On 7/22/12, client #1 reported to the Home Manager (HM) the Associate Manager (staff #11) put him in a seated baskethold. Client #1's plan did not include the use of a seated baskethold. The Findings of the investigation, dated 7/30/12, indicated client #1 reported staff #11 placed him in a baskethold and then a seated baskethold. Client #1 indicated staff #11 put hand sanitizer in his soda. Client #1 reported staff #11 put hand sanitizer on his own hands and then rubbed them on client #1's face getting into his eye. Client #1 reported staff #11</p>		<p>Plan of Prevention:</p> <p>Staff were retrained on the Stone Belt policy of Prevention of Abuse and Neglect and report immediately to the Program Coordinator and/or Director of Group Homes. Investigations will also be conducted on client-to-client aggression. (Attachment # 2 and # 2A)</p> <p>Quality Assurance Monitoring:</p> <p>The Stone Belt Staff receive training during new hire orientation and annually on The Stone Belt Abuse, Mistreatment, Neglect and Incident Report Policies.</p> <p>Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed, reported timely and investigated properly.</p> <p>The Program Coordinator and other administrative staff will</p>				

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	hit client #1's hand with the bottom of his closed fist. Client #1 reported the incident took place in client #1's bedroom, downstairs bathroom and laundry room. Client #1 indicated there were no witnesses. Staff #11 denied placing client #1 in restraints or using hand sanitizer on him. Client #1 was unable to recall a timeframe or timeline of events. The report indicated there was a 10-15 minute period in the evening when staff #11 was downstairs alone with client #1. This time period was described as a time when client #1 was upset and displaying negative behaviors. The allegation of abuse was inconclusive. The report indicated client #1 did not have a history of false allegations and historically presented as an accurate reporter. Client #1 had a history of trauma and had displayed symptoms of anxiety during the past week. Client #1 questioned the whereabouts of staff #11 and when he would return. Client #1 indicated staff #11 did not like him and staff #11 was mean to him. Client #1 appeared to be displaying some symptoms related to trauma. The report indicated, "Given the severity of allegation and [client #1's] history of trauma, it is recommended that [staff #11] no longer work with [client #1] or in his home." The report indicated, "It appears that weekend staff are not following [client #1's] BSP (Behavior		conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents.				

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	<p>Support Plan). They are implementing bribing techniques and using threats of losing money and outings. These techniques are not in [client #1's] BSP. These appear to be client rights violations." Staff #11 was terminated.</p> <p>7) On 6/6/12 at 11:30 PM, client #1 was upset a staff was leaving his shift. Client #1 threw bowls and lunchboxes. One of the lunchboxes went into client #3's room. Client #1 ran to the kitchen and dropped to the floor. Client #3 hit client #1 in the face. Client #1 got up and ran away. Client #3 followed him and hit him again. Client #1 had a split lip.</p> <p>8) On 5/24/12 at 10:15 PM, client #3 hit client #1 and scratched client #1's neck after client #1 sat outside client #3's bedroom door knocking on it for 15 minutes. Client #1 also hit his back on the bathroom counter causing a scrape about the size of a quarter.</p> <p>9) On 5/4/12 at 2:15 PM at the facility-operated day program, client #4 pushed a female peer after she tried to hug him. The peer bumped into a 2nd female peer causing the 2nd female peer to fall.</p> <p>10) On 4/25/12 at 7:30 PM, client #3 hit client #1.</p>			

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	<p>A review of the facility's abuse and neglect policy, dated 10/17/11, was conducted on 10/23/12 at 12:56 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a client, parent/guardian, advocate, staff member, or other involved party."</p>			

