

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G643	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/19/2016
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404
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W 0000  Bldg. 00	<p>This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00182639.</p> <p>Complaint #IN00182639: Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149 and W157.</p> <p>Survey Dates: February 11, 12, 15, 16, 17, 18 and 19, 2016</p> <p>Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/25/16.</p>	W 0000	<p>3/8/16 Stone Belt received a letter from ISDH that stated, "The plan of correction you submitted has been found to be incomplete. The responses to the following items are inadequate or incomplete: W249/W488-A more frequent on site monitoring system is initially needed to ensure compliance. W318/W331/W368-The POC does not specifically state what changes have been made to ensure medications are passed without error. The nurse is responsible for the med administration program. How is the nurse involved in training, teaching, modeling, and monitoring of staff that are making errors?" 3/9/16 Key members of the team met today in response to this letter and generated plans for increased monitoring. That includes documented visits by both the nurse and QIDP. Those POC items listed in the letter from ISDH have been changed to reflect this increase in monitoring. 3/11/16 ISDH wrote the following: "W249 A more frequent monitoring system is initially needed to ensure compliance. The facility has recommended that the QIDP monitor 1 time weekly to ensure compliance. How would monitoring 1 out of 7 days ensure</p>	

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>compliance? The expectation is that onsite monitoring occur at a minimum daily until competence/compliance is attained. Then, if appropriate, monitoring could fade as necessary keeping in mind that some type of routine monitoring is expected. W318 A more frequent monitoring system is initially needed to ensure compliance. The facility has recommended that the nurse monitor one med pass weekly. Has the facility considered having the staff retrained that made the error, then have the nurse watch that staff pass meds until competency is demonstrated. Has the facility investigated to learn if it is the same staff making recurring errors or if a multitude of staff are making the same error or multiple errors? Considering that the facility most likely has 2 med passes per day, recommending that the nurse watch 1 out of 28 med passes per week would not ensure compliance." 3/12/16 Stone Belt is revising the POC to meet these new requests with the following comments/explanations: W249 - proposed monitoring was a minimum of 1 in home and 1 day program monitoring visits per week. We will increase that as instructed. W318 - Staff responsible for medication errors have been retrained extensively and are monitored closely by the nurse. That will be reflected in the revised POC as instructed.</p>	

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W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) the bathroom in the hallway with the clients' bedrooms was in good repair, 2) appropriate corrective actions were implemented, including increased monitoring and supervision of medication administration, to address recurrent issues with medication errors, and 3) appropriate corrective actions were implemented to address two incidents of financial exploitation of the clients' personal funds entrusted to the facility.</p> <p>Findings include:</p>	W 0102	<p>Regarding repeat medication errors, two staff members were determined to be responsible for a large number of errors, including the most problematic errors and non-reporting of those errors. Neither staff member works for the agency at this point.</p> <p><b>W 102 Governing Body And Management(Condition)</b> The facility must ensure that specific governing body and management requirements are met. <b>Corrective action for resident(s) found to have been affected</b> The bathroom in the hallway will be repaired to remedy the issues noted in the survey. In order to reduce medication errors, a new medication summary sheet will be added to the home that simplifies directions for staff. All staff across all shifts will be trained to use this form. The QIDP will be trained on the agency's exploitation policy, including the need to follow-through until each issue is resolved. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in</b></p>	03/20/2016	

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	<p>1) Please refer to W104. For 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) the bathroom in the hallway with the clients' bedrooms was in good repair, 2) appropriate corrective actions were implemented, including increased monitoring and supervision of medication administration, to address recurrent issues with medication errors, and 3) appropriate corrective actions were implemented to address two incidents of financial exploitation of the clients' personal funds entrusted to the facility.</p> <p>2) Please refer to W122. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to implement its policies and procedures to prevent abuse, neglect and exploitation of the clients, ensure staff immediately reported abuse, neglect and exploitation to the administrator, ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conduct thorough investigations of falls with</p>		<p><b>place to ensure no recurrence</b> Repairs will be made; a new form will be used to summarize medication pass requirements and QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director(or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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W 0104	<p>injury, submit the results of an investigation to the administrator within 5 working days and take appropriate corrective actions to address medication errors and financial exploitation of the clients' finances.</p> <p>3) Please refer to W318. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to meet the Condition of Participation: Health Care Services. The facility's Health Care Services failed to implement appropriate corrective actions to address recurrent issues with medication errors. The facility's Health Care Services failed to implement increased monitoring and oversight of the clients' medication administration procedures to ensure staff administered the clients' medications in accordance with their physician's orders.</p> <p>This federal tag relates to complaint #IN00182639.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY</p>			

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Bldg. 00	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) the bathroom in the hallway with the clients' bedrooms was in good repair, 2) appropriate corrective actions were implemented, including increased monitoring and supervision of medication administration, to address recurrent issues with medication errors, and 3) appropriate corrective actions were implemented to address two incidents of financial exploitation of the clients' personal funds entrusted to the facility.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 2/11/16 from 3:43 PM to 5:55 PM and 2/12/16 from 6:03 AM to 8:16 AM. During the observations, there was a 5 inch by 4 inch area on the left side of the sink in the bathroom in the clients' hallway where the drywall was torn and the metal post securing the sink to the wall was exposed. The drywall was peeled off and broken in this area.</p>	W 0104	<p><b>W 104 Governing Body(Standard)</b> The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p><b>Corrective action for resident(s) found to have been affected</b> The bathroom in the hallway will be repaired to remedy the issues noted in the survey. In order to reduce medication errors, a new medication summary sheet will be added to the home that simplifies directions for staff. All staff across all shifts will be trained to use this form. The QIDP will be trained on the agency's exploitation policy, including the need to follow-through until each issue is resolved. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Repairs will be made; a new procedure will be developed for medication error tracking, and QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been</p>	03/20/2016			

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	<p>The area was without paint. The wall just below the sink had peeling paint. There was a 5 inch area below the sink near the toilet where there was a hole in the wall. The trim piece was missing exposing the hole in the wall. The vent cover above the sink was rusted. The caulking surrounding the shower in the bathroom was discolored (brown, black and gray). This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 2/16/16 at 1:59 PM, the Assistant Group Home Director (AGHD) indicated the issues noted with the bathroom at the group home needed to repaired and replaced.</p> <p>2) Please refer to W149. For 21 of 32 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the governing body neglected to implement its policies and procedures to prevent abuse, neglect and exploitation of the clients, ensure staff immediately reported abuse, neglect and exploitation to the administrator, ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conduct thorough investigations of falls with injury, submit the results of an investigation to the administrator within 5 working days and take appropriate</p>		<p>completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director(or designee), and incidents will not be considered closed until all follow-up actions are in place.</p>	

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W 0122	<p>corrective actions to address medication errors and financial exploitation of the clients' finances.</p> <p>3) Please refer to W157. For 11 of 32 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the governing body failed to implement appropriate corrective actions to address medications errors and financial exploitation.</p> <p>4) Please refer to W331. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to ensure the facility's nursing services implemented appropriate corrective actions to address recurrent issues with medication errors. The facility's Health Care Services failed to implement increased monitoring and oversight of the clients' medication administration procedures to ensure staff administered the clients' medications in accordance with their physician's orders.</p> <p>This federal tag relates to complaint #IN00182639.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS</p>						

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Bldg. 00	<p>The facility must ensure that specific client protections requirements are met. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent abuse, neglect and exploitation of the clients, ensure staff immediately reported abuse, neglect and exploitation to the administrator, ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conduct thorough investigations of falls with injury, submit the results of an investigation to the administrator within 5 working days and take appropriate corrective actions to address medication errors and financial exploitation of the clients' finances.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 21 of 32 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent abuse, neglect and exploitation of the clients, ensure staff immediately reported abuse, neglect and exploitation to the administrator, ensure incident reports</p>	W 0122	<p><b>W 122 Client Protections (Condition)</b> The facility must ensure that specific client protections requirements are met. <b>Corrective action for resident(s) found to have been affected</b> In order to reduce medication errors, a new medication summary sheet will be added to the home that simplifies directions for staff. All staff across all shifts will be trained to use this form. The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including the need to follow-through until each issue is resolved. The QIDP will be trained on investigations policy and procedure, including completing the investigation within five business days. Training will be completed with the QIDP and all staff about the need for immediate reporting for allegations of abuse, neglect and exploitation. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and all staff training will be conducted. A new medication summary sheet will be put in place and all staff will be trained <b>How corrective actions will be monitored to</b></p>	03/20/2016

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	<p>were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conduct thorough investigations of falls with injury, submit the results of an investigation to the administrator within 5 working days and take appropriate corrective actions to address medication errors and financial exploitation of the clients' finances.</p> <p>2) Please refer to W153. For 3 of 32 incident reports reviewed affecting client #2, the facility failed to ensure staff immediately reported an allegation of verbal abuse and a medication error resulting in seizure activity to the administrator and submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>3) Please refer to W154. For 2 of 32 incident/investigative reports reviewed affecting client #2, the facility failed to ensure thorough investigations were conducted to address falls with injury requiring medical treatment.</p> <p>4) Please refer to W156. For 1 of 32 incident/investigative reports reviewed affecting client #2, the facility failed to submit the results of an investigation, within 5 working days, to the</p>		<p><b>ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director, and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director(or designee), they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		

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W 0149 Bldg. 00	<p>administrator.</p> <p>5) Please refer to W157. For 11 of 32 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to implement appropriate corrective actions to address medications errors and financial exploitation.</p> <p>This federal tag relates to complaint #IN00182639.</p> <p>9-3-2(a)</p> <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 observation, record review and interview for 21 of 32 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent abuse, neglect and exploitation of the clients, ensure staff immediately reported abuse, neglect and exploitation to the administrator, ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conduct</p>	W 0149	<p><b>W 149 Staff Treatment of Clients (Standard)</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. <b>Corrective action for resident(s) found to have been affected</b> The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including the need to follow-through until each issue is resolved. The QIDP will be trained on investigations policy and procedure, including completing the investigation</p>	03/20/2016
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	<p>thorough investigations of falls with injury, submit the results of an investigation to the administrator within 5 working days and take appropriate corrective actions to address medication errors and financial exploitation of the clients' finances.</p> <p>Findings include:</p> <p>On 2/11/16 at 11:46 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 7/7/15 at 10:00 PM (reported to the administrator on 7/24/15), former staff #12 was verbally abusive to client #2. Staff #12's interview in the 7/28/15 investigation indicated, in part, "[Staff #12] was asked if he recalled a conversation with a staff at [name of group home] during an evening shift when [client #2] needed assistance with changing/emptying his ileostomy (surgical opening to pass waste) pouch, about [client #2] being compared to a fish. [Staff #12] stated that he did in fact recall this conversation and stated that he thought comparing [client #2's] intelligence to a fish was accurate as he only he only (sic) has an IQ of 8. [Staff #12] was asked if he said anything else regarding a fish and/or [client #2] and</p>		<p>within five business days. Training will be conducted with the QIDP and staff about the need for immediate reporting for allegations of abuse, neglect and exploitation. In order to reduce medication errors, a new medication summary sheet will be added to the home that simplifies directions for staff. All staff across all shifts will be trained to use this form. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> A new procedure will be developed for medication error tracking, and QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director(od designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all</p>		

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	<p>[staff #12] stated that [client #2's] memory is comparable to that of a fish due to his low IQ." The Investigation Report indicated, in part, "Substantiated. It has been determined, by interviews and self reporting, that [staff #12] made derogatory and insensitive comments regarding [client #2]. Some alleged statements were while caring for [client #2] and would fall within Stone Belt's definition of emotional/verbal abuse. Pejorative or derogatory terms used to describe persons with disabilities was (sic) used by [staff #12] in regards to [client #2]... [Staff #12's] employment was terminated."</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated the facility had a policy and procedure prohibiting abuse. The Coordinator indicated allegations of abuse should be reported immediately to the administrator.</p> <p>On 2/16/16 at 2:32 PM, the Assistant Group Home Director (AGHD) indicated the facility had a policy and procedure prohibiting abuse. The AGHD indicated allegations of abuse should be reported immediately to the administrator.</p> <p>2) On 9/13/15 at 11:00 AM, staff #2 counted client #6's money. Client #6 was missing \$20.00. The 9/13/15 Stone Belt</p>		documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.	

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	<p>ARC, Inc. Incident Report indicated in the Event section, "Steeling (sic) money from a client."</p> <p>The 9/15/15 Investigation Report indicated, in part, "...There was no receipt or other proof of the money being spent by [client #6]." The investigation indicated, "[Coordinator] reported the money was accounted for during the routine audit the night prior at approx. (approximately) 10 pm. She also stated that [former staff #8] was the only staff having access or knowledge of the money and that the other staff working/training were [another Coordinator in training] and [staff #9]." The investigation indicated staff #8 refused to cooperate during the investigation either by phone or email. Staff #8 did not provide information during the investigation. The Statement of Findings indicated, "Unsubstantiated. \$20 is missing but there is no proof that it was spent and receipt is missing or that money was stolen by staff. [Staff #8] would have been the only staff having access to money." The Recommendations section indicated, "\$20 was reimbursed by agency to client. Coordinator will assure money is no longer kept in the home. Audits will continue. [Staff #8] is no longer employed with Stone Belt due to attendance."</p>			

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	<p>On 2/11/16 at 4:03 PM, a review of the clients' finances was conducted. Clients #2, #3 and #4 had money at the group home.</p> <p>On 2/12/16 at 12:56 PM, the Fiscal Coordinator (FC) indicated client #6 was reimbursed on 9/16/15. The FC indicated when client #6's money came up missing, the former Coordinator pulled all the clients' money (cash) out of the group home. The FC indicated the clients still had access to their funds through the use of debit cards.</p> <p>On 2/11/16 from 3:43 PM to 5:55 PM, an observation was conducted at the group home. During the observation, clients #2, #3 and #4 had personal cash being kept at the group home.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated the former Coordinator brought the clients' funds to the office for a period of time. He was unsure when client #2, #3 and #4's personal cash was returned to the group home. The Coordinator indicated he was unsure how often the clients' personal funds were accounted for by the group home staff. The Coordinator indicated the Group Home Manager counted the clients' funds. The Coordinator indicated there was no</p>			

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	<p>change in the accounting of the clients' funds at the group home. The Coordinator indicated all the staff who worked at the group home continue to have access to the clients' funds.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated she was unsure when client #2, #3, and #4's personal funds were returned to the group home. The AGHD indicated she was unsure how often the clients' funds were accounted for by the group home staff. The AGHD indicated she was unsure if there was a policy to account for the clients' funds. The AGHD stated, "there's got to be a policy." The AGHD indicated there was no increased monitoring of the clients' funds or changes to the system for storing the clients' funds.</p> <p>3) On 11/16/15 at 2:00 PM, client #5 did not receive Clonidine (aggression and agitation) from staff #6. On 11/16/15 at 3:00 PM, client #5 did not receive Risperdal (aggression and agitation) from staff #6. The 11/17/15 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, in part, "This med error was discovered during a buddy check. There is no known effect to [client #5] due to the med error." The 11/16/15 Medication Error Report indicated, "Supervisor: Document action</p>			

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	<p>taken: Verbal discussion/training." There was no documentation staff #6 received training.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>4) On 11/19/15 at 11:30 AM at the facility operated day program, client #6 was preparing to eat his lunch when a peer bumped into him. Client #6 grabbed the peer's shirt and pulled him down. Client #6 pulled the peer's hair.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/16/16 at 2:32 PM, the AGHD</p>						

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	<p>indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>5) On 11/26/15 at 7:00 AM, client #4 did not receive Lisinopril (hypertension) from staff #10. The 11/26/15 Medication Error Report (MER) was blank in the Document Action Taken section. The MER indicated in the training section, "no," in response to whether or not the staff needed additional training. There was no documentation staff #10 received corrective action.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>6) On 12/5/15 at 7:00 AM, client #3 did not receive Levetiracetam</p>			

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	<p>(anticonvulsant) as ordered. Staff #5 administered one tab instead of two tabs to client #3. The 12/5/15 Medication Error Report (MER) was blank in the Document Action Taken section. The MER was blank in the training section in response to whether or not the staff needed additional training. There was no documentation staff #5 received corrective action.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>7) On 12/17/15 at 7:00 PM, staff #6 administered the incorrect dose of Tamsulosin (enlarged prostate) to client #4. Client #4 received one of two caps of the medication. The 12/19/15 BDDS report indicated, "On 12/18/2015, this med error was discovered during a buddy check. Pager was notified. There is no known effect to [client #4] due to this</p>			

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	<p>med error. Staff will be disciplined as per Stone Belt's med error policy." There was no documentation of corrective action with staff #6.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>8) On 12/22/15 at 7:00 AM (reported to BDDS on 1/4/16), client #2 did not receive Depakote Sprinkles (seizures) 1000 mg (milligrams) as ordered. The 1/4/16 BDDS report indicated, "...Although this med was prepared with applesauce, staff did not administer this medication. This med error was discovered on 12/22/2015 when day aide (sic) found the med cup and apple sauce. Nurse was notified with instructions to continue administering medications at 2:00 pm; nurse notified psych (psychiatrist) and neurologist. The effect to [client #2] was that he didn't get his</p>			

