

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2013
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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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: July 5, 8, 9, 10, 11 and 12, 2013.</p> <p>Facility Number: 000888 Provider Number: 15G374 AIM Number: 100239700</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/18/13 by Ruth Shackelford, QIDP.</p>	W000000			

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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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. 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 exercise operating direction over the facility by failing to ensure holes in the walls were repaired and the kitchen cabinets were cleaned and/or replaced.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/8/13 from 3:26 PM to 6:14 PM and 7/9/13 from 5:58 AM to 8:13 AM. In the hallway where the bedrooms were located, there was a hole 5 inches by 5 inches in the wall across from client #2's bedroom. In the living room near the front door, there was a hole 18 inches by 12 inches on the south wall, a hole 6 inches by 5 inches in the west wall, and a hole 5 inches by 4 inches on the east wall. In the living room next to the dining room, there was a line of holes 4 feet up from the floor extending from one window to another. An interview with the Program Coordinator (PC) was conducted on 7/8/13 at 4:42 PM. The PC indicated the line of holes was from the back of a couch recently removed from the group home. In client #1's bedroom,</p>	W000104	<p>W 104 GOVERNING BODY</p> <p>Plan of Correction:</p> <p>Stone Belt exercises general policy, budget, and operating direction over the facility.</p> <p>Specifically, Stone Belt will ensure that holes in the walls are repaired and kitchen cabinets maintained.</p> <p>Date of Completion:</p> <p>August 10, 2013</p> <p>Person Responsible:</p>	08/10/2013			

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	<p>there were several holes (6 inches by 12 inches hole, 2 inches by 2 inches, 8 inches by 8 inches, 4 inches by 7 inches with an electrical outlet exposed at the bottom of the wall) on the walls and one on the ceiling (3 inches by 2 inches). In the bathroom next to the kitchen, there was a hole 2 inches round behind the door from the doorknob. The bathroom also had peeling paint around the ceiling in the shower area. The walls in the bathroom were marked and discolored. The bathroom also had unpainted patches from previously repaired holes. The kitchen cabinets were discolored and stained on the lower cabinets near the sink and the oven. There were non-functioning drawers in the kitchen cabinets and a hole being covered up with a piece of wood. The black trim in the kitchen was chipped, stained and discolored. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with the Program Coordinator (PC) was conducted on 7/12/13 at 10:29 AM. The PC indicated the cabinets needed to be replaced. The PC stated the cabinets, "Need to be replaced. They're shot. Not functional. Seen their day." The PC indicated the facility was planning on replacing the cabinets.</p>		<p>Maxwell Program Coordinator</p> <p>Plan of Prevention:</p> <p>Stone Belt Maintenance Request has been submitted to repair the holes in the walls and clean/repair the kitchen cabinets.</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator will review all environmental aspects on a quarterly basis using the Quarterly House inspection form (Attachment # 1). This will be done with the House Manager and then reviewed by the SGL Director.</p>				

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	<p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated he was aware of the holes in the walls. The Director indicated the holes would be repaired when the clients moved out (not sure of a date) for the repair of the mold issues at the group home. The Director indicated he was not sure what needed to be done to repair the floors so he did not want to repair the walls until the rest of the home was repaired. The Director indicated any safety related holes would be repaired sooner.</p> <p>9-3-1(a)</p>			

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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to keep a complete accounting of client #4's personal money.</p> <p>Findings include:</p> <p>A review of the clients' personal money was conducted on 7/8/13 at 3:42 PM. Client #4's July 2013 ledger indicated he should have \$34.25. When the Home Manager (HM) counted client #4's money, the amount was \$30.05. The HM was unable to locate a receipt or documentation indicating where the \$4.20 was spent.</p> <p>An interview with the HM was conducted on 7/8/13 at 3:42 PM. The HM indicated the facility should account for the client's money to the penny. The HM indicated someone must have taken him out and not recorded the amount on his ledger.</p> <p>An interview with the Program Coordinator (PC) was conducted on 7/10/13 at 10:39 AM. The PC indicated client #4 spent the money to go bowling.</p>	W000140	<p>W 140 CLIENT FINANCES</p> <p>Plan of Correction:</p> <p>Stone Belt has system to assure a full and complete accounting of clients' personal funds that are entrusted to Stone Belt on behalf of the clients.</p> <p>Specifically, Stone Belt will follow the policy and procedure it has in place for Client Finances. (Attachment # 2)</p> <p>Date of Completion:</p> <p>August 10, 2013</p>	08/10/2013			

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	An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated the client's money should be accounted for. The Director indicated the facility would reimburse client #4's money. 9-3-2(a)		<p>Person Responsible:</p> <p>Maxwell Program Coordinator</p> <p>Plan of Prevention:</p> <p>Retraining on Stone Belt Client Finance Policy and Procedures was conducted. (Attachment # 2A). In addition, the client was reimbursed \$4.20. After review of the issue, a purchase was made by the client but no receipt was found.</p> <p>Quality Assurance Monitoring:</p> <p>House Manager will account for all client funds on a weekly basis per Stone Belt procedure. The Program Coordinator will review the finances every two weeks to assure accurate accountability.</p>		

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W000149	<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 17 of 59 incident/investigative reports reviewed affecting 6 of 6 clients (#1, #2, #3, #4, #5 and #6), the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, conduct investigations of client to client abuse, and report incidents to the Bureau of Developmental Disabilities Services (BDDS) timely.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/5/13 at 10:43 AM.</p> <p>1) A review of client #6's record was conducted on 7/9/13 at 10:36 AM. A Nurse On-Call Pager report, dated 9/1/12 at 5:38 PM, indicated, "Stated that this client hit another client can PRN (as needed) for agitation/behavior be given. Referred to behaviorist after I was assured that there was immediate danger of client seriously hurting himself or others." The facility did not have an incident report, BDDS report or an investigation regarding this incident.</p>	W000149	<p>W149</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt has policies and procedures that address mistreatment, neglect and abuse of clients.</p> <p>Responsible Person:</p> <p>Maxwell Program Coordinator</p> <p>Date of Completion:</p> <p>July 19, 2013</p>	07/19/2013			

