

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/10/2012
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>This visit resulted in an extended survey - Client Protections.</p> <p>Survey Dates: October 3, 4, 5, 9, and 10, 2012.</p> <p>Facility Number: 001209 Provider Number: 15G634 AIM Number: 100240160</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 10/15/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0104	<p><b>483.410(a)(1) GOVERNING BODY</b> 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 in the group home (#1, #2, #3, #4 and #5), the governing body failed to exercise operating direction over the facility by not ensuring the walls of the home were repainted.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/3/12 from 3:47 PM to 6:17 PM and 10/4/12 from 5:56 AM to 8:02 AM. During the observations, the walls throughout the home were scuffed, marked, stained and areas repaired from damage were not repainted. This affected clients #1, #2, #3, #4 and #5.</p> <p>An interview with staff #6 was conducted on 10/4/12 at 6:37 AM. Staff #6 indicated he had worked at the home for 2 years. Staff #6 indicated a few of the clients' bedrooms had been painted as well as touch ups but the whole house had not been painted.</p> <p>An interview with the home manager (HM) was conducted on 10/3/12 at 5:31 PM. The HM indicated he spoke to the maintenance supervisor about having the</p>	W0104	<p><b>W 104 GOVERNING BODY</b></p> <p><b>Plan of Correction:</b> Stone Belt exercises general policy, budget, and operating direction over the facility. Specifically, the facility will ensure that the interior walls of the home are painted and in good repair.</p> <p><b>Date of Completion:</b> November 9, 2012</p> <p><b>Person Responsible:</b> Deckard Program Coordinator</p> <p><b>Plan of Prevention:</b> Stone Belt Maintenance Manager has been notified of the need to repaint the interior walls at Deckard House.</p> <p><b>Quality Assurance Monitoring:</b> Program Coordinator and House Manager will conduct a Quarterly Internal Inspection of the home</p>	11/09/2012	

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	<p>home repainted recently however there was no documentation of a request. The HM indicated the home needed to be painted.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/9/12 at 11:35 AM. The QMRP indicated the home needed to be painted.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 10/9/12 at 11:35 AM. AS #1 indicated the home needed to be painted.</p> <p>9-3-1(a)</p>		<p>which will identify environmental needs. (Attachment # 1). Program Coordinator and SGL Director will review and prioritize various repairs.</p>		

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W0125	<p><b>483.420(a)(3)</b> <b>PROTECTION OF CLIENTS RIGHTS</b> The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1 had the right to due process in regard to staff removing his shoes to keep his from pushing back in his chair at dinner.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/3/12 from 3:47 PM to 6:17 PM. At 5:52 PM, client #1 was sitting at the dining room table. Staff #8 removed client #1's shoes and indicated he did so to ensure client #1 could not push himself back away from the table and into the wall.</p> <p>A review of client #1's record was conducted on 10/9/12 at 9:14 AM. Client #1's Individual Support Plan, dated 12/22/11, and Behavioral Support Plan, dated 4/12/12, did not include the restrictive intervention of staff removing client #1's shoes to keep him from pushing away from the dinner table.</p>	W0125	<p><b>W125</b></p> <p><b>PROTECTION OF CLIENT RIGHTS</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt ensures the rights of all clients and allows the clients to exercise their rights as clients of the facility, and as citizens of the United States. This includes the right to file complaints and the right to due process.</p> <p><b>Responsible Person:</b></p> <p>Deckard Program Coordinator</p> <p><b>Date of Completion:</b></p> <p>November 9, 2012</p> <p><b>Plan of Prevention:</b></p> <p>The client's behavioral support plan and individual support plan are being reviewed and updated to include strategies regarding the removal of client's shoes. This will include the client's consent to remove his shoes. House staff will be retrained on changes to</p>	11/09/2012			

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	An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/9/12 at 11:35 AM. The QMRP indicated staff removing client #1's shoes was not part of his plan. On 10/10/12 at 11:29 AM, the QMRP indicated the staff removing client #1's shoes should not have happened to keep him from pushing his chair back.  9-3-2(a)		the BSP as well as a review of Stone Belt policy on client rights.  <b>Quality Assurance Monitoring:</b>  The Deckard Program Coordinator and SGL Director will monitor during dinner time whether or not client removes his shoes as he so chooses. Announced and unannounced visits will continue to be conducted.		

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W0149	<p><b>483.420(d)(1)</b> <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 observation, record review of 3 of 5 incident reports reviewed and interview for 3 of 5 clients living in the group home (#2, #3, and #5), the facility neglected to implement its policies and procedures to prevent to client to client abuse.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 10/4/12 from 5:56 AM to 8:02 AM. At 6:38 AM, staff #10 went into client #3's bedroom to wake him up. At 6:39 AM, client #3 stated "F--- you, mother-----!" Client #3 then slammed his bedroom door. At 7:09 AM, client #3 stated to staff #10, "f--- you" after hearing what the breakfast menu indicated for breakfast. At 7:13 AM, client #3 indicated he wanted sugar. Client #3 was yelling, cursing and calling staff #10 names due to not having access to sugar. At 7:15 AM, client #3 was prompted he had sprayed enough spray butter on his waffles (sprayed over 30 sprays. Client #3 told staff #10 to "shut up." Client #5, who was also in the kitchen area with client #3 and staff #10, banged on the counter. Client #3 stated to client #5,</p>	W0149	<p><b>W149</b></p> <p><b>STAFF TREATMENT OF CLIENTS</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt Arc, Inc. will ensure any incidents of Abuse, Neglect, and/or mistreatment of the consumers will be reported immediately.</p> <p><b>Person Responsible:</b></p> <p>Deckard Program Coordinator</p> <p><b>Date of Completion:</b></p> <p>November 9, 2012</p> <p><b>Plan of Prevention:</b></p> <p>Staff will be retrained on the Stone Belt policy of Prevention of Abuse and Neglect and report immediately to the Program Coordinator and/or Director of Group Homes. Staff will also train on the specific clients behavior support plan to understand how to manage specific issues. Training on documenting incidents will occur also.</p> <p><b>Quality Assurance Monitoring:</b></p>	11/09/2012			

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	"dumb---." At 7:16 AM, client #3 was still spraying butter on his waffles. Client #5 attempted to get bread which was near client #3. When client #5 got the bread, client #3 told client #5 the bread was his and pushed client #5 two times and called him a "bi---." Client #5 hit client #3 in the stomach and then client #5 attempted to close the kitchen door. At 7:20 AM, client #5 returned to the kitchen and grabbed the bread. Client #3 hit client #5 on the neck as staff #10 stood in between the clients. Client #5 was prompted by staff #10 to leave the kitchen area however client #5 refused to leave. At 7:22 AM, client #2 entered the kitchen area where clients #3, #5 and staff #10 were located. At 7:24 AM, client #3 pushed client #2 after calling him a "bi--." Client #3 then called client #2 a "dumb---" two times. Client #3 stated to client #2 "f--- you, n----- mother fu----." At 7:26 AM, client #3 left the kitchen area to go to the dining room table. Client #3 sat down to eat and then jumped up and indicated he was going to stab client #2. Client #3 ran over to the door to the kitchen, which was closed and locked, and being blocked by staff #10. Client #3 lunged through the open window into the kitchen with a butter knife and swung the knife at both clients #2 and #5. Client #3 did not make contact with either client and was being		The Stone Belt Staff receive training during new hire orientation and annually on The Stone Belt Abuse, Mistreatment, Neglect and Incident Report Policies.  Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed.  The Program Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents.	