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	<p>next dose until 2:00 pm. Staff will be disciplined as per Stone Belt's med error policy." The 12/30/15 Medication Error Report indicated, in part, "Med was in apple sauce and set aside due to staff preparing the med to (sic) soon... Day aide (sic) got back to the house and found the med cup and apple sauce." The Document Action Taken section indicated, "Verbal Discussion/Training."</p> <p>The 1/11/16 Investigation Report indicated in the Brief Summary of the Reason to Investigate section, "There is evidence that medication administration at [name of group home] has not been accurate. There is evidence that Stone Belt medication administration policy has not been followed, resulting in medication errors. Moreover, medication errors have not been reported properly. Due to missed medication and lack of proper reporting, a client was at risk." The Evidence Summary section indicated, "Evidence shows that [client #2] did not receive his morning seizure medication, Depakote on 12/22/15 and 1/4/16 (see below for additional information). On 12/23/15 [client #2] had a seizure that required Diastat medication and to be seen at the emergency room. Staff did not follow medication administration policies as well as incident reporting policies for the</p>			

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	<p>12/22/15 incident. The result of the staff not following policies resulted in [client #2] missing his morning medication on 1/5/16. The result of [client #2] missing his medication was another severe seizure with admission of Diastat and 3 falls at day program." The Investigation Report indicated, "Was Stone Belt medication administration policy followed? NO. Staff that admitted to missing [client #2] morning medication twice, also admitted that he marked that the client HAD received his medication, as he marked it BEFORE actually giving it to the client. Was Stone Belt reporting policy followed? NO. The staff that found the med error, did not report the incident in writing until 12/30/15. The coordinator of the group home, received the medication error IR (incident report) on 12/30/15 but did not submit until 1/4/16. The coordinator requested that the IR be sent to the proper staff via email, however there was no follow up. Did the lack of proper medication administration and medication error reporting lead to a client having a medical injury? YES. [Client #2] has (sic) severe seizures following both days that he missed his morning medication, Depakote (he takes to control his seizures). The incident on 12/22/15, if properly reported, could have prevented the incident on 1/5/16." The</p>			

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	<p>investigation's Recommended Corrective Action(s) section indicated, "Staff to be re-trained on medication administration. Staff to be re-trained on reporting incidents. Staff to be trained on Prevention of Abuse and Neglect."</p> <p>The Investigation Report included the following timeline, in part:</p> <ul style="list-style-type: none"> <li>-12/22/15 [Staff #10] does not administer [client #2's] morning medication 1,000 mg Depakote. He signs that medication was administered.</li> <li>-12/22 [Staff #4] found medication, informed nurse and day program coordinator. She did not submit IR.</li> <li>-12/23 [Client #2] has severe seizure, needed Diastat medication and went to ER (emergency room).</li> <li>-Day program staff wrote IR for this incident and submitted it.</li> <li>-12/28 Day program coordinator, [name] spoke to [Group Home Coordinator] about recent incident of seizure activity in light of the missed medication. [Day Program Coordinator] asked about an IR for the missed meds.</li> <li>-12/29 [Group Home Coordinator] requests [staff #4] write IR for 12/22 missed medication incident and send to IR meds, as well as [former Group Home Director] and himself.</li> <li>-12/30 [Staff #4] wrote med error IR and sent to [Group Home Coordinator] and</li> </ul>			

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	<p>[Group Home Director]. NOT IR email. -1/4/16 IR was routed to [Administrative Assistant] who filed it with the state.</p> <p>The investigation indicated in the Disposition of the Investigation section, "For Allegations of Abuse, Neglect, or Exploitation (A/N/E), the allegation has been: Substantiated."</p> <p>On 2/16/16 at 1:03 PM, the AGHD provided a copy of staff #10's Performance Review. The review indicated, in part, "[Staff #10] failed to admin (administer) [client #2's] Depakote. Investigation is located in CIR (Confidential Incident Report). [Staff #10] will be required to complete Core A and B (facility's medication training program)." The Performance Review was dated 1/4/16 at the top of the form and staff #10 signed the form on 1/15/16.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's Seizure Tracking Log for December 2015 was reviewed. Client #2 had two seizures on 12/22/15. The first seizure was at 11:25 AM for 45 seconds. The second seizure was at 12:00 PM for 45 seconds. Client #2 had a 23 minute seizure on 12/23/15 at 1:00 PM.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 12/22/15 Nursing Consultation</p>			

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	<p>note indicated, in part, "Call received by nurse from day aide (sic) (11:45 AM) stating that [client #2] was not given his 7am medication by staff (which included medications for seizures and agitation). Day aide (sic) asking whether or not she can give [client #2's] 7am meds at day program and push back other med times. Nurse directed day aide (sic) to give [client #2] all of his 7am meds with the exception of his Depakote (seizures) and Carnitor (Carnitor is a naturally occurring substance that the cells of mammals need to produce energy. Carnitor is used to treat carnitine deficiency) since she receives these two meds three times daily and the next time to receive these is at 2pm (times too close together to spread out). Day aide (sic) verbalized understanding of directives. LL (Life Long Learning) Coordinator notified of missed medications, LL Coordinator states that day staff have not seen any seizure activity or unusual behaviors from [client #2] today. Nurse notified Coordinator of plan for [client #2] to receive all AM meds except for Depakote and Carnitor, Coordinator directed by nurse to give [client #2] these two meds at next scheduled time (2pm) as well as to continue to monitor [client #2] for any seizure activity - Coordinator verbalized understanding of directives. [Psychiatrist] and [Neurologist] notified</p>			

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	<p>by nurse of missed medications."</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 12/23/15 Outside Services Report indicated he was seen at the emergency room on 12/23/15 due to seizure activity.</p> <p>The facility failed to ensure the BDDS report was submitted within 24 hours. The facility failed to ensure the administrator was notified immediately regarding the incident.</p> <p>The facility failed to implement appropriate corrective action with staff #10 in a timely manner. There was no documentation staff #10 was retrained on Core A and B.</p> <p>There was no documentation of increased monitoring or oversight of the medication administration passes to the clients.</p> <p>On 2/11/16 at 2:41 PM, HR staff #1 provided a screen capture of staff #10's electronic employee file. The Status indicated, "Terminated 1/15/16." The Notes section indicated, "Substiated (sic) neglect."</p> <p>On 2/12/16 at 6:47 AM, staff #4 indicated on 12/22/15 she discovered client #2's medication (Depakote) in a</p>			

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	<p>cup of applesauce in the medication room. Staff #4 indicated client #2 had a seizure on 12/22/15 due to the missed medication. Staff #4 indicated staff #10 was terminated. Staff #4 indicated the group home staff received retraining on medication administration and the Nurse Manager observed all the staff administer medications during one medication pass.</p> <p>On 2/12/16 at 2:54 PM, the Nurse Manager (NM) stated he was "99% sure" client #2's seizure on 12/23/15 was related to missing his seizure medication on 12/22/15. On 2/16/16 at 11:38 AM, the NM indicated the staff should administer client #2's medication as prescribed by the physician. The NM indicated he observed two staff administer medications one time. The NM indicated he was not sure if the group home administrative staff increased the monitoring and supervision of medication administration. The NM indicated the facility should have increased the monitoring of medication administration to the clients.</p> <p>On 2/16/16 at 2:03 PM, the AGHD indicated the facility should ensure client #2's medications were administered as prescribed by his physicians. The AGHD indicated the facility suspended staff #10 after the 1/5/16 medication error to client</p>			

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	<p>#2 (see below), investigated the incident, and retrained staff on medication administration and reporting. The AGHD stated the corrective action was "not sufficient." The AGHD stated we, "need to do more." The AGHD indicated the staff should have immediately reported the incident to the administrator. The AGHD indicated the timeframe for reporting incidents to BDDS was 24 hours. The AGHD indicated the timeframe for submitting the results of investigations to the administrator was 5 working days.</p> <p>9) On 12/23/15 at 12:20 PM at the facility operated day program, client #2 had a seizure. After three minutes of continuous seizures, his PRN (as needed medication) was administered. Client #2 made brief eye contact after the as needed medication was administered. Client #2 continued to have tremors. Staff contacted the nurse. The plan was to monitor and if he continued to have seizures after the 30 minute mark, staff was to contact 911. At the 27 minute mark, client #2 made eye contact with staff. Shortly after the 30 minute mark, client #2 had another seizure. The nurse was contacted and 911 was called. Client #2 was transported to the emergency room (ER).</p>			

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	<p>On 2/16/16 at 11:22 AM, a review of client #2's 12/23/15 Nursing Consultation notes indicated, in part, "Call received by nurse from LL coordinator (12:35p) stating that [client #2] has been having seizure activity for the past 15 minutes, with the longest seizure being over 3 minutes. Per risk plan protocol coordinator stated [client #2] was given Diastat. Coordinator stated that [client #2] is currently on the floor and experiencing slight 'jerks' in the shoulder region, in able to respond to staff but is lethargic and has a 'dazed' look on his face. Coordinator also stated that at no time did [client #2] fall. Nurse directed coordinator to continue to monitor status, that the Diastat would make [client #2] a bit lethargic, and that if [client #2] experiences any more seizure activity over the next 10 minutes then he will need to go to the ER per risk plan for eval/tx (evaluation/treatment) - coordinator verbalized understanding of directives."</p> <p>A second Nursing Consultation note, dated 12/23/15 at 12:50 PM, indicated, "Nurse contacted LL coordinator to f/u (follow up) on [client #2's] current status, coordinator stated that [client #2] had returned to baseline, was lying on a mat playing with his rope and was responding to staff appropriately. Nurse directed</p>			

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	<p>coordinator to continue to monitor [client #2's] status and if seizure activity reoccurs to contact nurse immediately for further directives."</p> <p>A third Nursing Consultation note, dated 12/23/15 at 1:00 PM, indicated, "Call received by nurse from LL coordinator stating that [client #2] had resumed seizure activity, per risk plan nurse directed coordinator to call 911 and have [client #2] transported to the ER for treatment and eval."</p> <p>Client #2's 12/24/15 Nursing Consultation note indicated, "Nurse contacted house staff to f/u (follow up) on ER visit the previous afternoon/evening. Staff state that [client #2] is doing well, no adverse effects noted from seizure activity the previous day - no specific directives from the ER other than to f/u with his neurologist (name). Staff directed to call nurse/nurse pager if [client #2] starts experiencing continuous seizure activity again, staff verbalized understanding of directives."</p> <p>On 2/12/16 at 2:54 PM, the Nurse Manager (NM) stated he was "99% sure" client #2's seizure on 12/23/15 was related to missing his seizure medication on 12/22/15. On 2/16/16 at 11:54 AM, the NM indicated he was in</p>			

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	<p>communication with the LL Coordinator during client #2's seizure activity. The NM indicated client #2 had a seizure, returned to baseline and then had another seizure. The NM indicated he instructed the day program staff to call 911. The NM indicated none of the seizures lasted more than 5 minutes. The NM indicated client #2's plan indicated for staff to call 911 for any seizure activity lasting more than 5 minutes. The NM indicated since client #2 had continuous seizure activity, he directed the staff to call 911.</p> <p>10) On 12/29/15 at 11:54 AM at the facility operated day program, a peer at the day program "stomped" on client #2's foot without warning. The peer indicated, "Gotcha!" after stomping on client #2's foot. Client #2 was not injured.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AGHD</p>			

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	<p>indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>11) On 1/2/16, 1/3/16 and 1/4/16 during client #1's bedtime medication administration, staff #6 and #10 administered client #1 the wrong dose of is Levothyroxine (low thyroid). The 1/5/16 BDDS report indicated, in part, "...Physician's order is for [client #1] to be administered Levothyroxine 50 mcg (microgram) on Thursdays and Fridays only. However, this medication was given on Saturday, Sunday and Monday evenings. On 01/04/2016, this med error was found during a buddy check at HS (hour of sleep). There was no observable effect to [client #1] due to this med error." The BDDS report indicated, "Staff will be disciplined as per Stone Belt's med error policy." The 1/4/16 Medication Error Report was blank in the Document Action Taken section for corrective actions. There was no documentation staff #6 and #10 received corrective action.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective</p>						

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	<p>action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>12) On 1/5/16 at 7:15 AM, staff #10 did not administer client #2's Depakote Sprinkles 1000 mg (seizures) as ordered. The 1/6/16 BDDS report indicated, in part, "...This med error was discovered when staff found all meds in the applesauce in [client #2's] room. Nurse and client support Coordinator notified. The effect to [client #2] was seizures after noon and he was administered Diastat. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>On 1/5/16 at 9:30 AM at the facility operated day program, client #2 stepped backward and tripped. He fell backwards and hit the right side of his head.</p> <p>On 1/5/16 at 1:15 PM at the facility operated day program, client #2 was sitting in the hallway. Client #2 had a seizure, fell over and hit his head.</p> <p>On 1/5/16 at 2:10 PM at the facility operated day program, client #2 had a seizure, fell over and hit his head. Client</p>				

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	<p>#2 landed on his side and hit the back part of his head.</p> <p>The 1/11/16 Investigation Report indicated in the Brief Summary of the Reason to Investigate section, "There is evidence that medication administration at [name of group home] has not been accurate. There is evidence that Stone Belt medication administration policy has not been followed, resulting in medication errors. Moreover, medication errors have not been reported properly. Due to missed medication and lack of proper reporting, a client was at risk." The Evidence Summary section indicated, "Evidence shows that [client #2] did not receive his morning seizure medication, Depakote on 12/22/15 and 1/4/16 (see below for additional information). On 12/23/15 [client #2] had a seizure that required Diastat medication and to be seen at the emergency room. Staff did not follow medication administration policies as well as incident reporting policies for the 12/22/15 incident. The result of the staff not following policies resulted in [client #2] missing his morning medication on 1/5/16. The result of [client #2] missing his medication was another severe seizure with admission of Diastat and 3 falls at day program." The Investigation Report indicated, "Was Stone Belt</p>			

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	<p>medication administration policy followed? NO. Staff that admitted to missing [client #2] morning medication twice, also admitted that he marked that the client HAD received his medication, as he marked it BEFORE actually giving it to the client. Was Stone Belt reporting policy followed? NO. The staff that found the med error, did not report the incident in writing until 12/30/15. The coordinator of the group home, received the medication error IR (incident report) on 12/30/15 but did not submit until 1/4/16. The coordinator requested that the IR be sent to the proper staff via email, however there was no follow up. Did the lack of proper medication administration and medication error reporting lead to a client having a medical injury? YES. [Client #2] has (sic) severe seizures following both days that he missed his morning medication, Depakote (he takes to control his seizures). The incident on 12/22/15, if properly reported, could have prevented the incident on 1/5/16." The investigation's Recommended Corrective Action(s) section indicated, "Staff to be re-trained on medication administration. Staff to be re-trained on reporting incidents. Staff to be trained on Prevention of Abuse and Neglect."</p> <p>On 2/16/16 at 11:22 AM, a review of</p>			

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	<p>client #2's 1/5/16 Nursing Consultation note indicated, "Nurse visited with [client #2] at his home (in evening) following seizure activity at LL (day program) earlier in the day. [Client #2] was in good spirits, no s/s (signs/symptoms) of concussion noted. Previous red mark noted to right temple region still visible but much faded. House staff was directed to continue to monitor status and if seizure activity resumed to follow risk plan as written and contact nurse as needed. During conversation with one staff member, nurse found out that [client #2] did not receive his morning medications that day which included medication for seizures (Depakote), staff member showed nurse the cup of medication mixed with applesauce. When nurse asked staff member where he had found the cup of medicine, the staff member replied 'in [client #2's] room.' Reviewing the MARs (Medication Administration Record) the nurse noted that [client #2's] meds had been signed off as having been given. After further investigation nurse noted that staff member responsible for [client #2] missing AM (morning) meds was the same staff member who committed the same med error (not giving [client #2's] AM medications) on 12/22/15. Nurse consulted with SGL (Supported Group Living) director and coordinator</p>			

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	<p>responsible for the house, the decision was made that the staff person responsible for the error would have his med administration privileges suspended, that this staff person would have to re-take Core A and Med Administration training, and that after training it would be determined alone by the nurse if/when this particular staff person would have his med administration privileges reinstated."</p> <p>On 2/16/16 at 1:03 PM, the AGHD provided a copy of staff #10's Performance Review. The review indicated, in part, "[Staff #10] failed to admin (administer) [client #2's] Depakote. Investigation is located in CIR (Confidential Incident Report). [Staff #10] will be required to complete Core A and B (facility's medication training program)." The Performance Review was dated 1/4/16 at the top of the form and staff #10 signed the form on 1/15/16.</p> <p>The facility failed to implement appropriate corrective action with staff #10 in a timely manner. There was no documentation staff #10 was retrained on Core A and B.</p> <p>There was no documentation of increased monitoring or oversight of the medication administration passes to the clients.</p>			

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	<p>On 2/11/16 at 2:41 PM, HR staff #1 provided a screen capture of staff #10's electronic employee file. The Status indicated, "Terminated 1/15/16." The Notes section indicated, "Substatiated (sic) neglect."</p> <p>On 2/16/16 at 11:38 AM, the NM indicated the staff should administer client #2's medication as prescribed by the physician. The NM indicated he observed two staff administer medications one time. The NM indicated he was not sure if the group home administrative staff increased the monitoring and supervision of medication administration. The NM indicated the facility should have increased the monitoring of medication administration to the clients.</p> <p>On 2/16/16 at 2:03 PM, the AGHD indicated the facility should ensure client #2's medications were administered as prescribed by his physicians. The AGHD indicated the facility suspended staff #10 after the 1/5/16 medication error to client #2, investigated the incident, and retrained staff on medication administration and reporting. The AGHD stated the corrective action was "not sufficient." The AGHD stated we, "need to do more."</p>			

