

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421		
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: June 12, 13, 14 and 17, 2013.</p> <p>Facility Number: 001165 Provider Number: 15G650 AIM Number: 100240230</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/21/13 by Ruth Shackelford, QIDP.</p>	W000000			

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

TITLE

(X6) DATE

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

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W000149	<p>483.420(d)(1) <b>STAFF TREATMENT OF CLIENTS</b> 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 43 incident reports reviewed affecting client #1, the facility failed to implement its policies and procedures to ensure staff did not neglect client #1, incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and staff implemented client #1's dining plan as written.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/12/13 at 11:58 AM.</p> <p>1. An interview with the Home Manager (HM) was conducted on 6/12/13 at 3:48 PM. The HM indicated it was reported to her by staff #11 on 6/11/13 that on 6/8/13 staff #5 put client #1 to bed at 7:30 PM after being incontinent of urine and feces. Staff #11 assisted client #1 at 11:45 PM and found dried feces and urine. The HM stated, "It's neglect." The HM indicated she reported the incident to the Program Coordinator (PC). The HM indicated there was no BDDS report submitted. During the review of the incident reports, there was no documentation of this</p>	W000149	<p><b>W149 STAFF TREATMENT OF CLIENTS Plan of Correction:</b> Stone Belt develops and maintains written policies and procedures that prohibit mistreatment, neglect and abuse of the client. Specifically staff were retrained and received disciplinary action for neglect of a client. Staff were retrained on dining plans for a client. <b>Responsible Person:</b> Program Coordinator <b>Date of Completion:</b> July 3, 2013 <b>Plan of Prevention:</b> Program Coordinator completed training with staff at the home regarding Stone Belt's policy on Prevention of Abuse And Neglect. ( Attachment # 1 ). Specifically house staff were retrained on MIS which includes toileting, bed checks, Staff were retrained on dining plans. (Attachment #1A/C). <b>Quality Assurance Monitoring:</b> SGL Director and Program Coordinator review all Incident Reports to ensure they are reported accurately. Prevention of Abuse, Neglect and Client Rights are reviewed on a annual basis and is trained during new hire orientation.</p>	07/03/2013			

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	<p>incident on the facility's incident report or on a BDDS incident report.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/14/13 at 12:56 PM. The PC indicated the incident occurred over the weekend and the HM investigated it. The HM found out that staff #5 put client #1 to bed incontinent of urine and feces which was discovered by the night shift staff. The PC indicated staff #5 was going to receive a written warning for abuse and neglect. The PC indicated she was not sure if a report was submitted to BDDS. The PC indicated a report should have been submitted.</p> <p>2. On 10/20/12 at 5:30 PM, client #1 choked on mashed potatoes. The report indicated, "Staff seen (sic) she was turning blue and done (sic) the Heimlich maneuver (sic). [Client #1] is on a pureed diet, and this was followed." The BDDS follow-up report, dated 10/30/12, indicated client #1 choked on a "chunk of potato." The follow-up report indicated, "Coordinator completed an inquiry on the incident and found that the food was not prepared properly, as well as [client #1's] dining plan was not followed correctly." A BDDS follow-up report, dated 12/11/12, indicated, "The staff preparing the food did follow the pureed diet, but</p>			

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	<p>failed to see there was a lump in the mashed potatoes, which substantiated the neglect. It was failure to prepare the pureed food properly. Checks have been put into place after this incident, as well as training on pureed diets. Staff preparing foods will now check food, staff sitting with [client #1] will do a second check before [client #1] starts to eat, and one last check as [client #1] is assisted putting her food into her plate. Neglect was substantiated for both staff...".</p> <p>A review of the facility's abuse and neglect policy, dated 10/17/11, was conducted on 6/12/13 at 12:03 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any</p>						

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	<p>incident involving the use of physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a client, parent/guardian, advocate, staff member, or other involved party."</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/12/13 at 1:27 PM. The PC indicated BDDS reports were to be submitted within 24 hours. The PC indicated client #1's choking incident was due to staff not implementing her plan as written. The PC indicated both staff received disciplinary action and a plan was implemented for a second staff to check the consistency of client #1's food prior to the meal.</p> <p>9-3-2(a)</p>				

