

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND ST BEDFORD, IN 47421
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey dates: June 2, 3, 4 and 5, 2014</p> <p>Facility Number: 001094 Provider Number: 15G653 AIM Number: 100235630</p> <p>Survey Team: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/11/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 5 of 5 clients living at the group home (#1, #2, #3, #4 and #5) the governing body failed to exercise operating direction over the facility by failing to paint the group home walls.</p> <p>Findings include:</p>	W000104	<p>Addendum #2: Cleaning schedules are being monitored weekly by house manager and coordinator / QDIP. Home inspections are being completed monthly by coordinator / QDIP. These items are monitored by director monthly. Along with the completion of a walk through inspection Deep cleaning every</p>	06/19/2014

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>Observations were conducted at the group home on 6/2/14 from 3:13 PM to 5:32 PM and 6/3/14 from 5:58 AM to 7:53 AM. During the observations, the group home walls were scuffed, marked and stained with nicks and holes in the walls from nails being removed from the walls. This affected clients #1, #2, #3, #4 and #5.</p> <p>On 6/2/14 at 4:25 PM, the Coordinator indicated the group home needed to be painted. The Coordinator indicated there were plans to paint the walls however it had not been scheduled.</p> <p>On 6/2/14 at 5:01 PM, the Home Manager (HM) indicated the group home needed to be painted. The HM indicated getting the house painted had been discussed but it was not scheduled. The HM indicated they needed to pick out colors and submit a work order.</p> <p>On 6/3/14 at 6:45 AM, staff #2 indicated she had worked at the group home for 8-9 years and during that time, she could not remember if the home had been painted. Staff #2 stated if it was painted, it had been "several years." Staff #2 indicated the house needed to be painted. Staff #2 indicated client #5 was hard on the walls due to using a wheelchair.</p>		<p>11 weeks by professional cleaning agency. Are maintenance requests/needs able to be put in by any staff? Who ensures needed repairs are done? Who assesses the cleanliness and general condition of the home? The facility was cited for the home being in disrepair and dirty. How will the facility ensure that it does not get in that condition again? Compiling a quarterly list or monitoring quarterly is not acceptable.</p> <p>Facility staff may email maintenance / cleaning request they are immediately received and repairs are delegated by maintenance director Stephen (Attachment W104-B) Addendum: What Procedure is in place to handle repairs in between the 11 week cleanings? Overnight cleaning list has been implemented (W104-A) Training sheet (W104-B) Plan of Correction: The facility was professionally cleaned (Best & Co.) on 6/19/2014 including a thorough cleaning of black wheelchair scuff marks on all walls and wheelchair guards, and all floors were stripped and waxed. The crew did minor patching and wall repair. The facility is scheduled to be professionally painted. Plan of Prevention: This home is on a rotating schedule to be cleaned professionally every 11</p>		

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W000149	<p>On 6/3/14 at 7:00 AM, staff #6 indicated she had worked at the group home for 16 years. Staff #6 indicated the house had not been painted for the past 10 years. Staff #6 indicated the walls needed to be painted due to the scuffs and marks on the walls. Staff #6 indicated the scuffs and marks would not come off the walls when cleaned.</p> <p>9-3-1(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 record review and interview for 2 of 52 incident reports reviewed affecting clients #1 and #2, the facility neglected to implement its policy and procedure for conducting investigations of injuries of an unknown origin and reporting the incidents to the Bureau of Developmental Disabilities Services in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/2/14 at 11:46 AM and indicated the following:</p>	W000149	<p><i>weeks. The cleaning company writes a report of the condition of the house, makes minor repairs and records any items that need the attention of the maintenance department. The report is sent to the facility's maintenance staff and director. Quality Monitoring: The facility coordinator will complete a quality monitoring checklist at least quarterly which includes prompts on reporting matters of environmental cleanliness and repair. The facility director will review quality monitoring reports.</i></p> <p>Addendum #2: W149 What is the frequency by which the SGL Coordinator will monitor the incident reports? Facility SGL coordinator immediately monitors incident reports along with facility director. They are submitted on our online system and reviews / comments tracked. Plan of Correction: facility coordinator received training in investigating and reporting injuries of unknown origin on 6/7/2014. See Attachment #1 The facility coordinator trained the facility staff on incident reporting and</p>	06/13/2014			