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	<p>An interview with the Behavior Consultant (BC) was conducted on 10/24/12 at 11:01 AM. The BC indicated client #3 typically showed no signs of physical aggression prior to coming out of his room and striking. The BC stated client #3 implemented "country justice" when client #1 was having behaviors. The BC indicated the staff have been trained to keep an eye on client #3 when client #1 was having behavior issues. The BC indicated client #5 had a plan to address medication refusals. The staff were to try three prompts from three different staff to get him to take. The BC indicated the staff offer to take the meds to his room to administer however client #5 still refused. The BC indicated client #5 had sleep apnea however he had refused to use a CPAP machine during two different trials so the machine was taken away due to not being used. The BC indicated client #5 really was tired and due to being tired refused his medications.</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated client to client aggression was abuse. The PC indicated the facility prohibited abuse. The PC indicated BDDS reports should be submitted within 24 hours.</p>						

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 4 of 9 incidents of client to client abuse reviewed affecting clients #1, #4 and #6, the facility failed to conduct investigations of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/23/12 at 11:03 AM.</p> <p>1) On 8/25/12 at 5:00 AM, client #1 was eating a salad at the table. Client #6 was walking around the home. Client #6 attempted to take client #1's salad and client #1 poked client #6's hand with his fork causing an injury to client #6's thumb. The facility did not conduct an investigation of client to client abuse.</p> <p>2) On 8/9/12 at 10:00 PM, client #1 threw wads of paper at client #6 who was asleep on the couch. One of the wads hit client #6 in the face. The facility did not conduct an investigation of client to client abuse.</p> <p>3) On 8/9/12 at 10:00 PM, client #4 was hit in the head by client #1. The facility</p>	W0154	<p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that all allegations are investigated thoroughly.</p> <p>Date of Completion</p> <p>November 25, 2012</p> <p>Responsible Person</p> <p>Deckard Coordinator/SGL Director</p>	11/25/2012			

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	<p>did not conduct an investigation into client to client abuse.</p> <p>4) On 8/9/12 at 1:30 PM, client #1 was hit by a bag and binder thrown by a peer while at the facility-operated day program. The facility did not conduct an investigation into client to client abuse</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated client to client aggression was abuse. The PC indicated the facility should investigate client to client abuse.</p> <p>9-3-2(a)</p>		<p>Plan of Prevention</p> <p>The Coordinators reviewed and completed training on Stone Belt investigation procedures. This included how to conduct proper investigations and who should be interviewed. (Attachment # 3)</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure, after reviewing the incident, that investigations will be completed thoroughly.</p>		

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 clients in the sample (#1, #3 and #6), the Qualified Mental Retardation Professional (QMRP) failed to ensure the clients' quarterly reviews of progress on their training objectives was conducted.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 10/25/12 at 10:45 AM. Client #1 did not have a quarterly progress review of his training objectives since 6/26/12 (covering February, March and April 2012).</p> <p>A review of client #3's record was conducted on 10/25/12 at 11:33 AM. Client #3 did not have a quarterly progress review of his training objectives since 6/26/12 (covering February, March and April 2012).</p> <p>A review of client #6's record was conducted on 10/25/12 at 10:45 AM. Client #6 did not have a quarterly progress review in his record for review. Client #6 moved into the home on 5/1/12.</p>	W0159	<p>W159</p> <p>QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Plan of Correction:</p> <p>Stone Belt Program Coordinator will ensure that each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, quarterly reviews on training objectives will be completed accurately and timely.</p> <p>Person Responsible:</p> <p>Hite Program Coordinator</p> <p>Date of Completion:</p>	11/25/2012			

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	<p>An interview with the Program Coordinator (PC) was conducted on 10/25/12 at 1:25 PM. The PC indicated he had not conducted quarterly reviews. The PC indicated the former PC had not conducted the quarterly reviews when they were due. The PC indicated he was aware of the missing quarterly reviews.</p> <p>9-3-3(a)</p>		<p>November 25, 2012</p> <p>Plan of Prevention:</p> <p>Former Program Coordinator did not complete the quarterly review requirement on various clients at the home. New PC is completed quarterlies as required. (Attachment # 4)</p> <p>Quality Assurance Monitoring:</p> <p>Stone Belt Director of Group Homes will review all incidents and determine with the Program Coordinator if the incident requires a interdisciplinary team meeting.</p>		