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W000153	<p><b>483.420(d)(2)</b> <b>STAFF TREATMENT OF CLIENTS</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 through established procedures. Based on record review and interview for 1 of 43 incident reports reviewed affecting client #1, the facility failed to submit an incident report 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 6/12/13 at 11:58 AM.</p> <p>An interview with the Home Manager (HM) was conducted on 6/12/13 at 3:48 PM. The HM indicated it was reported to her by staff #11 on 6/11/13 that on 6/8/13 staff #5 put client #1 to bed at 7:30 PM after being incontinent of urine and feces. Staff #11 assisted client #1 at 11:45 PM and found dried feces and urine. The HM stated, "It's neglect." The HM indicated she reported the incident to the Program Coordinator (PC). The HM indicated there was no BDDS report submitted. During the review of the incident reports, there was no documentation of this</p>	W000153	<p><b>W153 STAFF TREATMENT OF CLIENTS Plan of Correction:</b> Stone Belt develops and maintains written policies and procedures that prohibit mistreatment, neglect and abuse of the client. In addition we have policies in place for timely incident reporting. <b>Responsible Person:</b> Program Coordinator <b>Date of Completion:</b> July 3, 2013 <b>Plan of Prevention:</b> Program Coordinator completed training with staff at the home regarding stone Belt's policy on Prevention of Abuse and Neglect ( Attachment # 1 ). Staff were also trained on proper incident reporting. (Attachment #2) <b>Quality Assurance Monitoring:</b> SGL Director and Program Coordinator review all Incident Reports to ensure they are reported accurately. Prevention of Abuse, Neglect and client Rights are reviewed on a annual basis and is trained during new hire orientation.</p>	07/03/2013			

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	<p>incident on the facility's incident report or on a BDDS incident report.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/14/13 at 12:56 PM. The PC indicated the incident occurred over the weekend and the HM investigated it. The HM found out that staff #5 put client #1 to bed incontinent of urine and feces which was discovered by the night shift staff. The PC indicated staff #5 was going to receive a written warning for abuse and neglect. The PC indicated she was not sure if a report was submitted to BDDS. The PC indicated a report should have been submitted.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/12/13 at 1:27 PM. The PC indicated BDDS reports were to be submitted within 24 hours.</p> <p>9-3-2(a)</p>				

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W000159	<p><b>483.430(a)</b> <b>QUALIFIED MENTAL RETARDATION PROFESSIONAL</b> 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, #2 and #6), the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure the clients' program plans were reviewed routinely.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 6/13/13 at 1:14 PM. Client #1's Individual Support Plan (ISP), dated 4/19/13, indicated she had training objectives to identify money, prepare a side dish, complete physical therapy exercises, swallow her medications, complete a dental desensitization program, take a shower and participate in an activity. Client #1's progress toward achieving her program training objectives was conducted on 9/1/12 and 12/1/12. There was no documentation in client #1's record indicating her progress was reviewed from 6/12/12 to 9/1/12 and 12/1/12 to 6/13/13.</p> <p>Client #2's record was reviewed on 6/13/13 at 1:55 PM. Client #2's ISP, dated 3/21/13, indicated she had training</p>	W000159	<p><b>W159</b></p> <p><b>QUALIFIED MENTAL RETARDATION PROFESSIONAL</b></p> <p><b>Plan of Correction:</b></p> <p>Each Stone Belt client's active treatment program is integrated coordinated and monitored by a qualified mental retardation professional. Plans are reviewed ona quarterly basis.</p> <p><b>Responsible Person:</b></p> <p>Program Coordinator</p> <p><b>Date of Completion:</b></p>	07/03/2013			

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	<p>objectives to exercise twice a day, use sign language, prepare a side dish, use a vending machine, participate in medical desensitization program, increase pedestrian safety, trail through doors and follow her medication routine. Client #2's progress toward achieving her program training objectives was conducted on 6/26/12, 9/1/12 and 12/1/12. There was no documentation in client #2's record indicating her progress was reviewed from 12/1/12 to 6/13/13.</p> <p>Client #6's record was reviewed on 6/13/13 at 2:27 PM. Client #6's ISP, dated 7/18/12, indicated she had training objectives to prepare a side dish, brush her teeth, complete the medication pass, identify money, and increase pedestrian safety skills. Client #6's progress toward achieving her program training objectives was conducted on 9/1/12 and 12/1/12. There was no documentation in client #6's record indicating her progress was reviewed from 6/12/12 to 9/1/12 and 12/1/12 to 6/13/13.</p> <p>An interview with the QIDP was conducted on 6/14/13 at 12:56 PM. The QIDP indicated the clients' program plan training objectives were reviewed every three months. The QIDP indicated the clients' quarterly reviews should be in their records for review.</p>		<p>July 3, 2013</p> <p><b>Plan of Prevention:</b></p> <p>Program Director completed training with Program Coordinator on tracking training objective progress with quarterly reviews. (Attachment #3).</p> <p><b>Quality Assurance Monitoring:</b></p> <p>SGL Director and Program coordinator Review all training objectives on a quarterly basis.</p>				