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	1. On 5/3/14 at 7:30 PM, the Stone Belt ARC, Inc. Incident Report, dated 5/3/14, indicated, in part, "When [client #1] got up this am for breakfast, she was limping and said her foot hurt and indicated it was her left foot. She normally has an unsteady gait. I checked her left foot and she had a small light blue bruise between the second and third toes and very minor swelling. I also called [staff #7] to look at it as well. I asked her how she hurt it and she said 'Don't know.' When assisting her this evening with changing her clothes I checked her foot again, she had not complained about it again the rest of the day. The second and third toes on her left foot were purple in color and and (sic) her foot was significantly more swollen that (sic) earlier. I again asked her how she hurt her foot and she said '[Client #5] ran over.' I called the pager cell phone and spoke with [name of Coordinator] who instructed me to go to the ER (emergency room). [Staff #2] came in early to take her. While at the ER she had xrays done and no bones were broken. Our instructions are to elevate her foot as much as she will tolerate. Use ice for swelling as tolerated for 15 to 20 minutes at a time. She is to visit her PCP (primary care physician) in 4 to 5 days." The injury of unknown origin requiring medical evaluation was not investigated.		recognizing and reporting injuries of unknown origin on 6/13/2014. See Attachments #2 and #3. Plan of Prevention: The agency's electronic incident report system has been amended to include a prompt in the way of an attached injury of unknown origin report form to be completed when the incident report describes an injury to a client and does not indicate the known cause. Quality Assurance Monitoring: The facility coordinator has requested that she be notified of all client injuries immediately to assist staff in taking the correct action as well as in meeting reporting requirements. The SGL director will monitor the facilities Incident Reports for compliance.				

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	<p>The 5/3/14 Stone Belt Outside Services Report indicated, "L (left) foot & some toes blue - think got run over by wheelchair. Left foot contusion."</p> <p>On 6/3/14 at 11:47 AM, the Director of Milestones (Division of Stone Belt) Clinical and Health Resources indicated the incident should have been investigated. The Director indicated the documentation was confusing and additional information should have been obtained.</p> <p>On 6/4/14 at 3:11 PM, the Coordinator indicated the incident should have been investigated. The Coordinator indicated the bruise was noted in the morning. When the staff asked client #1 what happened, she indicated she did not know. Later during the day when asked by staff, client #1 indicated client #5 ran over her foot with his wheelchair. The Coordinator indicated client #1 received a medical evaluation. The Coordinator indicated the incident should have been reported to BDDS.</p> <p>2. On 5/9/14 at 5:00 PM, the facility's Incident Report, dated 5/9/14, indicated, in part, "In the am (morning) staff noticed [client #2] had bloodshot eyes and some swelling to both eyes. Staff tried to</p>			

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	<p>contact PCP (primary care physician) who is out of office on Fridays. Staff then spoke with nurse form (sic) on call DR (doctor) and was told Dr (doctor) would call back. No call was ever returned, so Stone Belt nurse looked at [client #2] (and) made recommendations to go to walk-in clinic. Staff [staff #4's name] took [client #2] to Walk-in clinic and was told he should go to the ED (emergency department). Staff then took [client #2] to [name of hospital] for treatment. Was given script for Erythromycin ointment 5 mg (milligrams) to help prevent infection. Was told that blood should reabsorb in a few days and to use cold compresses as needed for swelling." The Stone Belt Outside Services Report, dated 5/9/14, indicated, in part, "Subconjunctival Hemorrhage Bilateral eyes. Cool compresses as needed to eyes." The Nursing Consultation, 2014, for client #2 indicated, in part, "5-9-14 Eye hemorrhages, allergy symptoms. 1645) Reported per Day Program Manager and staff: Today, several bloody-red areas were noted at sclera of OU (oculus uterque - both eyes). Also, client has had nasal drng (drainage)/swelling and had c/o (complained of) of (sic) a scratchy, sore throat. Only difference noted in client's schedule was that client participated at Special Olympics</p>			

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	<p>yesterday; activities held outside. Client left for home before this Nurse's arrival at [name of day program]. Visited client at home. Note several bloody area @ sclera of OU. Also note some swelling at bridge of nose and beneath OS (oculus sinister - the left eye). Freq (frequent) nasal drng noted this afternoon. At first, client stated he was 'alright,' but after further questioning, client admitted that his throat was sore and itching and that his eyes 'hurt.' Instructions given for client to be taken to [name of walk-in clinic]."</p> <p>On 6/4/14 at 3:11 PM, the Coordinator indicated the incident should have been investigated. The Coordinator indicated client #2 went to Special Olympics on a Thursday. When he arrived home, he drank a lot of water and then vomited. On Friday (the next day) when he woke up, his eyes were bloodshot. The staff were directed to take him to the walk-in clinic. The Coordinator indicated it was determined due to exertion from participating in the events, heat and possible allergies as well as the vomiting the night before, it caused petechiae (pinpoint, round spots that appear on the skin as a result of bleeding under the skin). The Coordinator indicated it was not an injury. The Coordinator indicated the cause of the injury was not</p>			