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	<p>13) On 1/5/16 at 9:30 AM at the facility operated day program, client #2 stepped backward and tripped. He fell backwards and hit the right side of his head. No injury noted at the time.</p> <p>14) On 1/5/16 at 1:15 PM at the facility operated day program, client #2 was sitting in the hallway. Client #2 had a seizure, fell over and hit his head. The incident was reported to BDDS on 1/7/16.</p> <p>The 1/7/16 BDDS report indicated, in part, "On 01/05/2016 at 1:15 pm, [client #2] was sitting out in the hallway of room 1 in day program. [Client #2] began seizing, fell over while seated and hit his head. [Client #2] fell to his right and hit the corner of the left side to his head. Coordinator and nurse were notified; [client #2] had no injury. [Client #2] fell 3x (three times) today (9:30 am, 1:15 pm, and 2:10 pm). He was checked by a nurse each time. He was willing to wear a helmet after the 3rd fall. He experienced a 3 minute plus seizure after the third fall, and diastat was administered per risk plan. I have emailed team requesting a consideration of changing [client #2's] schedule to help him have more time in the morning to prepare for the day, suggesting that his</p>			

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	<p>[day program] staff begin their day at [name of group home]. Staff will continue to monitor [client #2's] condition for injury."</p> <p>15) On 1/5/16 at 2:10 PM at the facility operated day program, client #2 had a seizure, fell over and hit his head. Client #2 landed on his side and hit the back part of his head. Client #2 put on his helmet following the seizure.</p> <p>On 2/12/16 at 2:54 PM, the NM indicated the staff failing to administer client #2's seizure medication caused client #2 to have seizures. The NM indicated the group home staff was retrained following the 1/5/16 medication error. The NM indicated the same staff was involved in both medication administration errors. The NM indicated he instructed the day aid to administer all morning medications following the two incidents.</p> <p>16) On 1/7/16 at 1:00 PM, client #2's \$10.00 gift card was missing from the group home. The 1/13/16 Investigation Report indicated, in part, "...In their statements, all staff claimed to have no knowledge of the whereabouts of [client #2's] [name of store] gift card. There are discrepancies between many of the statements, typically regarding the timeline of events: [Staff #4] sent an</p>			

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	<p>email on 1/7/16, stating that she'd discovered the missing card that day, but in verbal testimony to investigator, she stated that this happened on 1/6/16. [Staff #2] stated that he last saw the cards on 1/7/16, which is the day they were discovered to be missing. Several staff members raised suspicion about other staff members in their statement, either explicitly or implicitly. One staff member went so far as to name two other staff and call them 'liars, not to be trusted.'" The Analysis of Evidence &amp; (and) Findings section indicated, "It is not possible to determine who stole [client #2's] [name of store] gift card, though it was certainly a person with access to the house and knowledge of the cards' whereabouts. It is not possible to determine which staff member may have stolen the card. While the perpetrator of this theft cannot be named definitively, the fact that [client #2's] gift card was taken, combined with the fact that this occurred at the same time that two staff members claim that their cash holiday cards were also taken, indicates that financial exploitation did indeed occur... Substantiated." The Recommended Corrective Action(s) section indicated, "Replace [client #2's] \$10 [name of store] gift card. Retrain all [name of group home] staff on the prevention of abuse, neglect and exploitation. Retrain all staff</p>			

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	<p>regarding management of client finances and the proper way to document and safeguard client financial instruments. [Name of group home] support team should address and work to remedy the apparent culture of mistrust and suspicion among staff members. Reassignment of staff to alternate work sites may be a fitting option."</p> <p>On 2/12/16 at 12:56 PM, the Fiscal Coordinator (FC) indicated client #2 was reimbursed on 1/14/16.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated the former Coordinator brought the clients' funds to the office for a period of time in September 2015 after client #6 was missing \$20.00. The Coordinator indicated he was unsure how often the clients' personal funds were accounted for by the group home staff. The Coordinator indicated the Group Home Manager counted the clients' funds. The Coordinator indicated there was no change in the accounting of the clients' funds at the group home. The Coordinator indicated all the staff who worked at the group home continue to have access to the clients' funds.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated she was unsure when client #2, #3, and #4's personal funds were returned</p>			

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	<p>to the group home. The AGHD indicated she was unsure how often the clients' funds were accounted for by the group home staff. The AGHD indicated she was unsure if there was a policy to account for the clients' funds. The AGHD stated, "there's got to be a policy." The AGHD indicated there was no increased monitoring of the clients' funds or changes to the system for storing the clients' funds.</p> <p>17) On 1/15/16 at 9:00 PM, client #1 was not administered Levothyroxine 50 mg (hypothyroid - low thyroid) due to the medication not being in the home and was not delivered by the pharmacy. The 1/16/16 Medication Error Report was blank in the Document Action Taken section. There was no documentation staff #15 received corrective action.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have</p>			

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	<p>been implemented.</p> <p>18) On 1/26/16 at 11:00 AM at the facility operated day program, client #6 was stacking blocks when a peer hit him on the left shoulder. Client #6 was not injured.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>19) On 1/28/16 at 9:15 AM, client #2 was in the restroom preparing to take a shower. As he approached the shower, client #2 fell backwards. Client #2 landed on his back and buttocks. Staff was checking the temperature of the shower about 2 feet away. Client #2 stood up and staff observed that client #2 "split open the top of his head towards the back." The nurse assessed client #2</p>			

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	<p>and determined he needed to be checked out at the emergency room.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's record was conducted. A 1/28/16 Nursing Consultation form indicated, in part, "Staff informed nurse that [client #2] fell in the bathroom while heading to the shower causing a cut to the top of his head. Nurse visited [client #2] at his home for assessment, findings as follows: cut noted to the top of [client #2's] head (approximately) 1 1/2 inches long, cut noted to be deep, edges approximated, no active bleeding present (bleeding had subsided), no signs/symptoms of concussion noted - [client #2] was at baseline and was able to follow direction from nurse, demeanor pleasant, no signs/symptoms of extreme pain noted. Nurse directed LL staff and day aide (sic) to take [client #2] to the ER to get stitches placed and to get checked by MD (medical doctor) to rule out concussion - staff verbalized understanding of directives." A second 1/28/16 Nursing Consultation note indicated, "[Client #2] was seen by nurse at his home following visit to the ER to address cut on the top of his head (at the crown), nurse assessment as follows: 6 staples noted to the top of head at the crown, edges of skin well approximated, scant amount of dried blood noted - no</p>			

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	<p>other drainage (abnormal) noted at this time... No signs of distress or discomfort noted at this time by nurse, no concussive symptoms noted at this time. Per staff report blood work was done at the ER (CBC - complete blood count) along with a CT (computerized tomography) Scan - day aide (sic) stated that ER personnel reported to her that CT Scan came back normal (no concussion or bleeding). [Client #2] is to have his staples taken out in 7 - 10 days (nurse will attempt to remove staples), order from ER is to apply bacitracin ointment to wound twice daily for 10 - 12 days; [client #2] may shower as normal and per ER directives may apply soap to area, area should not be scrubbed vigorously...."</p> <p>There was no documentation the facility conducted an investigation to determine how client #2 fell.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated the facility did not investigate the incident in order to implement corrective actions to prevent a fall in the future. The Coordinator indicated the fall should have been investigated.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated the facility did not investigate the incident in order to implement corrective actions to prevent a fall in the</p>						

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	<p>future. The AGHD indicated the fall should have been investigated.</p> <p>20) On 2/2/16 at 2:20 PM at the facility operated day program, client #2 was walking around in the day program room. Client #2 was "wobbly" on his feet. Client #2 fell to the floor and hit his head. Staff was about a foot away. Client #2 hit his head and obtained a cut. Client #2 was transported to an urgent care facility to be assessed.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's record was conducted. A 2/2/16 Outside Services Report indicated in the Reason for Visit section, "Wound on forehead following fall." The Diagnosis/Results section indicated, "Laceration w/o (without) foreign body of other part of head." The Treatment/Tests Ordered section indicated, "Wound closed with Steri-strips." A 2/3/16 Nursing Consultation note indicated, in part, "Nurse visited with [client #2] at his home following falls the previous day in which he incurred a head injury, assessment as follows: 4 larger steri-strips noted to right eyebrow area, nurse unable to determine the length of cut d/t (due to) steri-strips being in place, slight reddened area noted to right cheek bone (approximately) size of half dollar. No s/s of concussion noted at this time -</p>			

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	<p>[client #2] was alert and responding appropriately to nurse. No s/s pain or discomfort noted at this time, no signs of distress. Staff directed to keep steri-strips in place and allow them to fall off naturally, when washing area to not scrub vigorously, to continue to watch for s/s of concussion which may include physical signs of increased discomfort, N/V (nausea/vomiting), increased lethargy, increase in instability regarding gait/ambulation."</p> <p>There was no documentation the facility conducted an investigation to determine how client #2 fell.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated the facility did not investigate the incident in order to implement corrective actions to prevent a fall in the future. The Coordinator indicated the fall should have been investigated.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated the facility did not investigate the incident in order to implement corrective actions to prevent a fall in the future. The AGHD indicated the fall should have been investigated.</p> <p>21) On 2/9/16 at 8:00 AM, client #2 did not receive MAPAP (aches and pains) as ordered from staff #11. The 2/10/16</p>				

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	<p>BDDS report indicated, "This med error was discovered during HS med pass... There was no noticeable effect to [client #2] due to this med error." Staff will be disciplined as per Stone Belt's med error policy." The 2/9/16 Medication Error Report was blank in the Document Action Taken section. There was no documentation staff #11 received corrective action.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>On 2/11/16 at 2:12 PM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 5/14/13, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services</p>				

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	<p>that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law...</p> <p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events." The</p>			

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	<p>policy indicated, "The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days." The policy indicated, in part, "Review the Incident Report to identify individuals and the nature of their participation, i.e. possible victims, perpetrators and witnesses. If there is an allegation of abuse/neglect or exploitation all staff assigned to the client(s) and present during the event, will be interviewed or asked to provide a written, signed statement. All perpetrators/alleged perpetrators will be interviewed or asked to provide a written, signed statement. All persons who saw the incident and are able to give substantial information are to be interviewed or provide written, signed statements. Those individuals who are not able to provide written or verbal statements due to disability are not required to provide statements. If statements can be interpreted by staff, or a 'knowledgeable other' familiar with the client's communication style, signed statements from these individuals are to be provided. In a residential setting, all residents present for the incident and able to participate in the interview process</p>			

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W 0153  Bldg. 00	<p>must be interviewed to assure they have not been victimized or traumatized by the event." The policy titled, Incident Reporting Procedure, dated 7/25/13, indicated, in part, "A staff member who witnesses an incident, discovers the results of an incident, or receives the initial report of an incident from a person not on staff, immediately does the following: interrupts the inappropriate behavior, takes measures to protect, comfort and ensure treatment of the individuals involved in the incident, obtaining emergency care as needed, requests assistance as needed from immediate supervisor and/or pager, in cases of suspected abuse/neglect or exploitation, the director of the program is to be notified immediately. If no action is taken in response to the report, continue to report to the supervisor or next level of management."</p> <p>This federal tag relates to complaint #IN00182639.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p>				

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	<p>Based on record review and interview for 3 of 32 incident reports reviewed affecting client #2, the facility failed to ensure staff immediately reported an allegation of verbal abuse and a medication error resulting in seizure activity to the administrator and submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 2/11/16 at 11:46 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 7/7/15 at 10:00 PM (reported to the administrator on 7/24/15), former staff #12 was verbally abusive to client #2. Staff #12's interview in the 7/28/15 investigation indicated, in part, "[Staff #12] was asked if he recalled a conversation with a staff at [name of group home] during an evening shift when [client #2] needed assistance with changing/emptying his ileostomy (surgical opening to pass waste) pouch, about [client #2] being compared to a fish. [Staff #12] stated that he did in fact recall this conversation and stated that he thought comparing [client #2's]</p>	W 0153	<p><b>W 153 Staff Treatment of Clients (Standard)</b> 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 though established procedures. <b>Corrective action for resident(s) found to have been affected</b> The QIDP and house staff will be trained on the agency's abuse, neglect and exploitation policy, including the need to follow-through until each issue is resolved and that each allegation is immediately reported. This training will include reporting highly unusual but important events, such as seizures where medical attention is required In order to reduce medication errors, a new medication summary sheet will be added to the home that simplifies directions for staff. All staff across all shifts will be trained to use this form. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and staff training will be conducted. A new medication summary sheet will be put in place and trained across staff <b>How corrective actions will be</b></p>	03/20/2016			

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	<p>intelligence to a fish was accurate as he only he only (sic) has an IQ of 8. [Staff #12] was asked if he said anything else regarding a fish and/or [client #2] and [staff #12] stated that [client #2's] memory is comparable to that of a fish due to his low IQ." The Investigation Report indicated, in part, "Substantiated. It has been determined, by interviews and self reporting, that [staff #12] made derogatory and insensitive comments regarding [client #2]. Some alleged statements were while caring for [client #2] and would fall within Stone Belt's definition of emotional/verbal abuse. Pejorative or derogatory terms used to describe persons with disabilities was (sic) used by [staff #12] in regards to [client #2]... [Staff #12's] employment was terminated."</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated allegations of abuse should be reported immediately to the administrator.</p> <p>On 2/16/16 at 2:32 PM, the Assistant Group Home Director (AGHD) indicated allegations of abuse should be reported immediately to the administrator.</p> <p>2) On 12/22/15 at 7:00 AM (reported to BDDS on 1/4/16), client #2 did not receive Depakote Sprinkles (seizures)</p>		<p><b>monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director(or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		

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	<p>1000 mg (milligrams) as ordered. The 1/4/16 BDDS report indicated, "...Although this med was prepared with applesauce, staff did not administer this medication. This med error was discovered on 12/22/2015 when day aide (sic) found the med cup and apple sauce. Nurse was notified with instructions to continue administering medications at 2:00 pm; nurse notified psych (psychiatrist) and neurologist. The effect to [client #2] was that he didn't get his next dose until 2:00 pm. Staff will be disciplined as per Stone Belt's med error policy." The 12/30/15 Medication Error Report indicated, in part, "Med was in apple sauce and set aside due to staff preparing the med to (sic) soon... Day aide (sic) got back to the house and found the med cup and apple sauce." The Document Action Taken section indicated, "Verbal Discussion/Training."</p> <p>The 1/11/16 Investigation Report indicated in the Brief Summary of the Reason to Investigate section, "There is evidence that medication administration at [name of group home] has not been accurate. There is evidence that Stone Belt medication administration policy has not been followed, resulting in medication errors. Moreover, medication errors have not been reported properly. Due to missed medication and lack of</p>				

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	<p>proper reporting, a client was at risk." The Evidence Summary section indicated, "Evidence shows that [client #2] did not receive his morning seizure medication, Depakote on 12/22/15 and 1/4/16 (see below for additional information). On 12/23/15 [client #2] had a seizure that required Diastat medication and to be seen at the emergency room. Staff did not follow medication administration policies as well as incident reporting policies for the 12/22/15 incident... Was Stone Belt reporting policy followed? NO. The staff that found the med error, did not report the incident in writing until 12/30/15. The coordinator of the group home, received the medication error IR (incident report) on 12/30/15 but did not submit until 1/4/16. The coordinator requested that the IR be sent to the proper staff via email, however there was no follow up. Did the lack of proper medication administration and medication error reporting lead to a client having a medical injury? YES. [Client #2] has (sic) severe seizures following both days that he missed his morning medication, Depakote (he takes to control his seizures). The incident on 12/22/15, if properly reported, could have prevented the incident on 1/5/16."</p> <p>On 2/16/16 at 2:03 PM, the AGHD</p>				

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	<p>indicated the staff should have immediately reported the incident to the administrator. The AGHD indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>3) On 1/5/16 at 7:15 AM, staff #10 did not administer client #2's Depakote Sprinkles 1000 mg (seizures) as ordered. The 1/6/16 BDDS report indicated, in part, "...This med error was discovered when staff found all meds in the applesauce in [client #2's] room. Nurse and client support Coordinator notified. The effect to [client #2] was seizures after noon and he was administered Diastat. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>The 1/11/16 Investigation Report indicated in the Brief Summary of the Reason to Investigate section, "There is evidence that medication administration at [name of group home] has not been accurate. There is evidence that Stone Belt medication administration policy has not been followed, resulting in medication errors. Moreover, medication errors have not been reported properly. Due to missed medication and lack of proper reporting, a client was at risk." The Evidence Summary section indicated, "Evidence shows that [client #2] did not receive his morning seizure</p>			

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	<p>medication, Depakote on 12/22/15 and 1/4/16 (see below for additional information). On 12/23/15 [client #2] had a seizure that required Diastat medication and to be seen at the emergency room. Staff did not follow medication administration policies as well as incident reporting policies for the 12/22/15 incident. The result of the staff not following policies resulted in [client #2] missing his morning medication on 1/5/16. The result of [client #2] missing his medication was another severe seizure with admission of Diastat and 3 falls at day program."</p> <p>On 1/5/16 at 1:15 PM at the facility operated day program, client #2 was sitting in the hallway. Client #2 had a seizure, fell over and hit his head. The incident was reported to BDDS on 1/7/16.</p> <p>The 1/7/16 BDDS report indicated, in part, "On 01/05/2016 at 1:15 pm, [client #2] was sitting out in the hallway of room 1 in day program. [Client #2] began seizing, fell over while seated and hit his head. [Client #2] fell to his right and hit the corner of the left side to his head. Coordinator and nurse were notified; [client #2] had no injury. [Client #2] fell 3x (three times) today (9:30 am, 1:15 pm, and 2:10 pm). He was checked by a</p>			