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	<p>2) On 9/10/12 at 7:00 PM, client #6 was left unsupervised in a parked van while at the facility-operated day program by staff #8. Client #4 was left unsupervised in a parked, running van while at the facility-operated day program by staff #8 for 1-2 minutes. The investigative report, dated 9/11/12, indicated, in part, "[Staff #8] admitted that he had made poor choices in terms of leaving [client #4] alone for a few minutes in a running van, while he brought the other van up to transfer [client #6] to the other van. According to his behavior plan, [client #6] is a client who is to be one-on-one in the community, and [client #4] is to be line of sight, and within arms reach when he is in the community. Both clients have elopement risks." Neglect was substantiated.</p> <p>3) A review of client #6's record was conducted on 7/9/13 at 10:36 AM. A SGL (Supported Group Living) Support Team Review Form, dated 10/31/12, indicated, "Elopement from home. Staffing issues addressed." The facility did not have an incident report, BDDS report or an investigation indicating when the incident occurred and the circumstances of the staffing issues.</p> <p>4) A review of client #6's record was conducted on 7/9/13 at 10:36 AM. A</p>		<p>Plan of Prevention:</p> <p>Maxwell House staff were retrained on the Stone Belt policy of the prevention of abuse, mistreatment and neglect. (Attachment # 3 and # 3A). This includes the Stone Belt policy on incident reporting within 24 hours.</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.</p> <p>The Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents.</p>				

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	<p>SGL Support Team Review Form, dated 2/5/13, indicated, "There has been several incidents where [client #6] has hit his peers at school." There were no incident reports, BDDS reports or investigations to review regarding client #6 hitting his peers at school.</p> <p>5) On 4/6/13 at 11:30 AM, client #6 ran into the office area and punched client #2 in the head. Client #2 was not injured.</p> <p>6) On 4/10/13 at 6:00 PM, client #3 was asked to set the table. Client #2 was sitting at the table. Client #3 hit client #2 on the back of the head.</p> <p>7) On 4/11/13 at 6:00 AM, the day shift staff reporting for work found the overnight staff (former staff #11) asleep on one couch. Client #6 was asleep on a second couch. The overnight staff did not set the door alarm. The day shift staff called staff #11's name five times to wake him up. The day shift staff checked on clients #1, #2, #3, #4 and #5 and all were asleep in their rooms. The BDDS follow-up report, dated 4/12/13, indicated, "Director interviewed [staff #11]. He admitted that he fell asleep due to being sick. SGL (Supported Group Living) Director placed [staff #11] on Investigatory Suspension while the review took place. SGL Director received (sic)</p>			

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	<p>written report from [day shift staff] who found [staff #11] asleep. SGL Director spoke to House Manager regarding the issue and reviewed the written report. [Staff #11] was terminated from his position on 4/12/13." Although this affected clients #1, #2, #3, #4, #5 and #6, the facility reported the incident to BDDS for client #6. The facility did not submit incident reports for clients #1, #2, #3, #4 and #5. The facility did not conduct an investigation.</p> <p>8) On 4/30/13 at 1:15 PM (reported to BDDS on 5/3/13), client #2 was given an as needed medication due to physical aggression toward staff and self injurious behavior. Due to continued self injurious behavior, a second as needed medication was administered.</p> <p>9) On 5/1/13 at 7:00 PM, client #5 was asleep on the couch. The former Home Manager (HM) woke up client #5 and told him he needed to take a shower and that it's "disgusting" to lie on the couch with soiled clothes. Client #5 went to his room. The HM followed and repeated he needed to take a shower. Client #5 shouted "No." HM shouted back at client #5 that he needed to shower. Client #5 screamed "no" over and over again, then shouted "mom." HM told client #5 that he could not call his mom until he</p>						

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	<p>showered. HM then said, "You're not going to call your mom if you're gonna throw things at me." HM shouted back and forth with client #5 for several minutes, then took client #5's video games from his room. Client #5 went to take a shower and cried in the shower. Later, client #5 went to get ice for his arm. Client #5 pointed at HM and said HM did this to him. Client #5 had a bruise on his upper left arm (from the HM pulling on client #5's arm to get client #5 off of his mattress). The investigative report indicated, in part, "The staff also reported that other clients were distressed by overhearing the loud shouting, yelling and client crying." The report indicated, in part, "All three accounts of the other staff indicated that they had attempted to have [HM] 'Step away' from the situation, and that HM declined to do so." The facility substantiated physical and emotional/verbal abuse. Client #5's guardians, per the investigative report dated 5/8/13, were not notified until they observed the bruises on 5/5/13.</p> <p>10) On 5/7/13 at 11:28 AM while at school (reported to BDDS on 5/9/13), client #6 ran over to another student and grabbed the student's face resulting in a scratch. The facility failed to conduct an investigation.</p>						

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	<p>11) On 5/8/13 at 5:30 PM, client #3 was asked to set the table. Client #3 said "No." Client #3 walked down the hallway and smacked client #2 on the back. Client #2 had a "small" red spot on his back. The investigation, dated 5/13/13, indicated there was no injury. The investigation indicated there were no prior incidents between the two clients.</p> <p>12) On 5/10/13 at 5:40 PM, client #3 picked up a plastic hanger and hit client #2 twice in the face. Client #2 was not injured. The facility did not conduct an investigation.</p> <p>13) On 5/12/13 at 6:30 PM, client #3 was in his room watching television. Client #3 "quietly ran down the hallway to where [client #2] was standing facing the wall and [client #3] pushed [client #2] into the wall, causing his forehead to hit the corner." The report indicated, "This caused a L-shaped cut on [client #2's] forehead that was bleeding and swelling. [Client #3] ran back to his room and staff asked him to remain there until calm." The report indicated client #2 was taken to the hospital to receive stitches to close the cut (BDDS report did not indicate the number of stitches).</p> <p>14) On 5/28/13 at 1:45 PM, client #1 wanted a soda. Client #1 punched</p>				

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	<p>cabinets, bit his fingers and broke a CD case. Client #1 punched himself and hit his face with his knees. Client #1 punched a hole in his bedroom wall. Client #1 was administered an as needed medication. The facility did not report the incident to BDDS.</p> <p>15) On 5/29/13 at 7:00 PM, client #3 hit client #2 on the head. Client #2 was not injured.</p> <p>16) On 6/15/13 at 12:00 PM (reported to BDDS on 6/17/13), while a new floor was being installed on 6/14/13 at the group home, mold was found. An Industrial Hygienist (IH) appointment was scheduled on 6/15/13. Client #2 was moved, temporarily, to another group home due to his "Severely compromised respiratory system" at the recommendation of the IH. The report indicated, "[IH] felt that the other clients (#1, #3, #4, #5 and #6) are safe to remain in the home with the use of an air scrubber and 3 dehumidifiers. In addition, the affected area has been contained and a piece of detached ductwork has been reconnected."</p> <p>17) On 6/29/13 at 2:00 PM (reported to BDDS on 7/1/13), client #2 was administered an as needed medication due to self-injurious behavior.</p>						