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	<p>blocked by staff #10. Client #3 had a fork in one hand and a butter knife in the other hand. Client #3 then hit staff #10 in the face two times. Staff #10 prompted client #3 to go calm down. Client #3 returned to the dining room table to eat his breakfast. During the incident, staff #5 was standing down the hall with client #1 and was able to observe the incident. Staff #5 did not assist staff #10 or inform staff #6 that staff #10 needed assistance. At 7:30 AM, staff #6 exited the medication room and entered the kitchen. Neither staff #6 nor staff #10 informed staff #6 of the incident. At 7:37 AM, client #3 was in the living room watching a television show. Staff #6 asked client #3 what the rules were about watching the particular show he was watching. Staff #6 indicated to client #3 there were two shows he was not allowed to watch in the living room and he was watching one of them. Staff #6 changed the channel. At 7:46 AM, client #3 stated to client #4, "F-- you, [client #4's last name]." Client #3 then went to the kitchen where client #2 and staff #6 were. Client #3 verbally threatened client #2. Staff #6 told client #3 he needed to leave the kitchen if he was going to threaten others. Client #2 got his lunch and left the kitchen. Staff #6 then prompted client #3 to take the television remote out of the kitchen. Client #3 stated to staff #6, "Why are you</p>			

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	<p>doing this?"</p> <p>On 10/4/12 at 8:37 AM, an interview with Administrative Staff #1 (AS) was conducted. AS #1 indicated he heard from the staff at drop off (8:10 AM) that client #3 was putting on a show for the surveyor during the morning shift. AS #1 indicated the surveyor's verbal report of the incident was the first he obtained specifics regarding the morning shift. AS #1 indicated he was not informed of the incident specifics by the group home staff by phone or drop off. At 9:14 AM, AS #1 indicated the group home staff did not inform the workshop staff during drop off about client #3's morning at the group home. AS #1 indicated he or the group home staff should have informed the workshop staff regarding client #3's behavior at the group home.</p> <p>On 10/4/12 at 9:04 AM, an interview with AS #2 (workshop supervisor) was conducted. AS #2 indicated she was informed of the incident by AS #1 "not too long ago." AS #2 indicated she was informed of the incident after client #3 was dropped off at the workshop. AS #2 indicated the workshop staff were not informed of client #3's behavior by the group home staff during drop off.</p> <p>A review of client #3's record was</p>						

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	<p>conducted on 10/9/12 at 10:36 AM. His record did not contain a report to the Bureau of Developmental Disabilities Services (BDDS) regarding the incident on 10/4/12. His Behavioral Support Plan, dated 9/5/12, indicated client #3 had the following targeted behaviors: refusals, aggressive behavior/property destruction, use of personal possessions, inappropriate telephone conduct, inappropriate sexual behavior, compulsive eating, false accusations, non-compliance to medical/dental procedures, and aggressive transportation behavior. The plan indicated, "[Client #3's] behaviors are primarily associated with his psychiatric illnesses and his developmental disability. He is often triggered by not wanted to do something, being told he cannot do something, being faced with something that scares him, and rigid scheduling." The proactive strategies section indicated, in part, "24. If [client #3] invades the space of another resident, staff will ask [client #3] to give space, and may physically assist him to do so, if necessary. Staff will review the importance of personal space with [client #3], and remind him that he does not like others to be in his space. 25. If [client #3] aggressively invades another resident's space (i.e. pushing, etc.), staff will ask [client #3] to take a break and think about the importance of respecting</p>			

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	<p>others' space. This break should likely take place in [client #3's] room and [client #3] does not necessarily have to be monitored so long as he does not continue to display inappropriate/disruptive behavior. 26. Staff will document any invasion of space and any breaks utilized on [client #3's] individualized behavior tracking form and on an incident report as appropriate." The plan defined aggressive behavior/property destruction as acting out towards staff or peers by hitting, kicking, pushing, biting, or swearing at staff or peers. The plan indicated aggressive behavior also involves property destruction or throwing items at others. The plan indicated, "Historically most aggression that [client #3] exhibits it towards staff. However, there have been times where he becomes aggressive towards other residents. Aggression if (sic) often the result of [client #3] not wanting to follow through with a staff request, or being told that he cannot do something." The Pro-Active Strategies section indicated, "1. Staff will need to reflect feelings, and let [client #3] know that they are picking up on what he is feeling. Staff may offer a discussion time to sit with [client #3] and talk about what he is agitated about. If [client #3] indicates with his behaviors (cussing, aggressive behaviors, name calling) that he does want to talk, staff should give</p>			

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	<p>[client #3] space and make no requests until he is calm. 2. Staff may suggest replacement behaviors if [client #3] continues to be angry (sic) example could be hitting his pillow in his room to release frustration. 3. Staff may also implement a partner switch if [client #3] continues to display aggressive behaviors. 4. It will be important to clear the area of others who might be in harms way whether this is peer roommates, or community members. 13. When [client #3] begins to show signs of aggression, staff will, when possible, move other consumers from the area until [client #3] is able to calm down. 14. Staff should allow [client #3] space and make no requests when [client #3] is displaying highly agitated behaviors. Historically, when [client #3] is agitated, staff request leads to increased behaviors and possibly physical aggression." The Restrictive Intervention Strategies section indicated, "15. If [client #3] is in danger of hurting himself or others, and he does not respond to lesser restrictive techniques, an approved Stone Belt physical restraint may be used. Approved techniques may include bear hug, or baskethold. 18. At times, [client #3's] aggression comes without warning. It seems that [client #3] actually 'loses control' during these times. Staff should remain calm and attempt to make [client #3] aware of his own actions. After one</p>			

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	<p>prompt to [client #3] to 'stop,' one of Stone Belt's approved physical intervention techniques may be implemented. 20. Due to recent threats made by [client #3] sharps (knives and other similar implements) will be kept locked in a keyed cabinet or lock box in the kitchen."</p> <p>The staff failed to implement client #3's plan as written for invading the space of others, prompting to take a break, documenting invasion of space on behavior tracking and incident report, reflecting feelings, offering a discussion time, suggesting a replacement behavior, switching partners, clearing the area, not making request of client #3 when he was highly agitated, and the use of restraint.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/4/12 at 11:43 AM. The QMRP indicated he was informed of the incident however he was not sure if an incident report was completed. At 11:59 AM, the QMRP indicated staff #10 did not document the incident on an incident report prior to leaving his shift. At 12:30 PM, the QMRP indicated staff #10 had issues at his previous work site with the provider of not completing incident reports. The QMRP indicated staff #10 would receive disciplinary action for not</p>						

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	<p>completing an incident report.</p> <p>A review of the incident report, submitted on 10/5/12 by staff #10, was conducted on 10/5/12 at 3:02 PM. The incident report included attachments indicating staff #10 received training on completing incident reports on 10/5/12. Staff #10 also received a disciplinary action, also attached, indicating, "[Staff #10] verbally informed another staff of an incident which took place that morning, but failed to fill out an incident report per Stone Belt Policy."</p> <p>An interview with staff #10 was conducted on 10/4/12 at 7:37 AM. Staff #10 indicated he was not injured. At 7:44 AM, staff #10 indicated he had seen similar behavior from client #3 in the past but never like what occurred during the shift. Staff #10 indicated client #3 typically threatens physical harm but never attempted to do so in the past. Staff #10 indicated the incident stemmed from the three clients being in the kitchen at the same time which rarely occurs.</p> <p>An interview with staff #5 was conducted on 10/4/12 at 7:58 AM. Staff #5 indicated he observed the behavior by client #3. Staff #5 indicated he had never seen client #3 that aggressive before which was surprising. Staff #5 indicated</p>			

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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408			
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	<p>client #3 targets new staff (#10) to test the staff. Staff #5 indicated none of the other clients were in danger since the staff were trained to stay in between. Staff #5 indicated most mornings were not as hectic and bad as this morning. Staff #5 indicated he did not assist staff #10 since client #1 needed "supervision." Staff #5 indicated the clients needed to be separated and not in the kitchen area at the same time.</p> <p>An interview with staff #6 was conducted on 10/4/12 at 12:21 PM. Staff #6 indicated he was not asked to assist with client #3's behavior. Staff #6 indicated he heard client #3 swearing but it was not out of the ordinary. Staff #6 indicated he was not informed of the incident until he and staff #10 returned to the group home after transporting the clients to the day program.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 10/9/12 at 12:23 PM. The BC indicated the staff should have implemented client #3's plan as written. The BC indicated the staff should have restrained client #3 due to the aggression toward staff and clients.</p> <p>2) On 9/14/12 at 2:00 PM while on break at the facility-operated workshop, client</p>						