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W000227	<p><b>483.440(c)(4)</b> <b>INDIVIDUAL PROGRAM PLAN</b> The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 3 clients in the sample (#6) and 1 of 3 non-sampled clients (#4), the facility failed to ensure 1) client #6 had a plan to address refusals to cooperate with medical appointments, 2) client #4 had a plan to address refusals to wear his compression hose and 3) client #4 had a plan to increase his communication skills.</p> <p>Findings include:</p> <p>1) A review of client #6's record was conducted on 6/13/13 at 2:27 PM. Client #6's Medical Information Sheet, dated 5/31/13, indicated for mammogram, "Unable to complete. Will do manual breast exams." An Outside Services Report, dated 9/27/10, indicated for her mammogram, "Not able to do procedure due to pt's (patient's) resistance." Her most recent mammogram was completed on 9/17/09. A Facsimile Transmission Cover Page for client #6's hearing exam, dated 3/7/05, indicated, "The patient's activity and muscular dysfunction precluded any hearing test evaluation today." Client #6's record did not include</p>	W000227	<p><b>W227</b></p> <p><b>INDIVIDUAL PROGRAM PLAN</b></p> <p><b>Plan of Correction:</b></p> <p>The individual program plan completed by the Program Coordinator will state specific objectives necessary to meet the clients needs.</p> <p><b>Responsible Person:</b></p> <p>Program Coordinator</p> <p><b>Date of Completion:</b></p>	07/03/2013			

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	<p>a hearing examination. Client #6's Behavior Support Plan (BSP), dated 3/30/12, and Individual Support Plan (ISP), dated 7/18/12, did not address refusals to cooperate with medical appointments.</p> <p>An interview with the nurse was conducted on 6/14/13 at 12:29 PM. The nurse indicated client #6 had a lot of problems with cooperating with medical appointments. The nurse stated, "She's hard to do anything with."</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/17/13 at 10:32 AM. The PC indicated client #6 should have a medical desensitization program in place.</p> <p>2) An observation was conducted at the group home on 6/13/13 from 5:53 AM to 7:55 AM. At 7:15 AM, staff #3 asked staff #7 if client #4 was wearing compression hose. Staff #7 indicated client #4 was not wearing his compression hose. Staff #7 indicated to staff #3 that client #4 pushed her hands away when she attempted to put his hose on. At 7:39 AM, staff #3 attempted to get client #4 to wear his compression hose. Client #4 refused. At 7:41 PM, client #4 allowed staff #3 to put his compression hose on.</p>		<p>July 3, 2013</p> <p><b>Plan of Prevention:</b></p> <p>House staff were trained on training objectives and adaptive equipment. Goals were added for medication refusals and increasing communication skills. Plan was added to MIS for Ted hose. (Attachments #4 and 4A ).</p> <p><b>Quality Assurance Monitoring:</b></p> <p>Program Coordinator will complete the goals which are reviewed by the SGL Director on a quarterly basis. Program Coordinator will review progress each month with all goals put into place.</p>				

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	<p>A review of the facility's incident reports was conducted on 6/12/13 at 11:58 AM.</p> <p>-On 5/21/13 at 7:51 AM, client #4 attempted to remove his compression hose. Client #4 pulled the hose down and staff #6 pulled them back up. Client #4 grabbed and squeezed staff #6's fingers.</p> <p>-On 5/28/13 at 6:00 AM when staff #9 arrived to work, staff #9 could hear client #4 yelling from outside the group home. Staff #6 indicated to staff #9 that client #4 was refusing to put on his compression hose.</p> <p>A review of client #4's record was conducted on 6/13/13 at 12:19 PM. Client #4's Medication Information Sheet, dated 6/6/13, indicated client #4 was ordered compression hose on 4/6/13 due to cellulitis and edema. The order indicated, "Jobst Compression Stockings 20-30 mm/hg. Wear when up in w/c (wheelchair) during daytime hours, off @ (at) bedtime." Client #4's record did not have a plan to address refusals to wear his compression hose. Client #4's Behavior Support Plan, dated 3/30/12, did not address refusals to wear compression hose. Client #4's Individual Support Plan, dated 2/29/12, did not address refusals to wear compression hose.</p> <p>An interview with the Behavior Clinician</p>						

