

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/06/2015
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
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W 0000  Bldg. 00	<p>This visit was for a full recertification and state licensure survey.</p> <p>This visit included the investigation of complaint #IN00175288.</p> <p>Complaint #IN00175288 - Substantiated, Federal and State deficiencies related to the allegation(s) cited at W154 and W157.</p> <p>Survey Dates: June 30, July 1, 2, and 6, 2015</p> <p>Facility Number: 001165 Provider Number: 15G650 AIM Number: 100240230</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0153  Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 15 incident/investigative reports</p>	W 0153	<b>W 153483.420(d)(2) STAFF TREATMENT OF CLIENTS</b>	07/13/2015

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

TITLE

(X6) DATE

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

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	<p>reviewed affecting client F, the facility failed to ensure an allegation of abuse was reported to the administrator immediately and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 6/30/15 at 12:25 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: An investigation, dated 6/11/15, indicated, "During a performance action with [former staff #9] she accused [name], the eye doctor of restraining [client F] unnecessary (sic). She (staff #9) was receiving a performance action for being banned from his office due (sic)." The investigation indicated that on 6/11/15 at 8:51 AM, the Behavior Specialist sent an email to the Group Home Director, "The team discussed this appointment in our support team meeting on 5/27/15. In that meeting, [Manager] reported that [name of doctor] office had banned [staff #9] from entering the building in the future, due to her actions during [client F's] appointment on 5/26/15. Apparently, [Manager] had a conversation with staff at [name of doctor] office and the decision to ban her from the office</p>		<p>Plan of correction: Support team met 7/15/15 and determined that staff was trained on bsp /hrp and no other concerns have been reported (attachmenta).</p> <p>Plan of prevention: Facility staff was trained on reporting mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator. (attachment a). Staff who failed to report fall to pager and administrator received an employee warning notice (attachmentc).</p> <p>Plan of monitoring: Coordinator / Q will immediately report mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator (attachment b).</p>	

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	<p>seemed justified. If we need more information about what happened during the appointment, I am certain the physician's office would be able to provide it. In our support team meeting, we also discussed how staff may not be able to restrain clients during appointments (unless there is an immediate risk to health and safety), but physicians and their staff are typically trained on the use of restraint to facilitate client cooperation during appointments. The tone and language of [staff #9] email (sent on 6/10/15 at 5:56 PM) suggests that she had developed some unhealthy and unprofessional relationships with the [name of group home] clients." On 6/11/15 at 9:04 AM, the Nurse Manager indicated in an email to the Group Home Director, "[Behavior Specialist] is exactly right, when it comes to using restraints (whether mechanical or chemical) that is the clinicians (sic) call and they are allowed to do this because they have the training. It is not staff's call whether or not a clinician should be allowed to use restraints (though I do feel that the staff should take mental notes and if they feel that use of restraints was excessive, they should report this through the proper channels and let their supervisors deal with this, not argue with the clinicians)."</p> <p>The Findings of the investigation</p>			

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	<p>indicated, "Not substantiated. [Name of doctor] placed his hand on [client F's] leg in attempt to calm her and to complete a vision exam. She was checked for injuries by [name] (house manager) the day of appointment. Support team met the next day and determined that a restraint wasn't utilized and if was (sic) it was the physicians (sic) discretion."</p> <p>On 6/30/15 at 7:11 PM, the Manager forwarded an email she sent to the Group Home Director on 5/26/15 at 1:28 PM. The email to the Group Home Director indicated, "[Staff #9] (Day Aide) ran an appointment this morning with [client F] to [name of doctor] office for her New Patient Examination. The appointment was an appointment that did require [client F] to have PRN (as needed) Diazepam (anxiety) 5 mg (milligrams) (Take 1 tablet 30 minutes prior to appointment, may repeat per [name of doctor]; her PCP (primary care physician) - both tablets had to (sic) administered, 1 prior to appointment and the other during the appointment). There were some issues from this appointment that resulted in me having to go to [name of doctor] office and speak with him, his Assistant, Receptionist and Office Manager personally. Here is what happened... [Staff #9] called me and informed me that [name of doctor] had touched [client</p>			

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	<p>F's] shoulders and tried to have her sit back in the chair and that she [staff #9] informed him not to touch her, and that if he needed her to do anything that [staff #9] would ask her to do it and [staff #9] would be the one to touch her. [Name of doctor] informed her that he would go see another patient so that she could administer the other Diazepam tablet, because only 1 tablet did not seem to effect (sic) her much at all and then he would come back. [Staff #9] administered the other tablet and then she and [name of doctor's] assistant, [name], administered the necessary eye drops into [client F's] eyes, so that [name of doctor] could complete the examination. [Name of doctor] then came back into the room and in his words 'attempted' to examine [client F's] eyes. [Staff #9] says that he was attempting to restrain [client F] in the chair, so that he could get a good look at her eyes and that he was rude with [client F] and [staff #9]. [Staff #9] said that she did inform him that he was not working with [client F] correctly and that she did put herself between him and [client F], so that he could not examine her because she felt as though he was trying to restrain her and not being appropriate with her. She said that she did allow him to complete an examination with her assistance. However, the report that I got from him</p>			

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	and his office personnel is that [staff #9] was very impatient and rude the moment that she came into the office. The Receptionist stated that she wanted to be put in a room right away and told them that they could not sit out in the waiting area like everyone else and wait. The Assistant informed me that she would not allow neither him nor [name of doctor] to do their jobs as they have been trained to do. The Office Manager stated that because of how she was towards the staff there and [name of doctor] that the appointments were behind by at least an hour or more all due to the fact that she would not allow anyone there to do the job that they were trained to do. [Name of doctor] informed me that he has never in the 30+ (plus) years that he has been a Doctor ever had someone come in and act the way that she did; he said that she questioned everything he was doing and tried to tell him how he was supposed to do it even after he informed her that he has been in his line of work for numerous years and has worked with everyone from children to elderly adults and people with disabilities and that he does have several years experience and training; he said that he was only trying to do his job that he has been trained to do and that he was not restraining or harming our client in any way and would never do anything such as that. He informed me that he was			

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W 0154 Bldg. 00	<p>able to examine her some, but not as thoroughly due to the fact that [staff #9] would continuously interfere with everything he was trying to do. He also stated that he does not want [staff #9] assisting any clients with appointments with him; he says that due to her behavior and actions towards him and his staff that she is not welcome back at his office, etc."</p> <p>There was no documentation the incident was reported to BDDS.</p> <p>On 7/1/15 at 1:42 PM, the Group Home Director (GHD) indicated the incident was not reported to BDDS. The GHD indicated the incident was an allegation of abuse. The GHD indicated the incident should have been reported to BDDS. The GHD indicated staff #9 should have immediately reported the allegation directly to her on 5/26/15. The GHD indicated staff #9 reported her concerns to the GHD on 6/10/15 when the GHD met with staff #9 to give her a performance review for her actions at the doctor's office.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>						