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	<p>investigated. The Coordinator indicated if client #2 was hit the staff would have indicated so and no one indicated he was hit. The Coordinator indicated the documentation does not capture the information conveyed to her by the staff. The Coordinator indicated she was not informed the bridge of client #2's nose was swollen. The Coordinator indicated the incident should have been reported to BDDS.</p> <p>On 6/2/14 at 12:13 PM, a review of the facility's policies and procedures was conducted. The Investigation Protocols, dated August 2010, indicated, in part, "Events Requiring Investigations: Injuries of Unknown Origin. The referral for an investigation of injuries of unknown origin is made by the director of the program to the immediate supervisor or designee." The facility's Incident Reporting Procedure, dated 9/2013, indicated, "Incidents listed 1 through 16 are to be reported to the State following state guidelines and timeframes. Incidents occurring in residential settings are delivered/faxed/sent to regional offices within 24 hours for review." The policy indicated, in part, "8) Injuries of unknown origin that require medical evaluation or treatment or could be indicative of abuse, neglect or</p>						

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W000153	<p>exploitation."</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. Based on record review and interview for 2 of 52 incident reports reviewed affecting clients #1 and #2, the facility failed to report, within 24 hours, in accordance with state law, injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS).</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/2/14 at 11:46 AM and indicated the following:</p> <p>1. On 5/3/14 at 7:30 PM, the Stone Belt ARC, Inc. Incident Report, dated 5/3/14, indicated, in part, "When [client #1] got up this am for breakfast, she was limping and said her foot hurt and indicated it was her left foot. She normally has an</p>	W000153	<p>Addendum #2: W153 Please explain how doing weekly observations would ensure that immediately reporting incidents is occurring? What is being monitored?</p> <p>Weekly observations completed by the coordinator would ensure that staff comprehend how to prevent and report incidents. Staff are trained monthly on prevention and reporting of abuse and neglect (Attachment W153)</p> <p>Addendum: W153 How will the facility monitor the to ensure compliance? Coordinator is to complete weekly house observations and ensure that allegations are reported and investigated (W104-C) See W 149 and attachments. Facility staff have been retrained on on all aspects of incidentreporting</p>	06/24/2014			

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	<p>unsteady gait. I checked her left foot and she had a small light blue bruise between the second and third toes and very minor swelling. I also called [staff #7] to look at it as well. I asked her how she hurt it and she said 'Don't know.' When assisting her this evening with changing her clothes I checked her foot again, she had not complained about it again the rest of the day. The second and third toes on her left foot were purple in color and and (sic) her foot was significantly more swollen that (sic) earlier. I again asked her how she hurt her foot and she said '[Client #5] ran over.' I called the pager cell phone and spoke with [name of Coordinator] who instructed me to go to the ER (emergency room). [Staff #2] came in early to take her. While at the ER she had xrays done and no bones were broken. Our instructions are to elevate her foot as much as she will tolerate. Use ice for swelling as tolerated for 15 to 20 minutes at a time. She is to visit her PCP (primary care physician) in 4 to 5 days." The injury of unknown origin requiring medical evaluation was not reported to BDDS.</p> <p>The 5/3/14 Stone Belt Outside Services Report indicated, "L (left) foot & some toes blue - think got run over by wheelchair. Left foot contusion."</p>		including what constitutes an incident, timelines including reporting to the administrator immediately and to the state agency within 24 hours of areportable condition.	

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	<p>On 6/3/14 at 11:47 AM, the Director of Milestones (Division of Stone Belt) Clinical and Health Resources indicated the incident should have been reported to BDDS.</p> <p>On 6/4/14 at 3:11 PM, the Coordinator indicated the incident should have been reported to BDDS.</p> <p>2. On 5/9/14 at 5:00 PM (incident was not reported to BDDS), the facility's Incident Report, dated 5/9/14, indicated, in part, "In the am staff noticed [client #2] had bloodshot eyes and some swelling to both eyes. Staff tried to contact PCP (primary care physician) who is out of office on Fridays. Staff then spoke with nurse form (sic) on call DR (doctor) and was told Dr (doctor) would call back. No call was ever returned, so Stone Belt nurse looked at [client #2] made recommendations to go to walk-in clinic. Staff [staff #4's name] took [client #2] to Walk-in clinic and was told he should go to the ED (emergency department). Staff then took [client #2] to [name of hospital] for treatment. Was given script for Erythromycin ointment 5 mg (milligrams) to help prevent infection. Was told that blood should reabsorb in a few days and to use cold compresses as needed for swelling." The Stone Belt Outside Services Report,</p>				