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	<p>(BC) was conducted on 6/12/13 at 1:56 PM. The BC indicated client #4 did not want to wear his compression hose. The BC indicated staff were trying to get him to wear the compression hose. The BC indicated there was no plan to get client #4 to wear his compression hose.</p> <p>An interview with the nurse was conducted on 6/14/13 at 12:29 PM. The nurse stated client #4 had been doing "very" well with wearing the compression hose and had not been refusing. The nurse indicated client #4 initially refused to wear the compression hose due to his leg being inflamed. The nurse indicated she updated his MIS to change the time when staff were to prompt him to wear from 5:00 AM to 6:00 AM. The nurse indicated this allowed for additional staff to try to get him to wear his hose.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/14/13 at 12:56 PM. The PC indicated, initially, client #4 did not need a plan to address refusals to wear compression hose. The PC indicated the staff try three different times with three different staff to get him to wear the hose. The PC indicated if client #4 refused, the staff were to leave him alone and give him time between attempts. The PC indicated the techniques staff were to implement</p>				

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	<p>should be in a plan.</p> <p>3) A review of client #4's record was conducted on 6/13/13 at 12:19 PM. Client #4's Behavior Support Plan, dated 3/30/12, indicated, in part, "[Client #4's] expressive language skills primarily consist of some verbal sounds i.e. laughing, crying, grunting and gestures i.e. holding/pulling staff's hand when he needs something/wants their help, putting his hands up in the air (rejection), stomping/biting his hand (anger), smiling, 'Ooh-Dah' sounds (contentment). Staff should assist [client #4] in learning some basic gestures and functional signs that would facilitate his communication skills." Client #4's Individual Support Plan (ISP), dated 2/29/12, did not include training objectives to increase his communication skills. The ISP section for Communication/Speech Summary was blank.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/14/13 at 12:56 PM. The PC indicated client #4 did not have a plan to increase his communication skills. On 6/17/13 at 10:32 AM, the PC indicated since there was a recommendation in client #4's Behavior Support Plan to increase his communication skills, he should have a plan.</p>						

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	<p>An interview with the Behavior Clinician (BC) was conducted on 6/12/13 at 1:56 PM. The BC indicated staff perceive client #4's pushing them away or grabbing their hands as aggression. The BC indicated client #4 was communicating his desires by these actions. The BC indicated she was not aware if client #4 had a training objective to address his communication skills. The BC indicated client #4 should have a plan to increase his communication skills.</p> <p>9-3-4(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure her program plan was implemented as written.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/12/13 from 4:17 PM to 6:47 PM and 6/13/13 from 5:53 AM to 7:55 AM. During the observations at the group home, there was no tape on the dining room table marking client #2's space at the table.</p> <p>Client #2's record was reviewed on 6/13/13 at 1:55 PM. Client #2's Behavior Support Plan (BSP), dated 4/15/13, indicated she had a targeted behavior of inappropriate mealtime behavior. Inappropriate mealtime behavior was defined as "Reaching for others' plates, eating with her fingers, shoveling food too quickly, eating other clients' food, not cooperating with hand over hand</p>	W000249	<p><b>W249</b></p> <p><b>PROGRAM IMPLEMENTATION</b></p> <p><b>Plan of Correction:</b></p> <p>Each Stone Belt client is to receive a continuous active treatment program consisting of needed assistance and interventions in sufficient number and frequency to support the clients individual program plan.</p> <p>Specifically, this includes tape on the table for inappropriate mealtime</p>	07/03/2013	

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	<p>instruction to cut her meat, feeling for food on the table, etc." The proactive or preventative strategies included, "Staff will tape off an area at the meal table to designate [client #2's] eating space i.e. where her food/drink/utensils are located/where she can place her hands, etc."</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/14/13 at 12:56 PM. The PC indicated there should be tape on the dining room table for client #2. The PC indicated this was part of her BSP and should be implemented as written.</p> <p>9-3-4(a)</p>		<p>Behaviors. (Attachment #5).</p> <p><b>Responsible Person:</b></p> <p>Program Coordinator</p> <p><b>Date of Completion:</b></p> <p>July 3, 2013</p> <p><b>Plan of Prevention:</b></p> <p>House staff were retrained on the BSP</p> <p>for an individual client that requires</p> <p>Ttpe on the table for mealtime behaviors.</p> <p>(Attachment # 5 )</p> <p><b>Quality Assurance Monitoring:</b></p>		

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			Program Coordinator will review and monitor plans to ensure they are being implemented. This will be reviewed during weekly visits to the home.	