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	<p>#5's peer walked up behind client #5 and put his arm around client #5's neck. Workshop staff prompted the peer to let go. The peer walked around to the front of client #5 and hit client #5 twice in the mouth, causing his lip to swell.</p> <p>3) On 8/28/12 at 7:15 PM, client #5 became upset that staff popped his meds out of the packaging (client #5 had a goal to do himself). Client #5 tried to prevent staff from administering client #5's meds. Staff prompted client #5 to leave the office. As the door was closing, client #5 attempted to hit staff and yelled at staff. Client #5 then ran to the kitchen and slapped client #2 in the face. Client #5 attempted to hit client #2 again and staff separated them. Client #5 attempted to strike both staff and client #2 so a restraint (baskethold) was used for 2 minutes. The report did not indicate whether or not client #2 was injured. The Inquiry of client to client abuse, dated 8/29/12, indicated the staff should have allowed client #5 more time to take his meds.</p> <p>A review of the facility's abuse and neglect policy, dated 10/17/11, was conducted on 10/3/12 at 1:53 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or</p>						

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	<p>emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical 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>9-3-2(a)</p>			

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W0153	<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 observation, interview and record review for an observed incident at the group home affecting clients #2, #3 and #5, the facility failed to ensure staff immediately notified the administrator of an incident of client to client abuse and a report was submitted to the Bureau of Developmental Disabilities Services (BDDS).</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/4/12 from 5:56 AM to 8:02 AM. At 6:38 AM, staff #10 went into client #3's bedroom to wake him up. At 6:39 AM, client #3 stated "F--- you, mother-----!" Client #3 then slammed his bedroom door. At 7:09 AM, client #3 stated to staff #10, "f--- you" after hearing what the breakfast menu indicated for breakfast. At 7:13 AM, client #3 indicated he wanted sugar. Client #3 was yelling, cursing and calling staff #10 names due to not having access to sugar. At 7:15 AM, client #3 was prompted he had sprayed enough spray butter on his</p>	W0153	<p><b>W153</b></p> <p><b>STAFF TREATMENT OF CLIENTS</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt Arc, Inc. will ensure any incidents of Abuse, Neglect, and/or mistreatment of the consumers will be reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p><b>Person Responsible:</b></p> <p>Deckard Program Coordinator</p> <p><b>Date of Completion:</b></p> <p>November 9, 2012</p> <p><b>Plan of Prevention:</b></p> <p>Staff will be retrained on the Stone Belt policy of Prevention of Abuse and Neglect and report immediately to the Program Coordinator and/or Director of Group Homes. Training on documenting incidents will occur</p>	11/09/2012			

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	waffles (sprayed over 30 sprays. Client #3 told staff #10 to "shut up." Client #5, who was also in the kitchen area with client #3 and staff #10, banged on the counter. Client #3 stated to client #5, "dumb---." At 7:16 AM, client #3 was still spraying butter on his waffles. Client #5 attempted to get bread which was near client #3. When client #5 got the bread, client #3 told client #5 the bread was his and pushed client #5 two times and called him a "bi---." Client #5 hit client #3 in the stomach and then client #5 attempted to close the kitchen door. At 7:20 AM, client #5 returned to the kitchen and grabbed the bread. Client #3 hit client #5 on the neck as staff #10 stood in between the clients. Client #5 was prompted by staff #10 to leave the kitchen area however client #5 refused to leave. At 7:22 AM, client #2 entered the kitchen area where clients #3, #5 and staff #10 were located. At 7:24 AM, client #3 pushed client #2 after calling him a "bi--." Client #3 then called client #2 a "dumb---" two times. Client #3 stated to client #2 "f--- you, n----- mother fu----." At 7:26 AM, client #3 left the kitchen area to go to the dining room table. Client #3 sat down to eat and then jumped up and indicated he was going to stab client #2. Client #3 ran over to the door to the kitchen, which was closed and locked, and being blocked by staff #10.		also.  <b>Quality Assurance Monitoring:</b>  The Stone Belt Staff receive training during new hire orientation and annually on The Stone Belt Abuse, Mistreatment, Neglect and Incident Report Policies.  Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed.  The Program Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents.	

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	<p>Client #3 lunged through the open window into the kitchen with a butter knife and swung the knife at both clients #2 and #5. Client #3 did not make contact with either client and was being blocked by staff #10. Client #3 had a fork in one hand and a butter knife in the other hand. Client #3 then hit staff #10 in the face two times. Staff #10 prompted client #3 to go calm down. Client #3 returned to the dining room table to eat his breakfast. During the incident, staff #5 was standing down the hall with client #1 and was able to observe the incident. Staff #5 did not assist staff #10 or inform staff #6 that staff #10 needed assistance. At 7:30 AM, staff #6 exited the medication room and entered the kitchen. Neither staff #6 nor staff #10 informed staff #6 of the incident. At 7:37 AM, client #3 was in the living room watching a television show. Staff #6 asked client #3 what the rules were about watching the particular show he was watching. Staff #6 indicated to client #3 there were two shows he was not allowed to watch in the living room and he was watching one of them. Staff #6 changed the channel. At 7:46 AM, client #3 stated to client #4, "F-- you, [client #4's last name]." Client #3 then went to the kitchen where client #2 and staff #6 were. Client #3 verbally threatened client #2. Staff #6 told client #3 he needed to leave the kitchen if he</p>			

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	<p>was going to threaten others. Client #2 got his lunch and left the kitchen. Staff #6 then prompted client #3 to take the television remote out of the kitchen. Client #3 stated to staff #6, "Why are you doing this?"</p> <p>An interview with staff #6 was conducted on 10/4/12 at 12:21 PM. Staff #6 indicated he was not asked to assist with client #3's behavior. Staff #6 indicated he heard client #3 swearing but it was not out of the ordinary. Staff #6 indicated he was not informed of the incident until he and staff #10 returned to the group home after transporting the clients to the day program.</p> <p>On 10/4/12 at 8:37 AM, an interview with Administrative Staff #1 (AS) was conducted. AS #1 stated he heard from the staff at drop off (8:10 AM) that client #3 was "putting on a show" for the surveyor during the morning shift. AS #1 indicated the surveyor's verbal report of the incident was the first he obtained specifics regarding the morning shift. AS #1 indicated he was not informed of the incident specifics by the group home staff by phone or drop off. At 9:14 AM, AS #1 indicated the group home staff did not inform the workshop staff during drop off about client #3's morning at the group home. AS #1 indicated he or the group</p>			

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	<p>home staff should have informed the workshop staff regarding client #3's behavior at the group home.</p> <p>On 10/4/12 at 9:04 AM, an interview with AS #2 (workshop supervisor) was conducted. AS #2 indicated she was informed of the incident by AS #1 "not too long ago." AS #2 indicated she was informed of the incident after client #3 was dropped off at the workshop. AS #2 indicated the workshop staff were not informed of client #3's behavior by the group home staff during drop off.</p> <p>A review of the incident report, submitted on 10/5/12 by staff #10, was conducted on 10/5/12 at 3:02 PM. The incident report included attachments indicating staff #10 received training on completing incident reports on 10/5/12. Staff #10 also received a disciplinary action, also attached, indicating, "[Staff #10] verbally informed another staff of an incident which took place that morning, but failed to fill out an incident report per Stone Belt Policy."</p> <p>A review of client #3's record was conducted on 10/9/12 at 10:36 AM. His record did not contain a report to the Bureau of Developmental Disabilities Services (BDDS) regarding the incident on 10/4/12.</p>				