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	<p>dated 5/9/14, indicated, in part, "Subconjunctival Hemorrhage Bilateral eyes. Cool compresses as needed to eyes." The Nursing Consultation, 2014, for client #2 indicated, in part, "5-9-14 Eye hemorrhages, allergy symptoms. 1645) Reported per Day Program Manager and staff: Today, several bloody-red areas were noted at sclera of OU (oculus uterque - both eyes). Also, client has had nasal drng (drainage)/swelling and had c/o (complained of) of (sic) a scratchy, sore throat. Only difference noted in client's schedule was that client participated at Special Olympics yesterday; activities held outside. Client left for home before this Nurse's arrival at [name of day program]. Visited client at home. Note several bloody area @ sclera of OU. Also note some swelling at bridge of nose and beneath OS. Freq (frequent) nasal drng noted this afternoon. At first, client stated he was 'alright,' but after further questioning, client admitted that his throat was sore and itching and that his eyes 'hurt.' Instructions given for client to be taken to [name of walk-in clinic]."</p> <p>On 6/4/14 at 3:11 PM, the Coordinator indicated the incident should have been reported to BDDS.</p>			

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W000154	<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 52 incident reports reviewed affecting clients #1 and #2, the facility failed to conduct investigations of injuries of an unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/2/14 at 11:46 AM and indicated the following:</p> <p>1. On 5/3/14 at 7:30 PM, the Stone Belt ARC, Inc. Incident Report, dated 5/3/14, indicated, in part, "When [client #1] got up this am for breakfast, she was limping and said her foot hurt and indicated it was her left foot. She normally has an unsteady gait. I checked her left foot and she had a small light blue bruise between the second and third toes and very minor swelling. I also called [staff #7] to look at it as well. I asked her how she hurt it and she said 'Don't know.' When assisting her this evening with changing</p>	W000154	<p>Facility coordinator / Qipd will complete investigations of all reported abuse and neglect or refer the case to social work department to initiate the investigation (<i>Attachment W153-A</i>). Facility staff have been trained on reporting abuse and neglect in a timely manner. Facility coordinator / Qipd has been trained to investigate all incidents of abuse and neglect Addendum W154 The facility was cited for NOT doing a thorough investigation into injuries of unknown source. How will the facility ensure that thorough investigations are completed?</p> <p>Facility Coordinator has been trained on the thorough investigation of injuries of unknown. New(7/14) Facility Regional Director has completed state investigator training by Stephen.</p>	06/13/2014

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	<p>her clothes I checked her foot again, she had not complained about it again the rest of the day. The second and third toes on her left foot were purple in color and and (sic) her foot was significantly more swollen that (sic) earlier. I again asked her how she hurt her foot and she said '[Client #5] ran over.' I called the pager cell phone and spoke with [name of Coordinator] who instructed me to go to the ER (emergency room). [Staff #2] came in early to take her. While at the ER she had xrays done and no bones were broken. Our instructions are to elevate her foot as much as she will tolerate. Use ice for swelling as tolerated for 15 to 20 minutes at a time. She is to visit her PCP (primary care physician) in 4 to 5 days." The injury of unknown origin requiring medical evaluation was not investigated.</p> <p>The 5/3/14 Stone Belt Outside Services Report indicated, "L (left) foot & some toes blue - think got run over by wheelchair. Left foot contusion."</p> <p>On 6/3/14 at 11:47 AM, the Director of Milestones (Division of Stone Belt) Clinical and Health Resources indicated the incident should have been investigated. The Director indicated the documentation was confusing and additional information should have been</p>			
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	<p>obtained.</p> <p>On 6/4/14 at 3:11 PM, the Coordinator indicated the incident should have been investigated. The Coordinator indicated the bruise was noted in the morning. When the staff asked client #1 what happened, she indicated she did not know. Later during the day when asked by staff, client #1 indicated client #5 ran over her foot with his wheelchair. The Coordinator indicated client #1 received a medical evaluation.</p> <p>2. On 5/9/14 at 5:00 PM, the facility's Incident Report, dated 5/9/14, indicated, in part, "In the am (morning) staff noticed [client #2] had bloodshot eyes and some swelling to both eyes. Staff tried to contact PCP (primary care physician) who is out of office on Fridays. Staff then spoke with nurse form (sic) on call DR (doctor) and was told Dr (doctor) would call back. No call was ever returned, so Stone Belt nurse looked at [client #2] (and) made recommendations to go to walk-in clinic. Staff [staff #4's name] took [client #2] to Walk-in clinic and was told he should go to the ED (emergency department). Staff then took [client #2] to [name of hospital] for treatment. Was given script for Erythromycin ointment 5 mg (milligrams) to help prevent infection.</p>						

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	<p>Was told that blood should reabsorb in a few days and to use cold compresses as needed for swelling." The Stone Belt Outside Services Report, dated 5/9/14, indicated, in part, "Subconjunctival Hemorrhage Bilateral eyes. Cool compresses as needed to eyes." The Nursing Consultation, 2014, for client #2 indicated, in part, "5-9-14 Eye hemorrhages, allergy symptoms. 1645) Reported per Day Program Manager and staff: Today, several bloody-red areas were noted at sclera of OU (oculus uterque - both eyes). Also, client has had nasal drng (drainage)/swelling and had c/o (complained of) of (sic) a scratchy, sore throat. Only difference noted in client's schedule was that client participated at Special Olympics yesterday; activities held outside. Client left for home before this Nurse's arrival at [name of day program]. Visited client at home. Note several bloody area @ sclera of OU. Also note some swelling at bridge of nose and beneath OS (oculus sinister - the left eye). Freq (frequent) nasal drng noted this afternoon. At first, client stated he was 'alright,' but after further questioning, client admitted that his throat was sore and itching and that his eyes 'hurt.' Instructions given for client to be taken to [name of walk-in clinic]."</p>			