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	<p>A review of the facility's abuse and neglect policy, dated 10/17/11, was conducted on 7/5/13 at 10:39 AM. 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,</p>			

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	<p>or other involved party."</p> <p>An interview with the Director was conducted on 7/8/13 at 1:33 PM. The Director indicated the facility had a policy and procedure preventing abuse and neglect of the clients. The Director indicated the policy was not followed. The Director indicated client to client aggression was considered abuse and should be prevented. The Director indicated client to client aggression should be investigated. The Director indicated incidents should be reported to BDDS within 24 hours of occurrence. The Director indicated the trend of client #3 targeting client #2 was noted and had been discussed. The Director indicated the staff were retrained on partnering to address client to client abuse at the group home. The Director indicated client #3 had increased anxiety due to the school year ending.</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 59 incident/investigative reports reviewed affecting 6 of 6 clients (#1, #2, #3, #4, #5 and #6), the facility failed to report incidents 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 conducted on 7/5/13 at 10:43 AM.</p> <p>On 4/11/13 at 6:00 AM, the day shift staff reporting for work found the overnight staff (former staff #11) asleep on one couch. Client #6 was asleep on a second couch. The overnight staff did not set the door alarm. The day shift staff called staff #11's name five times to wake him up. The day shift staff checked on clients #1, #2, #3, #4 and #5 and all were asleep in their rooms. The BDDS follow-up report, dated 4/12/13, indicated, "Director interviewed [staff #11]. He admitted that</p>	W000153	<p>W153</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>Maxwell Program Coordinator</p> <p>Date of Completion:</p>	07/19/2013			

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	<p>he fell asleep due to being sick. SGL (Supported Group Living) Director placed [staff #11] on Investigatory Suspension while the review took place. SGL Director received (sic) written report from [day shift staff] who found [staff #11] asleep. SGL Director spoke to House Manager regarding the issue and reviewed the written report. [Staff #11] was terminated from his position on 4/12/13." Although this affected clients #1, #2, #3, #4, #5 and #6, the facility reported the incident to BDDS for client #6. The facility did not submit incident reports for clients #1, #2, #3, #4 and #5.</p> <p>An interview with the Director was conducted on 7/8/13 at 1:33 PM. The Director indicated incidents should be reported to BDDS within 24 hours of occurrence.</p> <p>9-3-2(a)</p>		<p>July 19, 2013</p> <p>Plan of Prevention:</p> <p>Staff will be retrained to report immediately to the Coordinator and/or Director of Group Homes. (Attachment # 3 and # 3A)</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.</p> <p>The Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of</p>		

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			incidents.	

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W000154	<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 6 of 59 incident/investigative reports reviewed affecting 6 of 6 clients (#1, #2, #3, #4, #5 and #6), the facility failed to conduct thorough investigations of client to client abuse and staff neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/5/13 at 10:43 AM.</p> <p>1) A review of client #6's record was conducted on 7/9/13 at 10:36 AM. A Nurse On-Call Pager report, dated 9/1/12 at 5:38 PM, indicated, "Stated that this client hit another client can PRN (as needed) for agitation/behavior be given. Referred to behaviorist after I was assured that there was immediate danger of client seriously hurting himself or others." The facility did not have an investigation regarding this incident.</p> <p>2) A review of client #6's record was conducted on 7/9/13 at 10:36 AM. A SGL (Supported Group Living) Support Team Review Form, dated 10/31/12, indicated, "Elopement from home.</p>	W000154	<p>W154</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 are investigated thoroughly and will include clients at the home.</p> <p>Person Responsible:</p> <p>SGL Director & Coordinator</p> <p>Date of Completion:</p> <p>August 10, 2013</p>	08/10/2013			

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	<p>Staffing issues addressed." The facility did not have an investigation indicating when the incident occurred and the circumstances of the staffing issues.</p> <p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated there should have been an investigation of the incident.</p> <p>3) On 4/11/13 at 6:00 AM, the day shift staff reporting for work found the overnight staff (former staff #11) asleep on one couch. Client #6 was asleep on a second couch. The overnight staff did not set the door alarm. The day shift staff called staff #11's name five times to wake him up. The day shift staff checked on clients #1, #2, #3, #4 and #5 and all were asleep in their rooms. The BDDS follow-up report, dated 4/12/13, indicated, "Director interviewed [staff #11]. He admitted that he fell asleep due to being sick. SGL (Supported Group Living) Director placed [staff #11] on Investigatory Suspension while the review took place. SGL Director received (sic) written report from [day shift staff] who found [staff #11] asleep. SGL Director spoke to House Manager regarding the issue and reviewed the written report. [Staff #11] was terminated from his position on 4/12/13." The facility did not conduct an investigation.</p>		<p>Plan of Prevention:</p> <p>Program Coordinators have been retrained investigate thoroughly as indicated in the Stone Belt Investigation Protocols and using the new client-to-client aggression form. (Attachment # 4 & #4A)</p> <p>Quality Assurance Monitoring:</p> <p>Stone Belt Director of Group Homes will review all incidents and investigation reports to assure policy is being followed.</p>				

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	<p>4) On 5/7/13 at 11:28 AM while at school (reported to BDDS on 5/9/13), client #6 ran over to another student and grabbed the student's face resulting in a scratch. The facility failed to conduct an investigation.</p> <p>5) On 5/8/13 at 5:30 PM, client #3 was asked to set the table. Client #3 said "No." Client #3 walked down the hallway and smacked client #2 on the back. Client #2 had a "small" red spot on his back. The investigation, dated 5/13/13, indicated there was no injury. The investigation indicated there were no prior incidents between the two clients (client #3 hit client #2 on 4/10/13 at 6:00 PM).</p> <p>6) On 5/10/13 at 5:40 PM, client #3 picked up a plastic hanger and hit client #2 twice in the face. Client #2 was not injured. The facility did not conduct an investigation.</p> <p>An interview with the Director was conducted on 7/8/13 at 1:33 PM. The Director indicated client to client aggression should be investigated. The Director indicated the facility should conduct thorough investigations. On 7/10/13 at 10:37 AM, the Director indicated the incident on 4/11/13 did not have a written investigation. The Director</p>			

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	indicated he interviewed the staff and then terminated the staff for neglect. 9-3-2(a)			