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	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/4/12 at 11:43 AM. The QMRP indicated he was informed of the incident however he was not sure if an incident report was completed. At 11:59 AM, the QMRP indicated staff #10 did not document the incident on an incident report prior to leaving his shift. At 12:30 PM, the QMRP indicated staff #10 had issues at his previous work site with the provider of not completing incident reports. The QMRP indicated staff #10 would receive disciplinary action for not completing an incident report. On 10/10/12 at 11:29 AM, the QMRP indicated the staff should have immediately reported client to client abuse to the administrator and the facility should have submitted a BDDS report within 24 hours due to client to client abuse.</p> <p>On 10/9/12 at 11:35 AM an interview with Administrative Staff (AS) #1 was conducted. AS #1 indicated the staff should have immediately reported the incident to him and the facility should have submitted a BDDS report.</p> <p>9-3-2(a)</p>						

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W0159	<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 observation, record review and interview for an incident of client to client abuse involving clients #2, #3 and #5, the Qualified Mental Retardation Professional (QMRP) failed to ensure client #3's inter-disiplinary team convened to discuss the incident.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/4/12 from 5:56 AM to 8:02 AM. At 6:38 AM, staff #10 went into client #3's bedroom to wake him up. At 6:39 AM, client #3 stated "F--- you, mother-----!" Client #3 then slammed his bedroom door. At 7:09 AM, client #3 stated to staff #10, "f--- you" after hearing what the breakfast menu indicated for breakfast. At 7:13 AM, client #3 indicated he wanted sugar. Client #3 was yelling, cursing and calling staff #10 names due to not having access to sugar. At 7:15 AM, client #3 was prompted he had sprayed enough spray butter on his waffles (sprayed over 30 sprays. Client #3 told staff #10 to "shut up." Client #5, who was also in the kitchen area with client #3 and staff #10, banged on the</p>	W0159	<p><b>W159</b>  <b>QUALIFIED MENTAL RETARDATION PROFESSIONAL</b>  <b>Plan of Correction:</b>  Stone Belt Program Coordinator will ensure that each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, the Program Coordinator will facilitate a interdisciplinary team meeting as deemed necessary following incidents of client to client aggression.</p> <p><b>Person Responsible:</b>  Deckard Program Coordinator</p> <p><b>Date of Completion:</b>  November 9, 2012</p> <p><b>Plan of Prevention:</b>  Specifically, a interdisciplinary team met on October 26, 2012 to discuss the situation regarding the aggression of the client. (Attachment # 2)</p>	11/09/2012			

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	<p>counter. Client #3 stated to client #5, "dumb---." At 7:16 AM, client #3 was still spraying butter on his waffles. Client #5 attempted to get bread which was near client #3. When client #5 got the bread, client #3 told client #5 the bread was his and pushed client #5 two times and called him a "bi---." Client #5 hit client #3 in the stomach and then client #5 attempted to close the kitchen door. At 7:20 AM, client #5 returned to the kitchen and grabbed the bread. Client #3 hit client #5 on the neck as staff #10 stood in between the clients. Client #5 was prompted by staff #10 to leave the kitchen area however client #5 refused to leave. At 7:22 AM, client #2 entered the kitchen area where clients #3, #5 and staff #10 were located. At 7:24 AM, client #3 pushed client #2 after calling him a "bi--." Client #3 then called client #2 a "dumb---" two times. Client #3 stated to client #2 "f--- you, n----- mother fu----." At 7:26 AM, client #3 left the kitchen area to go to the dining room table. Client #3 sat down to eat and then jumped up and indicated he was going to stab client #2. Client #3 ran over to the door to the kitchen, which was closed and locked, and being blocked by staff #10. Client #3 lunged through the open window into the kitchen with a butter knife and swung the knife at both clients #2 and #5. Client #3 did not make</p>		<p><b>Quality Assurance Monitoring:</b></p> <p>Stone Belt Director of Group Homes will review all incidents and determine with the Program Coordinator if the incident requires a interdisciplinary team meeting.</p>	

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	<p>contact with either client and was being blocked by staff #10. Client #3 had a fork in one hand and a butter knife in the other hand. Client #3 then hit staff #10 in the face two times. Staff #10 prompted client #3 to go calm down. Client #3 returned to the dining room table to eat his breakfast. During the incident, staff #5 was standing down the hall with client #1 and was able to observe the incident. Staff #5 did not assist staff #10 or inform staff #6 that staff #10 needed assistance. At 7:30 AM, staff #6 exited the medication room and entered the kitchen. Neither staff #6 nor staff #10 informed staff #6 of the incident. At 7:37 AM, client #3 was in the living room watching a television show. Staff #6 asked client #3 what the rules were about watching the particular show he was watching. Staff #6 indicated to client #3 there were two shows he was not allowed to watch in the living room and he was watching one of them. Staff #6 changed the channel. At 7:46 AM, client #3 stated to client #4, "F-- you, [client #4's last name]." Client #3 then went to the kitchen where client #2 and staff #6 were. Client #3 verbally threatened client #2. Staff #6 told client #3 he needed to leave the kitchen if he was going to threaten others. Client #2 got his lunch and left the kitchen. Staff #6 then prompted client #3 to take the television remote out of the kitchen.</p>			

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	<p>Client #3 stated to staff #6, "Why are you doing this?"</p> <p>On 10/4/12 at 8:37 AM, an interview with Administrative Staff #1 (AS) was conducted. AS #1 stated he heard from the staff at drop off (8:10 AM) that client #3 was "putting on a show" for the surveyor during the morning shift. AS #1 indicated the surveyor's verbal report of the incident was the first he obtained specifics regarding the morning shift. AS #1 indicated he was not informed of the incident specifics by the group home staff by phone or drop off. At 9:14 AM, AS #1 indicated the group home staff did not inform the workshop staff during drop off about client #3's morning at the group home. AS #1 indicated he or the group home staff should have informed the workshop staff regarding client #3's behavior at the group home.</p> <p>On 10/4/12 at 9:04 AM, an interview with AS #2 (workshop supervisor) was conducted. AS #2 indicated she was informed of the incident by AS #1 "not too long ago." AS #2 indicated she was informed of the incident after client #3 was dropped off at the workshop. AS #2 indicated the workshop staff were not informed of client #3's behavior by the group home staff during drop off.</p>			

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	<p>A review of client #3's record was conducted on 10/9/12 at 10:36 AM. His record did not contain a report to the Bureau of Developmental Disabilities Services (BDDS) regarding the incident on 10/4/12. His record did not contain documentation the support team met to discuss the incident. His Behavioral Support Plan, dated 9/5/12, indicated client #3 had the following targeted behaviors: refusals, aggressive behavior/property destruction, use of personal possessions, inappropriate telephone conduct, inappropriate sexual behavior, compulsive eating, false accusations, non-compliance to medical/dental procedures, and aggressive transportation behavior. The plan indicated, "[Client #3's] behaviors are primarily associated with his psychiatric illnesses and his developmental disability. He is often triggered by not wanted to do something, being told he cannot do something, being faced with something that scares him, and rigid scheduling." The proactive strategies section indicated, in part, "24. If [client #3] invades the space of another resident, staff will ask [client #3] to give space, and may physically assist him to do so, if necessary. Staff will review the importance of personal space with [client #3], and remind him that he does not like others to be in his space. 25. If [client</p>			

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	#3] aggressively invades another resident's space (i.e. pushing, etc.), staff will ask [client #3] to take a break and think about the importance of respecting others' space. This break should likely take place in [client #3's] room and [client #3] does not necessarily have to be monitored so long as he does not continue to display inappropriate/disruptive behavior. 26. Staff will document any invasion of space and any breaks utilized on [client #3's] individualized behavior tracking form and on an incident report as appropriate." The plan defined aggressive behavior/property destruction as acting out towards staff or peers by hitting, kicking, pushing, biting, or swearing at staff or peers. The plan indicated aggressive behavior also involves property destruction or throwing items at others. The plan indicated, "Historically most aggression that [client #3] exhibits it towards staff. However, there have been times where he becomes aggressive towards other residents. Aggression if (sic) often the result of [client #3] not wanting to follow through with a staff request, or being told that he cannot do something." The Pro-Active Strategies section indicated, "1. Staff will need to reflect feelings, and let [client #3] know that they are picking up on what he is feeling. Staff may offer a discussion time to sit with [client #3] and talk about what			