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W 0154 Bldg. 00	<p>nurse each time. He was willing to wear a helmet after the 3rd fall. He experienced a 3 minute plus seizure after the third fall, and diastat was administered per risk plan. I have emailed team requesting a consideration of changing [client #2's] schedule to help him have more time in the morning to prepare for the day, suggesting that his [day program] staff begin their day at [name of group home]. Staff will continue to monitor [client #2's] condition for injury."</p> <p>On 2/16/16 at 2:03 PM, the AGHD indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 32 incident/investigative reports reviewed affecting client #2, the facility failed to ensure thorough investigations were conducted to address falls with injury requiring medical treatment.</p>	W 0154	<p><b>W 154 Staff Treatment of Clients(Standard)</b> The facility must have evidence that all alleged violations are thoroughly investigated. <b>Corrective action for resident(s) found to have been affected</b> QIDP will be trained on reporting falls with injury requiring medical treatment</p>	03/20/2016	

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	<p>Findings include:</p> <p>On 2/11/16 at 11:46 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/28/16 at 9:15 AM, client #2 was in the restroom preparing to take a shower. As he approached the shower, client #2 fell backwards. Client #2 landed on his back and buttocks. Staff was checking the temperature of the shower about 2 feet away. Client #2 stood up and staff observed that client #2 "split open the top of his head towards the back." The nurse assessed client #2 and determined he needed to be checked out at the emergency room.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's record was conducted. A 1/28/16 Nursing Consultation form indicated, in part, "Staff informed nurse that [client #2] fell in the bathroom while heading to the shower causing a cut to the top of his head. Nurse visited [client #2] at his home for assessment, findings as follows: cut noted to the top of [client #2's] head (approximately) 1 1/2 inches long, cut noted to be deep, edges approximated, no active bleeding present (bleeding had subsided), no signs/symptoms of concussion noted -</p>		<p>and follow-up investigations to determine the effectiveness of risk plans. The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including the need to follow-through until each issue is resolved. This includes follow-through for allegations of abuse as well as unusual, but important issues, such as seizures or fall where medical attention is required <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director(or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP.</p>	

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	[client #2] was at baseline and was able to follow direction from nurse, demeanor pleasant, no signs/symptoms of extreme pain noted. Nurse directed LL staff and day aide (sic) to take [client #2] to the ER to get stitches placed and to get checked by MD (medical doctor) to rule out concussion - staff verbalized understanding of directives." A second 1/28/16 Nursing Consultation note indicated, "[Client #2] was seen by nurse at his home following visit to the ER to address cut on the top of his head (at the crown), nurse assessment as follows: 6 staples noted to the top of head at the crown, edges of skin well approximated, scant amount of dried blood noted - no other drainage (abnormal) noted at this time... No signs of distress or discomfort noted at this time by nurse, no concussive symptoms noted at this time. Per staff report blood work was done at the ER (CBC - complete blood count) along with a CT (computerized tomography) Scan - day aide (sic) stated that ER personnel reported to her that CT Scan came back normal (no concussion or bleeding). [Client #2] is to have his staples taken out in 7 - 10 days (nurse will attempt to remove staples), order from ER is to apply bacitracin ointment to wound twice daily for 10 - 12 days; [client #2] may shower as normal and per ER directives may apply soap to area, area should not		The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.		

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	<p>be scrubbed vigorously...."</p> <p>There was no documentation the facility conducted an investigation to determine how client #2 fell.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated the facility did not investigate the incident. The Coordinator indicated the fall should have been investigated.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated the facility did not investigate the incident. The AGHD indicated the fall should have been investigated.</p> <p>2) On 2/2/16 at 2:20 PM at the facility operated day program, client #2 was walking around in the day program room. Client #2 was "wobbly" on his feet. Client #2 fell to the floor and hit his head. Staff was about a foot away. Client #2 hit his head and obtained a cut. Client #2 was transported to an urgent care facility to be assessed.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's record was conducted. A 2/2/16 Outside Services Report indicated in the Reason for Visit section, "Wound on forehead following fall." The Diagnosis/Results section indicated, "Laceration w/o (without) foreign body of other part of head." The</p>				

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	<p>Treatment/Tests Ordered section indicated, "Wound closed with Steri-strips." A 2/3/16 Nursing Consultation note indicated, in part, "Nurse visited with [client #2] at his home following falls the previous day in which he incurred a head injury, assessment as follows: 4 larger steri-strips noted to right eyebrow area, nurse unable to determine the length of cut d/t (due to) steri-strips being in place, slight reddened area noted to right cheek bone (approximately) size of half dollar. No s/s of concussion noted at this time - [client #2] was alert and responding appropriately to nurse. No s/s pain or discomfort noted at this time, no signs of distress. Staff directed to keep steri-strips in place and allow them to fall off naturally, when washing area to not scrub vigorously, to continue to watch for s/s of concussion which may include physical signs of increased discomfort, N/V (nausea/vomiting), increased lethargy, increase in instability regarding gait/ambulation."</p> <p>There was no documentation the facility conducted an investigation to determine how client #2 fell.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated the facility did not investigate the incident. The Coordinator indicated</p>			

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W 0156 Bldg. 00	<p>the fall should have been investigated.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated the facility did not investigate the incident. The AGHD indicated the fall should have been investigated.</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 working days of the incident.</p> <p>Based on record review and interview for 1 of 32 incident/investigative reports reviewed affecting client #2, the facility failed to submit the results of an investigation, within 5 working days, to the administrator.</p> <p>Findings include:</p> <p>On 2/11/16 at 11:46 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 12/22/15 at 7:00 AM, client #2 did not receive Depakote Sprinkles (seizures) 1000 mg (milligrams) as ordered. The 1/4/16 BDDS report indicated,</p>	W 0156	<p><b>W 156 Staff Treatment of Clients(Standard)</b> 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 working days of the incident. <b>Corrective action for resident(s) found to have been affected</b> The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including the need to report findings to SGL Director within five working days. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in</b></p>	03/20/2016

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	<p>"...Although this med was prepared with applesauce, staff did not administer this medication. This med error was discovered on 12/22/2015 when day aide (sic) found the med cup and apple sauce. Nurse was notified with instructions to continue administering medications at 2:00 pm; nurse notified psych (psychiatrist) and neurologist. The effect to [client #2] was that he didn't get his next dose until 2:00 pm. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>The 1/11/16 Investigation Report indicated in the Brief Summary of the Reason to Investigate section, "There is evidence that medication administration at [name of group home] has not been accurate. There is evidence that Stone Belt medication administration policy has not been followed, resulting in medication errors. Moreover, medication errors have not been reported properly. Due to missed medication and lack of proper reporting, a client was at risk." The Evidence Summary section indicated, "Evidence shows that [client #2] did not receive his morning seizure medication, Depakote on 12/22/15 and 1/4/16 (see below for additional information). On 12/23/15 [client #2] had a seizure that required Diastat medication and to be seen at the</p>		<p><b>place to ensure no recurrence</b> QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director(or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		

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	<p>emergency room. Staff did not follow medication administration policies as well as incident reporting policies for the 12/22/15 incident. The result of the staff not following policies resulted in [client #2] missing his morning medication on 1/5/16. The result of [client #2] missing his medication was another severe seizure with admission of Diastat and 3 falls at day program." The Investigation Report indicated, "Was Stone Belt medication administration policy followed? NO. Staff that admitted to missing [client #2] morning medication twice, also admitted that he marked that the client HAD received his medication, as he marked it BEFORE actually giving it to the client. Was Stone Belt reporting policy followed? NO. The staff that found the med error, did not report the incident in writing until 12/30/15. The coordinator of the group home, received the medication error IR (incident report) on 12/30/15 but did not submit until 1/4/16. The coordinator requested that the IR be sent to the proper staff via email, however there was no follow up. Did the lack of proper medication administration and medication error reporting lead to a client having a medical injury? YES. [Client #2] has (sic) severe seizures following both days that he missed his morning medication, Depakote (he takes to control his</p>				

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W 0157 Bldg. 00	<p>seizures). The incident on 12/22/15, if properly reported, could have prevented the incident on 1/5/16." The investigation's Recommended Corrective Action(s) section indicated, "Staff to be re-trained on medication administration. Staff to be re-trained on reporting incidents. Staff to be trained on Prevention of Abuse and Neglect."</p> <p>On 2/16/16 at 2:03 PM, the AGHD indicated the timeframe for submitting the results of investigations to the administrator was 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 11 of 32 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to implement appropriate corrective actions to address medications errors and financial exploitation.</p> <p>Findings include:  On 2/11/16 at 11:46 AM, a review of the facility's incident/investigative reports</p>	W 0157	<p><b>W 157 Staff Treatment of Clients(Standard)</b> If the alleged violation is verified, appropriate corrective action must be taken. <b>Corrective action for resident(s) found to have been affected</b> In order to reduce medication errors, a new medication summary sheet will be added to the home that simplifies directions for staff. All staff across all shifts will be trained to use this form. The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including the</p>	03/20/2016

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	<p>was conducted and indicated the following:</p> <p>1) On 9/13/15 at 11:00 AM, staff #2 counted client #6's money. Client #6 was missing \$20.00. The 9/13/15 Stone Belt ARC, Inc. Incident Report indicated in the Event section, "Steeling (sic) money from a client."</p> <p>The 9/15/15 Investigation Report indicated, in part, "...There was no receipt or other proof of the money being spent by [client #6]." The investigation indicated, "[Coordinator] reported the money was accounted for during the routine audit the night prior at approx. (approximately) 10 pm. She also stated that [former staff #8] was the only staff having access or knowledge of the money and that the other staff working/training were [another Coordinator in training] and [staff #9]." The investigation indicated staff #8 refused to cooperate during the investigation either by phone or email. Staff #8 did not provide information during the investigation. The Statement of Findings indicated, "Unsubstantiated. \$20 is missing but there is no proof that it was spent and receipt is missing or that money was stolen by staff. [Staff #8] would have been the only staff having access to money." The Recommendations section</p>		<p>need to follow-through until each issue is resolved. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> A new medication summary sheet will be put in place; QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> A new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director(or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		

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	<p>indicated, "\$20 was reimbursed by agency to client. Coordinator will assure money is no longer kept in the home. Audits will continue. [Staff #8] is no longer employed with Stone Belt due to attendance."</p> <p>On 2/11/16 at 4:03 PM, a review of the clients' finances was conducted. Clients #2, #3 and #4 had money at the group home.</p> <p>On 2/12/16 at 12:56 PM, the Fiscal Coordinator (FC) indicated client #6 was reimbursed on 9/16/15. The FC indicated when client #6's money came up missing, the former Coordinator pulled all the clients' money (cash) out of the group home. The FC indicated the clients still had access to their funds through the use of debit cards.</p> <p>On 2/11/16 from 3:43 PM to 5:55 PM, an observation was conducted at the group home. During the observation, clients #2, #3 and #4 had personal cash being kept at the group home.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated the former Coordinator brought the clients' funds to the office for a period of time. He was unsure when client #2, #3 and #4's personal cash was returned to the group home. The Coordinator</p>			

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	<p>indicated he was unsure how often the clients' personal funds were accounted for by the group home staff. The Coordinator indicated the Group Home Manager counted the clients' funds. The Coordinator indicated there was no change in the accounting of the clients' funds at the group home. The Coordinator indicated all the staff who worked at the group home continue to have access to the clients' funds.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated she was unsure when client #2, #3, and #4's personal funds were returned to the group home. The AGHD indicated she was unsure how often the clients' funds were accounted for by the group home staff. The AGHD indicated she was unsure if there was a policy to account for the clients' funds. The AGHD stated, "there's got to be a policy." The AGHD indicated there was no increased monitoring of the clients' funds or no changes to the system for storing the clients' funds.</p> <p>2) On 11/16/15 at 2:00 PM, client #5 did not receive Clonidine (aggression and agitation) from staff #6. On 11/16/15 at 3:00 PM, client #5 did not receive Risperdal (aggression and agitation) from staff #6. The 11/17/15 Bureau of Developmental Disabilities Services</p>						

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	<p>(BDDS) incident report indicated, in part, "This med error was discovered during a buddy check. There is no known effect to [client #5] due to the med error." The 11/16/15 Medication Error Report indicated, "Supervisor: Document action taken: Verbal discussion/training." There was no documentation staff #6 received training.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>3) On 11/26/15 at 7:00 AM, client #4 did not receive Lisinopril (hypertension) from staff #10. The 11/26/15 Medication Error Report (MER) was blank in the Document Action Taken section. The MER indicated in the training section, "no," in response to whether or not the staff needed additional training. There was no documentation staff #10 received corrective action.</p>				

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	<p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>4) On 12/5/15 at 7:00 AM, client #3 did not receive Levetiracetam (anticonvulsant) as ordered. Staff #5 administered one tab instead of two tabs to client #3. The 12/5/15 Medication Error Report (MER) was blank in the Document Action Taken section. The MER was blank in the training section in response to whether or not the staff needed additional training. There was no documentation staff #5 received corrective action.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective</p>			

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	<p>action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>5) On 12/17/15 at 7:00 PM, staff #6 administered the incorrect dose of Tamsulosin (enlarged prostate) to client #4. Client #4 received one of two caps of the medication. The 12/19/15 BDDS report indicated, "On 12/18/2015, this med error was discovered during a buddy check. Pager was notified. There is no known effect to [client #4] due to this med error. Staff will be disciplined as per Stone Belt's med error policy." There was no documentation of corrective action with staff #6.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have</p>				

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	<p>been implemented.</p> <p>6) On 12/22/15 at 7:00 AM, client #2 did not receive Depakote Sprinkles (seizures) 1000 mg (milligrams) as ordered. The 1/4/16 BDDS report indicated, "...Although this med was prepared with applesauce, staff did not administer this medication. This med error was discovered on 12/22/2015 when day aide (sic) found the med cup and apple sauce. Nurse was notified with instructions to continue administering medications at 2:00 pm; nurse notified psych (psychiatrist) and neurologist. The effect to [client #2] was that he didn't get his next dose until 2:00 pm. Staff will be disciplined as per Stone Belt's med error policy." The 12/30/15 Medication Error Report indicated, in part, "Med was in apple sauce and set aside due to staff preparing the med to (sic) soon... Day aide (sic) got back to the house and found the med cup and apple sauce." The Document Action Taken section indicated, "Verbal Discussion/Training."</p> <p>The 1/11/16 Investigation Report indicated in the Brief Summary of the Reason to Investigate section, "There is evidence that medication administration at [name of group home] has not been accurate. There is evidence that Stone Belt medication administration policy has</p>			

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	<p>not been followed, resulting in medication errors. Moreover, medication errors have not been reported properly. Due to missed medication and lack of proper reporting, a client was at risk." The Evidence Summary section indicated, "Evidence shows that [client #2] did not receive his morning seizure medication, Depakote on 12/22/15 and 1/4/16 (see below for additional information). On 12/23/15 [client #2] had a seizure that required Diastat medication and to be seen at the emergency room. Staff did not follow medication administration policies as well as incident reporting policies for the 12/22/15 incident. The result of the staff not following policies resulted in [client #2] missing his morning medication on 1/5/16. The result of [client #2] missing his medication was another severe seizure with admission of Diastat and 3 falls at day program." The Investigation Report indicated, "Was Stone Belt medication administration policy followed? NO. Staff that admitted to missing [client #2] morning medication twice, also admitted that he marked that the client HAD received his medication, as he marked it BEFORE actually giving it to the client. Was Stone Belt reporting policy followed? NO. The staff that found the med error, did not report the incident in writing until 12/30/15. The</p>			

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	<p>coordinator of the group home, received the medication error IR (incident report) on 12/30/15 but did not submit until 1/4/16. The coordinator requested that the IR be sent to the proper staff via email, however there was no follow up. Did the lack of proper medication administration and medication error reporting lead to a client having a medical injury? YES. [Client #2] has (sic) severe seizures following both days that he missed his morning medication, Depakote (he takes to control his seizures). The incident on 12/22/15, if properly reported, could have prevented the incident on 1/5/16." The investigation's Recommended Corrective Action(s) section indicated, "Staff to be re-trained on medication administration. Staff to be re-trained on reporting incidents. Staff to be trained on Prevention of Abuse and Neglect."</p> <p>The Investigation Report included the following timeline: -12/22/15 [Staff #10 does not administer [client #2's] morning medication 1,000 mg Depakote. He signs that medication was administered. -12/22 [Staff #4] found medication, informed nurse and day program coordinator. She did not submit IR. -12/23 [Client #2] has severe seizure, needed Diastat medication and went to</p>			

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	<p>ER (emergency room).</p> <p>-Day program staff wrote IR for this incident and submitted it.</p> <p>-12/28 Day program coordinator, [name] spoke to [Group Home Coordinator] about recent incident of seizure activity in light of the missed medication. [Day Program Coordinator] asked about an IR for the missed meds.</p> <p>-12/29 [Group Home Coordinator] requests [staff #4] write IR for 12/22 missed medication incident and send to IR meds, as well as [former Group Home Director] and himself.</p> <p>-12/30 [Staff #4] wrote med error IR and sent to [Group Home Coordinator] and [Group Home Director]. NOT IR email.</p> <p>-1/4/16 IR was routed to [Administrative Assistant] who filed it with the state.</p> <p>-The facility substantiated there was evidence of abuse/neglect/exploitation.</p> <p>On 2/16/16 at 1:03 PM, the AGHD provided a copy of staff #10's Performance Review. The review indicated, in part, "[Staff #10] failed to admin (administer) [client #2's] Depakote. Investigation is located in CIR (Confidential Incident Report). [Staff #10] will be required to complete Core A and B (facility's medication training program)." The Performance Review was dated 1/4/16 at the top of the form and staff #10 signed the form on 1/15/16.</p>				