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W0227	<p>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 observation, interview and record review for 1 of 3 clients in the sample (#6), the facility failed to ensure there were plans in place addressing 1) sleeping on the couch and 2) incontinence in his bedroom.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/24/12 from 5:51 AM to 7:45 AM.</p> <p>1) From 5:51 AM until 6:18 AM when client #6 was awakened by staff #10, client #6 was asleep on a loveseat in the living room next to the dining room. The lights in the living room were turned on as well as the hallway light and the dining room light.</p> <p>An interview with staff #8 (overnight staff) was conducted on 10/24/12 at 6:12 AM. Staff #8 stated client #6 "always sleeps on the couch." Staff #8 indicated client #6 wakes up several times during the night to seek food. Staff #8 indicated client #6 did not sleep in his room. At</p>	W0227	<p>W 227</p> <p>DIRECT CARE STAFF</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that the individual program plan will have specific objectives necessary to meet the client's needs, as identified in the comprehensive assessment. Specifically, plans have been put into place to address a client's 1) sleeping on the couch and 2) incontinence in the bedroom.</p> <p>Person Responsible:</p> <p>Hite Program Coordinator</p> <p>Date of Completion:</p>	11/25/2012			

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	<p>6:40 AM, staff #8 indicated he allowed client #6 to sleep wherever he wanted. Staff #8 indicated he did not prompt client #6 to sleep in his own room.</p> <p>A review of client #6's record was conducted on 10/25/12 at 12:28 PM. His Individual Support Plan (ISP), dated 5/23/12, did not address sleeping on the couch. His Behavioral Intervention Plan (BIP), dated 6/5/12, did not address sleeping on the couch.</p> <p>An interview with the nurse was conducted on 10/25/12 at 12:56 PM. The nurse indicated client #6 should have a plan addressing sleeping on the couch.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 10/24/12 at 11:01 AM. The BC indicated there was no plan addressing client #6 sleeping on the couch.</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/25/12 at 1:25 PM. The PC indicated there was no plan addressing client #6's sleeping on the couch. The PC indicated there should be a plan. He had a history of sleeping in clothes and shoes. The PC indicated the staff should encourage client #6 to sleep in his room.</p>		<p>November 25, 2012</p> <p>Plan of Prevention:</p> <p>Program Coordinator has created formal and informal goals to address both 1) sleeping on the couch and 2) incontinence in the bedroom. (Attachment # 5 and #5A) In addition, staff have been trained on tracking these goals. (Attachment # 6). ABC Behavior Tracking is being completed in regard to incontinence to determine if medical or behavioral. (Attachment # 7).</p> <p>Quality Assurance Monitoring:</p> <p>Program Coordinator will ensure that formal and informal goals are created and trained on for all staff working at the home. SGL Director reviews the quarterly review to ensure completion. Support Team will discuss on an monthly basis.</p>				

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	<p>2) The carpet in client #6's bedroom was stained and discolored. There was an area one foot by one foot in front of his closet with a stain. Staff #10 indicated, at 6:03 AM on 10/24/12, the stain was feces. Client #6's room had an odor of feces and urine.</p> <p>Staff #8 stated client #6 "pees on his bedroom floor" on 10/24/12 at 6:40 AM.</p> <p>A review of client #6's record was conducted on 10/25/12 at 12:28 PM. His Individual Support Plan (ISP), dated 5/23/12, indicated, "[Client #6] came to Stone Belt with a behavior plan in place from another agency (name of agency). The behavior plan was considered moderately successful; however, [client #6] continues to display his Targeted Behaviors of Food-seeking, Vacating, SIB (self-injurious behavior), and Incontinence. Incontinence is not typically considered a 'target behavior'; however, it needs to be tracked for [client #6's] well-being and there are certain staff responses that have helped [client #6] feel more comfortable about staff doing his self-care." The plan did not indicate what the "certain staff responses" were. The ISP indicated, "[Client #6's] targeted behaviors will be: Food-seeking; Vacating; Self-injurious behaviors; and incontinence." A review of client #6's</p>				