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	<p>alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 15 incident/investigative reports reviewed affecting client F, the facility failed to ensure allegations of abuse were thoroughly investigated.</p> <p>Findings include:</p> <p>On 6/30/15 at 12:25 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) An investigation, dated 6/11/15, indicated, "During a performance action with [former staff #9] she accused [name], the eye doctor of restraining [client F] unnecessary (sic). She (staff #9) was receiving a performance action for being banned from his office due (sic)." The investigation indicated that on 6/11/15 at 8:51 AM, the Behavior Specialist sent an email to the Group Home Director, "The team discussed this appointment in our support team meeting on 5/27/15. In that meeting, [Manager] reported that [name of doctor] office had banned [staff #9] from entering the building in the future, due to her actions during [client F's] appointment on 5/26/15. Apparently, [Manager] had a conversation with staff at [name of doctor] office and the decision to ban her</p>	W 0154	<p><b>W 154483.420(d)(3) STAFF TREATMENT OF CLIENTS</b></p> <p>Plan of correction: Support team met 7/15/15 to discuss investigation and determined that staff was trained on bsp /hrp and reporting abuse and neglect immediately so administrator could start investigation (attachmenta).</p> <p>Plan of prevention: Facility staff was trained on reporting mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator so investigation can be initiated (attachmenta). Staff f</p> <p>Plan of monitoring: Coordinator / Q will immediately report mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator (attachment b). Coordinator / Q will undergo investigation training (attachment b).</p>	07/13/2015	

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	<p>from the office seemed justified. If we need more information about what happened during the appointment, I am certain the physician's office would be able to provide it. In our support team meeting, we also discussed how staff may not be able to restrain clients during appointments (unless there is an immediate risk to health and safety), but physicians and their staff are typically trained on the use of restraint to facilitate client cooperation during appointments. The tone and language of [staff #9] email (sent on 6/10/15 at 5:56 PM) suggests that she had developed some unhealthy and unprofessional relationships with the [name of group home] clients." On 6/11/15 at 9:04 AM, the Nurse Manager indicated in an email to the Group Home Director, "[Behavior Specialist] is exactly right, when it comes to using restraints (whether mechanical or chemical) that is the clinicians (sic) call and they are allowed to do this because they have the training. It is not staff's call whether or not a clinician should be allowed to use restraints (though I do feel that the staff should take mental notes and if they feel that use of restraints was excessive, they should report this through the proper channels and let their supervisors deal with this, not argue with the clinicians)."</p> <p>The Findings of the investigation</p>			

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	<p>indicated, "Not substantiated. [Name of doctor] placed his hand on [client F's] leg in attempt to calm her and to complete a vision exam. She was checked for injuries by [name] (house manager) the day of appointment. Support team met the next day and determined that a restraint wasn't utilized and if was (sic) it was the physicians discretion."</p> <p>The investigation was not thorough. The investigation did not describe the allegation and the events that occurred on 5/26/15. The investigation did not address that staff #9 failed to immediately report the allegation to the administrator. The following information was not included in the investigation: On 6/30/15 at 7:11 PM, the Manager forwarded an email she sent to the Group Home Director on 5/26/15 at 1:28 PM. The email to the Group Home Director indicated, "[Staff #9] (Day Aide) ran an appointment this morning with [client F] to [name of doctor] office for her New Patient Examination. The appointment was an appointment that did require [client F] to have PRN (as needed) Diazepam (anxiety) 5 mg (milligrams) (Take 1 tablet 30 minutes prior to appointment, may repeat per [name of doctor]); her PCP (primary care physician) - both tablets had to (sic) administered, 1 prior to appointment and the other during</p>			

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	<p>the appointment). There were some issues from this appointment that resulted in me having to go to [name of doctor] office and speak with him, his Assistant, Receptionist and Office Manager personally. Here is what happened... [Staff #9] called me and informed me that [name of doctor] had touched [client F's] shoulders and tried to have her sit back in the chair and that she [staff #9] informed him not to touch her, and that if he needed her to do anything that [staff #9] would ask her to do it and [staff #9] would be the one to touch her. [Name of doctor] informed her that he would go see another patient so that she could administer the other Diazepam tablet, because only 1 tablet did not seem to effect (sic) her much at all and then he would come back. [Staff #9] administered the other tablet and then she and [name of doctor's] assistant, [name], administered the necessary eye drops into [client F's] eyes, so that [name of doctor] could complete the examination. [Name of doctor] then came back into the room and in his words 'attempted' to examine [client F's] eyes. [Staff #9] says that he was attempting to restrain [client F] in the chair, so that he could get a good look at her eyes and that he was rude with [client F] and [staff #9]. [Staff #9] said that she did inform him that he was not working with [client F] correctly and that</p>			

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	<p>she did put herself between him and [client F], so that he could not examine her because she felt as though he was trying to restrain her and not being appropriate with her. She said that she did allow him to complete an examination with her assistance. However, the report that I got from him and his office personnel is that [staff #9] was very impatient and rude the moment that she came into the office. The Receptionist stated that she wanted to be put in a room right away and told them that they could not sit out in the waiting area like everyone else and wait. The Assistant informed me that she would not allow neither him nor [name of doctor] to do their jobs as they have been trained to do. The Office Manager stated that because of how she was towards the staff there and [name of doctor] that the appointments were behind by at least an hour or more all due to the fact that she would not allow anyone there to do the job that they were trained to do. [Name of doctor] informed me that he has never in the 30+ (plus) years that he has been a Doctor ever had someone come in and act the way that she did; he said that she questioned everything he was doing and tried to tell him how he was supposed to do it even after he informed her that he has been in his line of work for numerous years and has worked with everyone from</p>			

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	<p>children to elderly adults and people with disabilities and that he does have several years experience and training; he said that he was only trying to do his job that he has been trained to do and that he was not restraining or harming our client in any way and would never do anything such as that. He informed me that he was able to examine her some, but not as thoroughly due to the fact that [staff #9] would continuously interfere with everything he was trying to do. He also stated that he does not want [staff #9] assisting any clients with appointments with him; he says that due to her behavior and actions towards him and his staff that she is not welcome back at his office, etc."</p> <p>There was no documentation the incident was reported to BDDS.</p> <p>On 7/1/15 at 1:42 PM, the Group Home Director (GHD) indicated the facility should conduct thorough investigations.</p> <p>2) On 6/7/15 at 8:18 AM, staff #4 reported to the Home Manager that when she left her shift on 6/6/15 at 9:30 PM, staff #10 was assisting/prompting client F to go to bed. When staff #4 returned to the home the next morning at 6:00 AM, client F was sitting at the table where she was the night before. Staff #10 was</p>			