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	<p>On 2/16/16 at 11:22 AM, a review of client #2's Seizure Tracking Log for December 2015 was reviewed. Client #2 had two seizures on 12/22/15. The first seizure was at 11:25 AM for 45 seconds. The second seizure was at 12:00 PM for 45 seconds. Client #2 had a 23 minute seizure on 12/23/15 at 1:00 PM.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 12/22/15 Nursing Consultation note indicated, in part, "Call received by nurse from day aide (sic) (11:45 AM) stating that [client #2] was not given his 7am medication by staff (which included medications for seizures and agitation). Day aide (sic) asking whether or not she can give [client #2's] 7am meds at day program and push back other med times. Nurse directed day aide (sic) to give [client #2] all of his 7am meds with the exception of his Depakote (seizures) and Carnitor (Carnitor is a naturally occurring substance that the cells of mammals need to produce energy. Carnitor is used to treat carnitine deficiency) since she receives these two meds three times daily and the next time to receive these is at 2pm (times too close together to spread out). Day aide (sic) verbalized understanding of directives. LL (Life Long Learning) Coordinator notified of missed medications, LL</p>			

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	<p>Coordinator states that day staff have not seen any seizure activity or unusual behaviors from [client #2] today. Nurse notified Coordinator of plan for [client #2] to receive all AM meds except for Depakote and Carnitor, Coordinator directed by nurse to give [client #2] these two meds at next scheduled time (2pm) as well as to continue to monitor [client #2] for any seizure activity - Coordinator verbalized understanding of directives. [Psychiatrist] and [Neurologist] notified by nurse of missed medications."</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 12/23/15 Outside Services Report indicated he was seen at the emergency room on 12/23/15 due to seizure activity.</p> <p>The facility failed to implement appropriate corrective action with staff #10 in a timely manner. There was no documentation staff #10 was retrained on Core A and B.</p> <p>There was no documentation of increased monitoring or oversight of the medication administration passes to the clients.</p> <p>On 2/11/16 at 2:41 PM, HR staff #1 provided a screen capture of staff #10's electronic employee file. The Status indicated, "Terminated 1/15/16." The</p>			

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	<p>Notes section indicated, "Substantiated (sic) neglect."</p> <p>On 2/12/16 at 6:47 AM, staff #4 indicated on 12/22/15 she discovered client #2's medication (Depakote) in a cup of applesauce in the medication room. Staff #4 indicated client #2 had a seizure on 12/22/15 due to the missed medication. Staff #4 indicated staff #10 was terminated. Staff #4 indicated the group home staff received retraining on medication administration and the Nurse Manager observed all the staff administer medications during one medication pass.</p> <p>On 2/12/16 at 2:54 PM, the Nurse Manager (NM) stated he was "99% sure" client #2's seizure on 12/23/15 was related to missing his seizure medication on 12/22/15. On 2/16/16 at 11:38 AM, the NM indicated the staff should administer client #2's medication as prescribed by the physician. The NM indicated he observed two staff administer medications one time. The NM indicated he was not sure if the group home administrative staff increased the monitoring and supervision of medication administration. The NM indicated the facility should have increased the monitoring of medication administration to the clients.</p>			

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	<p>On 2/16/16 at 2:03 PM, the AGHD indicated the facility suspended staff #10 after the 1/5/16 medication error to client #2 (see below), investigated the incident, and retrained staff on medication administration and reporting. The AGHD stated the corrective action was "not sufficient." The AGHD stated we, "need to do more."</p> <p>7) On 12/23/15 at 12:20 PM at the facility operated day program, client #2 had a seizure. After three minutes of continuous seizures, his PRN (as needed medication) was administered. Client #2 made brief eye contact after the as needed medication was administered. Client #2 continued to have tremors. Staff contacted the nurse. The plan was to monitor and if he continued to have seizures after the 30 minute mark, staff was to contact 911. At the 27 minute mark, client #2 made eye contact with staff. Shortly after the 30 minute mark, client #2 had another seizure. The nurse was contacted and 911 was called. Client #2 was transported to the emergency room (ER).</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 12/23/15 Nursing Consultation notes indicated, in part, "Call received by nurse from LL coordinator (12:35p) stating that [client #2] has been having</p>			

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	<p>seizure activity for the past 15 minutes, with the longest seizure being over 3 minutes. Per risk plan protocol coordinator stated [client #2] was given Diastat. Coordinator stated that [client #2] is currently on the floor and experiencing slight 'jerks' in the shoulder region, in able to respond to staff but is lethargic and has a 'dazed' look on his face. Coordinator also stated that at no time did [client #2] fall. Nurse directed coordinator to continue to monitor status, that the Diastat would make [client #2] a bit lethargic, and that if [client #2] experiences any more seizure activity over the next 10 minutes then he will need to go to the ER per risk plan for eval/tx (evaluation/treatment) - coordinator verbalized understanding of directives."</p> <p>A second Nursing Consultation note, dated 12/23/15 at 12:50 PM, indicated, "Nurse contacted LL coordinator to f/u (follow up) on [client #2's] current status, coordinator stating that [client #2] had returned to baseline, was lying on a mat playing with his rope and was responding to staff appropriately. Nurse directed coordinator to continue to monitor [client #2's] status and if seizure activity reoccurs to contact nurse immediately for further directives."</p>			

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	<p>A third Nursing Consultation note, dated 12/23/15 at 1:00 PM, indicated, "Call received by nurse from LL coordinator stating that [client #2] had resumed seizure activity, per risk plan nurse directed coordinator to call 911 and have [client #2] transported to the ER for treatment and eval."</p> <p>Client #2's 12/24/15 Nursing Consultation note indicated, "Nurse contacted house staff to f/u (follow up) on ER visit the previous afternoon/evening. Staff state that [client #2] is doing well, no adverse effects noted from seizure activity the previous day - no specific directives from the ER other than to f/u with his neurologist (name). Staff directed to call nurse/nurse pager if [client #2] starts experiencing continuous seizure activity again, staff verbalized understanding of directives."</p> <p>On 2/12/16 at 2:54 PM, the Nurse Manager (NM) stated he was "99% sure" client #2's seizure on 12/23/15 was related to missing his seizure medication on 12/22/15. On 2/16/16 at 11:54 AM, the NM indicated he was in communication with the LL Coordinator during client #2's seizure activity. The NM indicated client #2 had a seizure, returned to baseline and then had another seizure. The NM indicated he instructed</p>			

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	<p>the day program staff to call 911. The NM indicated none of the seizures lasted more than 5 minutes. The NM indicated client #2's plan indicated for staff to call 911 for any seizure activity lasting more than 5 minutes. The NM indicated since client #2 had continuous seizure activity, he directed the staff to call 911.</p> <p>8) On 1/2/16, 1/3/16 and 1/4/16 during client #1's bedtime medication administration, staff #6 and #10 administered client #1 the wrong dose of is Levothyroxine (low thyroid). The 1/5/16 BDDS report indicated, in part, "...Physician's order is for [client #1] to be administered Levothyroxine 50 mcg (microgram) on Thursdays and Fridays only. However, this medication was given on Saturday, Sunday and Monday evenings. On 01/04/2016, this med error was found during a buddy check at HS (hour of sleep). There was no observable effect to [client #1] due to this med error." The BDDS report indicated, "Staff will be disciplined as per Stone Belt's med error policy." The 1/4/16 Medication Error Report was blank in the Document Action Taken section for corrective actions. There was no documentation staff #6 and #10 received corrective action.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator</p>						

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	<p>indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>9) On 1/5/16 at 7:15 AM, staff #10 did not administer client #2's Depakote Sprinkles 1000 mg (seizures) as ordered. The 1/6/16 BDDS report indicated, in part, "...This med error was discovered when staff found all meds in the applesauce in [client #2's] room. Nurse and client support Coordinator notified. The effect to [client #2] was seizures after noon and he was administered Diastat. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>The 1/11/16 Investigation Report indicated in the Brief Summary of the Reason to Investigate section, "There is evidence that medication administration at [name of group home] has not been accurate. There is evidence that Stone Belt medication administration policy has not been followed, resulting in</p>			

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	<p>medication errors. Moreover, medication errors have not been reported properly. Due to missed medication and lack of proper reporting, a client was at risk." The Evidence Summary section indicated, "Evidence shows that [client #2] did not receive his morning seizure medication, Depakote on 12/22/15 and 1/4/16 (see below for additional information). On 12/23/15 [client #2] had a seizure that required Diastat medication and to be seen at the emergency room. Staff did not follow medication administration policies as well as incident reporting policies for the 12/22/15 incident. The result of the staff not following policies resulted in [client #2] missing his morning medication on 1/5/16. The result of [client #2] missing his medication was another severe seizure with admission of Diastat and 3 falls at day program." The Investigation Report indicated, "Was Stone Belt medication administration policy followed? NO. Staff that admitted to missing [client #2] morning medication twice, also admitted that he marked that the client HAD received his medication, as he marked it BEFORE actually giving it to the client. Was Stone Belt reporting policy followed? NO. The staff that found the med error, did not report the incident in writing until 12/30/15. The coordinator of the group home, received</p>			

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	<p>the medication error IR (incident report) on 12/30/15 but did not submit until 1/4/16. The coordinator requested that the IR be sent to the proper staff via email, however there was no follow up. Did the lack of proper medication administration and medication error reporting lead to a client having a medical injury? YES. [Client #2] has (sic) severe seizures following both days that he missed his morning medication, Depakote (he takes to control his seizures). The incident on 12/22/15, if properly reported, could have prevented the incident on 1/5/16." The investigation's Recommended Corrective Action(s) section indicated, "Staff to be re-trained on medication administration. Staff to be re-trained on reporting incidents. Staff to be trained on Prevention of Abuse and Neglect."</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 1/5/16 Nursing Consultation note indicated, "Nurse visited with [client #2] at his home (in evening) following seizure activity at LL (day program) earlier in the day. [Client #2] was in good spirits, no s/s (signs/symptoms) of concussion noted. Previous red mark noted to right temple region still visible but much faded. House staff was directed to continue to monitor status and if seizure activity resumed to follow risk</p>				

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	<p>plan as written and contact nurse as needed. During conversation with one staff member, nurse found out that [client #2] did not receive his morning medications that day which included medication for seizures (Depakote), staff member showed nurse the cup of medication mixed with applesauce. When nurse asked staff member where he had found the cup of medicine, the staff member replied 'in [client #2's] room.' Reviewing the MARs (Medication Administration Record) the nurse noted that [client #2's] meds had been signed off as having been given. After further investigation nurse noted that staff member responsible for [client #2] missing AM (morning) meds was the same staff member who committed the same med error (not giving [client #2's] AM medications) on 12/22/15. Nurse consulted wit SGL (Supported Group Living) director and coordinator responsible for the house, the decision was made that the staff person responsible for the error would have his med administration privileges suspended, that this staff person would have to re-take Core A and Med Administration training, and that after training it would be determined alone by the nurse if/when this particular staff person would have his med administration privileges reinstated."</p>			

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	<p>On 2/16/16 at 1:03 PM, the AGHD provided a copy of staff #10's Performance Review. The review indicated, in part, "[Staff #10] failed to admin (administer) [client #2's] Depakote. Investigation is located in CIR (Confidential Incident Report). [Staff #10] will be required to complete Core A and B (facility's medication training program). The Performance Review was dated 1/4/16 at the top of the form and staff #10 signed the form on 1/15/16.</p> <p>The facility failed to implement appropriate corrective action with staff #10 in a timely manner. There was no documentation staff #10 was retrained on Core A and B.</p> <p>There was no documentation of increased monitoring or oversight of the medication administration passes to the clients.</p> <p>On 2/11/16 at 2:41 PM, HR staff #1 provided a screen capture of staff #10's electronic employee file. The Status indicated, "Terminated 1/15/16." The Notes section indicated, "Substiated (sic) neglect."</p> <p>On 2/16/16 at 11:38 AM, the NM indicated the staff should administer client #2's medication as prescribed by the physician. The NM indicated he</p>			

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	<p>observed two staff administer medications one time. The NM indicated he was not sure if the group home administrative staff increased the monitoring and supervision of medication administration. The NM indicated the facility should have increased the monitoring of medication administration to the clients.</p> <p>On 2/16/16 at 2:03 PM, the AGHD indicated the facility should ensure client #2's medications were administered as prescribed by his physicians. The AGHD indicated the facility suspended staff #10 after the 1/5/16 medication error to client #2, investigated the incident, and retrained staff on medication administration and reporting. The AGHD stated the corrective action was "not sufficient." The AGHD stated we, "need to do more."</p> <p>10) On 1/7/16 at 1:00 PM, client #2's \$10.00 gift card was missing from the group home. The 1/13/16 Investigation Report indicated, in part, "...In their statements, all staff claimed to have no knowledge of the whereabouts of [client #2's] [name of store] gift card. There are discrepancies between many of the statements, typically regarding the timeline of events: [Staff #4] sent an email on 1/7/16, stating that she'd</p>			

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	<p>discovered the missing card that day, but in verbal testimony to investigator, she stated that this happened on 1/6/16. [Staff #2] stated that he last saw the cards on 1/7/16, which is the day they were discovered to be missing. Several staff members raised suspicion about other staff members in their statement, either explicitly or implicitly. One staff member went so far as to name two other staff and call them 'liars, not to be trusted.'" The Analysis of Evidence &amp; (and) Findings section indicated, "It is not possible to determine who stole [client #2's] [name of store] gift card, though it was certainly a person with access to the house and knowledge of the cards' whereabouts. It is not possible to determine which staff member may have stolen the card. While the perpetrator of this theft cannot be named definitively, the fact that [client #2's] gift card was taken, combined with the fact that this occurred at the same time that two staff members claim that their cash holiday cards were also taken, indicates that financial exploitation did indeed occur... Substantiated." The Recommended Corrective Action(s) section indicated, "Replace [client #2's] \$10 [name of store] gift card. Retrain all [name of group home] staff on the prevention of abuse, neglect and exploitation. Retrain all staff regarding management of client finances</p>				

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	<p>and the proper way to document and safeguard client financial instruments. [Name of group home] support team should address and work to remedy the apparent culture of mistrust and suspicion among staff members. Reassignment of staff to alternate work sites may be a fitting option."</p> <p>On 2/12/16 at 12:56 PM, the Fiscal Coordinator (FC) indicated client #2 was reimbursed on 1/14/16.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated the former Coordinator brought the clients' funds to the office for a period of time in September 2015 after client #6 was missing \$20.00. The Coordinator indicated he was unsure how often the clients' personal funds were accounted for by the group home staff. The Coordinator indicated the Group Home Manager counted the clients' funds. The Coordinator indicated there was no change in the accounting of the clients' funds at the group home. The Coordinator indicated all the staff who worked at the group home continue to have access to the clients' funds.</p> <p>On 2/16/16 at 2:32 PM, the AGHD indicated she was unsure when client #2, #3, and #4's personal funds were returned to the group home. The AGHD indicated</p>			

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	<p>she was unsure how often the clients' funds were accounted for by the group home staff. The AGHD indicated she was unsure if there was a policy to account for the clients' funds. The AGHD stated, "there's got to be a policy." The AGHD indicated there was no increased monitoring of the clients' funds or no changes to the system for storing the clients' funds.</p> <p>11) On 1/15/16 at 9:00 PM, client #1 was not administered Levothyroxine 50 mg (hypothyroid - low thyroid) due to the medication not being in the home and was not delivered by the pharmacy. The 1/16/16 Medication Error Report was blank in the Document Action Taken section. There was no documentation staff #15 received corrective action.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p>			

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W 0159 Bldg. 00	<p>This federal tag relates to complaint #IN00182639.</p> <p>9-3-2(a)</p> <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 (#3 and #5), the Qualified Intellectual Disabilities Professional (QIDP) failed to coordinate, integrate and monitor the clients' program plans by failing to review the clients' progress toward completing their training objectives.</p> <p>Findings include:</p> <p>On 2/12/16 at 1:48 PM, a review of client #3's record was conducted. There was no documentation client #3's training objectives were reviewed on a regular basis during the past 12 months (February 2015 to February 2016). There was no documentation client #3's training objectives were reviewed monthly or quarterly during the past 12 months. There was no documentation of changes made to client #3's objectives when he</p>	W 0159	<p><b>W 159 QIDP(Standard)</b> Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. <b>Corrective action for resident(s) found to have been affected</b> The QIDP will be trained on active treatment programing, development and implementation. The QIDP will be trained on quarterly reports, meetings and documentation of ISP progress towards goals set by the IST. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program</p>	03/20/2016

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W 0249 Bldg. 00	<p>met or did not meet the criteria for completion.</p> <p>On 2/16/16 at 1:12 PM, a review of client #5's record was conducted. There was no documentation in client #5's record indicating client #5's training objectives were reviewed for completion since 9/11/15. There were quarterly reviews completed on 3/7/15, 6/9/15 and 9/11/15 but no additional documentation since 9/11/15 his training objectives were reviewed for completion or revisions needed to be made to the plan.</p> <p>On 2/12/16 at 2:39 PM, the Coordinator (QIDP) indicated the clients' progress toward achieving their program training objectives should be reviewed on a quarterly basis.</p> <p>9-3-3(a)</p> <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 5 of 6 clients living in</p>	W 0249	<p>implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p><b>W 249 Program Implementation (Standard) Client ISPs must consist of needed interventions</b></p>	03/20/2016			