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	<p>Behavioral Intervention Plan (BIP), dated 6/5/12, indicated his targeted behaviors were food-seeking, vacating and SIB. There was no targeted behavior of incontinence in his BIP.</p> <p>A review of an email sent from the PC to maintenance staff, dated 10/18/12, was conducted on 10/26/12 at 12:29 PM. The email indicated, "We need the carpets in [client #6's] room removed. The incontinence issues are extreme."</p> <p>An interview with the Behavior Consultant (BC) was conducted on 10/24/12 at 11:01 AM. The BC indicated there was no plan addressing client #6's incontinence in his bedroom.</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated the carpet in client #6's room was going to be replaced with some type of flooring besides carpeting due to incontinence issues.</p> <p>9-3-4(a)</p>				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 1 of 4 clients observed to receive their medication from staff #8, the facility failed to ensure staff implemented the client's medication administration training objective.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/24/12 from 5:51 AM to 7:45 AM. At 6:34 AM, client #3 received his medications (Chlorhexidine Glucon for gingivitis, Docusate Sodium for a stool softener and Magnesium Oxide for muscle spasms). During the med pass, staff #8 did not prompt client #3 to name his meds, dose, purpose or side effects.</p> <p>A review of client #3's record was conducted on 10/25/12 at 11:33 AM. His Individual Support Plan, dated 8/24/12, indicated he had a training objective to state the names of his meds, dosage, purpose and 2 side effects.</p>	W0249	<p>W 249</p> <p>PROGRAM IMPLEMENTATION</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that each client will receive continuous active treatment as designated by each individual's program plan. This will include interventions and services frequent enough to support the achievement of the objectives. Specifically, staff will ensure that a client's medication administration training objective will be implemented.</p> <p>Date of Completion:</p>	11/25/2012			

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	<p>An interview with staff #8 was conducted on 10/24/12 at 6:36 AM. Staff #8 stated, "He don't want to participate in nothing." Staff #8 indicated he did not ask client #3 to name his meds, purpose, dosage or side effects because client #3 did not participate in the past.</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated client #3's med administration training objective was to name his meds, number of pills he took, purpose and side effects. The PC indicated the training objective should have been implemented.</p> <p>9-3-4(a)</p>		<p>November 25, 2012</p> <p>Person Responsible:</p> <p>Hite Program Coordinator</p> <p>Plan of Prevention:</p> <p>The Stone Belt Support Team will ensure that behavior and active treatment plans are followed in general and specifically on medication administration of one particular client. Training was completed on November 9, 2012, on all client's ISP goals and objectives. (Attachment # 8)</p> <p>Quality Assurance Monitoring:</p> <p>Hite Program Coordinator and other Administrative Staff will conduct announced and announced visits to ensure that plans are being carried out as presented. SGL Director will</p>		

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			review monthly and quarterly tracking.		

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W0312	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 3 of 3 clients in the sample (#1, #3 and #6), the facility failed to ensure there was a specific plan of reduction for each psychotropic medication.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 10/25/12 at 10:45 AM. His Behavioral Intervention Plan (BIP), dated 8/8/12, indicated he took Lamictal, Intuniv and Xanax as psychotropic medications. The plan indicated, "Lamictal is one component of [client #1's] treatment for Impulse Control as measured by aggression. When incidents of physical aggression decrease to a rate of one or fewer per month for six consecutive months, the team will discuss the appropriateness of a medication reduction with [client #1's] psychiatrist." The plan indicated, "Intuniv is one component of [client #1's] treatment for Mood disorder as measured by aggression/agitation. When incidents of physical aggression decrease to a rate of</p>	W0312	<p>W 312</p> <p>DRUG USAGE</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Date of Completion:</p> <p>November 25, 2012</p>	11/25/2012	