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W000159	<p>On 6/4/14 at 3:11 PM, the Coordinator indicated the incident should have been investigated. The Coordinator indicated client #2 went to Special Olympics on a Thursday. When he arrived home, he drank a lot of water and then vomited. On Friday (the next day) when he woke up, his eyes were bloodshot. The staff were directed to take him to the walk-in clinic. The Coordinator indicated it was determined due to exertion from participating in the events, heat and possible allergies as well as the vomiting the night before, it caused petechiae (pinpoint, round spots that appear on the skin as a result of bleeding under the skin). The Coordinator indicated it was not an injury. The Coordinator indicated the cause of the injury was not investigated. The Coordinator indicated if client #2 was hit the staff would have indicated so and no one indicated he was hit. The Coordinator indicated the documentation does not capture the information conveyed to her by the staff. The Coordinator indicated she was not informed the bridge of client #2's nose was swollen.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION</p>				

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	<p>PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 clients in the sample (#1, #3 and #4), the Qualified Intellectual Disabilities Professional (QIDP) failed to conduct reviews of the clients' progress on their individualized program plans.</p> <p>Findings include:</p> <p>On 6/3/14 at 12:55 PM, client #1's record was reviewed. Client #1's record indicated the QIDP conducted quarterly reviews on her progress of her individualized program plan, dated 6/19/13, on 8/31/13. There was no documentation additional quarterly reviews were conducted.</p> <p>On 6/3/14 at 1:33 PM, client #3's record was reviewed. Client #3's record indicated the QIDP conducted quarterly reviews of her progress on her individualized program plan, dated 6/19/13, on 7/31/13 and 11/26/13. There was no documentation additional quarterly reviews were conducted.</p> <p>On 6/3/14 at 2:07 PM, client #4's record was reviewed. Client #4's record did not contain documentation the QIDP reviewed and monitored the progress or</p>	W000159	Plan of Correction: The director retrained the facility coordinator on all aspects of regulations W210-265. See Attachment #1. The facility coordinator has completed or located the quarterly reviews of clients #1, 3 and 4. See attachments #4, #5, #6. Completed 6/3/2014. Plan of Prevention: The coordinator has created an annual and quarterly calendar to prompt her to complete her progress reports in a timely manner. Quality Assurance Monitoring: The facility coordinator will complete the monthly/quarterly quality checklists which prompt on the timely completion of quarterly reports. The SGL director will review all quality reports for compliance.	06/13/2014			

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W000249	<p>lack of progress client #4 made on his individualized program plan, dated 10/30/13, from 6/2/13 to 6/3/14.</p> <p>On 6/3/14 at 11:47 AM, the Director of Milestones (Division of Stone Belt) Clinical and Health Resources indicated the QIDP was aware of her responsibility to conduct quarterly reviews of the clients' program plans. The Director indicated she trained the QIDP to conduct quarterly reviews. The Director indicated the quarterly reviews should be in the clients' records for review.</p> <p>On 6/4/14 at 3:11 PM, the Coordinator indicated the clients' review of their progress should be conducted quarterly (every 3 months). The Coordinator indicated the quarterlies should be in the clients' record for review.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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>			
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	<p>Based on observation, interview and record review for 3 of 3 clients (#3, #4 and #5) observed to receive their medications, the facility failed to ensure staff implemented the clients' medication administration training objectives.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 6/3/14 from 5:58 AM to 7:53 AM:</p> <p>At 6:04 AM, client #4 received his medications from staff #2. Staff #2 asked client #4 to tell her the name of one medication and the purpose of the medication. Client #4 stated, "Reglan" and "stomach." Client #4 was not asked to state the number of pills he took, the time he took his medications, names and purposes of his medications.</p> <p>At 7:14 AM, staff #2 indicated client #4 had a medication training objective to identify Reglan and the purpose of the medication.</p> <p>A review of client #4's record was conducted on 6/3/14 at 2:07 PM. His 10/30/13 Individual Program Plan (IPP), dated 10/30/13, indicated he had a medication identification training objective. The training form indicated,</p>	W000249	<p>Addendum (10/13/14): All Stone Belt DSP and supervisors were trained on active treatment and implementation of formal and informal training on a 15 minute or continuous basis each and every day This training occurred 10/03 10am at Shiloh Church Facility house manager and coordinator will be responsible to observe and make sure this training is occurring W249 It is the expectation that toensure compliance that objectives are being implemented on a daily basis at formal and informal training opportunities that monitoring will occur daily. Nothing less will be accepted as an approved plan of correction. Addendum #2: Qidp has been trained to complete all assessments then with the assistance of IDT formulate an IPP that provides continuous active treatment (W249). Facility director / Qidp will review plans monthly along with conducting active treatment observations to monitor that client's plans are compliant. Addendum: W249 A more frequent monitoring system is initially needed to ensure compliance. Qidp has been trained to complete all assessments then with the assistance of IDT formulate an</p>	06/15/2014			