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	<p>sitting in the living room watching television. The Stone Belt ARC, Inc. Incident Report indicated, "[Staff #10] told me that [client F] didn't get up from the dining room table the whole night. [Staff #10] said that she did try to prompt [client F] every few minutes or so to get up and go to bed, but then stated to me that she started thinking and thought 'What's the point? she gets up early anyways'; and she did not prompt [client F] again. She instead just let her continue to sit at the dining room table in the same spot for the rest of the night. I noticed that not only did [client F] sit in the chair all night without staff assisting her to her bed, but the other clients were not being assisted as well due to [staff #10] just sitting and watching TV." The report indicated, "[Client F] was left in a dining room chair at the dining room table all night long, from 9:30 PM until after 6 AM, without being assisted to the restroom or to her bedroom."</p> <p>The investigation, dated 6/10/15, indicated, in part, "The purpose of this investigation is to determine if staff neglected [client F] during the overnight shift beginning at approximately 9:30pm Saturday, June 6th (2015) and ending at approximately 6:30am Sunday, June 7th (2015) when she remained at the kitchen table for the overnight shift. [Staff #10]</p>			

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	<p>was asked to recall the incident that occurred on June 6th into June 7th at [name of group home]. [Staff #10] reported that when she arrived at [name of group home] at approximately 9pm staff [staff #4] advised that [client F] was still up and had been prompted to go to bed but refused. [Staff #10] stated [client F] was sitting at the kitchen table and refused to move. [Staff #10] reported that she prompted [client F] every 15-30 minutes to go to bed but stopped asking at approximately 4am as that is the time that [client F] typically wakes up and begins breakfast. [Staff #10] reported that she gave her breakfast and [client F] continued to sit at the table and eat until [staff #4] arrived at approximately 6:20am. While this was happening during the overnight shift, [staff #10] indicated that she emptied the trash, cleaned the bathrooms, did laundry, and mopped. She reported that other clients were in bed with the exception of one individual getting up to use the bathroom. Interviewer asked [staff #10] if she felt she could have done anything differently and she responded no, she prompted [client F] but she refused. [Staff #10] stated she wanted [client F] to stay on her routine so (sic) fed her breakfast at 4am per their usual schedule.</p> <p>[Staff #4] was asked to recall the incident</p>			

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	<p>that occurred on the night of June 6th overnight into June 7th at [name of group home]. [Staff #4] reported that she was evening staff and [client F] refused to go to bed that night. She stated that when [staff #10] arrived at 9pm [staff #4] asked [staff #10] to attempt to get [client F] to go to bed, and that [staff #10] attempted one time while [staff #4] was still in the house, leaving at approximately 9:30pm. [Staff #4] reports that when she returned to the home at 6am, [client F] was in the same place at the table and [staff #10] walked in from the living room. [Staff #4] reports that [staff #10] stated that she prompted until 2:30am and then felt it was pointless because [client F] would be getting up soon anyway (referencing her daily routine of breakfast around 4am). [Staff #4] reports that two clients were up when she arrived but one who has typically started a shower by that time was not up. [Staff #4] gave medications to [client F] as she was eating breakfast and then assisted her into the bathroom and to bed to lie down. [Staff #4] reports that a typical response to a refusal by [client F] is to prompt every 15 minutes until she complies."</p> <p>The report indicated, "Human Rights Policy of Stone Belt prohibits neglect, outlined as follows: Neglect: Any action or behavioral interventions that risks the</p>			

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	<p>physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to:</p> <ol style="list-style-type: none"> <li>1. Failure to provide a safe, clean and sanitary environment.</li> <li>2. Failure to provide appropriate supervision, care, or training.</li> <li>3. Failure to provide food and medical services as needed.</li> <li>4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan.</li> </ol> <p>There is not evidence to support the allegation that [staff #10] neglected client [F] during the overnight shift starting Saturday, June 6th into Sunday, June 7th. The reports of [staff #10] and [staff #4] contain conflicting information, and [staff #4] was not present to directly witness what occurred between 9:30pm and 6am. [Staff #10] reports that she did prompt [client F] per the BSP (Behavior Support Plan) however [client F] refused to move from the table. It is also noted that [client F] is physically able to get up from the table on her own if she so desires. The allegation is not substantiated." The report indicated in the Recommendations section, "Staff</p>			

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	<p>training for [staff #10] on [client F's] BSP including strategies to engage her. Also re-training on active treatment."</p> <p>The investigation did not include interviews or attempted interviews with clients A, B, C, D and E. The investigation did not include a review of staff #10's employee file. The investigation was not thorough.</p> <p>On 7/1/15 at 8:52 AM, a review of staff #10's employee file was conducted and indicated the following:</p> <ul style="list-style-type: none"> <li>-12/4/09 - indicated first written warning due to using inappropriate tone of voice with the client she was working with - indicated same issue addressed on 11/14/09 with little to no progress</li> <li>-On 12/15/09 staff #10 received an Employee Warning. The form indicated staff #10 was insubordinate due to failing to take a comforter out of a client's room with feces on it, as directed.</li> <li>-On 12/5/09 staff #10 received an Employee Warning for using an inappropriate tone of voice with a client (client not indicated). The form indicated, "House manager has addressed this to her on 11/14/09 with little to no progress. It was also dicused (sic) on</li> </ul>			

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	<p>11/30/09 with her consumers (sic) behavior specialist...."</p> <p>-On 1/6/10 staff #10 received an Employee Warning for using an inappropriate tone with a client (client not indicated).</p> <p>-On 8/10/10 staff #10 received an Employee Warning Notice for failing to administer, but documenting she had administered, a client's medication on 8/2/10 and 8/4/10. The form indicated staff #10 also failed to administer another client his medication on 8/2/10.</p> <p>-On 3/12/12 staff #10 committed a medication error. She gave two doses of Levothyroxine to client A. Staff #10 received a Performance Review on 3/13/12.</p> <p>-On 3/17/12 staff #10 committed a medication error. She gave ½ dose of Doc-Q-Lace to client D. Staff #10 received a Performance Review on 3/30/12.</p> <p>-On 6/30/12 staff #10 committed a medication error. Staff #10 gave two doses of Loratadine to a former client. Staff #10 received an Employee Warning Notice on 7/6/12.</p> <p>-On 10/31/12 staff #10 was given a</p>						