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	<p>one or fewer per month for six consecutive months, the team will discuss the appropriateness of a medication reduction with [client #1's] psychiatrist." The plan indicated, "Xanax XR is one component of [client #1's] treatment for Anxiety Disorder NOS (not otherwise specified) as measured by aggression and disruptive behaviors. When incidents of physical aggression decrease to a rate of one or fewer per month for six consecutive months, the team will discuss the appropriateness of a medication reduction with [client #1's] psychiatrist."</p> <p>A review of client #3's record was conducted on 10/25/12 at 11:33 AM. His BIP, dated 8/8/12, indicated he took Abilify and Restoril as psychotropic medications. The plan indicated, "Abilify is used as one component in [client #3's] treatment of Oppositional Defiance Disorder and Bipolar Disorder. If symptoms of these disorders as measured by the target behavior of refusal behavior, occurs at a rate of 3 or fewer instances per month for 6 consecutive months, [client #3's] team and psychiatrist will assess the appropriateness of a medication reduction." The plan indicated, "Restoril is used as one component of [client #3's] PDD (Pervasive Developmental Disorder) NOS and sleep disturbance. If symptoms of these disorders occur at a rate of zero</p>		<p>Person Responsible:</p> <p>Hite Program Coordinator /Behavior Specialist</p> <p>Plan of Prevention:</p> <p>The Milestones Psychiatrist meets with clients on a quarterly basis to review psychotropic medications. As necessary the doctor will reduce medications based on the individual plan for medication reduction. The Milestones Director, Behavioral Specialist Manager and Doctor are reviewing current practices for medication reduction and assess the need to change to be more specific as required within the standard.</p> <p>Quality Assurance Monitoring:</p> <p>A quarterly review will take place regarding the reduction in psychotropic medications for each Stone Belt client.</p>	

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	<p>instances per month for one year, [client #3's] team and psychiatrist will assess the appropriateness of a medication reduction."</p> <p>A review of client #6's record was conducted on 10/25/12 at 12:28 PM. His BIP, dated 8/8/12, indicated he took Lexapro and Ativan as psychotropic medications. The plan indicated, "Lexapro is one component of [client #6's] treatment for Depressive D/O (disorder) NOS as measured by vacating, food-seeking, and SIB (self-injurious behavior). When [client #6] has had fewer than two episodes of food-seeking, vacating, or SIB per quarter for four consecutive quarters, his team will consult with his psychiatrist and discuss a possible medication reduction." The plan indicated, "Ativan is one component of [client #6's] treatment for Anxiety Disorder NOS as measured by vacating and yelling. When [client #6] has had fewer than two episodes of food-seeking, vacating, or SIB per quarter for four consecutive quarters, his team will consult with his psychiatrist and discuss a possible medication reduction."</p> <p>An interview with the Behavior Consultant (BC) was conducted on 10/26/12 at 11:14 AM. The BC indicated the plans needed to be more specific</p>				

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	<p>however it was not her call to reduce the medications. The BC indicated a medication would be reduced in consultation with the psychiatrist. The BC indicated the med reduction plans did not include dosages for reduction in the plan. The BC indicated there should be a specific plan of reduction for each psychotropic medication.</p> <p>9-3-5(a)</p>				