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W000159	<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 2 of 3 clients in the sample (#4 and #6), the Qualified Intellectual Disabilities Professional (QIDP) failed to review the clients' progress toward achieving their training objectives.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 7/9/13 at 9:57 AM. The facility had documentation one quarterly review of client #4's progress was completed on 8/7/12. Client #4's Individual Support Plan (ISP), dated 4/17/12, indicated his training objectives included reaching for a medication picture symbol when it was time for medication administration, activate cause/effect toy while at home or do interactive play with peers or staff, brush his teeth with an electronic toothbrush, eliminate in the toilet, request a drink and cross the street safely.</p> <p>A review of client #6's record was conducted on 7/9/13 at 10:36 AM. There was no documentation in client #6's record the facility reviewed the client's</p>	W000159	<p>W 159</p> <p>QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will ensure that each client's active treatment program is integrated, coordinated and monitored by the House Program Coordinator.</p> <p>Person Responsible:</p> <p>Maxwell Program Coordinator</p> <p>Date of Completion:</p> <p>August 10, 2013</p>	08/10/2013			

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	<p>progress toward achieving his training objectives. Client #6's ISP, dated 6/27/12, indicated his training objectives included exhibiting zero incidents of property destruction, putting his clothes away, applying hand sanitizer for medication administration, demonstrating appropriate kitchen safety skills and dietary skills, and crossing the street safely.</p> <p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated the previous QIDP and the Director failed to ensure the clients' quarterly progress reviews were completed.</p> <p>9-3-3(a)</p>		<p>Plan of Prevention:</p> <p>QMRP/Coordinator will ensure that all quarterly reviews are completed for each client.</p> <p>Quality Assurance Monitoring:</p> <p>A monthly checklist will be completed by the House Coordinator or designee and will include the review of quarterly program plans. This will also be reviewed by SGL Director.</p> <p>The SGL Director will review and sign off on monthly progress reports as well as quarterly reviews.</p>		

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure the client's comprehensive functional assessment (CFA) was conducted within thirty days after admission.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 7/9/13 at 11:16 AM. Client #5's record did not contain a CFA. Client #5's admission date to the group home was 4/17/13.</p> <p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated the client's CFA should have been conducted since he moved in on 4/17/13.</p> <p>9-3-4(a)</p>	W000210	<p>W 210</p> <p>INDIVIDUAL PROGRAM PLAN</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that within 30 days of admission, the interdisciplinary team must perform accurate assessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Specifically, the program assessment for the new admission on 4/17/13 was not completed.</p> <p>Date of Completion:</p> <p>August 10, 2013</p>	08/10/2013			

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			<p>Person Responsible:</p> <p>Maxwell Program Coordinator</p> <p>Plan of Prevention:</p> <p>Program Assessment will be completed by 8/10/13 on new admission.</p> <p>Quality Assurance Monitoring:</p> <p>SGL Director and House Program Coordinator will review all annual and admission packets upon completion to ensure that the program assessment is completed.</p>		

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W000226	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure the client's Individual Support Plan (ISP) was completed within 30 days after admission to the group home.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 7/9/13 at 11:16 AM. Client #5's record did not contain an ISP. Client #5's admission date to the group home was 4/17/13.</p> <p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated client #5 should have had an ISP.</p> <p>9-3-4(a)</p>	W000226	<p>W 226</p> <p>INDIVIDUAL PROGRAM PLAN</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that within 30 days of admission, the interdisciplinary team must complete and individual program plan for each client.</p> <p>Specifically, the individual support plan for the new admission on 4/17/13 was not completed.</p> <p>Date of Completion:</p> <p>August 10, 2013</p>	08/10/2013	

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			<p>Person Responsible:</p> <p>Maxwell Program Coordinator</p> <p>Plan of Prevention:</p> <p>Individual Support Plan will be completed by 8/10/13 on new admission.</p> <p>Quality Assurance Monitoring:</p> <p>SGL Director and House Program Coordinator will review all annual and admission packets upon completion to ensure that the individual support plan is completed within 30 days.</p>		

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W000249	<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 2 of 3 clients observed to receive their medication (#1 and #4), the facility failed to ensure staff implemented the clients' medication administration training objectives.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 7/9/13 from 5:58 AM to 8:13 AM. At 6:56 AM, client #4 received his medications including Polyethylene glycol (constipation), Omeprazole (stomach acid), Lactase (lactose intolerance), Simethicone (gas), Domperidone (increased movement of bowels), Chlorhexidine (oral hygiene), Benzoyl Peroxide (acne), Fluticasone Propionate (allergies), and Balmex (prevent rash) from staff #5. During the medication administration to client #4, staff #5 did not give him a picture to show staff when he was ready for his medications. At 7:24 PM, client #1 received his medications (Cetirizine for</p>	W000249	<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.</p> <p>Date of Completion:</p> <p>July 19, 2013</p>	07/19/2013	

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	<p>allergies, Lithium Carbonate for bipolar disorder, Lorazepam for anxiety, Multivitamin for nutritional supplement, Quetiapine for mood disorder, and Erythromycin and Benzoyl Peroxide for acne) from staff #5. Staff #5 did not prompt client #1 to name the purpose and side effects of his medications.</p> <p>An interview with staff #5 was conducted on 7/9/13 at 7:39 AM. Staff #5 indicated client #4 had a medication training objective for staff to give him a picture to show staff when he was ready for his medications. Staff #5 stated she "forgot about it this morning." Staff #5 indicated client #1's medication goal was to name his medications.</p> <p>A review of client #4's record was conducted on 7/9/13 at 9:57 AM. Client #4's Individual Support Plan (ISP), dated 4/17/12, indicated he had a medication training objective to reach for the medication picture symbol when it was time for his medications.</p> <p>A review of client #1's record was conducted on 7/9/13 at 9:37 AM. Client #1's ISP, dated 3/2/12, indicated he had a medication training objective to name his medications, their purpose and main side effects.</p>		<p>Person Responsible:</p> <p>Maxwell Program Coordinator</p> <p>Plan of Prevention:</p> <p>The Medication Administration Objectives for clients at Maxwell House were retrained on 7/19/2013.</p> <p>Quality Assurance Monitoring:</p> <p>House Coordinator and other Administrative Staff will conduct announced and announced visits during med administration to assure that staff are reviewing objectives with the clients.</p>	

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	<p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated the staff should implement the clients' medication administration training objectives at each medication administration.</p> <p>9-3-4(a)</p>			