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	<p>Performance Review. The documentation indicated, "[Staff #10] did not follow dining plan of [client A] resulting in [client A] choking. Heimlich maneuver had to be used due to this."</p> <p>-On 1/31/13 staff #10 was given a Performance Review for insubordination for failing to assist client C as instructed. The form indicated, "After training [staff #10] on Hoyer lift for [client C] she was told to use lift to put [client C] to bed that evening with [name of staff]. This was not done as asked by [name of former Program Director and House Manager]."</p> <p>-On 6/3/13 - signed off on a buddy check for medications but there was an error she did not catch. Performance review dated 6/17/13.</p> <p>-On 6/6/14 staff #10 burned a hamburger during the overnight shift causing fire alarm to go off requiring an evacuation of the home. Staff #10 received a Performance Review on 7/23/14.</p> <p>On 7/1/15 at 2:02 PM, staff #4 indicated when staff #10 arrived for her shift, client F was at the dining room table. Staff #4 indicated she told staff #10 to keep prompting client F to go to bed. Staff #10 indicated when she arrived the next</p>			

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	<p>morning, client F was still at the table. Staff #4 indicated staff #10 told her she prompted client F every 15-30 minutes but at 2:30 AM she stopped prompting client F. Staff #4 indicated client F would not have continued to sit at the table if staff #10 continued to prompt her as directed. Staff #4 stated, "I don't think she worked with her at all." Staff #4 indicated she thought staff #10 was negligent in her duties. Staff #4 indicated staff #10 allowed client F to sit at the table all night. Staff #4 stated, "that's not right." Staff #4 indicated client A was awake and in the living room when she arrived. Staff #4 indicated client A usually did not get up on the weekends until later in the morning. Staff #4 indicated client D was in the living room. On 6/30/15 at 3:07 PM, the Home Manager (HM) indicated staff #4 reported the incident to her after staff #10 left her shift on 6/7/15. The HM indicated staff #4 reported that client F had been sitting at the table all night and was in the same place as when she left on 6/6/15. The HM indicated staff #4 reported that staff #10 was sitting in the living room watching television when she</p>			

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	<p>arrived. Staff #4 indicated staff #10 told her that she prompted client F however client F did not respond to her prompts. The HM indicated staff #10 had worked at the group home since the incident. The HM indicated she (HM) was not going to allow staff #10 to work during the overnight shift anymore. The HM indicated staff #10 needed to be told how to do things numerous times before she seems to understand the task. The HM stated staff #10 needed to be shown "over and over" how to do something before she understood a task or what was being asked of her. The HM indicated she thought from staff #4's report that staff #10 was negligent due to not assisting the clients. The HM indicated staff #10 did not assist client #10 to the restroom or to her room for bed.</p> <p>On 7/2/15 at 11:52 AM the Group Home Director (GHD) indicated staff #10's supervisor and the investigator should have reviewed staff #10's employee file during the investigation for patterns of issues. The GHD indicated she was not aware if this was completed during the investigation. The GHD indicated the investigator should have interviewed the other clients. The GHD indicated the investigation was not thorough. The</p>			

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W 0156  Bldg. 00	<p>GHD indicated she should have sent the investigation back for additional information including interviews with the other clients. The GHD indicated the facility should conduct thorough investigations.</p> <p>On 7/6/15 at 12:39 PM, the Program Coordinator (PC) indicated she did not review staff #10's employee file until the surveyor requested to review the file during the survey. The PC indicated she did not know how staff #10 was still employed by the agency. The PC indicated since staff #10 was a substitute staff she did not directly supervise staff #10. The PC indicated staff #10 had numerous supervisors during her employment at the agency. The PC indicated staff #10's employee file should have been reviewed during the investigation.</p> <p>This federal tag relates to complaint #IN00175288.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five</p>						

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	<p>working days of the incident.</p> <p>Based on record review and interview for 1 of 15 incident/investigative reports reviewed affecting client F, the facility failed to conduct an investigation within 5 working days of an allegation of abuse.</p> <p>Findings include:</p> <p>On 6/30/15 at 12:25 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: An investigation, dated 6/11/15, indicated, "During a performance action with [former staff #9] she accused [name], the eye doctor of restraining [client F] unnecessary (sic). She (staff #9) was receiving a performance action for being banned from his office due (sic)." The investigation indicated that on 6/11/15 at 8:51 AM, the Behavior Specialist sent an email to the Group Home Director, "The team discussed this appointment in our support team meeting on 5/27/15. In that meeting, [Manager] reported that [name of doctor] office had banned [staff #9] from entering the building in the future, due to her actions during [client F's] appointment on 5/26/15. Apparently, [Manager] had a conversation with staff at [name of doctor] office and the decision to ban her from the office seemed justified. If we need more</p>	W 0156	<p><b>W 156483.420(d)(4) STAFF TREATMENT OF CLIENTS</b></p> <p>Plan of correction: Support team met 7/15/15 to discuss investigation and determined that staff was trained on bsp /hrp and reporting abuse and neglect immediately so administrator could start investigation (attachmenta). House manager has received training on verbally reporting allegations to director (attachment f).</p> <p>Plan of prevention: Facility staff was trained on reporting mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator so investigation can be initiated (attachmenta). Staff f received a written warning and chose to resign from her position with Stone Belt (attachment e).</p> <p>Plan of monitoring: Coordinator / Q will immediately report mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator (attachment b). Coordinator / Q will undergo investigation training (attachment b).</p>	07/15/2015			

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	<p>information about what happened during the appointment, I am certain the physician's office would be able to provide it. In our support team meeting, we also discussed how staff may not be able to restrain clients during appointments (unless there is an immediate risk to health and safety), but physicians and their staff are typically trained on the use of restraint to facilitate client cooperation during appointments. The tone and language of [staff #9] email (sent on 6/10/15 at 5:56 PM) suggests that she had developed some unhealthy and unprofessional relationships with the [name of group home] clients." On 6/11/15 at 9:04 AM, the Nurse Manager indicated in an email to the Group Home Director, "[Behavior Specialist] is exactly right, when it comes to using restraints (whether mechanical or chemical) that is the clinicians (sic) call and they are allowed to do this because they have the training. It is not staff's call whether or not a clinician should be allowed to use restraints (though I do feel that the staff should take mental notes and if they feel that use of restraints was excessive, they should report this through the proper channels and let their supervisors deal with this, not argue with the clinicians)."</p> <p>The Findings of the investigation indicated, "Not substantiated. [Name of</p>			