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	<p>"Names the medication, states purpose, states time given and states # (number) of pills."</p> <p>At 6:15 AM, client #5 received his medications from staff #2. Staff #2 did not prompt client #5 to pour his drink or get his cup.</p> <p>At 7:14 AM, staff #2 indicated client #5 had a medication training objective to pour his drink or get his cup. Staff #2 indicated the training objective was not implemented during the observation.</p> <p>A review of client #5's record was conducted on 6/3/14 at 11:58 AM. Client #5's IPP, dated 5/8/13, indicated he had a medication training objective to go to the medication room at the correct time, sanitize his hands, get a cup, put drink in the cup, swallow his medications, and throw away his cup.</p> <p>At 6:27 AM, client #3 received her medications from staff #2. Staff #2 did not prompt client #3 to obtain a cup and a spoon for the medication administration.</p> <p>At 7:14 AM, staff #2 indicated client #3 had a medication training objective to bring in a cup and spoon. Staff #2 indicated the training objective was not implemented during the observation.</p>		<p>IPP that provides continuous active treatment (W249). Facility director / Qidp will review plans monthly along with conducting activetreatment observations to monitor that client's plans are compliant. Plan of Correction: The coordinator has revised the IHPs of clients #3,4 and 5 to include clearer and helpful staff training interventions and to address particular difficulties staff were observed to have which were noted in the survey. 6/3/2014 See Attachments #7, #8. Plan of Prevention: facility staff have been trained on clients #3,4,5 revised medication administration training IHPs. Quality Assurance Monitoring: Coordinator will conduct home visits and observe 2 staffed passes per month and include observations on the quality monitoring reports. SGL director will review quality monitoring reports.</p>		

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W000259	<p>A review of client #3's record was conducted on 6/3/14 at 1:33 PM. Client #3's IPP, dated 6/19/13, indicated she had a medication administration training objective to take a red cup and spoon to the medication area.</p> <p>On 6/3/14 at 11:47 the Director of Milestones (Division of Stone Belt) Clinical and Health Resources indicated the staff should implement the clients' medication training objectives at each medication pass. The Director indicated the staff should know, teach and train the clients on their medication training objectives.</p> <p>On 6/3/14 at 2:47 PM, the Coordinator indicated the staff should implement the clients' medication training objectives at each medication administration time.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 clients in the sample (#4), the</p>	W000259	The director retrained the facility coordinator on all aspects of regulations W210-265. See	06/13/2014

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W000312	<p>facility failed to ensure client #4's comprehensive functional assessment (CFA) was reviewed, at least annually, for relevancy and updated as needed.</p> <p>Findings include:</p> <p>On 6/3/14 at 2:07 PM, client #4's record was reviewed. Client #4's most recent CFA was dated 9/16/11. There was no documentation in client #4's record indicating his CFA was reviewed annually for relevancy and updated as needed since 9/16/11.</p> <p>On 6/3/14 at 2:45 PM, the Coordinator indicated she had not updated client #4's CFA. The Coordinator indicated client #4's CFA should be reviewed and updated at least annually.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 clients (#1) in the sample with psychotropic medications, the facility failed to ensure the medication reduction</p>	W000312	<p>Attachment #1. The facility coordinator has completed the comprehensive functional assessment for client # 4. See Attachment 9. Completed 6/3/2014. Plan of Prevention: The coordinator has created a calendar with annual dates of all the facility clients to prompt herto update all assessments and program revisions in a timely manner. Quality Assurance Monitoring: The facility coordinator will complete the monthly/quarterly quality checklists which prompt a chart review with all elements of the clients program plan. The SGL director will review all quality reports for compliance.</p> <p>Plan of Correction: Facility behaviorist has revised Client #1 behavior tracking forms to include psychotic statements/episodes and</p>	06/30/2014			