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	<p>the group home (#1, #2, #4, #5 and #6), the facility failed to ensure staff implemented the clients' program plans as written.</p> <p>Findings include:</p> <p>1) On 2/12/16 from 6:03 AM to 8:16 AM, an observation was conducted at the group home. From 6:03 AM to 7:55 AM (at 7:55 AM, client #5's day program staff arrived to work with him), client #5 was walking around the group home without a staff within arm's length of him. Staff #13 and #14 did not keep client #5 within arm's length and did not position themselves in order to see where he was going when he left the living room where they were located. The staff did not position themselves between client #5 and his peers. Clients #1, #3, #4 and #6 were awake and in the common areas of the group home.</p> <p>On 2/16/16 at 1:12 PM, a review of client #5's record was conducted. Client #5's 12/14/15 Behavior Support Plan indicated, in part, "Summary of Procedure(s): General Proactive Strategies: 1. [Client #5] will have a specific staff member assigned as his dedicated staff (intensive staffing), in anticipation of [client #5] waking in the morning, and during each shift. The</p>		<p>and include continuous active treatment. <b>Corrective action for resident(s) found to have been affected</b> QIDP will be trained on active treatment programing, development and implementation. QIDP and staff will be trained on client's ISP and active treatment programing, including use of adaptive equipment (helmet, knee pads) and engaging clients in active treatment (money goals, self care) <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and staff training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility. Until competence/compliance is attained, The QIDP or other QIDP-qualified team members will monitor program implementation at least daily in the home or day program. Competence will be demonstrated by at least seven consecutive visits without program problems such as physical problems in the home, adherence to dining requirements, errorless medication administration, and</p>	

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	<p>dedicated staff will supervise [client #5] so that he does not enter the personal space of his housemates or others, in order to ensure that [client #5] does not have any opportunities to aggress on peers. The dedicated staff will stay within arm's length of [client #5] unless he is in a private space by himself, such as his room, the bathroom, or at home with no other clients present... Staff may keep a light touch or loose grasp on part of [client #5's] clothing in order to keep up with his often darting and unpredictable movements. Any staff assigned to be [client #5's] dedicated staff will retain these responsibilities unless another staff specifically agrees to take over... All staff working around [client #5] as well as his dedicated staff must always be aware of where [client #5] is, what he is doing, what is he looking at and what mood he is in...."</p> <p>On 2/16/16 at 2:15 PM, the Coordinator indicated the staff should implement client #5's plan as written.</p> <p>On 2/16/16 at 2:15 PM, the Assistant Group Home Director indicated the staff should implement client #5's plan as written.</p> <p>2) On 2/11/16 from 3:43 PM to 5:55 PM, an observation was conducted at the</p>		<p>other program implementation taking place during observation. Once competence has been achieved on this level, monitoring will be reduced to a minimum of four observations in home or day program per calendar week until at least two weeks of errorless program implementation is observed. Once this has been met, the minimum monitoring through at least April 20, or longer if needed, will be one documented visit to the home site and one documented visit to the day program per calendar week. When appropriate, the visit will include documentation of providing guidance, mentoring and/or teaching staff members on the correct way to implement program plans. The QIDP is supervised by the SGL Director, and they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>group home. At 4:13 PM when client #6 arrived to the group home, he pushed a walker while walking on his knees into the group home. Client #6 was not prompted to stand up to walk. Client #6 was not encouraged to not walk on his knees. Client #6 was not wearing knee pads during the observation. Client #6 was not prompted to wear his knee pads.</p> <p>On 2/12/16 from 6:03 AM to 8:16 AM, an observation was conducted at the group home. At 6:54 AM, client #6 entered the dining room walking on his knees while pushing a wheelchair. Client #6 was not encouraged to wear knee pads. Client #6 was not encouraged to not walk on his knees.</p> <p>On 2/12/16 at 1:29 PM, a focused review of client #6's record was conducted. Client #6's 11/30/15 Physician's Orders indicated, in part, "Knee pads to be worn during the day to protect knees (ambulation on his knees) as nursing measures are needed." Client #6's 1/20/16 Medication Information Sheet indicated, "Despite repeated refusals, staff will encourage [client #6] to wear knee pads daily as needed during waking hours to protect knees (ambulates on his knees)." Client #6's 2/11/15 Behavior Support Plan indicated, in part, "[Client #6] also has knee pads that he may be</p>			

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	<p>encouraged to wear while he is crawling behind his walker. These are not mandatory, and [client #6] may remove them if he chooses."</p> <p>On 2/16/16 at 11:17 AM, the Nurse Manager (NM) indicated client #6's knee pads were implemented due to thinking he was damaging his knees while walking on them. The NM indicated client #6's physician assessed his knees and client #6 was not damaging his knees however the physician ordered the use of knee pads. The NM indicated client #6 refused to wear his knee pads. The NM indicated the staff should encourage client #6 to not walk on his knees.</p> <p>3) On 2/11/16 from 2:52 PM to 3:12 PM and 2/12/16 from 11:58 AM to 12:52 PM, observations were conducted in the facility-operated day program room where clients #2, #4 and #6 were located. On 2/11/16 at 2:52 PM, client #2 stood by the exit door to the room. Client #4 was sitting in a chair next to the exit door. Client #6 was in a chair with rollers moving around the room. At 3:06 PM, client #2 was asleep. Client #4 was sitting in the chair by the door. Client #6 was in the chair with rollers. During the 2/11/16 observation, clients #2, #4 and #6 were not engaged in activities and were not prompted to participate in</p>			

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	<p>activities. There were no activities offered or provided to the clients. On 2/12/16 at 11:58 AM, client #4 was sitting in a chair by the door wearing a coat and gloves. Client #6 was eating lunch. Client #2 was in a recliner asleep. At 12:06 PM, client #2 was asleep, client #6 finished his meal and left his lunch supplies on the table. Client #4 was sitting in a chair by the door. At 12:13 PM, client #6 was in a rolling chair looking out the window. Client #2 was asleep in a recliner. Client #4 was sitting in a chair by the door. At 12:27 PM, there was no change. At 12:37 PM, client #2 was awake and sitting in the recliner. Client #4 was sitting in a chair by the door. Client #6 was looking out the window. At 12:43 PM, client #2 got up to eat his lunch. Client #4 was in the chair by the door and client #6 continued to look out the window. At 12:52 PM, client #2 was eating lunch, client #4 was sitting in a chair and client #6 was looking out the window.</p> <p>On 2/12/16 at 12:22 PM, a review of the undated active treatment schedule posted on the wall indicated from 12:00 PM to 1:00 PM, the clients were to eat lunch and watch a video. Clients #2, #4 and #6 were not interested or engaged in the video and were not provided/offered alternative activities.</p>						

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	<p>On 2/16/16 at 11:22 AM, a review of client #2's 4/8/15 Individual Program Plan (IPP) indicated he had the following training objectives: participate in ostomy care routine, engage with money, exercise pedestrian safety skills, engage with staff while listening to the self protective response questions, go to the medication area when it was time for medications and comply with his toothbrushing routine.</p> <p>On 2/12/16 at 1:21 PM, a review of client #4's 3/31/15 IPP indicated he had the following training objectives: remain engaged for 10 minutes or more in Lifelong Learning (day program) activities, make a purchase, pedestrian safety skills, brush his teeth and use mouthwash, fill water pitcher for medication pass and follow diet guidelines.</p> <p>On 2/12/16 at 1:29 PM, a review of client #6's 7/7/15 IPP indicated he had the following training objectives: wash his hands after being shown a picture card, view and hold a \$1.00 bill for at least 10 seconds, use the restroom without prompts, pedestrian safety skills, respond to being told it was time for medications by going to the medication area and brush his teeth.</p>			

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	<p>On 2/12/16 at 2:51 PM, the Coordinator indicated the clients should be engaged in activities while at the facility-operated day program. The Coordinator indicated the clients had program plans the staff could work on at the day program.</p> <p>On 2/12/16 at 2:52 PM, the Nurse Manager indicated the staff should engage the clients at least every 15 minutes.</p> <p>On 2/16/16 at 2:20 PM, the Assistant Group Home Director (AGHD) indicated the clients needed to be engaged in activities. The AGHD indicated the clients had plans that needed to be implemented during the day program hours (8:00 AM to 4:00 PM).</p> <p>4) On 2/12/16 from 6:03 AM to 8:16 AM, an observation was conducted at the group home. At 7:15 AM while client #1 was eating oatmeal with bananas at the dining room table, he was not supervised/monitored by the staff. Client #1 was unsupervised for a period of three minutes.</p> <p>On 2/12/16 at 1:00 PM, a review of client #1's record was conducted. Client #1's 10/1/15 IPP indicated, in part, "[Client #1] NEEDS MONITORED AT ALL</p>			

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W 0259 Bldg. 00	<p>TIMES WHILE EATING. HE WILL PUT TOO MUCH FOOD IN HIS MOUTH AT TIMES. HE COULD BE AT RISK FOR CHOKING DUE TO THIS."</p> <p>On 2/12/16 at 3:05 PM, the Coordinator indicated client #1's plan should be implemented as written for supervision during meal times.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; 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 1 of 3 clients in the sample (#5), the facility failed to ensure client #5's comprehensive functional assessment was reviewed for relevancy and updated as needed at least annually.</p> <p>Findings include:</p> <p>On 2/16/16 at 1:12 PM, a review of client #5's record was conducted. Client #5's most recent comprehensive functional assessment (CFA) was dated 12/15/14. There was no documentation in client</p>	W 0259	<p><b>W 259 Program Monitoring and Change(Standard)</b> At least annually, the comprehensive functional assessment of each client must be reviewed by interdisciplinary team for relevancy and updated as needed. <b>Corrective action for resident(s) found to have been affected</b> The QIDP will be trained on comprehensive functional assessments. Training will include annual update and review to ensure that the assessment remains relevant. <b>How facility will identify other residents potentially affected &amp; what</b></p>	03/20/2016

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W 0260 Bldg. 00	<p>#5's record indicating his CFA was reviewed and updated annually.</p> <p>On 2/16/16 at 2:59 PM, the Assistant Group Home Director (AGHD) indicated the CFA should be reviewed and updated at least annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; 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 1 of 3 clients in the sample (#5), the facility failed to ensure client #5's individual program plan was revised at least annually.</p> <p>Findings include:</p> <p>On 2/16/16 at 1:12 PM, a review of client #5's record was conducted. Client #5's most recent individual program plan was</p>	W 0260	<p><b>measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p><b>W 260 Program Monitoring and Change(Standard)</b> At least annually, the individual program plan must be revised. <b>Corrective action for resident(s) found to have been affected</b> The QIDP will be trained on individual program planning. Ongoing internal review of client records, including ISP by SGL director. Schedule of all annual meetings to be implemented. <b>How facility will identify other residents potentially affected &amp;</b></p>	03/20/2016

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W 0318 Bldg. 00	<p>dated 12/15/14. There was no documentation in client #5's record indicating his program plan was revised and updated annually.</p> <p>On 2/16/16 at 2:59 PM, the Assistant Group Home Director (AGHD) indicated the program plan should be revised and updated annually.</p> <p>9-3-4(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Health Care Services. The facility's Health Care Services failed to implement appropriate corrective actions to address recurrent issues with medication errors. The facility's Health Care Services failed to implement increased monitoring and oversight of the clients' medication administration procedures to ensure staff administered</p>	W 0318	<p><b>what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p> <p><b>W 318 Health Care Services (Condition)</b>The facility must ensure that specific health care services requirements are met.<b>Corrective action for resident(s) found to have been affected</b>Those staff members who were responsible for medication errors will be fully retrained, including competency-based observation of errorless medication pass. In order to reduce future medication errors, a new medication summary sheet will be added to the home that simplifies</p>	03/20/2016	

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	<p>the clients' medications in accordance with their physician's orders.</p> <p>Findings include:</p> <p>1) Please refer to W331. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's nursing services failed to implement appropriate corrective actions to address recurrent issues with medication errors. The facility's Health Care Services failed to implement increased monitoring and oversight of the clients' medication administration procedures to ensure staff administered the clients' medications in accordance with their physician's orders.</p> <p>2) Please refer to W368. For 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to administer the clients' medications in accordance with their physician's orders.</p> <p>9-3-6(a)</p>		<p>directions for staff. All staff across all shifts will be trained to use this form. Documented oversight, including medication administration monitoring, will be increased by nursing staff and QIDP. When new errors occur, quick and thorough follow-up will be put in place, including retraining and discipline where warranted. Each incident report will be reviewed during the new Incident Oversight meeting, which is a regular team and administrator meeting that will be held in order to ensure that adequate follow-up takes place to prevent recurrence for each incident report in the home, including medication errors. <b>How facility will identify other residents potentially affected &amp; what measures taken</b>All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b>Added oversight, including medication administration monitoring will be increased and documented. QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility, including medication errors. The nurse also coordinates health care and monitors medication</p>	

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			<p>administration. Until competence/compliance is attained, The QIDP or other QIDP-qualified team members will monitor program implementation at least daily in the home or day program. At least two of these visits per week will include a medication pass observation. Competence will be demonstrated by at least seven consecutive visits without program problems such as physical problems in the home, adherence to dining requirements, errorless medication administration, and other program implementation taking place during observation.</p> <p>Once competence has been achieved on this level, monitoring will be reduced to a minimum of four observations in home or day program per week until at least two weeks of errorless program implementation is observed. At least one of these observations will include medication pass.</p> <p>Once this has been met, the minimum monitoring through at least April 20, or longer if needed, will be one documented visit to the home site and one documented visit to the day program per calendar week. When appropriate, all visits listed above will include documentation of providing guidance, mentoring and/or teaching staff members on the correct way to implement program plans. In addition, until at</p>	

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W 0331  Bldg. 00	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 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's	W 0331	least April 20, and longer if medication error problems persist, the nurse will monitor two or more medication passes per calendar week. These visits will be documented on a home visit form that includes a check off for observation of medication pass. Each form also includes an area for the nurse to summarize counseling/training when that is appropriate. In addition, a new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.  <b>W 331 Nursing Services (Standard)</b> The facility must provide clients with nursing	03/20/2016	

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	<p>nursing services failed to implement appropriate corrective actions to address recurrent issues with medication errors. The facility's Health Care Services failed to implement increased monitoring and oversight of the clients' medication administration procedures to ensure staff administered the clients' medications in accordance with their physician's orders.</p> <p>Findings include:</p> <p>On 2/11/16 at 11:46 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 11/16/15 at 2:00 PM, client #5 did not receive Clonidine (aggression and agitation) from staff #6. On 11/16/15 at 3:00 PM, client #5 did not receive Risperdal (aggression and agitation) from staff #6. The 11/17/15 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, in part, "This med error was discovered during a buddy check. There is no known effect to [client #5] due to the med error." The 11/16/15 Medication Error Report indicated, "Supervisor: Document action taken: Verbal discussion/training." There was no documentation staff #6 received training.</p>		<p>services in accordance with their needs. <b>Corrective action for resident(s) found to have been affected</b> In order to reduce medication errors, a new medication summary sheet will be added to the home that simplifies directions for staff. All staff across all shifts will be trained to use this form. Added oversight, including medication administration monitoring will be increased and documented by nursing staff and QIDP following medication errors This monitoring activity will be reviewed during the new Incident Oversight meeting, which is a regular team and administrator meeting that will be held to ensure that adequate follow-up takes place to prevent recurrence for each incident report in the home. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Added oversight, including medication administration monitoring will be increased and documented. QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> Until at least April 20, and longer if medication error problem persists, the nurse will monitor one or more medication</p>	

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	<p>2) On 11/26/15 at 7:00 AM, client #4 did not receive Lisinopril (hypertension) from staff #10. The 11/26/15 Medication Error Report (MER) was blank in the Document Action Taken section. The MER indicated in the training section, "no," in response to whether or not the staff needed additional training. There was no documentation staff #10 received corrective action.</p> <p>3) On 12/5/15 at 7:00 AM, client #3 did not receive Levetiracetam (anticonvulsant) as ordered. Staff #5 administered one tab instead of two tabs to client #3. The 12/5/15 Medication Error Report (MER) was blank in the Document Action Taken section. The MER was blank in the training section in response to whether or not the staff needed additional training. There was no documentation staff #5 received corrective action.</p> <p>4) On 12/17/15 at 7:00 PM, staff #6 administered the incorrect dose of Tamsulosin (enlarged prostate) to client #4. Client #4 received one of two caps of the medication. The 12/19/15 BDDS report indicated, "On 12/18/2015, this med error was discovered during a buddy check. Pager was notified. There is no known effect to [client #4] due to this med error. Staff will be disciplined as</p>		<p>pass per calendar week. These visits will be documented on a home visit form that includes a check off for observation of medication pass. Each form also includes an area for the nurse to summarize counseling/training when that is appropriate. In addition, a new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>				