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	<p>doctor] placed his hand on [client F's] leg in attempt to calm her and to complete a vision exam. She was checked for injuries by [name] (house manager) the day of appointment. Support team met the next day and determined that a restraint wasn't utilized and if was (sic) it was the physicians discretion."</p> <p>On 6/30/15 at 7:11 PM, the Manager forwarded an email she sent to the Group Home Director on 5/26/15 at 1:28 PM. The email to the Group Home Director indicated, "[Staff #9] (Day Aide) ran an appointment this morning with [client F] to [name of doctor] office for her New Patient Examination. The appointment was an appointment that did require [client F] to have PRN (as needed) Diazepam (anxiety) 5 mg (milligrams) (Take 1 tablet 30 minutes prior to appointment, may repeat per [name of doctor]; her PCP (primary care physician) - both tablets had to (sic) administered, 1 prior to appointment and the other during the appointment). There were some issues from this appointment that resulted in me having to go to [name of doctor] office and speak with him, his Assistant, Receptionist and Office Manager personally. Here is what happened... [Staff #9] called me and informed me that [name of doctor] had touched [client F's] shoulders and tried to have her sit</p>			

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	<p>back in the chair and that she [staff #9] informed him not to touch her, and that if he needed her to do anything that [staff #9] would ask her to do it and [staff #9] would be the one to touch her. [Name of doctor] informed her that he would go see another patient so that she could administer the other Diazepam tablet, because only 1 tablet did not seem to effect (sic) her much at all and then he would come back. [Staff #9] administered the other tablet and then she and [name of doctor's] assistant, [name], administered the necessary eye drops into [client F's] eyes, so that [name of doctor] could complete the examination. [Name of doctor] then came back into the room and in his words 'attempted' to examine [client F's] eyes. [Staff #9] says that he was attempting to restrain [client F] in the chair, so that he could get a good look at her eyes and that he was rude with [client F] and [staff #9]. [Staff #9] said that she did inform him that he was not working with [client F] correctly and that she did put herself between him and [client F], so that he could not examine her because she felt as though he was trying to restrain her and not being appropriate with her. She said that she did allow him to complete an examination with her assistance. However, the report that I got from him and his office personnel is that [staff #9]</p>			

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	<p>was very impatient and rude the moment that she came into the office. The Receptionist stated that she wanted to be put in a room right away and told them that they could not sit out in the waiting area like everyone else and wait. The Assistant informed me that she would not allow neither him nor [name of doctor] to do their jobs as they have been trained to do. The Office Manager stated that because of how she was towards the staff there and [name of doctor] that the appointments were behind by at least an hour or more all due to the fact that she would not allow anyone there to do the job that they were trained to do. [Name of doctor] informed me that he has never in the 30+ (plus) years that he has been a Doctor ever had someone come in and act the way that she did; he said that she questioned everything he was doing and tried to tell him how he was supposed to do it even after he informed her that he has been in his line of work for numerous years and has worked with everyone from children to elderly adults and people with disabilities and that he does have several years experience and training; he said that he was only trying to do his job that he has been trained to do and that he was not restraining or harming our client in any way and would never do anything such as that. He informed me that he was able to examine her some, but not as</p>			

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W 0157  Bldg. 00	<p>thoroughly due to the fact that [staff #9] would continuously interfere with everything he was trying to do. He also stated that he does not want [staff #9] assisting any clients with appointments with him; he says that due to her behavior and actions towards him and his staff that she is not welcome back at his office, etc."</p> <p>The incident occurred on 5/26/15. The investigation was completed on 6/11/15. The investigation was not completed timely.</p> <p>On 7/2/15 at 11:52 AM, the Group Home Director (GHD) indicated the timeframe for completing investigations was 5 working days. The GHD indicated the investigation should have been completed within 5 working days.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 15 incident/investigative reports reviewed affecting client F, the facility failed to take appropriate corrective action to address an allegation of neglect by failing to retrain staff #10, increase the</p>	W 0157	<p><b>W 157483.420(d)(4) STAFF TREATMENT OF CLIENTS</b></p> <p><b>Plan of correction: Staff #10 has received a performance action for failure to care for client f (attachment k).</b></p>	07/15/2015			

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	<p>supervision of staff #10 and increase the supervision of the night shift staff.</p> <p>Findings include:</p> <p>On 6/30/15 at 12:25 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 6/7/15 at 8:18 AM, staff #4 reported to the Home Manager that when she left her shift on 6/6/15 at 9:30 PM, staff #10 (substitute staff) was assisting/prompting client F to go to bed. When staff #4 returned to the home the next morning at 6:00 AM, client F was sitting at the table where she was the night before. Staff #10 was sitting in the living room watching television. The Stone Belt ARC, Inc. Incident Report indicated, "[Staff #10] told me that [client F] didn't get up from the dining room table the whole night. [Staff #10] said that she did try to prompt [client F] every few minutes or so to get up and go to bed, but then stated to me that she started thinking and thought 'What's the point? she gets up early anyways'; and she did not prompt [client F] again. She instead just let her continue to sit at the dining room table in the same spot for the rest of the night. I noticed that not only did [client F] sit in the chair all night without staff assisting her to her bed, but the other clients were not being assisted</p>		<p><b>Plan of prevention: Support team discussed client f needs and revised her bsp to provide staff support. Facility has hired a skills development clinician to receive enhanced training to provide client f the level of training and care that she currently requires (attachment m).</b></p> <p><b>Plan of monitoring: Staff #10 is a sub that will be observed during each shift she works by her supervisor, who has been trained to provide enhanced supervision on staff #10 (attachment l).</b></p>	

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	<p>as well due to [staff #10] just sitting and watching TV." The report indicated, "[Client F] was left in a dining room chair at the dining room table all night long, from 9:30 PM until after 6 AM, without being assisted to the restroom or to her bedroom."</p> <p>The investigation, dated 6/10/15, indicated, in part, "The purpose of this investigation is to determine if staff neglected [client F] during the overnight shift beginning at approximately 9:30pm Saturday, June 6th (2015) and ending at approximately 6:30am Sunday, June 7th (2015) when she remained at the kitchen table for the overnight shift. [Staff #10] was asked to recall the incident that occurred on June 6th into June 7th at [name of group home]. [Staff #10] reported that when she arrived at [name of group home] at approximately 9pm staff [staff #4] advised that [client F] was still up and had been prompted to go to bed but refused. [Staff #10] stated [client F] was sitting at the kitchen table and refused to move. [Staff #10] reported that she prompted [client F] every 15-30 minutes to go to bed but stopped asking at approximately 4am as that is the time that [client F] typically wakes up and begins breakfast. [Staff #10] reported that she gave her breakfast and [client F] continued to sit at the table and eat until</p>			