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W000260	<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 non-sampled clients (#4), the facility failed to ensure client #4's Individual Support Plan (ISP) was reviewed annually.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 6/13/13 at 12:19 PM. Client #4's ISP was dated 4/1/12 on one form and 2/29/12 on another form. There was no documentation in the record indicating client #4's ISP was reviewed/revised since either 2/29/12 or 4/1/12.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/14/13 at 12:56 PM. The PC indicated the client's ISP should be revised/reviewed annually. The PC indicated client #4 had an annual program plan meeting since 2012 and the documentation should be in the record for review.</p> <p>9-3-4(a)</p>	W000260	<p><b>W260</b></p> <p><b>PROGRAM MONITORING AND CHANGE</b></p> <p><b>Plan of Correction:</b></p> <p>Each Stone Belt Client is to receive an Individual Support Plan that is revised and reviewed annually.</p> <p><b>Responsible Person:</b></p> <p>Program Coordinator</p> <p><b>Date of Completion:</b></p>	07/03/2013			

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			<p>July 3, 2013</p> <p><b>Plan of Prevention:</b></p> <p>Individual Support Plans will be reviewed and revised annually to meet the needs of an individual client. (Attachment # 6)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>Program Coordinator will review and monitor plans to ensure they are updated annually. House manager also does file reviews monthly.</p>		

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W000323	<p><b>483.460(a)(3)(i) PHYSICIAN SERVICES</b></p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#6), the facility failed to ensure client #6 had an annual physical examination including an evaluation of her vision and hearing.</p> <p>Findings include:</p> <p>A review of client #6's record was conducted on 6/13/13 at 2:27 PM. Client #6's most recent physical examination, dated 5/15/13, did not include an evaluation of her hearing and vision. Client #6's record did not include a hearing evaluation. On 3/13/08, an Outside Services Report indicated for hearing, "Impacted cerumen in each ear. Return for cerumen removal from each ear, hearing test after removal." Client #6's Medical Information Sheet, dated 5/31/13, indicated for hearing, "D/C (discontinue) hearing exams per orders of [name of primary care physician] (8/15/08)." On 6/17/13 at 11:00 AM, the facility provided documentation, dated 8/15/08, indicating, "D/C hearing exam every 3 yrs (years). Resident does not require hearing testing and heavy sedation required would be detrimental to her</p>	W000323	<p><b>W323</b></p> <p><b>PHYSICIAN SERVICES</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt will obtain annual physical examinations for each client that includes vision and hearing.</p> <p><b>Responsible Person:</b></p> <p>Program Coordinator</p> <p><b>Date of Completion:</b></p> <p>July 3, 2013</p>	07/03/2013			

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	<p>health (with) little benefit." There was no documentation the facility followed-up with client #6 ' s primary care physician to ensure her hearing was adequate for her needs since 8/15/08. The facility did not have documentation the primary care physician assessed client #6 ' s hearing. An Outside Services Report, dated 2/2/12, indicated for vision, "Trace Blepharitis (infection of the eyelids). Follow-up for this problem: 12 mos (months)." There was no documentation in client #6's record her vision was evaluated annually.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/14/13 at 12:56 PM. The PC indicated client #6 should have had an a follow-up vision exam within 12 months of her most recent appointment. The PC stated, "I believe there's a doctor's order for hearing to not have to have."</p> <p>An interview with the nurse was conducted on 6/14/13 at 12:29 PM. The nurse indicated client #6 had a lot of problems with cooperating with medical appointments. The nurse stated, "She's hard to do anything with." The nurse indicated the most recent hearing examination was attempted in March 2005. The nurse indicated there was an order on 8/15/08 canceling the exam. The nurse indicated unless client #6 had a</p>		<p><b>Plan of Prevention:</b></p> <p>Stone Belt nurse and Program Coordinator</p> <p>will review annual physical forms to</p> <p>ensure that annual vision and hearing</p> <p>were checked. Appointments are to be scheduled by the Stone Belt nurse or Day Aide.</p>		

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	<p>problem, there was no benefit to doing a sedated hearing exam. The nurse indicated the doctor was not going to try the exam unless under general anesthesia. The nurse indicated client #6 should have had a follow-up vision appointment in 12 months from her most recent appointment.</p> <p>9-3-6(a)</p>			