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 clients in the sample (#4 and #6), the facility failed to ensure the clients' comprehensive functional assessments (CFA) were conducted, reviewed annually and updated as needed.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 7/9/13 at 9:57 AM. Client #4's most recent CFA was dated 4/12/12. There was no documentation in client #4's record the CFA was reviewed and updated since 4/12/12.</p> <p>A review of client #6's record was conducted on 7/9/13 at 10:36 AM. Client #6's most recent CFA was dated 6/27/12. There was no documentation in client #6's record the CFA was reviewed and updated since 6/27/12.</p> <p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated the clients' CFA should be reviewed and updated annually.</p> <p>9-3-4(a)</p>	W000259	<p>W 259</p> <p>PROGRAM MONITORING AND CHANGE</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that each client's comprehensive functional assessment will be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Date of Completion:</p> <p>August 10, 2013</p> <p>Person Responsible:</p>	08/10/2013	

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			<p>Maxwell Program Coordinator</p> <p>Plan of Prevention:</p> <p>Maxwell Program Coordinator is completing/scheduling annual reviews for all clients at Maxwell to ensure that the annual information is complete, including the functional assessment.</p> <p>Quality Assurance Monitoring:</p> <p>House Coordinator and SGL Director will review annual meetings to ensure that the comprehensive assessment is completed as part of the annual review.</p>		

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W000260	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (#4 and #6), the facility failed to ensure the clients' Individual Support Plans (ISPs) were revised and updated annually.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 7/9/13 at 9:57 AM. Client #4's most recent ISP was dated 4/17/12. There was no documentation in client #4's record indicating his ISP had been revised since 4/17/12.</p> <p>A review of client #6's record was conducted on 7/9/13 at 10:36 AM. Client #6's most recent ISP was dated 6/27/12. There was no documentation in client #6's record the ISP was revised and updated since 6/27/12.</p> <p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director stated the clients' ISPs were "outdated." The Director indicated the clients' ISPs should be revised annually.</p> <p>9-3-4(a)</p>	W000260	<p>W 260</p> <p>PROGRAM MONITORING AND CHANGE</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that each client's individual program plan will be reviewed and revised, as needed, on an annual basis.</p> <p>Date of Completion:</p> <p>August 10, 2013</p> <p>Person Responsible:</p> <p>Maxwell Program Coordinator</p>	08/10/2013			

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			<p>Plan of Prevention:</p> <p>Maxwell Program Coordinator is completing/scheduling annual reviews for all clients at Maxwell to ensure that the annual information is complete, including the individual program plan</p> <p>Quality Assurance Monitoring:</p> <p>House Coordinator and SGL Director will review annual meetings to ensure that the individual program plan is completed as part of the annual review.</p>		

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4 had an annual physical exam including an evaluation of his vision and hearing.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 7/9/13 at 9:57 AM. Client #4's most recent hearing evaluation was conducted on 2/23/10. Client #4's most recent vision evaluation was conducted on 4/12/12. Client #4's most recent annual physical examination was conducted on 4/22/13. Client #4's vision and hearing were not assessed during the annual exam. The annual physical examination form indicated, in the vision and hearing sections, "Unable."</p> <p>An interview with the nurse was conducted on 7/9/13 at 12:05 PM. The nurse indicated client #4's hearing examination could not be conducted due to wax build up on 6/20/12. The nurse indicated the client was taken to the primary care physician on 6/24/13 and the wax was removed. The nurse indicated</p>	W000323	<p>W 323 PHYSICIAN SERVICES</p> <p>Plan of Correction:</p> <p>Stone Belt will provide or obtain annual physical examinations of each client that includes at a minimum an evaluation of vision and hearing.</p> <p>Date of Completion:</p> <p>August 10, 2013</p> <p>Person Responsible:</p> <p>House Program Coordinator</p> <p>Plan of Prevention:</p>	08/10/2013			

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	<p>initially the hearing appointment was rescheduled for 7/29/13. On 7/10/13 at 10:53 AM, the nurse indicated client #4's hearing examination was being done on 7/10/13.</p> <p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated the client's vision and hearing should be evaluated annually.</p> <p>9-3-6(a)</p>		<p>During most recent annual physical examination the primary physician indicated that he was "unable" to complete the hearing and vision. The hearing and vision exam has been scheduled. Hearing completed on July 10, 2013. (Attachment # 7A)</p> <p>Quality Assurance Monitoring:</p> <p>House Program Coordinator will review, on a monthly basis, all required physical exams to ensure that they are completed in a timely manner. This review is also seen by the SGL Director.</p>		

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W000331	<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 3 of 3 clients in the sample (#4, #5 and #6), the facility's Licensed Practical Nurse (nurse) failed to ensure: 1) client #4 had an annual vision and hearing evaluation, 2) client #4's recommendations from physical therapy and speech assessments were obtained, 3) client #5 obtained hearing aids and dentures, 4) client #6 returned for a dilated vision exam, and 5) client #6's recommendations from an Occupational Therapy assessment were obtained.</p> <p>Findings include:</p> <p>1) A review of client #4's record was conducted on 7/9/13 at 9:57 AM. Client #4's most recent hearing evaluation was conducted on 2/23/10. Client #4's most recent vision evaluation was conducted on 4/12/12. Client #4's most recent annual physical examination was conducted on 4/22/13. Client #4's vision and hearing were not assessed during the annual exam. The annual physical examination form indicated, in the vision and hearing sections, "Unable."</p> <p>An interview with the nurse was conducted on 7/9/13 at 12:05 PM. The</p>	W000331	<p>W 331</p> <p>NURSING SERVICES</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that clients will receive nursing services consistent with their needs. Specifically various clients need to have any assessments/exams completed in a timely manner.</p> <p>Date of Completion:</p> <p>August 10, 2013</p> <p>Person Responsible:</p> <p>House Program Coordinator</p>	08/10/2013			

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	<p>nurse indicated client #4's hearing examination could not be conducted due to wax build up on 6/20/12. The nurse indicated the client was taken to the primary care physician on 6/24/13 and the wax was removed. The nurse indicated initially the hearing appointment was rescheduled for 7/29/13. On 7/10/13 at 10:53 AM, the nurse indicated client #4's hearing examination was being done on 7/10/13.</p> <p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated the client's vision and hearing should be evaluated annually.</p> <p>2) A review of client #4's record was conducted on 7/9/13 at 9:57 AM. Client #4 had an Augmentative Communication Evaluation conducted on 1/3/13. The recommendations, dated 1/18/13, from the evaluation were not in client #4's record. Client #4 had a physical therapy evaluation on 5/24/13. The recommendations from the appointment were not in client #4's record for review.</p> <p>An interview with the nurse was conducted on 7/9/13 at 12:05 PM. The nurse indicated he was unable to locate the report. The nurse indicated the facility usually received the report after the evaluation. The nurse indicated he</p>		<p>Plan of Prevention:</p> <p>1) During most recent annual physical examination the primary physician indicated that he was "unable" to complete the hearing and vision. The hearing (# 7A) and vision exam has been scheduled. 2) PT completed for specific client on July 11, 2013 (# 7B) 3) Support Team will review the need for specific client's hearing aids and dentures. This meeting takes place on August 6, 2013. 4) Client's mother requested that the dilated vision exam not be conducted. 5) Recommendations for OT assessment were obtained (# 7C) and sensory diet implemented and trained with staff (# 7 D)</p> <p>Quality Assurance Monitoring:</p> <p>Maxwell Program Coordinator will review the Group Home Checklist (Attachment # 7) to ensure all annual requirements are completed. This is also reviewed by SGL Director.</p>				