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	<p>he is agitated about. If [client #3] indicates with his behaviors (cussing, aggressive behaviors, name calling) that he does want to talk, staff should give [client #3] space and make no requests until he is calm. 2. Staff may suggest replacement behaviors if [client #3] continues to be angry (sic) example could be hitting his pillow in his room to release frustration. 3. Staff may also implement a partner switch if [client #3] continues to display aggressive behaviors. 4. It will be important to clear the area of others who might be in harms way whether this is peer roommates, or community members. 13. When [client #3] begins to show signs of aggression, staff will, when possible, move other consumers from the area until [client #3] is able to calm down. 14. Staff should allow [client #3] space and make no requests when [client #3] is displaying highly agitated behaviors. Historically, when [client #3] is agitated, staff request leads to increased behaviors and possibly physical aggression." The Restrictive Intervention Strategies section indicated, "15. If [client #3] is in danger of hurting himself or others, and he does not respond to lesser restrictive techniques, an approved Stone Belt physical restraint may be used. Approved techniques may include bear hug, or baskethold. 18. At times, [client #3's] aggression comes without warning. It</p>			

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	<p>seems that [client #3] actually 'loses control' during these times. Staff should remain calm and attempt to make [client #3] aware of his own actions. After one prompt to [client #3] to 'stop,' one of Stone Belt's approved physical intervention techniques may be implemented. 20. Due to recent threats made by [client #3] sharps (knives and other similar implements) will be kept locked in a keyed cabinet or lock box in the kitchen."</p> <p>The staff failed to implement client #3's plan as written for invading the space of others, prompting to take a break, documenting invasion of space on behavior tracking and incident report, reflecting feelings, offering a discussion time, suggesting a replacement behavior, switching partners, clearing the area, not making request of client #3 when he was highly agitated, and the use of restraint.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/4/12 at 11:43 AM. The QMRP indicated he was informed of the incident however he was not sure if an incident report was completed. At 11:59 AM, the QMRP indicated staff #10 did not document the incident on an incident report prior to leaving his shift. At 12:30 PM, the QMRP indicated staff #10 had</p>						

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	<p>issues at his previous work site with the provider of not completing incident reports. The QMRP indicated staff #10 would receive disciplinary action for not completing an incident report.</p> <p>A review of the incident report, submitted on 10/5/12 by staff #10, was conducted on 10/5/12 at 3:02 PM. The incident report included attachments indicating staff #10 received training on completing incident reports on 10/5/12. Staff #10 also received a disciplinary action, also attached, indicating, "[Staff #10] verbally informed another staff of an incident which took place that morning, but failed to fill out an incident report per Stone Belt Policy."</p> <p>An interview with staff #10 was conducted on 10/4/12 at 7:37 AM. Staff #10 indicated he was not injured. At 7:44 AM, staff #10 indicated he had seen similar behavior from client #3 in the past but never like what occurred during the shift. Staff #10 indicated client #3 typically threatens physical harm but never attempted to do so in the past. Staff #10 indicated the incident stemmed from the three clients being in the kitchen at the same time which rarely occurs.</p> <p>An interview with staff #5 was conducted on 10/4/12 at 7:58 AM. Staff #5</p>				

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	<p>indicated he observed the behavior by client #3. Staff #5 indicated he had never seen client #3 that aggressive before which was surprising. Staff #5 indicated client #3 targets new staff (#10) to test the staff. Staff #5 indicated none of the other clients were in danger since the staff were trained to stay in between. Staff #5 indicated most mornings were not as hectic and bad as this morning. Staff #5 indicated he did not assist staff #10 since client #1 needed "supervision." Staff #5 indicated the clients needed to be separated and not in the kitchen area at the same time.</p> <p>An interview with staff #6 was conducted on 10/4/12 at 12:21 PM. Staff #6 indicated he was not asked to assist with client #3's behavior. Staff #6 indicated he heard client #3 swearing but it was not out of the ordinary. Staff #6 indicated he was not informed of the incident until he and staff #10 returned to the group home after transporting the clients to the day program.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 10/9/12 at 12:23 PM. The BC indicated the staff should have implemented client #3's plan as written. The BC indicated the staff should have restrained client #3 due to the aggression toward staff and</p>						

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	<p>clients.</p> <p>An interview with the QMRP was conducted on 10/9/12 at 11:35 AM. The QMRP indicated the inter-disiplinary support team had not met to discuss the incident. The QMRP indicated the support team met on 10/2/12 and would convene, most likely, next week to discuss the incident.</p> <p>9-3-3(a)</p>			

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W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review, and interview for 3 of 5 clients (#2, #3, and #5) involved in an incident during the morning observations at the group home, the facility failed to ensure staff were appropriately deployed to meet the needs of the clients.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/4/12 from 5:56 AM to 8:02 AM. At 6:38 AM, staff #10 went into client #3's bedroom to wake him up. At 6:39 AM, client #3 stated "F--- you, mother-----!" Client #3 then slammed his bedroom door. At 7:09 AM, client #3 stated to staff #10, "f--- you" after hearing what the breakfast menu indicated for breakfast. At 7:13 AM, client #3 indicated he wanted sugar. Client #3 was yelling, cursing and calling staff #10 names due to not having access to sugar. At 7:15 AM, client #3 was prompted he had sprayed enough spray butter on his</p>	W0186	<p><b>W 186 DIRECT CARE STAFF Plan of Correction:</b> Stone Belt will provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. <b>Person Responsible:</b> Deckard Program Coordinator <b>Date of Completion:</b> November 9, 2012 <b>Plan of Prevention:</b> Program Coordinator and House Manager conducted a training to review and ensure that staff are deployed properly within the home. Due to the majority of incidents occurring during the morning shift and around the kitchen, a staff will be assigned specifically to the kitchen. In addition, staff were trained on asking for assistance if the situation escalates. (Attachment A). <b>Quality Assurance Monitoring:</b> Announced and unannounced visits by the Program Coordinator and SGL Director will ensure that staff are being deployed properly during the given shifts.</p>	11/09/2012	

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	<p>waffles (sprayed over 30 sprays. Client #3 told staff #10 to "shut up." Client #5, who was also in the kitchen area with client #3 and staff #10, banged on the counter. Client #3 stated to client #5, "dumb---." At 7:16 AM, client #3 was still spraying butter on his waffles. Client #5 attempted to get bread which was near client #3. When client #5 got the bread, client #3 told client #5 the bread was his and pushed client #5 two times and called him a "bi---." Client #5 hit client #3 in the stomach and then client #5 attempted to close the kitchen door. At 7:20 AM, client #5 returned to the kitchen and grabbed the bread. Client #3 hit client #5 on the neck as staff #10 stood in between the clients. Client #5 was prompted by staff #10 to leave the kitchen area however client #5 refused to leave. At 7:22 AM, client #2 entered the kitchen area where clients #3, #5 and staff #10 were located. At 7:24 AM, client #3 pushed client #2 after calling him a "bi-- -." Client #3 then called client #2 a "dumb---" two times. Client #3 stated to client #2 "f--- you, n----- mother fu----." At 7:26 AM, client #3 left the kitchen area to go to the dining room table. Client #3 sat down to eat and then jumped up and indicated he was going to stab client #2. Client #3 ran over to the door to the kitchen, which was closed and locked, and being blocked by staff #10.</p>			

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	<p>Client #3 lunged through the open window into the kitchen with a butter knife and swung the knife at both clients #2 and #5. Client #3 did not make contact with either client and was being blocked by staff #10. Client #3 had a fork in one hand and a butter knife in the other hand. Client #3 then hit staff #10 in the face two times. Staff #10 prompted client #3 to go calm down. Client #3 returned to the dining room table to eat his breakfast. During the incident, staff #5 was standing down the hall with client #1 and was able to observe the incident. Staff #5 did not assist staff #10 or inform staff #6 that staff #10 needed assistance. At 7:30 AM, staff #6 exited the medication room and entered the kitchen. Neither staff #6 nor staff #10 informed staff #6 of the incident. At 7:37 AM, client #3 was in the living room watching a television show. Staff #6 asked client #3 what the rules were about watching the particular show he was watching. Staff #6 indicated to client #3 there were two shows he was not allowed to watch in the living room and he was watching one of them. Staff #6 changed the channel. At 7:46 AM, client #3 stated to client #4, "F-- you, [client #4's last name]." Client #3 then went to the kitchen where client #2 and staff #6 were. Client #3 verbally threatened client #2. Staff #6 told client #3 he needed to leave the kitchen if he</p>						