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 2 of 6 clients living at the group home with adaptive equipment (#2 and #4), the facility failed to provide the clients' rocker knives during breakfast.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 6/13/13 from 5:53 AM to 7:55 AM. During the observation, clients #2 and #4 were not offered or provided their rocker knives during breakfast. At 6:16 AM, client #2 was given a plate with toast and eggs with salsa by staff #9. Client #2's food was cut up into bite size pieces prior to client #2 sitting at the table. Client #2 was not involved in cutting up her food or using a rocker knife. At 6:55 AM, client #4 was assisted to the dining room table. Staff #9 took client #4 his breakfast of eggs and toast which were cut up prior to being served. Client #4 was not involved in cutting up his food or using a rocker knife.</p> <p>A review of client #2's record was</p>	W000436	<p><b>W436</b></p> <p><b>SPACE AND EQUIPMENT</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt will provide and maintain adaptive equipment as identified by the interdisciplinary team as needed by the client.</p> <p><b>Responsible Person:</b></p> <p>Program Coordinator</p>	07/03/2013			

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	<p>conducted on 6/13/13 at 1:55 PM. Client #2's Medication Information Sheet (MIS), dated 5/17/13, indicated client #2 had a rocker knife as adaptive equipment.</p> <p>A review of client #4's record was conducted on 6/13/13 at 12:19 PM. Client #4's MIS, dated 6/6/13, indicated client #4 had a rocker knife as adaptive equipment.</p> <p>An interview with the nurse was conducted on 6/14/13 at 12:29 PM. The nurse indicated the clients should be offered or provided their rocker knives during every meal to cut up their food.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/14/13 at 12:56 PM. The PC indicated the clients should be provided their rocker knives for each meal.</p> <p>9-3-7(a)</p>		<p><b>Date of Completion:</b></p> <p>July 3, 2013</p> <p><b>Plan of Prevention:</b></p> <p>House staff were retrained on house of adaptive equipment and active treatment. Program Coordinator does announced an unannounced house visits to ensure adaptive equipment is being used.</p> <p>(Attachment # 7 )</p>		

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W000448	<p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure issues noted during evacuation drills were investigated.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 6/12/13 at 3:26 PM.</p> <p>1. On 6/30/12 at 5:00 AM, a fire drill was conducted. The total time to complete the drill was 5 minutes and 27 seconds. The drill report indicated, "[Client #4] got up out of wheelchair went back into the home to use restroom (sic). [Client #6] refused to walk to van tried to re-enter house (sic)." There was no documentation the facility investigated the issues noted during the drill. The section indicating "Team Reviewed Problem (if applicable)" was blank.</p> <p>2. On 9/8/12 at 10:50 PM, a fire drill was conducted. The total time to complete the drill was 3 minutes and 47 seconds. The drill form indicated, "[Client #2] had to have full assist out of bed and down hallway. Also, [client #6] was trying to re-enter house. [Client #5] couldn't get over her (foot) rail." There was no</p>	W000448	<p><b>W448</b></p> <p><b>EVACUATION DRILLS</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt group homes are to hold evacuation drills at least quarterly for each shift of personnel.</p> <p>problems during drills are to be noted investigated.</p> <p><b>Responsible Person:</b></p> <p>Program Coordinator</p> <p><b>Date of Completion:</b></p>	07/03/2013			

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	<p>documentation the facility investigated the issues noted during the drill. The section indicating "Team Reviewed Problem (if applicable)" was blank.</p> <p>3. On 10/18/12 at 8:49 AM, a fire drill was conducted. The time to complete the drill was 38 seconds. The form indicated, "[Client #2] resisted going out the front door - took 2 staff to grab her arms to get her to come outside." There was no documentation the facility investigated the issues noted during the drill. The section indicating "Team Reviewed Problem (if applicable)" was blank.</p> <p>4. On 12/6/12 at 4:45 AM, a fire drill was conducted. The time to complete the drill was 2 minutes and 22 seconds. The form indicated, "[Client #4] did not get up, [client #2] had to be pushed out the doorway, would not go voluntarily. [Client #5] would not attempt to get out of bed with staff, she had to be pulled up and into wheelchair." The drill form's section for "Evaluation of any problem with the drill" was blank. There was no documentation the facility investigated the issues noted during the drill.</p> <p>5. On 12/23/12 at 10:00 PM, a fire drill was conducted. The time to complete the drill was 2 minutes and 20 seconds. The form indicated, "[Client #2] had to be</p>		<p>July 3, 2013</p> <p><b>Plan of Prevention:</b></p> <p>House staff were retrained on the evacuation drill frequency and procedures.</p> <p>(Attachment # 8 ).</p> <p><b>Quality Assurance Monitoring:</b></p> <p>Program Coordinator will review drills on a monthly basis to ensure that all evacuation drills are conducted according to standards and any problem areas are addressed.</p> <p>Timing of these drills are also reviewed</p> <p>By the Stone Belt Quality Assurance</p>		