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	<p>had not seen the report. The nurse indicated someone should follow-up to obtain the report. On 7/10/13 at 11:03 AM, the nurse indicated client #4's physical therapy recommendations were not located. The nurse indicated client #4 had an appointment scheduled on 7/11/13 for further evaluation. The nurse indicated he did not know why the evaluations were scheduled three months apart.</p> <p>3) A review of client #5's record was conducted on 7/9/13 at 11:16 AM. On 5/16/13, client #5 was seen by his dentist. The dentist indicated client #5 was edentulous (without teeth). The dentist referred client #5 for dentures. On 6/10/13, client #5 was seen for a consultation for dentures. The Outside Services Report indicated, "Needs new full set of dentures." There was no documentation the facility followed up on obtaining dentures for client #5.</p> <p>On 5/30/13, client #5 was seen for his annual speech and hearing exam. The Outside Services Report indicated, "Moderate permanent high frequency hearing loss. Consider use of hearing aids. Rtn (return) 1 yr (year) to monitor loss if aids not fit."</p> <p>The Audiological Evaluation, dated</p>						

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	<p>5/30/13, indicated, in part, "Today's results indicate a mild to moderate high frequency sensorineural loss, with the left ear having overall poorer hearing than the right. This degree of hearing loss makes many of the consonants in speech inaudible and may lead to an inability to understand well, especially in the presence of background noise. A phone call to [client #5's] mother revealed that a hearing loss has not been previously diagnosed. [Client #5] could benefit from amplification and speech and language therapy might be considered to improve his intelligibility. [Client #5] may be eligible for hearing aids through Medicaid and would need to be further evaluated at a facility that dispenses hearing aids through Medicaid... If it is decided not to pursue amplification, an annual hearing evaluation is recommended to monitor any progression of hearing loss."</p> <p>Client #5's record did not contain documentation the interdisciplinary team met to discuss the use of dentures or hearing aids. There was no documentation indicating the facility took steps to acquire hearing aids or dentures for client #5. There was no documentation the facility contacted client #5's guardian to discuss the dentures or hearing aids.</p>						

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	<p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated Medicaid would not pay for the dentures. The Director indicated Stone Belt would pay if the dentures were a necessity. The Director indicated the IDT had not discussed the dentures.</p> <p>An interview with the Program Coordinator (PC) was conducted on 7/10/13 at 10:39 AM. The PC indicated the IDT had not convened to discuss client #5's dentures.</p> <p>An interview with the nurse was conducted on 7/9/13 at 12:05 PM. The nurse indicated the dentist recommended dentures for client #5. Client #5 went to a denture specialist but the facility found out Medicaid would not pay for dentures. The nurse indicated the dentist recommended the dentures but did not say client #5 needed them, not a necessity. The nurse indicated if it was a necessity, Stone Belt would pay for the dentures. On 7/10/13 at 11:03 AM, the nurse indicated there was no follow-up scheduled to address the recommendation for dentures. The nurse indicated a follow-up appointment needed to be scheduled. The nurse indicated client #5 was recommended to have hearing aids. The nurse indicated client #5 was to</p>				

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	<p>return in one year if hearing aids were not obtained. The nurse indicated he was not sure if Medicaid denied or not. The nurse indicated he had not reviewed the Outside Services Report and was not sure of the status of the hearing aids.</p> <p>4) A review of client #6's record was conducted on 7/9/13 at 10:36 AM. On 11/29/12, client #6 had a vision examination. The Outside Services Report, dated 11/29/12, indicated, "Hyperopia, external ocular health OK, internal health not fully assessed. RTC (return) 1 wk (week) for dilated portion of exam." On 5/17/13, client #6's mother wrote a letter (the letter was not in client #6's record) indicating, "My child [client #6] dob (date of birth) (omitted) was in your eye care center on 11/29/12 for his yearly exam with (name of group home) house staff. The clinic was unsuccessful at getting [client #6] to take the eye drops given to do his eye exam for glaucoma. The drops were sent home with house staff to try administering at home and they were also unsuccessful. I would like to give my acknowledgement of this. I would like for his exam to be signed off without the drops." There was no documentation in client #6's record indicating the optometrist received the letter or acknowledged the receipt of the letter.</p>						

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	<p>An interview with the nurse was conducted on 7/9/13 at 12:05 PM. The nurse indicated the facility should have followed up with the optometrist.</p> <p>5) A review of client #6's record was conducted on 7/9/13 at 10:36 AM. Client #6 had occupational therapy (OT) assessments conducted on 10/22/12 and 6/21/13. There was no documentation in client #6's record indicating the facility received or followed up on obtaining the recommendations from the assessments.</p> <p>An interview with the nurse was conducted on 7/9/13 at 12:05 PM. The nurse indicated he did not receive the recommendations from the OT assessments. The nurse indicated he did not have the 6/21/13 assessment in his records.</p> <p>9-3-6(a)</p>				

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W000346	<p>483.460(d)(4) NURSING STAFF</p> <p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Based on record review and interview for 6 of 6 clients (#1, #2, #3, #4, #5 and #6), the facility failed to ensure there was a Registered Nurse (RN) available for consultation for the group home Licensed Practical Nurse (LPN).</p> <p>Findings include:</p> <p>The facility was unable to provide documentation of a formal contract between the facility and a RN to be available for consultation for the group home's LPN. The information was requested on 7/9/13 at 12:05 PM. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with the LPN was conducted on 7/9/13 at 12:05 PM. Initially, the LPN indicated the former Director of Nursing was still available for consultation. On 7/10/13 at 11:02 AM, the LPN indicated he spoke to the Director of Health Services who indicated the facility did not have a RN to consult.</p> <p>An interview with the Director was</p>	W000346	<p>W 346</p> <p>NURSING STAFF</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that a formal arrangement with a registered nurse is provided for verbal or onsite consultation to the licensed practical nurses providing health services.</p> <p>Date of Completion:</p> <p>July 31, 2013</p>	07/31/2013	