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 2 clients observed to use Chlorhexidine (clients #3 and #4), the nurse failed to ensure the clients used the medication per Physician's Orders.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/24/12 from 5:51 AM to 7:45 AM. At 6:34 AM, client #3 received Chlorhexidine (gingivitis) mouth rinse from staff #8. Client #3 took the mouth rinse to the restroom, swished for less than 5 seconds and then spit out the mouth rinse. Staff #8 did not prompt client #3 to swish for a length of time. The bottle of Chlorhexidine indicated, "Swish for 30 seconds." At 7:06 AM, client #4 received Chlorhexidine from staff #8. Client #4 took the Chlorhexidine into the restroom, gargled it for less than 3 seconds and spit out. Client #4 did not brush it on his teeth. The bottle indicated, "brush 1/2 fluid ounce BID (twice daily)." Staff #8 did not prompt client #4 to brush with the Chlorhexidine.</p> <p>A review of client #3's record was conducted on 10/25/12 at 11:33 AM. His</p>	W0331	<p>W331</p> <p>NURSING SERVICES</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that clients will be provided nursing services in accordance with their needs..</p> <p>Date of Completion</p> <p>November 25, 2012</p> <p>Responsible Person</p> <p>Hite Program Coordinator</p> <p>Plan of Prevention</p>	11/25/2012			

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	<p>Physician's Orders, dated 9/19/12, indicated "rinse as directed 2 times daily."</p> <p>A review of client #4's record was conducted on 10/26/12 at 1223 PM. His Physician's Orders, dated 9/19/12, indicated, "Brush with 1/2 fl (fluid) ounce two times a day, then expectorate. Do not swallow."</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated client #3 should swish for a longer period time. The PC indicated client #4 should brush using Chlorhexidine.</p> <p>An interview with the nurse was conducted on 10/25/12 at 12:56 PM. The nurse indicated the staff should prompt the clients to follow the physician's orders for longer periods of time.</p> <p>9-3-6(a)</p>		<p>The Hite Program Coordinator created an informal goal for the specific client regarding the use of his mouthwash. (Attachment # 8A) and it was trained on with staff on November 9, 2012. (Attachment # 8).</p> <p>Quality Assurance Monitoring</p> <p>The Program Coordinator will ensure that goals and objectives are being documented and followed as scheduled. SGL Director reviews monthly and quarterly reviews of the various goals and objectives.</p>		

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W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure there was one evacuation drill conducted per quarter per shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 10/23/12 at 12:12 PM. During the day shift (6:00 AM to 2:00 PM), there were no drills conducted from 4/20/12 to 8/25/12. During the night shift (10:00 PM to 6:00 AM), there were no drills conducted from 2/29/12 to 6/28/12. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with the Director of Supported Group Living was conducted on 10/26/12 at 10:39 AM. The Director indicated there should be one per shift per quarter.</p> <p>9-3-7(a)</p>	W0440	<p>W 440</p> <p>EVACUATION DRILLS</p> <p>Plan of Correction</p> <p>Hite House will hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Date of Completion</p> <p>November 25, 2012</p> <p>Responsible Person</p> <p>Hite Program Coordinator</p> <p>Plan of Prevention</p> <p>The Program Coordinator will</p>	11/25/2012			

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			<p>review drill schedule to ensure that all drills are completed timely and accurately. Training on Emergency Drills was completed on November 9, 2012. (Attachment # 9)</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director and Program Coordinator will ensure drills are done timely and accurately.</p>	

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W0448	<p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. 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 ensure issues noted during evacuation drills were investigated.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 10/23/12 at 12:12 PM. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>1) On 11/9/11 at 7:00 AM, a fire drill was conducted. The total time to complete the drill was documented as "approximately" 5 minutes. There was no documentation issues with the drill were investigated.</p> <p>2) On 11/16/11 at 5:35 AM, a fire drill was conducted. The total time to complete the drill was documented as 15 minutes. The issues noted indicated, "[Client #5] only put on underwear and never left the house. [Client #5] didn't evacuate the house." There was no documentation the Program Coordinator (PC) investigated the issues noted on the form.</p>	W0448	<p>W 448</p> <p>EVACUATION DRILLS</p> <p>Plan of Correction</p> <p>Stone Belt will investigate all problems with evacuation drills, including accidents. In addition to the drill report and investigation document will address any individual issues with the given drill.</p> <p>Date of Completion</p> <p>November 25, 2012</p> <p>Responsible Person</p> <p>Hite Program Coordinator</p>	11/25/2012			