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	<p>per Stone Belt's med error policy." There was no documentation of corrective action with staff #6.</p> <p>5) On 12/22/15 at 7:00 AM, client #2 did not receive Depakote Sprinkles (seizures) 1000 mg (milligrams) as ordered. The 1/4/16 BDDS report indicated, "...Although this med was prepared with applesauce, staff did not administer this medication. This med error was discovered on 12/22/2015 when day aide (sic) found the med cup and apple sauce. Nurse was notified with instructions to continue administering medications at 2:00 pm; nurse notified psych (psychiatrist) and neurologist. The effect to [client #2] was that he didn't get his next dose until 2:00 pm. Staff will be disciplined as per Stone Belt's med error policy." The 12/30/15 Medication Error Report indicated, in part, "Med was in apple sauce and set aside due to staff preparing the med to (sic) soon... Day aide (sic) got back to the house and found the med cup and apple sauce." The Document Action Taken section indicated, "Verbal Discussion/Training."</p> <p>The 1/11/16 Investigation Report indicated in the Brief Summary of the Reason to Investigate section, "There is evidence that medication administration at [name of group home] has not been</p>				

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	<p>accurate. There is evidence that Stone Belt medication administration policy has not been followed, resulting in medication errors. Moreover, medication errors have not been reported properly. Due to missed medication and lack of proper reporting, a client was at risk." The Evidence Summary section indicated, "Evidence shows that [client #2] did not receive his morning seizure medication, Depakote on 12/22/15 and 1/4/16 (see below for additional information). On 12/23/15 [client #2] had a seizure that required Diastat medication and to be seen at the emergency room. Staff did not follow medication administration policies as well as incident reporting policies for the 12/22/15 incident. The result of the staff not following policies resulted in [client #2] missing his morning medication on 1/5/16. The result of [client #2] missing his medication was another severe seizure with admission of Diastat and 3 falls at day program." The Investigation Report indicated, "Was Stone Belt medication administration policy followed? NO. Staff that admitted to missing [client #2] morning medication twice, also admitted that he marked that the client HAD received his medication, as he marked it BEFORE actually giving it to the client. Was Stone Belt reporting policy followed? NO. The staff that</p>						

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	<p>found the med error, did not report the incident in writing until 12/30/15. The coordinator of the group home, received the medication error IR (incident report) on 12/30/15 but did not submit until 1/4/16. The coordinator requested that the IR be sent to the proper staff via email, however there was no follow up. Did the lack of proper medication administration and medication error reporting lead to a client having a medical injury? YES. [Client #2] has (sic) severe seizures following both days that he missed his morning medication, Depakote (he takes to control his seizures). The incident on 12/22/15, if properly reported, could have prevented the incident on 1/5/16." The investigation's Recommended Corrective Action(s) section indicated, "Staff to be re-trained on medication administration. Staff to be re-trained on reporting incidents. Staff to be trained on Prevention of Abuse and Neglect."</p> <p>The Investigation Report included the following timeline: -12/22/15 [Staff #10 does not administer [client #2's] morning medication 1,000 mg Depakote. He signs that medication was administered. -12/22 [Staff #4] found medication, informed nurse and day program coordinator. She did not submit IR.</p>			

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	<p>-12/23 [Client #2] has severe seizure, needed Diastat medication and went to ER (emergency room). -Day program staff wrote IR for this incident and submitted it. -12/28 Day program coordinator, [name] spoke to [Group Home Coordinator] about recent incident of seizure activity in light of the missed medication. [Day Program Coordinator] asked about an IR for the missed meds. -12/29 [Group Home Coordinator] requests [staff #4] write IR for 12/22 missed medication incident and send to IR meds, as well as [former Group Home Director] and himself. -12/30 [Staff #4] wrote med error IR and sent to [Group Home Coordinator] and [Group Home Director]. NOT IR email. -1/4/16 IR was routed to [Administrative Assistant] who filed it with the state. -The facility substantiated there was evidence of abuse/neglect/exploitation.</p> <p>On 2/16/16 at 1:03 PM, the AGHD provided a copy of staff #10's Performance Review. The review indicated, in part, "[Staff #10] failed to admin (administer) [client #2's] Depakote. Investigation is located in CIR (Confidential Incident Report). [Staff #10] will be required to complete Core A and B (facility's medication training program)." The Performance Review</p>			

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	<p>was dated 1/4/16 at the top of the form and staff #10 signed the form on 1/15/16.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's Seizure Tracking Log for December 2015 was reviewed. Client #2 had two seizures on 12/22/15. The first seizure was at 11:25 AM for 45 seconds. The second seizure was at 12:00 PM for 45 seconds. Client #2 had a 23 minute seizure on 12/23/15 at 1:00 PM.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 12/22/15 Nursing Consultation note indicated, in part, "Call received by nurse from day aide (sic) (11:45 AM) stating that [client #2] was not given his 7am medication by staff (which included medications for seizures and agitation). Day aide (sic) asking whether or not she can give [client #2's] 7am meds at day program and push back other med times. Nurse directed day aide (sic) to give [client #2] all of his 7am meds with the exception of his Depakote (seizures) and Carnitor (Carnitine is a naturally occurring substance that the cells of mammals need to produce energy. Carnitor is used to treat carnitine deficiency) since she receives these two meds three times daily and the next time to receive these is at 2pm (times too close together to spread out). Day aide (sic) verbalized understanding of directives.</p>			

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	<p>LL (Life Long Learning) Coordinator notified of missed medications, LL Coordinator states that day staff have not seen any seizure activity or unusual behaviors from [client #2] today. Nurse notified Coordinator of plan for [client #2] to receive all AM meds except for Depakote and Carnitor, Coordinator directed by nurse to give [client #2] these two meds at next scheduled time (2pm) as well as to continue to monitor [client #2] for any seizure activity - Coordinator verbalized understanding of directives. [Psychiatrist] and [Neurologist] notified by nurse of missed medications."</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 12/23/15 Outside Services Report indicated he was seen at the emergency room on 12/23/15 due to seizure activity.</p> <p>On 2/12/16 at 6:47 AM, staff #4 indicated on 12/22/15 she discovered client #2's medication (Depakote) in a cup of applesauce in the medication room. Staff #4 indicated client #2 had a seizure on 12/22/15 due to the missed medication. Staff #4 indicated staff #10 was terminated. Staff #4 indicated the group home staff received retraining on medication administration and the Nurse Manager observed all the staff administer medications during one medication pass.</p>			

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	<p>On 2/12/16 at 2:54 PM, the Nurse Manager (NM) stated he was "99% sure" client #2's seizure on 12/23/15 was related to missing his seizure medication on 12/22/15. On 2/16/16 at 11:38 AM, the NM indicated the staff should administer client #2's medication as prescribed by the physician. The NM indicated he observed two staff administer medications one time. The NM indicated he was not sure if the group home administrative staff increased the monitoring and supervision of medication administration. The NM indicated the facility should have increased the monitoring of medication administration to the clients.</p> <p>On 2/16/16 at 2:03 PM, the AGHD stated the corrective action was "not sufficient." The AGHD stated we, "need to do more."</p> <p>6) On 12/23/15 at 12:20 PM at the facility operated day program, client #2 had a seizure. After three minutes of continuous seizures, his PRN (as needed medication) was administered. Client #2 made brief eye contact after the as needed medication was administered. Client #2 continued to have tremors. Staff contacted the nurse. The plan was to monitor and if he continued to have seizures after the 30 minute mark, staff</p>			

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	<p>was to contact 911. At the 27 minute mark, client #2 made eye contact with staff. Shortly after the 30 minute mark, client #2 had another seizure. The nurse was contacted and 911 was called. Client #2 was transported to the emergency room (ER).</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 12/23/15 Nursing Consultation notes indicated, in part, "Call received by nurse from LL coordinator (12:35p) stating that [client #2] has been having seizure activity for the past 15 minutes, with the longest seizure being over 3 minutes. Per risk plan protocol coordinator stated [client #2] was given Diastat. Coordinator stated that [client #2] is currently on the floor and experiencing slight 'jerks' in the shoulder region, in able to respond to staff but is lethargic and has a 'dazed' look on his face. Coordinator also stated that at no time did [client #2] fall. Nurse directed coordinator to continue to monitor status, that the Diastat would make [client #2] a bit lethargic, and that if [client #2] experiences any more seizure activity over the next 10 minutes then he will need to go to the ER per risk plan for eval/tx (evaluation/treatment) - coordinator verbalized understanding of directives."</p>			

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	<p>A second Nursing Consultation note, dated 12/23/15 at 12:50 PM, indicated, "Nurse contacted LL coordinator to f/u (follow up) on [client #2's] current status, coordinator stating that [client #2] had returned to baseline, was lying on a mat playing with his rope and was responding to staff appropriately. Nurse directed coordinator to continue to monitor [client #2's] status and if seizure activity reoccurs to contact nurse immediately for further directives."</p> <p>A third Nursing Consultation note, dated 12/23/15 at 1:00 PM, indicated, "Call received by nurse from LL coordinator stating that [client #2] had resumed seizure activity, per risk plan nurse directed coordinator to call 911 and have [client #2] transported to the ER for treatment and eval."</p> <p>Client #2's 12/24/15 Nursing Consultation note indicated, "Nurse contacted house staff to f/u (follow up) on ER visit the previous afternoon/evening. Staff state that [client #2] is doing well, no adverse effects noted from seizure activity the previous day - no specific directives from the ER other than to f/u with his neurologist (name). Staff directed to call nurse/nurse pager if [client #2] starts experiencing continuous seizure activity again, staff</p>			

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	<p>verbalized understanding of directives."</p> <p>On 2/12/16 at 2:54 PM, the Nurse Manager (NM) stated he was "99% sure" client #2's seizure on 12/23/15 was related to missing his seizure medication on 12/22/15. On 2/16/16 at 11:54 AM, the NM indicated he was in communication with the LL Coordinator during client #2's seizure activity. The NM indicated client #2 had a seizure, returned to baseline and then had another seizure. The NM indicated he instructed the day program staff to call 911. The NM indicated none of the seizures lasted more than 5 minutes. The NM indicated client #2's plan indicated for staff to call 911 for any seizure activity lasting more than 5 minutes. The NM indicated since client #2 had continuous seizure activity, he directed the staff to call 911.</p> <p>7) On 1/2/16, 1/3/16 and 1/4/16 during client #1's bedtime medication administration, staff #6 and #10 administered client #1 the wrong dose of is Levothyroxine (low thyroid). The 1/5/16 BDDS report indicated, in part, "...Physician's order is for [client #1] to be administered Levothyroxine 50 mcg (microgram) on Thursdays and Fridays only. However, this medication was given on Saturday, Sunday and Monday evenings. On 01/04/2016, this med error</p>			

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	<p>was found during a buddy check at HS (hour of sleep). There was no observable effect to [client #1] due to this med error." The BDDS report indicated, "Staff will be disciplined as per Stone Belt's med error policy." The 1/4/16 Medication Error Report was blank in the Document Action Taken section for corrective actions. There was no documentation staff #6 and #10 received corrective action.</p> <p>8) On 1/5/16 at 7:15 AM, staff #10 did not administer client #2's Depakote Sprinkles 1000 mg (seizures) as ordered. The 1/6/16 BDDS report indicated, in part, "...This med error was discovered when staff found all meds in the applesauce in [client #2's] room. Nurse and client support Coordinator notified. The effect to [client #2] was seizures after noon and he was administered Diastat. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>On 1/5/16 at 9:30 AM at the facility operated day program, client #2 stepped backward and tripped. He fell backwards and hit the right side of his head. No injury noted at the time.</p> <p>On 1/5/16 at 1:15 PM at the facility operated day program, client #2 was sitting in the hallway. Client #2 had a</p>			

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	<p>seizure, fell over and hit his head.</p> <p>On 1/5/16 at 2:10 PM at the facility operated day program, client #2 had a seizure, fell over and hit his head. Client #2 landed on his side and hit the back part of his head. Client #2 put on his helmet following the seizure.</p> <p>On 2/12/16 at 2:54 PM, the NM indicated the staff failing to administer client #2's seizure medication caused client #2 to have seizures. The NM indicated the group home staff was retrained following the 1/5/16 medication error. The NM indicated the same staff was involved in both medication administration errors. The NM indicated he instructed the day aid to administer all morning medications following the two incidents.</p> <p>The 1/7/16 BDDS report indicated, in part, "On 01/05/2016 at 1:15 pm, [client #2] was sitting out in the hallway of room 1 in day program. [Client #2] began seizing, fell over while seated and hit his head. [Client #2] fell to his right and hit the corner of the left side to his head. Coordinator and nurse were notified; [client #2] had no injury. [Client #2] fell 3x (three times) today (9:30 am, 1:15 pm, and 2:10 pm). He was checked by a nurse each time. He was willing to wear a helmet after the 3rd fall. He</p>				

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	<p>experienced a 3 minute plus seizure after the third fall, and diastat was administered per risk plan. I have emailed team requesting a consideration of changing [client #2's] schedule to help him have more time in the morning to prepare for the day, suggesting that his [day program] staff begin their day at [name of group home]. Staff will continue to monitor [client #2's] condition for injury."</p> <p>The 1/11/16 Investigation Report indicated in the Brief Summary of the Reason to Investigate section, "There is evidence that medication administration at [name of group home] has not been accurate. There is evidence that Stone Belt medication administration policy has not been followed, resulting in medication errors. Moreover, medication errors have not been reported properly. Due to missed medication and lack of proper reporting, a client was at risk." The Evidence Summary section indicated, "Evidence shows that [client #2] did not receive his morning seizure medication, Depakote on 12/22/15 and 1/4/16 (see below for additional information). On 12/23/15 [client #2] had a seizure that required Diastat medication and to be seen at the emergency room. Staff did not follow medication administration policies as</p>			

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	<p>well as incident reporting policies for the 12/22/15 incident. The result of the staff not following policies resulted in [client #2] missing his morning medication on 1/5/16. The result of [client #2] missing his medication was another severe seizure with admission of Diastat and 3 falls at day program." The Investigation Report indicated, "Was Stone Belt medication administration policy followed? NO. Staff that admitted to missing [client #2] morning medication twice, also admitted that he marked that the client HAD received his medication, as he marked it BEFORE actually giving it to the client. Was Stone Belt reporting policy followed? NO. The staff that found the med error, did not report the incident in writing until 12/30/15. The coordinator of the group home, received the medication error IR (incident report) on 12/30/15 but did not submit until 1/4/16. The coordinator requested that the IR be sent to the proper staff via email, however there was no follow up. Did the lack of proper medication administration and medication error reporting lead to a client having a medical injury? YES. [Client #2] has (sic) severe seizures following both days that he missed his morning medication, Depakote (he takes to control his seizures). The incident on 12/22/15, if properly reported, could have prevented</p>			

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	<p>the incident on 1/5/16." The investigation's Recommended Corrective Action(s) section indicated, "Staff to be re-trained on medication administration. Staff to be re-trained on reporting incidents. Staff to be trained on Prevention of Abuse and Neglect."</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's 1/5/16 Nursing Consultation note indicated, "Nurse visited with [client #2] at his home (in evening) following seizure activity at LL (day program) earlier in the day. [Client #2] was in good spirits, no s/s (signs/symptoms) of concussion noted. Previous red mark noted to right temple region still visible but much faded. House staff was directed to continue to monitor status and if seizure activity resumed to follow risk plan as written and contact nurse as needed. During conversation with one staff member, nurse found out that [client #2] did not receive his morning medications that day which included medication for seizures (Depakote), staff member showed nurse the cup of medication mixed with applesauce. When nurse asked staff member where he had found the cup of medicine, the staff member replied 'in [client #2's] room.' Reviewing the MARs (Medication Administration Record) the nurse noted that [client #2's] meds had been signed</p>			

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	<p>off as having been given. After further investigation nurse noted that staff member responsible for [client #2] missing AM (morning) meds was the same staff member who committed the same med error (not giving [client #2's] AM medications) on 12/22/15. Nurse consulted with SGL (Supported Group Living) director and coordinator responsible for the house, the decision was made that the staff person responsible for the error would have his med administration privileges suspended, that this staff person would have to re-take Core A and Med Administration training, and that after training it would be determined alone by the nurse if/when this particular staff person would have his med administration privileges reinstated."</p> <p>On 2/16/16 at 1:03 PM, the AGHD provided a copy of staff #10's Performance Review. The review indicated, in part, "[Staff #10] failed to admin (administer) [client #2's] Depakote. Investigation is located in CIR (Confidential Incident Report). [Staff #10] will be required to complete Core A and B (facility's medication training program)." The Performance Review was dated 1/4/16 at the top of the form and staff #10 signed the form on 1/15/16.</p> <p>On 2/16/16 at 11:38 AM, the NM</p>			

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	<p>indicated the staff should administer client #2's medication as prescribed by the physician. The NM indicated he observed two staff administer medications one time. The NM indicated he was not sure if the group home administrative staff increased the monitoring and supervision of medication administration. The NM indicated the facility should have increased the monitoring of medication administration to the clients.</p> <p>On 2/16/16 at 2:03 PM, the AGHD indicated the facility should ensure client #2's medications were administered as prescribed by his physicians. The AGHD indicated the facility suspended staff #10 after the 1/5/16 medication error to client #2, investigated the incident, and retrained staff on medication administration and reporting. The AGHD stated the corrective action was "not sufficient." The AGHD stated we, "need to do more."</p> <p>9) On 1/15/16 at 9:00 PM, client #1 was not administered Levothyroxine 50 mg (hypothyroid - low thyroid) due to the medication not being in the home and was not delivered by the pharmacy. The 1/16/16 Medication Error Report was blank in the Document Action Taken section. There was no documentation</p>			