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	<p>conducted on 7/8/13 at 1:33 PM. The Director indicated the former Director of Nursing left the facility approximately two weeks ago. The Director indicated the facility did not have a RN for the LPN to consult with.</p> <p>9-3-6(a)</p>		<p>Person Responsible:</p> <p>Milestones Director</p> <p>Plan of Prevention:</p> <p>At the time of the survey, Stone Belt did not have a Registered Nurse as the previous RN resigned her position on July 1, 2013. The hiring process had begun to replace the RN and a new RN has been hired and begins with Stone Belt on August 12, 2013.. However, during the interim period Stone Belt nursing staff had immediate access to Milestones Dr.'s Kettinis and Weakley for consultation.</p> <p>Quality Assurance Monitoring:</p> <p>RN has been hired and begins August 12, 2013. In the interim, the LPN's have access to Dr.'s Kettinis and Weakley at Milestones.</p>		

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5's recommended dentures and hearing aids were obtained or discussed by the interdisciplinary team.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 7/9/13 at 11:16 AM.</p> <p>On 5/16/13, client #5 was seen by his dentist. The dentist indicated client #5 was edentulous (without teeth). The dentist referred client #5 for dentures. On 6/10/13, client #5 was seen for a consultation for dentures. The Outside Services Report indicated, "Needs new full set of dentures." There was no documentation the facility followed up on obtaining dentures for client #5.</p> <p>On 5/30/13, client #5 was seen for his annual speech and hearing exam. The Outside Services Report indicated, "Moderate permanent high frequency</p>	W000436	<p>W 436</p> <p>SPACE AND EQUIPMENT</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that proper adaptive equipment is furnished, in good repair and training is conducted to teach clients the use of the particular devices. These devices are identified by the Support Team and needed by the client.</p> <p>Date of Completion:</p> <p>August 10, 2013</p>	08/10/2013	

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	<p>hearing loss. Consider use of hearing aids. Rtn (return) 1 yr (year) to monitor loss if aids not fit."</p> <p>The Audiological Evaluation, dated 5/30/13, indicated, in part, "Today's results indicate a mild to moderate high frequency sensorineural loss, with the left ear having overall poorer hearing than the right. This degree of hearing loss makes many of the consonants in speech inaudible and may lead to an inability to understand well, especially in the presence of background noise. A phone call to [client #5's] mother revealed that a hearing loss has not been previously diagnosed. [Client #5] could benefit from amplification and speech and language therapy might be considered to improve his intelligibility. [Client #5] may be eligible for hearing aids through Medicaid and would need to be further evaluated at a facility that dispenses hearing aids through Medicaid... If it is decided not to pursue amplification, an annual hearing evaluation is recommended to monitor any progression of hearing loss."</p> <p>Client #5's record did not contain documentation the interdisciplinary team met to discuss the use of dentures or hearing aids. There was no documentation indicating the facility took steps to acquire hearing aids or dentures</p>		<p>Person Responsible:</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention:</p> <p>The Support Team will meet on August 6, 2013 to discuss the specific clients' need for dentures and hearing aids. Previous family information stated that the client had both hearing aids and dentures but broke them while living at home. Family did not replace. Client was admitted to Stone Belt in April, 2013.</p> <p>Quality Assurance Monitoring:</p> <p>Appropriate documentation and process will be taken following the Support Team meeting on August 6, 2013.</p>				

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	<p>for client #5. There was no documentation the facility contacted client #5's guardian to discuss the dentures or hearing aids.</p> <p>An interview with the nurse was conducted on 7/9/13 at 12:05 PM. The nurse indicated the dentist recommended dentures for client #5. Client #5 went to a denture specialist but the facility found out Medicaid would not pay for dentures. The nurse indicated the dentist recommended the dentures but did not say client #5 needed them, not a necessity. The nurse indicated if it was a necessity, Stone Belt would pay for the dentures. On 7/10/13 at 11:03 AM, the nurse indicated there was no follow-up scheduled to address the recommendation for dentures. The nurse indicated a follow-up appointment needed to be scheduled. The nurse indicated client #5 was recommended to have hearing aids. The nurse indicated client #5 was to return in one year if hearing aids were not obtained. The nurse indicated he was not sure if Medicaid denied or not. The nurse indicated he had not reviewed the Outside Services Report and was not sure of the status of the hearing aids.</p> <p>An interview with the Director was conducted on 7/10/13 at 10:39 AM. The Director indicated Medicaid would not</p>						

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	<p>pay for the dentures. The Director indicated Stone Belt would pay if the dentures were a necessity. The Director indicated the IDT had not discussed the dentures.</p> <p>An interview with the Program Coordinator (PC) was conducted on 7/10/13 at 10:39 AM. The PC indicated the IDT had not convened to discuss client #5's dentures.</p> <p>9-3-7(a)</p>			

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W000440	<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 at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 7/5/13 at 10:44 AM. The facility did not conduct drills during the day shift (6:00 AM to 2:00 PM) from 1/23/13 to 5/18/13. The facility did not conduct drills during the evening shift (2:00 PM to 10:00 PM) from 12/8/12 to 5/14/13. The facility did not conduct drills during the night shift (10:00 PM to 6:00 AM) from 3/23/13 to 7/5/13. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview was conducted with the Director on 7/8/13 at 1:33 PM. The Director indicated the facility should conduct quarterly drills for each shift. The Director stated the drills, "Weren't being done."</p> <p>9-3-7(a)</p>	W000440	<p>W 440</p> <p>EVACUATION DRILLS</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that evacuation drills will be conducted at least quarterly for each shift.</p> <p>Date of Completion:</p> <p>August 10, 2013</p> <p>Person Responsible:</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention:</p>	08/10/2013			

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			<p>House Manager and other designees were trained to conduct drills in accordance with the requirement of one drill per shift, per quarter. (Attachment # 8)</p> <p>Quality Assurance Monitoring:</p> <p>House Coordinator or Designee will track drills to ensure compliance. In addition, the Stone Belt Organizational Effectiveness Coordinator is tracking and advising SGL Director when house has drill out of compliance.</p>		