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	<p>plans were attainable.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 6/3/14 at 12:55 PM. Client #1's Behavior Support Plan, dated 7/31/13, indicated client #3 was prescribed Depakote, Seroquel and Fanapt. Client #1's 5/21/13 psychiatric visit form indicated, in part, "Depakote: Depakote is prescribed as one component of [client #1's] treatment plan for major depression with recurrent psychotic features and obsessive compulsive traits. When aggressive behavior, as evidenced by aggression to peers, aggression to staff and property destruction, has decreased to fewer than one episode per month for twelve consecutive months, [client #1's] team will consider the appropriateness of reduction. Seroquel: Seroquel is administered as a component of [client #1's] treatment plan for major depression with recurrent psychotic features and obsessive-compulsive traits. When psychotic ideation, as evidence (sic) by non-reality based statements and verbalizing in strange voices, is observed zero times per quarter for four consecutive quarters, [client #1's] team will assess the appropriateness of reduction. Fanapt: Fanapt is administered as a component of [client</p>		<p>has revised the Behavior Support Plano to include proactive and reactive strategies for psychotic episodes and revised the medication reduction plan accordingly. See Attachment 10. The behaviorist has trained facility staff on changes in client #1's behavior plan. See attachment 11. Plan of Prevention: The manager of Behavior Support Services has revised the Milestones Behavior Intervention Plan Format to include a prompt for behavior staff to ensure that the plan reflects a behavioral plan component for every medication prescribed for behavior. See attachment 12. Quality Assurance Monitoring: The coordinator will complete a monthly/quarterly Quality Assurance Monitoring checklist which has a prompt to review all behavior medications for a corresponding training component. The SGL director will review all quality assurance reports.</p>				

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	<p>#1's] treatment plan for major depression with recurrent psychotic features and obsessive-compulsive traits. When psychotic ideation, as evidence (sic) by non-reality based statements and verbalizing in strange voices, is observed zero times per quarter for four consecutive quarters, [client #1's] team will assess the appropriateness of reduction."</p> <p>A review of client #3's Behavior Support Services Quarterly Behavior Summary, dated 3/26/14, indicated there was no data being collected on property destruction and psychotic ideation. From June 2013 to February 2014, client #1 engaged in 9 incidents of physical aggression.</p> <p>On 6/4/14 at 3:11 PM, the Coordinator indicated there was no data being collected on property destruction and psychotic ideation.</p> <p>On 6/5/14 at 9:43 AM, the Behavior Consultant (BC) indicated the medication reduction plan for Seroquel and Fanapt addressed part of her mental health diagnosis. The BC indicated the staff were not documenting the occurrences of psychotic ideation. The BC indicated the staff informed her in person, by phone or by email of the occurrences of psychotic</p>						

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W000436	<p>ideation and the incidents of psychotic ideation were communication to the psychiatrist during the appointments. The BC indicated she was not sure why tracking for psychotic ideation was not being documented. The BC indicated she did not know how many occurrences of psychotic ideation had occurred during the past 12 months.</p> <p>9-3-5(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, record review and interview for 1 of 3 clients in the sample (#4), the facility failed to furnish and teach client #4 to use and to make informed choices addressing his refusals to wear his glasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/2/14 from 3:13 PM to 5:32 PM and 6/3/14 from 5:58 AM to 7:53 AM. During the observations, client</p>	W000436	Addendum: Qidp will monitor to ensure staff are following orders and documenting concerns online for director / qidp to review. Staff were all trained to follow plans and IPPs at a monthly meeting. This training will occur each month. Director will conduct monthly observations that are submitted online for the CEO to review. Plan of Correction: The coordinator has revised client #4's IHP to include a training goal to wear glasses. Plan of Prevention: Tracking forms will be put in place to record the	06/30/2014

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	<p>#4 was not observed to wear glasses. Client #4 was not prompted to wear glasses during the observations.</p> <p>On 6/3/14 at 2:07 PM, client #4's record was reviewed. Client #4's Individualized Program Plan, dated 10/30/13, did not include a training objective for client #4 to increase the time he wore his glasses. Client #4's behavior plan, dated 10/30/13, did not include interventions in the refusals section of the plan for client #4 to increase the time he spent wearing his glasses. Client #4's 6/28/13 Nurse Quarterly Physical indicated, in part, "Eye exam on 4-25-13 @ [name of clinic]. Client received new glasses to be worn routinely for near activities @ PRN (as needed) for distance vision. Client wore glasses for a few days, but now rarely wears." Client #4's Nurse Quarterly Physical, dated 3/31/14, indicated, in part, "Eyeglasses to be worn routinely for near activities & PRN for distance vision. Client rarely wears glasses." Client #4's Outside Services Report for Vision, dated 4/25/13, indicated, in part, "Hyperopic astigmatism; good ocular health. Release glasses Rx (prescription) & order new glasses. Wear for near activities & as needed for distance." Client #4's Outside Services Report for Vision, dated 5/29/13, indicated, in part, "Pick up new</p>		<p>progress of client #4 and will bereviewed monthly by the coordinator. 6/30/2014. Quality Monitoring: Quarterly reportsincluding progress on all IHP goals will be reviewed by the SGL director.</p>				