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	<p>was going to threaten others. Client #2 got his lunch and left the kitchen. Staff #6 then prompted client #3 to take the television remote out of the kitchen. Client #3 stated to staff #6, "Why are you doing this?"</p> <p>A review of client #3's record was conducted on 10/9/12 at 10:36 AM. His record did not contain a report to the Bureau of Developmental Disabilities Services (BDDS) regarding the incident on 10/4/12. His Behavioral Support Plan, dated 9/5/12, indicated client #3 had the following targeted behaviors: refusals, aggressive behavior/property destruction, use of personal possessions, inappropriate telephone conduct, inappropriate sexual behavior, compulsive eating, false accusations, non-compliance to medical/dental procedures, and aggressive transportation behavior. The plan indicated, "[Client #3's] behaviors are primarily associated with his psychiatric illnesses and his developmental disability. He is often triggered by not wanted to do something, being told he cannot do something, being faced with something that scares him, and rigid scheduling." The proactive strategies section indicated, in part, "24. If [client #3] invades the space of another resident, staff will ask [client #3] to give space, and may physically assist him to do so, if</p>			

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	<p>physical restraint may be used. Approved techniques may include bear hug, or baskethold. 18. At times, [client #3's] aggression comes without warning. It seems that [client #3] actually 'loses control' during these times. Staff should remain calm and attempt to make [client #3] aware of his own actions. After one prompt to [client #3] to 'stop,' one of Stone Belt's approved physical intervention techniques may be implemented. 20. Due to recent threats made by [client #3] sharps (knives and other similar implements) will be kept locked in a keyed cabinet or lock box in the kitchen."</p> <p>The staff failed to implement client #3's plan as written for invading the space of others, prompting to take a break, documenting invasion of space on behavior tracking and incident report, reflecting feelings, offering a discussion time, suggesting a replacement behavior, switching partners, clearing the area, not making request of client #3 when he was highly agitated, and the use of restraint.</p> <p>An interview with staff #10 was conducted on 10/4/12 at 7:37 AM. Staff #10 indicated he was not injured. At 7:44 AM, staff #10 indicated he had seen similar behavior from client #3 in the past but never like what occurred during the</p>				

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	<p>shift. Staff #10 indicated client #3 typically threatens physical harm but never attempted to do so in the past. Staff #10 indicated the incident stemmed from the three clients being in the kitchen at the same time which rarely occurs.</p> <p>An interview with staff #5 was conducted on 10/4/12 at 7:58 AM. Staff #5 indicated he observed the behavior by client #3. Staff #5 indicated he had never seen client #3 that aggressive before which was surprising. Staff #5 indicated client #3 targets new staff (#10) to test the staff. Staff #5 indicated none of the other clients were in danger since the staff were trained to stay in between. Staff #5 indicated most mornings were not as hectic and bad as this morning. Staff #5 indicated he did not assist staff #10 since client #1 needed "supervision." Staff #5 indicated the clients needed to be separated and not in the kitchen area at the same time.</p> <p>An interview with staff #6 was conducted on 10/4/12 at 12:21 PM. Staff #6 indicated he was not asked to assist with client #3's behavior. Staff #6 indicated he heard client #3 swearing but it was not out of the ordinary. Staff #6 indicated he was not informed of the incident until he and staff #10 returned to the group home after transporting the clients to the day</p>				

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	<p>program.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 10/9/12 at 11:35 AM. AS #1 indicated the staff failed to deploy appropriately to meet the needs of the clients. AS #1 indicated staff #10 or #5 should have asked staff #6 for his assistance with the behavior.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/10/12 at 11:29 AM. The QMRP indicated the staff failed to deploy themselves appropriately. The QMRP indicated staff #10 should have asked for assistance from staff #5 and #6. The QMRP indicated he thought the incident could have been avoided if the staff would have communicated with each other. The QMRP indicated staff #10 did not utilize the other staff very well.</p> <p>9-3-3(a)</p>						

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W0249	<p><b>483.440(d)(1) PROGRAM IMPLEMENTATION</b></p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 2 of 3 clients in the sample (#1 and #3), the facility failed to ensure staff implemented 1) client #1's risk plan for falls, 2) client #3's behavior plan, and 3) client #1's plan for using his rocker knife.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 10/4/12 from 5:56 AM to 8:02 AM. Upon arrival to the group home, client #1 was awake and walking down the hallway. Client #1 was not wearing a gait belt or helmet. Staff #10 stated client #1 was, "pretty wobbly" this morning. Client #1 then banged his head on the dining room table. Staff #10 blocked further attempts of client #1 banging his head on the table with his hand. Staff #10 stated to client #1, "If your banging your head we will have to put on your helmet." At 6:04 AM, client #1 was in the formal living room unsupervised. Staff #10, who was in the</p>	W0249	<p><b>W 249</b></p> <p><b>PROGRAM IMPLEMENTATION</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt will ensure that each client will receive continuous active treatment as designated by each individual's program plan. This will include interventions and services frequent enough to support the achievement of the objectives.</p> <p><b>Date of Completion:</b></p> <p>November 9, 2012</p>	11/09/2012			

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	<p>main living room, when to check on client #1. At 6:07 AM while staff #10 was in the main living room, the front door alarm sounded. Staff #10 went to check on client #1, who was standing at the front door. Staff #10 indicated client #1 was prone to falls but not during the overnight shift. At 6:17 AM, staff #6 arrived to the group home. Staff #6 escorted client #1 to his room and when client #1 returned to the dining room, he was wearing a gait belt and helmet.</p> <p>A review of client #1's record was conducted on 10/9/12 at 9:14 AM. A risk plan for falls, dated 9/25/12, indicated, "[Client #1] is at risk for falls due to his history and diagnosis...". The plan indicated, "Staff will use a gait belt with [client #1] (around waist) at all times when [client #1] is ambulating, whether at home or in the community. While at home [client #1] will also wear a helmet to prevent head injury in case of a fall." The plan indicated, in bold, "At all times staff will remain close to [client #1] during times of transition from standing to sitting, sitting to standing, as well as walking to ensure his safety."</p> <p>An interview with staff #6 was conducted on 10/4/12 at 6:49 AM. Staff #6 indicated client #1 had a risk plan to wear a gait belt and helmet when he was</p>		<p><b>Person Responsible:</b></p> <p>Deckard Program Coordinator</p> <p><b>Plan of Prevention:</b></p> <p>The Stone Belt Support Team will ensure that behavior and active treatment plans are followed in general and specifically as follows 1) client fall risk plan, 2) client's behavior support plan followed 3) client's rocker knife and proper usage of such. Training occurred on fall risk plan, rocker knife and the BSP. (Attachment B &amp; C)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>Deckard Program Coordinator and other Administrative Staff will conduct announced and announced visits to ensure that plans are being carried out as presented.</p>				