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	<p>3) On 12/16/11 at 5:30 AM, a fire drill was conducted. The time to complete the drill indicated 6 minutes. There was no documentation issues were investigated.</p> <p>4) On 12/20/11 at 7:30 AM, a fire drill was conducted. It took 7 minutes to complete the drill. The form indicated there were no issues noted during the drill.</p> <p>5) On 12/26/11 at 10:15 AM, a fire drill was conducted. It took 4 minutes to complete. There was no documentation into the issues with the drill.</p> <p>6) On 1/22/12 at 6:30 PM, a fire drill was conducted. It took 5 minutes to complete. The form indicated client #1 refused to go outside. There was no documentation the PC investigated issues noted during the drill.</p> <p>7) On 1/25/12 at 6:45 AM, a fire drill was conducted. It took 15 minutes to complete. The form indicated clients #3 and #4 refused to go away from the house. Client #5 refused to leave his room or get dressed. The PC did not investigate issues noted during the drill.</p> <p>8) On 2/27/12 at 7:30 AM, a fire drill was conducted. It took 7 minutes to complete. There was no documentation</p>		<p>Plan of Prevention</p> <p>In addition to the drill report and investigation document will address any individual issues with the given drill. (Attachment # 10) The Program Coordinator will review concerns at the monthly Support Team meeting. In addition, a Social Story regarding "Fires" was completed by the Hite Social Worker.</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director and Program Coordinator will ensure that individual issues are addressed at the monthly Support Team meeting and plans put into place to address those issues.</p>				

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	<p>the facility investigated issues.</p> <p>9) On 2/29/12 at 5:30 AM, a fire drill was conducted. It took 10 minutes to complete. The form indicated client #5 refused to get out of bed. There was no investigation of the issue noted.</p> <p>10) On 4/20/12 at 7:40 AM, a fire drill was conducted. It took 1 minute and 30 seconds to complete. The issues section indicated client #5's name however there was no documentation of what client #5 did or did not do during the drill. There was no investigation.</p> <p>11) On 6/28/12 at 5:30 AM, a fire drill was conducted taking 4 minutes to complete. The form indicated client #5 never got up or turned on his light. The form indicated client #5 stated, "I'm tired." There was no investigation conducted.</p> <p>12) On 7/24/12 at 7:10 (no AM or PM noted), a fire drill was conducted taking 15 minutes to complete. The form indicated client #4 just got out of the shower and took 15 minutes to complete the drill. The form indicated client #5 took 12 minutes to complete the drill. There was no documentation an investigation was conducted.</p>						

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	<p>13) On 8/25/12 (no time but morning marked), a fire drill was conducted taking 5 minutes to complete. There was no investigation conducted.</p> <p>14) On 9/9/12 at 8:15 PM, a fire drill was conducted taking 4 minutes to complete. There was no investigation conducted.</p> <p>15) On 9/29/12 at 10:15 PM, a fire drill was conducted. The form did not indicate a duration for the drill. The form indicated client #5 did not leave his room and client #6 did not wake up or respond to prompts. The form indicated client #2 took 15 minutes to conduct the drill. There was no documentation an investigation was conducted.</p> <p>An interview with the PC was conducted on 10/24/12 at 10:58 AM. The PC indicated the targeted time was completing drills was 90 seconds. The PC indicated was responsible for investigating issues noted during drills. The PC indicated the former PC did not investigate issues noted during drills. The PC indicated there were known issues with drills at the group home. The PC indicated an investigation should be conducted when the targeted time was not met or there were issues during the drill.</p> <p>9-3-7(a)</p>						