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W009999	<p>glasses."</p> <p>On 6/3/14 at 2:45 PM, the Coordinator indicated client #4 refused to wear his glasses. The Coordinator stated, "He won't wear them." The Coordinator indicated client #4 used to have a plan addressing his refusals to wear his glasses. The Coordinator indicated she was unsure why client #4 did not have a current plan to increase the use of his glasses. The Coordinator indicated client #4 needed a plan to increase his use of his glasses.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>1) 460 IAC 9-3-1(b) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written</p>	W009999	<p>Plan of Correction: 1) facility coordinator received training in investigating and reporting incidents on 6/7/2014. See Attachment #1. The facility coordinator trained the facility staff on incident reporting on 6/13/2014. See Attachments #2 and #3. 2) Staff # 8 training records were located and she successfully completed Core A (1/29/2014) and Core B (1/30/2014) and medication administration (1/30/2014). See attachment 14. Quality Assurance Monitoring: The facility coordinator</p>	06/13/2014
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	<p>summaries as requested by the division:</p> <p>11) An emergency intervention for the individual resulting from: a) a physical symptom, b) a medical or psychiatric condition, c) any other event and 15) a fall resulting in injury, regardless of the severity of the injury.</p> <p>Based on interview and record review for 2 of 52 incident reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility failed to report an incident of a fall with injury, and an emergency intervention related to an intruder at the group home to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/2/14 at 11:46 AM and indicated the following:</p> <p>1. On 5/7/14 at 5:40 PM (reported to BDDS on 5/9/14 at 1:36 PM), the BDDS report indicated, "All staff and clients (#1, #2, #3, #4 and #5) were sitting at the dining room table having dinner. An intruder just walked into the house without knocking or ringing the door bell. He (the intruder) told us he was sorry. Thought he was at an apartment</p>		<p>receives electronic copies of incident reports with 24 hours of occurrence. She will monitor for staff compliance and ensure that reports are filed timely. The SGL director will monitor the facility's Incident Reports for compliance.</p>				

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	<p>building. Told staff that he was being chased by 2 men and needed to use our phone. The intruder appeared intoxicated and his eyes were glassy. Staff walked the intruder out and let him use the phone. Staff (outside with the intruder) texted us (staff inside) to call 911. Staff called 911 and reported the incident. Police located intruder and arrested him for public intoxication and possession of meth. Supervisor documentation: Incident occurred due to state regulation not allowing exterior doors to be locked until after 7 PM. Staff will continue to follow procedures to keep clients safe."</p> <p>On 6/3/14 at 11:47 AM, the Director of Milestones (Division of Stone Belt) Clinical and Health Resources indicated the incident should have been reported to BDDS within 24 hours.</p> <p>On 6/4/14 at 3:11 PM, the Coordinator indicated the incident should have been reported to BDDS within 24 hours.</p> <p>2. On 1/5/14 at 3:30 PM, client #3 was walking from the living room to the dining room. She was wearing knee pads and a gait belt as indicated in her risk plan for falls. Client #3 fell forward when she stepped from the carpeted area to the vinyl floor in the dining room. Staff #4 was unable to stop her fall. She</p>						

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	<p>landed on her stomach but hit her chin on the floor and bit into her lip. Her lip bled and staff #4 applied an ice pack to the area to reduce swelling. Staff #4 took her to the restroom to check for any other injuries and to examine her mouth/teeth. Staff #4 did not observe any injuries to her teeth or not any other bruises. Her lips were swollen and bruised and staff #4 continued to apply the ice pack as tolerated. The fall with injury was not reported to BDDS.</p> <p>On 6/3/14 at 11:47 AM, the Director of Milestones (Division of Stone Belt) Clinical and Health Resources indicated the incident should have been reported to BDDS.</p> <p>On 6/4/14 at 3:11 PM, the Coordinator indicated the incident should have been reported to BDDS.</p> <p>2) 460 IAC 9-3-6 (b) Health Care Services</p> <p>(b) All personnel who administer medication to residents or observe residents self-administering medication shall have received and successfully completed training using materials approved by the council.</p> <p>Based on record review and interview for</p>						

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	<p>1 of 3 employee files reviewed affecting clients #1, #2, #3, #4, and #5, the facility failed to ensure staff #8's record included documentation staff #8 received training in Core A and Core B.</p> <p>Findings include:</p> <p>On 6/2/14 at 12:51 PM, a review of the employee files was conducted. Staff #8's employee file did not contain documentation she received training on the facility's medication administration procedures including Core A and Core B.</p> <p>On 6/2/14 at 1:15 PM, the Human Resources Director indicated staff #8's employee file should contain documentation indicating staff #8 successfully completed Core A and Core B training.</p> <p>On 6/2/14 at 7:08 AM, staff #8 indicated she had taken and passed Core A and Core B medication administration training. Staff #8 indicated she administered medications at the group home.</p> <p>9-3-1(b) 9-3-6(b)</p>			

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