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	<p>complete assist. [Client #2] not hearing alarm (maybe). Maybe an alarm in her room?" There was no documentation the facility investigated the issues noted during the drill.</p> <p>6. On 3/15/13 at 10:00 PM, a fire drill was conducted. The time to complete the drill was 2 minutes and 17 seconds. The form indicated, "[Clients #4, #6, #2] still in bed. [Client #2] physical assist from bed down hallway and to van. Tried to go back. Tried to sit. [Client #4] assist from bed to chair. [Client #6] tried to go wrong way." There was no documentation the facility investigated the issues noted during the drill.</p> <p>7. On 3/27/13 at 5:00 AM, a fire drill was conducted. The time to complete the drill was 2 minutes and 48 seconds. The form indicated, "[Client #2] wanted to stop at doorway and not evacuate. She also did not want to get out of bed. [Client #4] sat on side of bed waiting for someone to come to get him. [Client #6] did not get up on her own." There was no documentation the facility investigated the issues noted during the drill.</p> <p>The Program Coordinator (PC), on 6/14/13 at 12:56 PM, indicated the clients had evacuation drill training objectives in place. The PC indicated the staff had</p>			

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	<p>been instructed to repeat drills if there were issues noted. The PC indicated she should document on the drill forms she looked into the issues since she reviewed the drill forms. The PC indicated, "My mistake."</p> <p>9-3-7(a)</p>			

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W000488	<p><b>483.480(d)(4)</b> <b>DINING AREAS AND SERVICE</b> 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 dinner and breakfast preparation.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/12/13 from 4:17 PM to 6:47 PM and 6/13/13 from 5:53 AM to 7:55 AM. On 6/12/13 at 4:29 PM, staff #4 assisted client #4 to the dining room table. Staff #4 then got client #4's snack ready (graham crackers) and took them to client #4. At 5:45 PM, clients #1, #2, #4 and #6 were sitting at the dining room table. Staff #1 was in the kitchen making pasta salad. At 6:25 PM, staff #1 made a pitcher of juice. At 6:29 PM, staff #1 poured client #5's juice. At 6:30 PM, staff #1 served client #6 pasta salad, fish, salad and tartar sauce. Staff #1 cut up client #6's fish in small pieces. Staff #1 got up from the table to get two rocker knives. Staff #1 cut up client #1's fish with one of the rocker knives. At 6:36 PM, staff #1 served client #6 more fish. At 6:41 PM, staff #1 cut up client #6's fish. On 6/13/13 at 5:54 AM, staff #9</p>	W000488	<p><b>W488</b></p> <p><b>DINING AREAS AND SERVICE</b></p> <p><b>Plan of Correction:</b></p> <p>Each Stone Belt group home client will eat meals consistent with their developmental level. Specifically preparing, serving and eating meals according to their diet plan and adaptive equipment.</p> <p><b>Responsible Person:</b></p> <p>Program Coordinantor</p>	07/03/2013			

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	<p>gave client #5 her breakfast (toast with jelly and eggs). At 5:59 AM, staff #9 was in the kitchen using a food processor to puree client #1's breakfast. Client #1 was in the living room and available to assist but was not asked to assist. At 6:01 AM, staff #9 used the food processor to puree toast. At 6:16 AM, client #2 was given a plate with toast and eggs with salsa by staff #9. Client #2's food was cut up into bite size pieces prior to client #2 sitting at the table. Client #2 was not involved in serving herself or cutting up her food. At 6:38 AM, staff #9 asked client #3 if she wanted grape jelly. Staff #9 made client #3's breakfast and carried it to the table. At 6:55 AM, client #4 was assisted to the dining room table. Staff #9 took client #4 his breakfast of eggs and toast. At 7:02 AM, staff #9 took client #3's cup and plate to the sink and rinsed them off. At 7:03 AM, client #6's food was served onto her plate and cut up by staff #9. Staff #9 went into the kitchen to load the dishwasher. At 7:05 AM, staff #9 gave client #6 her plate with her food on it and cut up. Staff #9 took client #6 her juice. At 7:13 AM, staff #9 served client #6 yogurt. At 7:45 AM, staff #9 got clients #1, #2, #3, #4, #5 and #6's lunch boxes and took them out to the van.</p> <p>An interview with the Program Coordinator (PC) was conducted on</p>		<p><b>Date of Completion:</b></p> <p>July 3, 2013</p> <p><b>Plan of Prevention:</b></p> <p>House staff were retrained on dining plans and service for mealtimes.</p> <p>(Attachment # 7 )</p> <p><b>Quality Assurance and Monitoring:</b></p> <p>Program Coordinator will conduct observations during weekly house visits that dining plans and active treatment is taking place.</p>		