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	<p>[staff #4] arrived at approximately 6:20am. While this was happening during the overnight shift, [staff #10] indicated that she emptied the trash, cleaned the bathrooms, did laundry, and mopped. She reported that other clients were in bed with the exception of one individual getting up to use the bathroom. Interviewer asked [staff #10] if she felt she could have done anything differently and she responded no, she prompted [client F] but she refused. [Staff #10] stated she wanted [client F] to stay on her routine so (sic) fed her breakfast at 4am per their usual schedule.</p> <p>[Staff #4] was asked to recall the incident that occurred on the night of June 6th overnight into June 7th at [name of group home]. [Staff #4] reported that she was evening staff and [client F] refused to go to bed that night. She stated that when [staff #10] arrived at 9pm [staff #4] asked [staff #10] to attempt to get [client F] to go to bed, and that [staff #10] attempted one time while [staff #4] was still in the house, leaving at approximately 9:30pm. [Staff #4] reports that when she returned to the home at 6am, [client F] was in the same place at the table and [staff #10] walked in from the living room. [Staff #4] reports that [staff #10] stated that she prompted until 2:30am and then felt it was pointless because [client F] would be</p>			

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	<p>getting up soon anyway (referencing her daily routine of breakfast around 4am). [Staff #4] reports that two clients were up when she arrived but one who has typically started a shower by that time was not up. [Staff #4] gave medications to [client F] as she was eating breakfast and then assisted her into the bathroom and to bed to lie down. [Staff #4] reports that a typical response to a refusal by [client F] is to prompt every 15 minutes until she complies."</p> <p>The report indicated, "Human Rights Policy of Stone Belt prohibits neglect, outlined as follows: Neglect: Any action or behavioral interventions that risks the physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to:</p> <ol style="list-style-type: none"> <li>1. Failure to provide a safe, clean and sanitary environment.</li> <li>2. Failure to provide appropriate supervision, care, or training.</li> <li>3. Failure to provide food and medical services as needed.</li> <li>4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan.</li> </ol>			

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	<p>There is not evidence to support the allegation that [staff #10] neglected client [F] during the overnight shift starting Saturday, June 6th into Sunday, June 7th. The reports of [staff #10] and [staff #4] contain conflicting information, and [staff #4] was not present to directly witness what occurred between 9:30pm and 6am. [Staff #10] reports that she did prompt [client F] per the BSP (Behavior Support Plan) however [client F] refused to move from the table. It is also noted that [client F] is physically able to get up from the table on her own if she so desires. The allegation is not substantiated." The report indicated in the Recommendations section, "Staff training for [staff #10] on [client F's] BSP including strategies to engage her. Also re-training on active treatment."</p> <p>There was no documentation presented during the survey to indicate staff #10 was retrained on client F's BSP and active treatment. This information was requested by email from the Group Home Director on 7/1/15 at 2:20 PM. There was no documentation the facility increased the supervision of staff #10. There was no documentation the facility increased the supervision of the overnight shift.</p> <p>On 7/3/15 at 9:05 AM, an email from the</p>			

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W 0186	<p>Group Home Manager indicated, in part, "No, the supervision of the night shift staff was not increased due to the fact that none of the night shift house staff have had issues with [client F] going to bed and it was only [staff #10] (who is not a house staff) that had the issue."</p> <p>On 7/1/15 at 8:52 AM, a review of staff #10's employee file was conducted and indicated there was no documentation the facility retrained the staff on client F's BSP and active treatment.</p> <p>On 7/6/15 at 12:37 PM, the Program Coordinator (PC) indicated the supervision of staff #10 had increased however there was no documentation of the increased supervision being conducted. The PC indicated the supervision of the overnight staff at the group home had not increased since staff #10 had not worked at the group home during the overnight shift since the incident.</p> <p>This federal tag relates to complaint #IN00175288.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2)</p>			

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Bldg. 00	<p><b>DIRECT CARE STAFF</b></p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to provide sufficient staffing during the overnight shift to manage and supervise the clients in accordance to their individual program plans.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 7/1/15 at 9:19 AM. Client A's Individual Support Plan (ISP), dated 5/8/15, indicated she used a wheelchair for ambulation.</p> <p>A review of client B's record was conducted on 7/1/15 at 10:21 AM. Client B's ISP, dated 4/15/15, indicated she was blind and had a plan to increase her participate in evacuation drills.</p> <p>A review of client C's record was conducted on 7/6/15 at 12:52 PM. Client C's ISP, dated 9/3/14, indicated client C required physical assistance with most</p>	W 0186	<p><b>W 186483.430(d)(1-2) DIRECT CARE STAFF</b></p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Plan of correction: Facility has reviewed drills and behavior tracking and determined that client f evacuations and current level of care has resulted in the need for a second overnight staff and a skills development staff during awake hours(attachment m).</p> <p>Plan of prevention: Facility HR director emailed regarding the needs to hire overnight staff to ensure safety (attachment n).</p> <p>Plan of monitoring: Facility coordinator / Q received training on assessing clients needs and devising schedules and plans to teach and ensure safety of clients(attachment b).</p>	08/03/2015

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	<p>daily living skills due to spina bifida (a birth defect in which a developing baby's spinal cord fails to develop properly) and using an electric wheelchair.</p> <p>A review of client D's record was conducted on 7/6/15 at 12:56 PM. Client D's ISP, dated 3/17/15, indicated she required 24 hour supervision and supports. Client D's Medication Information Sheet (MIS), dated 6/25/15, indicated client D used a wheelchair, hospital bed with side rails and a gait belt.</p> <p>A review of client E's record was conducted on 7/6/15 at 1:00 PM. Client E's ISP, dated 7/16/14, indicated client E moved quickly and had demonstrated possible risk for elopement. Client E's MIS, dated 6/25/15, indicated she had bilateral knee braces for better balance and steadier gait when walking.</p> <p>A review of client F's record was conducted on 7/1/15 at 10:57 AM. Client F's ISP, dated 5/10/15, indicated she used a wheelchair for ambulation as needed and had a training objective to increase her participation in evacuation drills.</p> <p>On 6/30/15 at 1:17 PM a review of the facility evacuation drills was conducted and indicated the following:</p>			