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	<p>ambulating.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/9/12 at 11:35 AM. The QMRP indicated as soon as client #1 got out of bed staff #10 should have put on his helmet and gait belt.</p> <p>2) An observation was conducted at the group home on 10/4/12 from 5:56 AM to 8:02 AM. At 6:38 AM, staff #10 went into client #3's bedroom to wake him up. At 6:39 AM, client #3 stated "F--- you, mother-----!" Client #3 then slammed his bedroom door. At 7:09 AM, client #3 stated to staff #10, "f--- you" after hearing what the breakfast menu indicated for breakfast. At 7:13 AM, client #3 indicated he wanted sugar. Client #3 was yelling, cursing and calling staff #10 names due to not having access to sugar. At 7:15 AM, client #3 was prompted he had sprayed enough spray butter on his waffles (sprayed over 30 sprays. Client #3 told staff #10 to "shut up." Client #5, who was also in the kitchen area with client #3 and staff #10, banged on the counter. Client #3 stated to client #5, "dumb---." At 7:16 AM, client #3 was still spraying butter on his waffles. Client #5 attempted to get bread which was near client #3. When client #5 got the bread, client #3 told client #5 the bread was his</p>			
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	<p>and pushed client #5 two times and called him a "bi---." Client #5 hit client #3 in the stomach and then client #5 attempted to close the kitchen door. At 7:20 AM, client #5 returned to the kitchen and grabbed the bread. Client #3 hit client #5 on the neck as staff #10 stood in between the clients. Client #5 was prompted by staff #10 to leave the kitchen area however client #5 refused to leave. At 7:22 AM, client #2 entered the kitchen area where clients #3, #5 and staff #10 were located. At 7:24 AM, client #3 pushed client #2 after calling him a "bi--." Client #3 then called client #2 a "dumb---" two times. Client #3 stated to client #2 "f--- you, n----- mother fu----." At 7:26 AM, client #3 left the kitchen area to go to the dining room table. Client #3 sat down to eat and then jumped up and indicated he was going to stab client #2. Client #3 ran over to the door to the kitchen, which was closed and locked, and being blocked by staff #10. Client #3 lunged through the open window into the kitchen with a butter knife and swung the knife at both clients #2 and #5. Client #3 did not make contact with either client and was being blocked by staff #10. Client #3 had a fork in one hand and a butter knife in the other hand. Client #3 then hit staff #10 in the face two times. Staff #10 prompted client #3 to go calm down. Client #3 returned</p>			

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	<p>to the dining room table to eat his breakfast. During the incident, staff #5 was standing down the hall with client #1 and was able to observe the incident. Staff #5 did not assist staff #10 or inform staff #6 that staff #10 needed assistance. At 7:30 AM, staff #6 exited the medication room and entered the kitchen. Neither staff #6 nor staff #10 informed staff #6 of the incident. At 7:37 AM, client #3 was in the living room watching a television show. Staff #6 asked client #3 what the rules were about watching the particular show he was watching. Staff #6 indicated to client #3 there were two shows he was not allowed to watch in the living room and he was watching one of them. Staff #6 changed the channel. At 7:46 AM, client #3 stated to client #4, "F-- you, [client #4's last name]." Client #3 then went to the kitchen where client #2 and staff #6 were. Client #3 verbally threatened client #2. Staff #6 told client #3 he needed to leave the kitchen if he was going to threaten others. Client #2 got his lunch and left the kitchen. Staff #6 then prompted client #3 to take the television remote out of the kitchen. Client #3 stated to staff #6, "Why are you doing this?"</p> <p>A review of client #3's record was conducted on 10/9/12 at 10:36 AM. His Behavioral Support Plan, dated 9/5/12,</p>			

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	<p>indicated client #3 had the following targeted behaviors: refusals, aggressive behavior/property destruction, use of personal possessions, inappropriate telephone conduct, inappropriate sexual behavior, compulsive eating, false accusations, non-compliance to medical/dental procedures, and aggressive transportation behavior. The plan indicated, "[Client #3's] behaviors are primarily associated with his psychiatric illnesses and his developmental disability. He is often triggered by not wanted to do something, being told he cannot do something, being faced with something that scares him, and rigid scheduling." The proactive strategies section indicated, in part, "24. If [client #3] invades the space of another resident, staff will ask [client #3] to give space, and may physically assist him to do so, if necessary. Staff will review the importance of personal space with [client #3], and remind him that he does not like others to be in his space. 25. If [client #3] aggressively invades another resident's space (i.e. pushing, etc.), staff will ask [client #3] to take a break and think about the importance of respecting others' space. This break should likely take place in [client #3's] room and [client #3] does not necessarily have to be monitored so long as he does not continue to display inappropriate/disruptive</p>			

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	behavior. 26. Staff will document any invasion of space and any breaks utilized on [client #3's] individualized behavior tracking form and on an incident report as appropriate." The plan defined aggressive behavior/property destruction as acting out towards staff or peers by hitting, kicking, pushing, biting, or swearing at staff or peers. The plan indicated aggressive behavior also involves property destruction or throwing items at others. The plan indicated, "Historically most aggression that [client #3] exhibits it towards staff. However, there have been times where he becomes aggressive towards other residents. Aggression if (sic) often the result of [client #3] not wanting to follow through with a staff request, or being told that he cannot do something." The Pro-Active Strategies section indicated, "1. Staff will need to reflect feelings, and let [client #3] know that they are picking up on what he is feeling. Staff may offer a discussion time to sit with [client #3] and talk about what he is agitated about. If [client #3] indicates with his behaviors (cussing, aggressive behaviors, name calling) that he does want to talk, staff should give [client #3] space and make no requests until he is calm. 2. Staff may suggest replacement behaviors if [client #3] continues to be angry (sic) example could be hitting his pillow in his room to release			

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	<p>frustration. 3. Staff may also implement a partner switch if [client #3] continues to display aggressive behaviors. 4. It will be important to clear the area of others who might be in harms way whether this is peer roommates, or community members. 13. When [client #3] begins to show signs of aggression, staff will, when possible, move other consumers from the area until [client #3] is able to calm down. 14. Staff should allow [client #3] space and make no requests when [client #3] is displaying highly agitated behaviors. Historically, when [client #3] is agitated, staff request leads to increased behaviors and possibly physical aggression." The Restrictive Intervention Strategies section indicated, "15. If [client #3] is in danger of hurting himself or others, and he does not respond to lesser restrictive techniques, an approved Stone Belt physical restraint may be used. Approved techniques may include bear hug, or baskethold. 18. At times, [client #3's] aggression comes without warning. It seems that [client #3] actually 'loses control' during these times. Staff should remain calm and attempt to make [client #3] aware of his own actions. After one prompt to [client #3] to 'stop,' one of Stone Belt's approved physical intervention techniques may be implemented. 20. Due to recent threats made by [client #3] sharps (knives and</p>			

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	<p>other similar implements) will be kept locked in a keyed cabinet or lock box in the kitchen."</p> <p>The staff failed to implement client #3's plan as written for invading the space of others, prompting to take a break, documenting invasion of space on behavior tracking and incident report, reflecting feelings, offering a discussion time, suggesting a replacement behavior, switching partners, clearing the area, not making request of client #3 when he was highly agitated, and the use of restraint.</p> <p>An interview with staff #10 was conducted on 10/4/12 at 7:37 AM. Staff #10 indicated he was not injured. At 7:44 AM, staff #10 indicated he had seen similar behavior from client #3 in the past but never like what occurred during the shift. Staff #10 indicated client #3 typically threatens physical harm but never attempted to do so in the past. Staff #10 indicated the incident stemmed from the three clients being in the kitchen at the same time which rarely occurs.</p> <p>An interview with staff #5 was conducted on 10/4/12 at 7:58 AM. Staff #5 indicated he observed the behavior by client #3. Staff #5 indicated he had never seen client #3 that aggressive before which was surprising. Staff #5 indicated</p>			

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	<p>client #3 targets new staff (#10) to test the staff. Staff #5 indicated none of the other clients were in danger since the staff were trained to stay in between. Staff #5 indicated most mornings were not as hectic and bad as this morning. Staff #5 indicated he did not assist staff #10 since client #1 needed "supervision." Staff #5 indicated the clients needed to be separated and not in the kitchen area at the same time.</p> <p>An interview with staff #6 was conducted on 10/4/12 at 12:21 PM. Staff #6 indicated he was not asked to assist with client #3's behavior. Staff #6 indicated he heard client #3 swearing but it was not out of the ordinary. Staff #6 indicated he was not informed of the incident until he and staff #10 returned to the group home after transporting the clients to the day program.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 10/9/12 at 12:23 PM. The BC indicated the staff should have implemented client #3's plan as written. The BC indicated the staff should have restrained client #3 due to the aggression toward staff and clients.</p> <p>3) An observation was conducted at the group home on 10/3/12 from 3:47 PM to</p>						