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	6/14/13 at 12:56 PM. The PC indicated the clients should be involved with meal preparation. The PC indicated the clients were capable of assisting with meal preparation and should be involved.  9-3-8(a)				

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (Direct Care Staff #1), the facility failed to ensure</p>	W009999	<p><b>W9999</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt follows community residential facilities for persons with Developmental Disabilities Rules.</p> <p><b>Responsible Person:</b></p> <p>Program Coordinator</p> <p><b>Date of Completion:</b></p> <p>July 3, 2013</p> <p><b>Plan of Prevention:</b></p> <p><b>#1 FACILITY STAFFING</b></p>	07/03/2013	

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	<p>an annual Mantoux (STU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 6/13/13 at 12:51 PM. Direct Care Staff #1 had a negative Mantoux on 11/7/11. There was no documentation Direct Care Staff #1 had a Mantoux conducted since 11/7/11.</p> <p>An interview was conducted with the Administrative Assistant (AA) #1 in Personnel on 6/13/13 at 1:20 PM. AA #1 indicated the staff should have an annual Mantoux.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/14/13 at 12:56 PM. The PC indicated the staff should have an annual TB test.</p> <p>2) 460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. (An emergency intervention for the individual resulting from: A physical symptom; a medical or psychiatric</p>		<p>All residential staff will submit written evidence that a Mantoux is completed.</p> <p>(Attachment #9)</p> <p><b>#2 GOVERNING BODY</b></p> <p>Stone Belt shall report incidents to division no later than the first business day.</p> <p>Staff were retrained on reporting.</p> <p>(Attachment #2)</p> <p><b>QUALITY ASSURANCE AND MONITORING:</b></p> <p>Program Coordinator will review TB testing on an annual basis. Program Coordinator will ensure that all incidents are reported on a timely</p>				

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	<p>condition; Any other event.)</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 7 of 43 incident reports reviewed affecting clients #1, #2 and #3, the facility failed to ensure a fall with injury and medication errors were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/12/13 at 11:58 AM.</p> <ol style="list-style-type: none"> <li>1. On 3/9/13 at 5:45 PM (reported to BDDS on 3/11/13), client #1 fell during a transfer from her recliner to her wheelchair. Client #1 hit her head. The BDDS report indicated, "Possible bump on her left side of head."</li> <li>2. On 12/14/13 at 7:00 PM (reported to BDDS on 12/19/12), client #3 received one of two Senna laxatives.</li> <li>3. On 12/1/12 at 7:00 AM (reported to BDDS on 12/9/12), client #3 received one of two Oxaprozin.</li> <li>4. On 10/1/12 at 7:00 AM (reported to</li> </ol>		fashion.		

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	<p>BDDS on 10/8/12), client #2 was to receive Fluconazole every fourth day. Staff #8 gave the medication at the wrong time. The report indicated, "Reported late due to Coordinator being out of office until 10.08.2012."</p> <p>5. On 10/21/12 at 7:00 AM (not reported to BDDS), client #3 did not receive Oxaprozin due to not having in the home to administer.</p> <p>6. On 9/28/12 at 7:00 AM (reported to BDDS on 10/8/12), client #3 received one of two Cipro pills.</p> <p>7. On 8/26/12 at 7:00 PM (reported to BDDS on 9/25/12), client #2 received Fluconazole two days in a row. Medication to be administered every fourth day.</p> <p>An interview with the Program Coordinator (PC) was conducted on 6/12/13 at 1:27 PM. The PC indicated BDDS reports were to be submitted within 24 hours. The PC indicated there would not be medication errors or issues with reporting timely if the staff implemented the buddy check during medication administration.</p> <p>9-3-3(e) 9-3-1(b)</p>				

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