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W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview for 3 of 6 clients living at the group home (#3, #4 and #5), the facility failed to ensure the clients received the items or an appropriate nutritionally equivalent substitution from the menu.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/24/12 from 5:51 AM to 7:45 AM. During the morning observation, clients #3 and #5 were not observed to eat breakfast (client #3 went back to bed and stayed in his room until it was time to leave for day program and client #5 stayed in bed until it was time for his medications and then it was time to leave for day program). The staff were not observed to prompt and encourage the clients to eat breakfast. At 7:22 AM, client #4 was observed eating two biscuits and 1 liter of Mountain Dew. Client #4 was not prompted to follow the posted menu.</p> <p>A review of the menu, dated Fall/Winter 2012, was conducted on 10/24/12 at 5:53 AM. The menu indicated the following for 10/24/12 (Wednesday): 6 ounces of</p>	W0460	<p>W 460</p> <p>FOOD AND NUTRITION SERVICES</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that each client will receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Date of Completion</p> <p>November 25, 2012</p> <p>Responsible Person</p> <p>Hite Program Coordinator</p>	11/25/2012			

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	<p>juice, 1/2 cup of hot or 3/4 cup cold cereal, 1/2 banana, 1 toaster waffle, 1 teaspoon of margarine, 1 tablespoon of syrup and 1 cup of milk.</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated the staff should have prompted client #4 to follow the menu. The PC indicated the clients should be prompted to eat breakfast.</p> <p>An interview with the nurse was conducted on 10/25/12 at 12:56 PM. The nurse indicated the clients should be prompted to eat breakfast following the posted menu.</p> <p>9-3-8(a)</p>		<p>Plan of Prevention</p> <p>The Program Coordinator conducted training on following of menu's and created informal training goals for specific clients. (Attachment # 11 and # 11A). Training of staff on informal goals occurred on November 9, 2012. (Attachment # 8)</p> <p>Quality Assurance Monitoring</p> <p>The Hite Program Coordinator will ensure that individual goals and objectives are followed and tracked when pertaining to menu/food issues. Announced and unannounced visits during meal time will be conducted by the Program Coordinator and Administrative staff.</p>		

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division (15. A fall resulting in injury, regardless of the severity of the injury.).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 6 of 100 incident/investigative reports reviewed affecting clients #1 and #5, the facility failed to ensure a fall with injury and refusals to take medications were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was</p>	W9999	<p>W 9999</p> <p>FINAL OBSERVATIONS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that incidents will be reported in 24 hours, in accordance with state law.</p> <p>Date of Completion</p> <p>November 25, 2012</p> <p>Responsible Person</p> <p>Hite Program Coordinator</p> <p>Plan of Prevention</p>	11/25/2012			

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	<p>conducted on 10/23/12 at 11:03 AM.</p> <p>1) On 10/20/12 at 10:00 PM, client #5 refused his medication. The BDDS report was submitted on 10/22/12.</p> <p>2) On 10/15/12 at 7:30 AM, client #1 tripped and fell, scratching his right elbow. The facility did not submit a BDDS report.</p> <p>3) On 10/2/12 at 5:00 PM, client #5 refused his medication. The BDDS report was submitted on 10/4/12.</p> <p>4) On 9/24/12 at 5:00 PM, client #5 refused his medications. The BDDS report was submitted on 9/27/12.</p> <p>5) On 9/17/12 at 5:00 PM, client #5 refused his medications. The BDDS report was submitted on 9/20/12.</p> <p>6) On 9/7/12 at 11:00 PM, client #5 refused his medications. The BDDS report was submitted on 9/13/12.</p> <p>An interview with the Program Coordinator (PC) was conducted on 10/24/12 at 11:01 AM. The PC indicated BDDS reports should be submitted within 24 hours.</p> <p>9-3-1(b)</p>		<p>All state reportable incidents will be reported within 24 hours per Stone Belt policy and procedure. (Attachment # 12)</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director and Program Coordinator will review all incident reports to ensure they are reported timely and accurately.</p>		