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W000448	<p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct an investigation of an evacuation drill with issues noted.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 7/5/13 at 10:44 AM. The facility did not conduct an investigation of a fire drill conducted on 6/28/13 at 9:15 PM. The drill report indicated the drill took five minutes to complete. The form indicated "None" in the section for an evaluation of any problem with drill. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview was conducted with the Director on 7/8/13 at 1:33 PM. The Director indicated the facility's targeted time for conducting drills was two minutes. The Director indicated since the drill took five minutes to complete, an investigation should have been conducted. 9-3-7(a)</p>	W000448	<p>W 448</p> <p>EVACUATION DRILLS</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that evacuation drills will be conducted at least quarterly for each shift and that any problems will be investigated and addressed by the Support Team.</p> <p>Date of Completion:</p> <p>August 10, 2013</p> <p>Person Responsible:</p> <p>Maxwell Program Coordinator</p>	08/10/2013			

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			<p>Plan of Prevention:</p> <p>House Manager and other designees will be trained to conduct drills in accordance with the requirement of one drill per shift, per quarter and will investigate as to why problems occurred when drills are not completed within the proper time frame of two minutes.</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator or Designee will review all drills to ensure they are being completed timely and, if not, review with Support Team any problems.</p>		

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W000488	<p>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 1 of 3 clients who attended the facility-operated day program (#5), the facility failed to ensure the clients participated with preparing their lunches.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 7/9/13 from 5:58 AM to 8:13 AM. At 8:01 AM, staff #5 and #7 packed client #5's lunch. Staff #5 put a frozen dinner staff #7 got out of a chest freezer in the dining room. Staff #5 then packed two juice boxes in client #5's lunchbox. Client #5 was present and available to assist. Staff #5 and #7 did not prompt client #5 to assist with packing his own lunch. At 8:04 AM, client #5 looked in his lunchbox and unpacked the frozen dinner. Client #5 put the frozen dinner back into the freezer and got out a package of frozen chicken. Staff #5 assisted client #5 with packing a serving size portion of chicken from the large package. Staff #5 gave client #5 his shoes to put on while she finished packing his lunch.</p> <p>An interview with the Director was</p>	W000488	<p>W 488</p> <p>DINING AREAS and SERVICES</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that each client eats in a manner consistent with his development plan.</p> <p>Date of Completion:</p> <p>August 10, 2013</p> <p>Person Responsible:</p> <p>Maxwell Program Coordinator</p> <p>Plan of Prevention:</p>	08/10/2013			

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	<p>conducted on 7/10/13 at 10:39 AM. The Director indicated the clients should be involved with lunch preparation.</p> <p>9-3-8(a)</p>		<p>House staff were retrained (Attachment # 9) on clients ability to assist with meal preparation, specifically packing of lunches for day programming.</p> <p>Quality Assurance Monitoring:</p> <p>Program Coordinator will make announced and unannounced visits to observe that all meal preparation objectives are being implemented.</p>		

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (Direct Care Staff #4), the facility failed to ensure</p>	W009999	<p>W 9999</p> <p>FINAL OBSERVATIONS</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that each residential staff shall submit written evidence that a Mantoux tuberculosis skin test or chest x-ray is completed.</p> <p>Date of Completion:</p> <p>July 19, 2013</p> <p>Person Responsible:</p> <p>Coordinator & House Manager</p> <p>Plan of Prevention:</p>	07/19/2013			

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	<p>an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 7/8/13 at 12:59 PM. Direct Care Staff #4 had a negative chest x-ray on 3/23/12. There was no documentation in Direct Care Staff #4's personnel file staff #4 had a annual screening conducted since 3/23/12.</p> <p>An interview was conducted with the Administrative Assistant (AA) #1 in Personnel on 7/8/13 at 1:09 PM. AA #1 indicated the staff should have an annual Mantoux.</p> <p>An interview was conducted with Administrative Personnel Staff (APS) #1 on 7/8/13 at 1:19 PM. APS indicated staff #4 should have had an annual screening on 3/23/13. APS indicated the screening was to be completed annually.</p> <p>An interview with the Director was conducted on 7/8/13 at 1:33 PM. The Director indicated staff #4 should have a screening conducted annually.</p> <p>2) 460 IAC 9-3-1 Governing Body</p>		<p>The House Manager will review on a monthly basis all staff trainings and testings to ensure that staff working in the home have the proper training and testing. The individual involved specifically with this citation received a TB Screening on May 19, 2013. (Attachment # 10)</p> <p>Quality Assurance Monitoring:</p> <p>The Coordinator and House Manager will review records provided by the Stone Belt Human Resource Department on a quarterly basis to ensure that all staff have necessary training and testing, including Mantoux test. The Stone Belt Organizational Effectiveness Coordinator monitors training and testing as well.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2013	
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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	<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. (An emergency intervention for the individual resulting from: A physical symptom; a medical or psychiatric condition; Any other event.)</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 4 of 59 incident/investigative reports reviewed affecting 6 of 6 clients (#1, #2, #3, #4, #5 and #6), the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>A review of the facility's incident/investigative reports was conducted on 7/5/13 at 10:43 AM.</p> <p>1) On 4/30/13 at 1:15 PM (reported to BDDS on 5/3/13), client #2 was given an as needed medication due to physical aggression toward staff and self injurious behavior. Due to continued self injurious behavior, a second as needed medication was administered.</p>						

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	<p>2) On 5/28/13 at 1:45 PM, client #1 wanted a soda. Client #1 punched cabinets, bit his fingers and broke a CD case. Client #1 punched himself and hit his face with his knees. Client #1 punched a hole in his bedroom wall. Client #1 was administered an as needed medication. The facility did not report the incident to BDDS.</p> <p>3) On 6/15/13 at 12:00 PM (reported to BDDS on 6/17/13), while a new floor was being installed on 6/14/13 at the group home, mold was found. An Industrial Hygienist (IH) appointment was scheduled on 6/15/13. Client #2 was moved, temporarily, to another group home due to his "Severely compromised respiratory system" at the recommendation of the IH. The report indicated, "[IH] felt that the other clients (#1, #3, #4, #5 and #6) are safe to remain in the home with the use of an air scrubber and 3 dehumidifiers. In addition, the affected area has been contained and a piece of detached ductwork has been reconnected."</p> <p>4) On 6/29/13 at 2:00 PM (reported to BDDS on 7/1/13), client #2 was administered an as needed medication due to self-injurious behavior.</p> <p>An interview with the Director was</p>						

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	<p>conducted on 7/8/13 at 1:33 PM. The Director indicated incidents should be reported to BDDS within 24 hours of occurrence.</p> <p>9-3-3(e) 9-3-1(b)</p>			