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	<p>staff #15 received corrective action.</p> <p>10) On 2/9/16 at 8:00 AM, client #2 did not receive MAPAP (aches and pains) as ordered from staff #11. The 2/10/16 BDDS report indicated, "This med error was discovered during HS med pass... There was no noticeable effect to [client #2] due to this med error." Staff will be disciplined as per Stone Belt's med error policy." The 2/9/16 Medication Error Report was blank in the Document Action Taken section. There was no documentation staff #11 received corrective action.</p> <p>On 2/16/16 at 2:31 PM, the Coordinator indicated every medication error should have documented corrective action implemented. The Coordinator indicated it was the responsibility of the Coordinator to implement the corrective action.</p> <p>On 2/16/16 at 10:50 AM, the AGHD indicated there was no documentation corrective action was taken. The AGHD indicated corrective action should have been implemented.</p> <p>On 2/16/16 at 11:29 AM, the Nurse Manager (NM) indicated the Coordinator was responsible for conducting the recommended corrective actions for</p>						

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W 0368  Bldg. 00	<p>medication errors. The NM indicated implementing corrective actions was not a nursing responsibility. The NM indicated every medication error should have corrective action including but not limited to verbal, written, mini plan of correction and suspension of medication administration privileges. The NM indicated he observed, one time, staff #6 who was involved in a medication error to client #1. The NM indicated he observed, one time, staff #4 pass medications to client #2 since she was present on the two days when client #2 did not receive his medications. The NM stated, "I don't know" when asked if there was increased monitoring/supervision of the clients' medication administration by the administrative staff. The NM indicated there should have been more oversight of the staff passing medications than just him.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. 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</p>	W 0368	<p><b>W 368 Drug Administration(Standard)</b> The system for drug administration must assure that all drugs are</p>	03/20/2016			

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	<p>failed to administer the clients' medications in accordance with their physician's orders.</p> <p>Findings include:</p> <p>On 2/11/16 at 11:46 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 11/16/15 at 2:00 PM, client #5 did not receive Clonidine (aggression and agitation). On 11/16/15 at 3:00 PM, client #5 did not receive Risperdal (aggression and agitation). The 11/17/15 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, in part, "This med error was discovered during a buddy check. There is no known effect to [client #5] due to the med error."</p> <p>2) On 11/26/15 at 7:00 AM, client #4 did not receive Lisinopril (hypertension).</p> <p>3) On 12/5/15 at 7:00 AM, client #3 did not receive Levetiracetam (anticonvulsant) as ordered. Staff #5 administered one tab instead of two tabs to client #3.</p> <p>4) On 12/22/15 at 7:00 AM, client #2 did not receive Depakote Sprinkles (seizures)</p>		<p>administered in compliance with the physician's orders <b>Corrective action for resident(s) found to have been affected</b> QIDP and staff will be trained in medication administration. In order to reduce medication errors, a new medication summary sheet will be added to the home that simplifies directions for staff. All staff across all shifts will be trained to use this form. Added oversight, including medication administration monitoring will be increased and documented by nursing staff and QIDP following medication errors. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and staff training will be conducted. Added oversight, including medication administration monitoring will be increased and documented. <b>How corrective actions will be monitored to ensure no recurrence</b> Until at least April 20, and longer if medication error problem persists, the nurse will monitor one or more medication pass per calendar week. These visits will be documented on a home visit form that includes a check off for observation of medication pass. Each form also includes an area for the nurse to summarize</p>				

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	<p>1000 mg (milligrams) as ordered. The 1/4/16 BDDS report indicated, "...Although this med was prepared with applesauce, staff did not administer this medication. This med error was discovered on 12/22/2015 when day aide (sic) found the med cup and apple sauce. Nurse was notified with instructions to continue administering medications at 2:00 pm; nurse notified psych (psychiatrist) and neurologist. The effect to [client #2] was that he didn't get his next dose until 2:00 pm. Staff will be disciplined as per Stone Belt's med error policy." The 12/30/15 MER indicated, in part, "Med was in apple sauce and set aside due to staff preparing the med to (sic) soon... Day aide (sic) got back to the house and found the med cup and apple sauce."</p> <p>5) On 12/17/15 at 7:00 PM, staff #6 administered the incorrect dose of Tamsulosin (enlarged prostate) to client #4. Client #4 received one of two caps of the medication. The 12/19/15 BDDS report indicated, "On 12/18/2015, this med error was discovered during a buddy check. Pager was notified. There is no known effect to [client #4] due to this med error. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>6) On 1/2/16, 1/3/16 and 1/4/16 during</p>		<p>counseling/training when that is appropriate. In addition, a new Incident Oversight meeting will take place on a regular basis to ensure that all corrective action has been completed for incident reports, including medication error reports. The meeting will be chaired by SGL Director (or designee), and incidents will not be considered closed until all follow-up actions are in place. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		

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	<p>client #1's bedtime medication administration, staff #6 and #10 administered client #1 the wrong dose of is Levothyroxine (low thyroid). The 1/5/16 BDDS report indicated, in part, "...Physician's order is for [client #1] to be administered Levothyroxine 50 mcg (microgram) on Thursdays and Fridays only. However, this medication was given on Saturday, Sunday and Monday evenings. On 01/04/2016, this med error was found during a buddy check at HS (hour of sleep). There was no observable effect to [client #1] due to this med error."</p> <p>7) On 1/5/16 at 7:15 AM, staff #10 did not administer client #2's Depakote Sprinkles 1000 mg (seizures) as ordered. The BDDS report indicated, in part, "...This med error was discovered when staff found all meds in the applesauce in [client #2's] room. Nurse and client support Coordinator notified. The effect to [client #2] was seizures after noon and he was administered Diastat. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>8) On 1/15/16 at 9:00 PM, client #1 was not administered Levothyroxine 50 mg (hypothyroid - low thyroid) due to the medication not being in the home and was not delivered by the pharmacy.</p>			

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W 0436 Bldg. 00	<p>9) On 2/9/16 at 8:00 AM, client #2 did not receive MAPAP (aches and pains) as ordered from staff #11. The 2/10/16 BDDS report indicated, "This med error was discovered during HS med pass... There was no noticeable effect to [client #2] due to this med error."</p> <p>On 2/16/16 at 11:38 AM, the Nurse Manager indicated the staff should administer the clients' medications as prescribed by their physicians.</p> <p>On 2/16/16 at 2:03 PM, the Assistant Group Home Director (AGHD) indicated the staff should administer the clients' medications as prescribed by their physicians.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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. Based on observation, interview and record review for 1 of 3 clients in the</p>	W 0436	<b>W 436 Space and Equipment(Standard)</b> The facility must furnish,maintain in	03/20/2016

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	<p>sample with adaptive equipment (#2) and one additional client (#6), the facility failed to ensure client #2 and #6's equipment was present and available to use at the facility-operated day program and client #2's helmet strap was in good repair.</p> <p>Findings include:</p> <p>1) On 2/11/16 from 1:34 PM to 2:00 PM and 2:52 PM to 3:17 PM, an observation was conducted at the facility-operated day program. During the observations, client #2's helmet was not present and available for him to use.</p> <p>On 2/11/16 at 3:11 PM, day program staff #1 was asked if client #2's helmet was present and available for him to wear. Staff #1 checked client #2's backpack and indicated his helmet was not present. Staff #1 indicated client #2 had a plan to use a helmet and the helmet should be available for him to wear.</p> <p>On 2/11/16 from 3:43 PM to 5:55 PM, an observation was conducted at the group home. At 4:16 PM, client #2 arrived home from the day program. Client #2 was not wearing a helmet and there was no helmet in his backpack. None of the evening shift staff knew where client #2's helmet was located.</p>		<p>good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p><b>Corrective action for resident(s) found to have been affected</b> QIDP will be trained about client's adaptive equipment, use and maintenance. New procedure will be developed, to ensure clients are receiving equipment that are ordered for them. A daily check list, derived from the client's need for adaptive equipment will be utilized by house staff and day program staff</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and staff training will be conducted. New procedure will be developed and implemented; check list added</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility, which includes oversight of adaptive equipment. The QIDP is supervised by the SGL Director, they meet regularly.</p>	

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	<p>On 2/11/16 at 4:16 PM, the Coordinator indicated client #2's helmet should be available and present for him to wear when he was at the facility-operated day program. The Coordinator indicated the day program staff should know where client #2's helmet was located.</p> <p>On 2/12/16 from 11:58 AM to 12:52 PM, an observation was conducted at the facility-operated day program. On 2/12/16 at 12:08 PM, day program staff #2 indicated client #2's helmet was in his backpack. Staff #2 indicated client #2's helmet was found on 2/12/16 under his bed. Staff #2 indicated the strap on the helmet was broken therefore the strap could not be used to secure the helmet in place.</p> <p>On 2/16/16 at 11:22 AM, a review of client #2's record was conducted. Client #2's 2/4/16 Fall Risk Plan indicated, in part, "...Staff may also utilize a helmet with [client #2] as needed during times of increased instability in order to protect his head in the event of a fall..."</p> <p>On 2/12/16 at 2:54 PM, the Nurse Manager (NM) indicated client #2's helmet should be present at the facility-operated day program and in good condition. The NM indicated the</p>		<p>The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>use of a helmet was part of client #2's risk plan for falls.</p> <p>On 2/12/16 at 3:05 PM, the Coordinator indicated client #2's helmet was found under his bed on 2/12/16. The Coordinator indicated the strap on the helmet needed to be replaced due to the strap not being able to be fastened.</p> <p>On 2/16/16 at 1:59 PM, the Assistant Group Home Director (AGHD) indicated client #2's helmet should be available to client #2 no matter where he was located. The AGHD indicated the helmet should be in good repair.</p> <p>2) On 2/11/16 from 1:34 PM to 2:00 PM and 2:52 PM to 3:17 PM, an observation was conducted at the facility-operated day program. Client #6 was not wearing knee pads and was not prompted to wear them.</p> <p>On 2/11/16 from 3:43 PM to 5:55 PM, an observation was conducted at the group home. At 4:13 PM when client #6 arrived to the group home, he pushed a walker while walking on his knees into the group home. Client #6 was not prompted to stand up to walk. Client #6 was not wearing knee pads during the observation and he was not prompted to wear them.</p>			

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	<p>On 2/12/16 from 11:58 AM to 12:52 PM, an observation was conducted at the facility-operated day program. During the observations, client #6 was not wearing knee pads and was not prompted to wear them.</p> <p>On 2/12/16 at 1:29 PM, a focused review of client #6's record was conducted. Client #6's 11/30/15 Physician's Orders indicated, in part, "Knee pads to be worn during the day to protect knees (ambulation on his knees) as nursing measures are needed." Client #6's 1/20/16 Medication Information Sheet indicated, "Despite repeated refusals, staff will encourage [client #6] to wear knee pads daily as needed during waking hours to protect knees (ambulates on his knees)." Client #6's 2/11/15 Behavior Support Plan indicated, in part, "[Client #6] also has knee pads that he may be encouraged to wear while he is crawling behind his walker. These are not mandatory, and [client #6] may remove them if he chooses."</p> <p>On 2/16/16 at 11:14 AM, client #6's day program instructor indicated client #6 had a plan to encourage him to not walk on his knees. The instructor stated the plan was "pointless." The instructor indicated client #6 would stand for a</p>			

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W 0440	<p>minute and then get back on his knees. The instructor indicated she was not sure why he did not have knee pads. The instructor indicated she was unaware client #6 should have knee pads. The instructor indicated client #6's knee pads were not sent in and he did not wear them. The instructor indicated the group home staff should bring the knee pads in for the day program to implement the plan. The instructor indicated client #6 could work on wearing his knee pads while at the day program. The instructor indicated she should have known client #6 had as needed knee pads.</p> <p>On 2/16/16 at 11:17 AM, the NM indicated client #6's knee pads were implemented due to thinking he was damaging his knees while walking on them. The NM indicated client #6's physician assessed his knees and client #6 was not damaging his knees however the physician ordered the use of knee pads. The NM indicated client #6 refused to wear his knee pads. The NM indicated the staff encourage client #6 to not walk on his knees.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p>			

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Bldg. 00	<p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p> <p>On 2/11/16 at 3:49 PM, a review of the facility's evacuation drills was conducted. During the day shift (6:00 AM to 2:00 PM), there were no evacuation drills conducted from 10/18/15 to 2/11/16. During the evening shift (2:00 PM to 10:00 PM), there were no evacuation drills conducted from 2/11/15 to 5/31/15. During the night shift (10:00 PM to 6:00 AM), there was one evacuation drill conducted, on 12/17/15, from 2/11/15 to 2/11/16. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 2/11/16 at 4:00 PM, the Coordinator indicated the group home should conduct quarterly evacuation drills for each shift of personnel.</p> <p>9-3-7(a)</p>	W 0440	<p><b>W 440 Evacuation Drills(Standard)</b> The facility must hold evacuation drills at least quarterly for each shift of personnel. <b>Corrective action for resident(s) found to have been affected</b> QIDP and staff will be trained on scheduling and implementing evacuation drills. Ongoing internal review of house drill schedule and implementation of drills. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility, which includes ensuring evacuation drills take place as scheduled. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	03/20/2016	
W 0454	483.470(l)(1) INFECTION CONTROL				

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Bldg. 00	<p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure client #5 and/or the staff immediately cleaned and disinfected the couch after client #5 was incontinent of feces while sitting on the couch.</p> <p>Findings include:</p> <p>On 2/12/16 from 6:03 AM to 8:16 AM, an observation was conducted at the group home. At 6:53 AM, client #5 moaned loudly, bit his hand and hit himself on the head while sitting on a couch in the living room. Client #5 stood up and his garment had feces on it. Client #5 was assisted by staff to clean himself and change his clothes. Staff #13 and #14 who were in the area at the time did not immediately clean the feces off the couch. At 7:17 AM, the feces was still on the couch. From 6:53 AM until 8:00 AM, staff #4, #13 and #14 were in and out of the living room multiple times. None of the staff cleaned the feces off the couch. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>At 8:00 AM when the Day Program Coordinator arrived to the group home,</p>	W 0454	<p><b>W 454 Infection Control(Standard)</b> The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p><b>Corrective action for resident(s) found to have been affected QIDP and all staff</b>, including all working shifts will be trained on infection control, including providing a sanitary environment for clients. The training will include specific examples, such as why and how to respond to a client who is incontinent <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and staff training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility. this includes training and monitoring staff members to ensure that a sanitary environment is maintained. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that</p>	03/20/2016

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W 0488 Bldg. 00	<p>he immediately observed the feces on the couch and stated, "that's interesting." The Day Program Coordinator obtained cleaning supplies and cleaned the feces off of the couch. The Coordinator also removed a cushion from a chair which had a similar area on it and took it to the laundry room. The Coordinator indicated the staff should have immediately cleaned the feces off of the couch.</p> <p>On 2/12/16 at 3:05 PM, the Group Home Coordinator indicated the staff should have immediately cleaned the feces off of the couch.</p> <p>9-3-7(a)</p> <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.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved with meal preparing, serving themselves and packing their own lunches.</p> <p>Findings include:  On 2/11/16 from 3:43 PM to 5:55 PM, an observation was conducted at the group</p>	W 0488	<p>all corrections are in place and that documentation is available at resurvey.</p> <p><b>W 488 Dining Area and Service (Standard)</b> The facility must assure that each client eats in a manner consistent with his or her developmental level. <b>Corrective action for resident(s) found to have been affected QIDP</b> and staff will be trained on importance of ensuring clients are involved in meal preparation, serving themselves and packing their own lunches, consistent with individual developmental level. Staff will be trained on each individual client,</p>	03/20/2016

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	<p>home. At 4:49 PM, staff #6 was in the kitchen cooking dinner. Clients #1, #2, #3, #4, #5 and #6 were not involved with cooking dinner and were not prompted to assist with dinner preparation. Staff #6 prepared the chicken pot pies and salad without the clients' assistance.</p> <p>On 2/12/16 from 6:03 AM to 8:16 AM, an observation was conducted at the group home. At 7:00 AM, client #1 was sitting at the dining room table as staff #4 prepared his oatmeal. At 7:04 AM, staff #4 stirred the oatmeal. At 7:05 AM, staff #4 cut up a banana and put the banana in client #1's oatmeal. At 7:13 AM, staff #13 packed client #1, #2, #3, #4, #5 and #6's lunchboxes. Staff #13 took containers with food in them from the refrigerator and placed them into each of the clients' lunchboxes. At 7:17 AM, staff #13 put bananas into the clients' lunchboxes. Staff #13 placed cheese crackers into the clients' lunchboxes. At 7:35 AM, staff #4 closed up the clients' lunchboxes. At 7:39 AM, staff #4 carried the clients' lunchboxes to the van. At 7:53 AM, staff #4 washed client #1's plate he was using to eat his breakfast and gave it back to him to take to the day program.</p> <p>On 2/12/16 at 2:46 PM, the Coordinator indicated to their ability, the clients</p>		<p>and how to engage them in their home, using specific ideas generated by the support team. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> QIDP and staff training will be conducted. <b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for program implementation and monitoring of the facility. This includes ensuring that clients are engaged in their environment in a way that is consistent with their developmental level. Until at least April 20, and longer if needed, the QIDP will conduct a minimum of one documented visit to the home site and one documented visit to the day program per calendar week. When appropriate, the visit will include documentation of providing guidance, mentoring and/or teaching staff members on the correct way to implement program plans. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>should be involved in meal preparation. The Coordinator indicated there should be some client involvement with meal preparation. The Coordinator indicated the clients should be involved with packing their own lunches.</p> <p>9-3-8(a)</p>				