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	<p>-On 6/9/15 at 3:45 AM a fire drill was conducted at the facility. The drill took 3 minutes and 45 seconds to complete with one staff.</p> <p>-On 6/29/15 at 2:45 AM a fire drill was conducted at the facility. The drill took 11 minutes and 12 seconds to complete with one staff. The drill form indicated, "It took awhile to get [client F] out of bed and moving, but she did follow prompts. Just took her time on them." There was no documentation of corrective action taken. There was no documentation of additional staff being added to the overnight shift (10:00 PM to 6:00 AM).</p> <p>On 7/2/15 at 1:15 PM, the Nurse Manager (NM) indicated one staff was not sufficient due to the needs of the clients during the overnight shift. The NM indicated client A utilized a wheelchair for ambulation, client B was blind, client C used a wheelchair for ambulation, client D used a wheelchair for ambulation, client E's gait was unsteady and client F was blind and ambulated slowly.</p> <p>On 7/1/15 at 1:42 PM, the Group Home Director (GHD) indicated the group home was going to have staff stay until 12:00 AM and another staff come in at 5:00 AM. The GHD stated, when asked if one staff during the overnight shift was</p>			

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	<p>sufficient, "Still sorting it out and need to hold additional drills. The team needs to discuss. The drills look okay. Thought they did more drills than one during the overnight shift (since client F moved in)." The GHD indicated the group home needed to hold additional evacuation drills. The GHD stated the group home was "trying to figure it out. Had a position (for the overnight shift) posted. Might have used (the staffing hours) for [client F] during the day." The GHD indicated she had a conversation with the Manager and Program Coordinator (PC) and they thought one staff was not sufficient. The GHD indicated the PC and Manager could decide how to use the staffing hours.</p> <p>On 7/1/15 at 2:02 PM, staff #4 indicated since client F moved in, one staff was not sufficient during the overnight shift. Staff #4 stated the overnight shift needed to have two staff "for safety."</p> <p>On 7/6/15 at 12:28 PM, the Program Coordinator (PC) indicated the facility had two overnight (10:00 PM to 6:00 AM) staff during the overnight shift after client F for about 30 days until the second overnight staff quit. The PC indicated the staffing level at the group home during the overnight shift was assessed and determined to be two staff.</p>			

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W 0227 Bldg. 00	<p>The PC indicated the facility was not currently staffed with two staff. The PC indicated the facility was trying to fill the overnight shift with a second staff. The PC indicated two staff were needed due to the needs of the clients. The PC indicated clients B and F were blind and both were resistant to evacuation drills. The PC indicated client F could ambulate but slowly; client F had a wheelchair to use as needed. The PC indicated client E was ambulatory but had issues with falls in the past. The PC indicated client A used a wheelchair and required total assistance. The PC indicated client C needed total assistance to transfer from her bed to her wheelchair using a slide board. The PC indicated client D required total assistance to transfer from her bed to her wheelchair.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>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 (F), the facility failed to ensure client F had a plan to encourage her to</p>	W 0227	<p><b>W 227483.440(c)(4) INDIVIDUAL PROGRAM PLAN</b></p> <p>Plan of correction: Client f assessment reviewed and</p>	07/15/2015

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	<p>keep her head elevated during meals.</p> <p>Findings include:</p> <p>On 6/30/15 from 11:23 AM to 12:18 PM, an observation was conducted at the facility-operated day program. At 11:31 AM, client F was eating her lunch (sandwich) in the cafeteria. Client F's chin was next to her chest and her head was at a 90 degree angle to her body. During lunch, client F was not prompted to lift her head while eating. Client F continued to eat and drink with her head at a 90 degree angle to her torso until 12:03 PM when she finished her lunch.</p> <p>On 6/30/15 at 11:42 AM, day program staff #1 indicated client F did not have a plan to encourage her to lift her head up during meals. Staff #1 indicated client F would lift her head when prompted. Staff #1 did not prompt client F to lift her head up while eating. Staff #1 indicated client F started eating her lunch at 11:00 AM.</p> <p>On 6/30/15 at 11:42 AM, day program staff #2 indicated client F did not have a plan to encourage her to lift her head up during meals. Staff #2 indicated client F would lift her head when prompted. Staff #2 did not prompt client F to lift her head up while eating.</p>		<p>training plan with objectives meeting her needs introduced (attachment n). Plan of prevention: Coordinator / q trained on identifying client needs by comprehensive assessment and creating objectives to meet these identified needs (attachment b). Plan of monitoring: Support team meets monthly to review assessments and plans to ensure they are suitable and relevant. Director will provide monitoring of plans. Internal audits will be completed quarterly by peers to review assessments and plans to provide additional monitoring (attachment o).</p>				

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	<p>On 6/30/15 from 3:53 PM to 6:04 PM an observation was conducted at the group home. At 5:46 PM, client F was seated at the dining room table for dinner. Client F's head was down and she was not prompted to lift her head during dinner.</p> <p>On 7/1/15 from 5:56 AM to 7:59 AM an observation was conducted at the group home. At 6:19 AM client F was sitting at the dining room table for breakfast. During breakfast, which client F refused to eat, client F sat at the dining room table with her head down with her chin on her chest. Client F was not prompted to lift her head.</p> <p>On 7/1/15 at 6:38 AM, the Manager indicated client F had an occupational/physical therapy (OT/PT) evaluation which was sent to client F's primary care physician (PCP) for review. The Manager indicated the evaluation recommended the use of a neck brace. The Manager indicated the group home was waiting for the PCP to sign off on the OT/PT recommendation. The Manager indicated client F would lift her head when prompted. The Manager indicated there was no plan in place to address the positioning of her head during meals. The Manager indicated client F needed a plan to address lifting her head during meals.</p>			

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	<p>On 7/2/15 at 1:15 PM, the Nurse Manager (NM) indicated the staff should prompt client F to keep her head up during meals. The NM indicated the OT/PT recommended a neck brace. The NM indicated without the brace, client F could not lift her head past a certain angle. The NM indicated the staff should encourage client F to lift her head up. The NM indicated client F needed a plan.</p> <p>On 7/1/15 at 10:57 AM a review of client F's record was conducted. There was no documentation in client F's 5/10/15 Individual Support Plan and 4/10/15 Behavior Support Plan addressing her positioning during meals. Client F's Program Assessment, dated 4/24/15, did not address the positioning of her head during meals. An OT/PT assessment, dated 6/8/15, indicated, in part, "Strongly recommend daily PROM/AAROM (passive range of motion/active-assistive range of motion) to neck. Recommend neck ext (extension) brace but unclear if pt (patient) will tolerate it."</p> <p>On 7/6/15 at 12:33 PM, the Program Coordinator (PC) indicated the facility was developing a plan for client F to keep her head up. The PC indicated client F needed a plan. The PC indicated client F will raise her head when prompted by the</p>			

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W 0449 Bldg. 00	<p>staff. The PC indicated client F's plan needed to include the staff prompting her to keep her head up.</p> <p>9-3-4(a)</p> <p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills and take corrective action.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to take appropriate corrective action to address issues noted during an evacuation drill.</p> <p>Findings include:</p> <p>On 6/30/15 at 1:17 PM a review of the facility's evacuation drills was conducted and indicated the following:</p> <p>-On 6/9/15 at 3:45 AM a fire drill was conducted at the facility. The drill took 3 minutes and 45 seconds to complete with two staff.</p> <p>-On 6/29/15 at 2:45 AM a fire drill was conducted at the facility. The drill took 11 minutes and 12 seconds to complete with one staff. The drill form indicated, "It took awhile to get [client F] out of bed and moving, but she did follow prompts. Just took her time on them." There was</p>	W 0449	<p><b>W 449483.470(i)(2)(iv) EVACUATION DRILLS</b></p> <p>Plan of correction: Facility drill was completed and scanned into Fortis demonstrating successful overnight evacuation (attachment g). Objective introduced to train client to evacuate in timely manner.</p> <p>Plan of prevention: House manager will ensure that drills are completed quarterly for each shift of personnel within guidelines and report problems with evacuation promptly to coordinator (attachment h).</p> <p>Plan of monitoring : Coordinator / Q will ensure monitor and ensure that drills are completed with no problems each quarter for each shift and personnel. If problems are noted they will be investigated and a plan devised (attachment b).</p>	08/03/2015

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W 0488	<p>no documentation of corrective action taken. There was no documentation of additional staff being added to the overnight shift (10:00 PM to 6:00 AM). There was no documentation additional drills were conducted.</p> <p>On 7/2/15 at 11:52 AM, the Group Home Director (GHD) stated, "the drills look alright. They all have a plan for evacuation." The GHD indicated the home needed to have additional drills. The GHD stated the home was "still sorting it out and need to hold additional drills. The team needs to discuss. The drills look okay. Thought they did more drills than one during the overnight shift (since client F moved in on 4/2/15)."</p> <p>On 7/6/15 at 12:36 PM, the Program Coordinator (PC) indicated the facility did not hold additional drills during the overnight shift following the drill on 6/29/15. The PC indicated additional drills needed to be held. The PC indicated there was no corrective action taken to address the drill on 6/29/15. The PC indicated the targeted time for conducting drills was 3 minutes or less.</p> <p>9-3-7(a)</p> <p>483.480(d)(4)</p>				

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Bldg. 00	<p><b>DINING AREAS AND SERVICE</b></p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to ensure the clients served themselves and client A assisted with preparing her pureed food.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 6/30/15 from 3:53 PM to 6:04 PM. At 4:32 PM, client B was given a cup of water by staff #7. Client B was not prompted to go to the kitchen to get the cup or fill it up. At 5:22 PM, the Home Manager (HM) used the food processor to puree client A's dinner. At 5:46 PM, staff #2 poured client B and F's drinks. At 5:51 PM, staff #7 used client B's rocker knife to cut up banana peppers. Staff #7 served client D cottage cheese. At 5:58 PM when client B finished her first serving of banana peppers, the HM served her more peppers.</p> <p>An observation was conducted at the group home on 7/1/15 from 5:58 AM to 7:59 AM. At 6:19 AM, staff #3 and #8 took plates with food on them to the table for clients A, B, D, E and F. At 6:23 AM, staff #8 put a plate on the table with</p>	W 0488	<p><b>W 488483.480(d)(4) DINING AREAS AND SERVICE</b> Plan of correction: Facility staff were trained on trainingclients on utilizing prescribed adaptive equipment by following plan put into place by coordinator and Q (attachment i). Plan of prevention: House manager will ensure clients plans are being followed per assessed needs of team and physician's' orders. House manager / associate manager will observe each mealtime to monitor (attachment j). Plan of monitoring : Coordinator / Q will ensure monitor and complete weekly observations of facility to ensure plans are appropriate and being followed by staff (attachment b).</p>	07/13/2015			

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W 9999 Bldg. 00	<p>two pieces of toast for client C. At 6:32 AM, client E was given orange juice, thickened, by staff #7. Client E was not involved in getting the cup, pouring the orange juice, adding thickener, stirring and taking the cup to the table. At 6:36 AM, staff #3 was in the kitchen loading the dishwasher. Staff #3 came to the table with a cup and a straw for client F.</p> <p>On 7/1/15 at 1:42 PM, the Group Home Director (GHD) indicated the clients should serve themselves and be involved with pureeing their own food. The GHD indicated client B should use her rocker knife, not the staff. The GHD indicated the clients should serve themselves and assist with clean up.</p> <p>9-3-8(a)</p> <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 Governing Body</p>	W 9999	<p><b>W9999FINAL OBSERVATIONS</b></p> <p><b>W9999</b> Plan of correction: Facility staff trained on documenting and reporting signs of skinbreakdown, reporting any occurrence of skin breakdown related to a decubitusulcer, regardless of severity, immediately and submitting an incident report to nurse and administrator(attachment a).</p>	07/15/2015

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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:</p> <p>14. A significant injury to an individual that includes but is not limited to: f. any occurrence of skin breakdown related to a decubitus ulcer, regardless of severity.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 clients in the sample (client A), the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, for a pressure sore on client A's right elbow.</p> <p>Findings include:</p> <p>On 7/1/15 at 9:19 AM a review of client A's record was conducted. On 4/8/15, client A was seen by a Nurse Practitioner for a "reddened bump on elbow (right)." The Outside Services Report, dated 4/8/15, indicated in the Diagnosis/Results section "Pressure sore (right) elbow."</p> <p>On 6/30/15 at 12:25 PM, a review of the facility's incident/investigative reports was conducted. There was no</p>		<p>Plan of prevention: Facility nurse and house manager will review skin break down tracking weekly and investigate concerns. Facility staff trained to detect and reporting any occurrence of skin breakdown related to a decubitus ulcer, regardless of severity immediately (attachment a)</p> <p>Plan of monitoring: Coordinator / Q will provide continuous education and support to staff regarding decubitus ulcers and reporting immediately (attachment b).</p>		

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	<p>documentation in client A's record indicating the facility reported the pressure sore to BDDS.</p> <p>On 7/2/15 at 11:52 AM the Group Home Director indicated the incident should have been reported to BDDS.</p> <p>9-3-1(b)</p>				