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	<p>6:17 PM. At 6:06 PM, staff #3 used client #1's rocker knife to cut up client #1's dinner. Staff #3 did not prompt client #1 to assist or offer client #1 training to use the rocker knife.</p> <p>A review of client #1's record was conducted on 10/9/12 at 9:14 AM. Client #1's Individual Support Plan (ISP), dated 12/22/11, indicated client #1 had a training objective to use his rocker knife to cut up his food.</p> <p>An interview with the QMRP was conducted on 10/9/12 at 11:35 AM. The QMRP indicated the staff should have prompted/trained client #1 to use the rocker knife.</p> <p>9-3-4(a)</p>				

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W0253	<p><b>483.440(e)(2)</b> <b>PROGRAM DOCUMENTATION</b> The facility must document significant events that are related to the client's individual program plan and assessments. Based on observation, record review, and interview for 1 of 3 clients involved in an incident during morning observations, the facility failed to ensure staff documented the incident.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/4/12 from 5:56 AM to 8:02 AM. At 6:38 AM, staff #10 went into client #3's bedroom to wake him up. At 6:39 AM, client #3 stated "F--- you, mother-----!" Client #3 then slammed his bedroom door. At 7:09 AM, client #3 stated to staff #10, "f--- you" after hearing what the breakfast menu indicated for breakfast. At 7:13 AM, client #3 indicated he wanted sugar. Client #3 was yelling, cursing and calling staff #10 names due to not having access to sugar. At 7:15 AM, client #3 was prompted he had sprayed enough spray butter on his waffles (sprayed over 30 sprays. Client #3 told staff #10 to "shut up." Client #5, who was also in the kitchen area with client #3 and staff #10, banged on the counter. Client #3 stated to client #5, "dumb---." At 7:16 AM, client #3 was still spraying butter on his waffles. Client</p>	W0253	<p><b>W 253</b> <b>PROGRAM DOCUMENTATION</b></p> <p><b>Plan of Correction:</b> Stone Belt will ensure that significant events that are related to the client's individual program plan and assessment will be documented.</p> <p><b>Date of Completion:</b> November 9, 2012</p> <p><b>Person Responsible:</b> Deckard Program Coordinator</p> <p><b>Plan of Prevention:</b> Training will take place documenting incidents. Staff received disciplinary action for not documenting incident. (Attachment # 3)</p> <p><b>Quality Assurance Monitoring:</b> Program Coordinator and SGL Director will review all incident reports to assure that reporting is done immediately by staff.</p>	11/09/2012			

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	<p>#5 attempted to get bread which was near client #3. When client #5 got the bread, client #3 told client #5 the bread was his and pushed client #5 two times and called him a "bi---." Client #5 hit client #3 in the stomach and then client #5 attempted to close the kitchen door. At 7:20 AM, client #5 returned to the kitchen and grabbed the bread. Client #3 hit client #5 on the neck as staff #10 stood in between the clients. Client #5 was prompted by staff #10 to leave the kitchen area however client #5 refused to leave. At 7:22 AM, client #2 entered the kitchen area where clients #3, #5 and staff #10 were located. At 7:24 AM, client #3 pushed client #2 after calling him a "bi--." Client #3 then called client #2 a "dumb---" two times. Client #3 stated to client #2 "f--- you, n----- mother fu----." At 7:26 AM, client #3 left the kitchen area to go to the dining room table. Client #3 sat down to eat and then jumped up and indicated he was going to stab client #2. Client #3 ran over to the door to the kitchen, which was closed and locked, and being blocked by staff #10. Client #3 lunged through the open window into the kitchen with a butter knife and swung the knife at both clients #2 and #5. Client #3 did not make contact with either client and was being blocked by staff #10. Client #3 had a fork in one hand and a butter knife in the other</p>			

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	<p>hand. Client #3 then hit staff #10 in the face two times. Staff #10 prompted client #3 to go calm down. Client #3 returned to the dining room table to eat his breakfast. During the incident, staff #5 was standing down the hall with client #1 and was able to observe the incident. Staff #5 did not assist staff #10 or inform staff #6 that staff #10 needed assistance. At 7:30 AM, staff #6 exited the medication room and entered the kitchen. Neither staff #6 nor staff #10 informed staff #6 of the incident. At 7:37 AM, client #3 was in the living room watching a television show. Staff #6 asked client #3 what the rules were about watching the particular show he was watching. Staff #6 indicated to client #3 there were two shows he was not allowed to watch in the living room and he was watching one of them. Staff #6 changed the channel. At 7:46 AM, client #3 stated to client #4, "F-- you, [client #4's last name]." Client #3 then went to the kitchen where client #2 and staff #6 were. Client #3 verbally threatened client #2. Staff #6 told client #3 he needed to leave the kitchen if he was going to threaten others. Client #2 got his lunch and left the kitchen. Staff #6 then prompted client #3 to take the television remote out of the kitchen. Client #3 stated to staff #6, "Why are you doing this?"</p>						

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	<p>On 10/4/12 at 8:37 AM, an interview with Administrative Staff #1 (AS) was conducted. AS #1 indicated he heard from the staff at drop off (8:10 AM) that client #3 was putting on a show for the surveyor during the morning shift. AS #1 indicated the surveyor's verbal report of the incident was the first he obtained specifics regarding the morning shift. AS #1 indicated he was not informed of the incident specifics by the group home staff by phone or drop off. At 9:14 AM, AS #1 indicated the group home staff did not inform the workshop staff during drop off about client #3's morning at the group home. AS #1 indicated he or the group home staff should have informed the workshop staff regarding client #3's behavior at the group home.</p> <p>On 10/4/12 at 9:04 AM, an interview with AS #2 (workshop supervisor) was conducted. AS #2 indicated she was informed of the incident by AS #1 "not too long ago." AS #2 indicated she was informed of the incident after client #3 was dropped off at the workshop. AS #2 indicated the workshop staff were not informed of client #3's behavior by the group home staff during drop off.</p> <p>A review of client #3's record was conducted on 10/9/12 at 10:36 AM. His record did not contain a report to the</p>						

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	<p>Bureau of Developmental Disabilities Services (BDDS) regarding the incident on 10/4/12 or a facility incident report. His Behavioral Support Plan, dated 9/5/12, indicated, "26. Staff will document any invasion of space and any breaks utilized on [client #3's] individualized behavior tracking form and on an incident report as appropriate." There was no documentation on 10/4/12 regarding the incident at the group home during the morning observation.</p> <p>The staff failed to implement client #3's plan as written for invading the space of others, prompting to take a break, documenting invasion of space on behavior tracking and incident report, reflecting feelings, offering a discussion time, suggesting a replacement behavior, switching partners, clearing the area, not making request of client #3 when he was highly agitated, and the use of restraint.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/4/12 at 11:43 AM. The QMRP indicated he was informed of the incident however he was not sure if an incident report was completed. At 11:59 AM, the QMRP indicated staff #10 did not document the incident on an incident report prior to leaving his shift. At 12:30 PM, the QMRP indicated staff #10 had</p>			

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	<p>issues at his previous work site with the provider of not completing incident reports. The QMRP indicated staff #10 would receive disciplinary action for not completing an incident report. On 10/10/12 at 11:29 AM, the QMRP indicated staff #10 should have documented the incident on an incident report, on the tally sheets and the behavior tracking sheets (ABC sheets).</p> <p>A review of the incident report, submitted on 10/5/12 by staff #10, was conducted on 10/5/12 at 3:02 PM. The incident report included attachments indicating staff #10 received training on completing incident reports on 10/5/12. Staff #10 also received a disciplinary action, also attached, indicating, "[Staff #10] verbally informed another staff of an incident which took place that morning, but failed to fill out an incident report per Stone Belt Policy."</p> <p>9-3-4(a)</p>				

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W0312	<p><b>483.450(e)(2) DRUG USAGE</b> 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 2 of 3 clients in the sample (#1 and #3), the facility failed to ensure there was a psychotropic medication reduction plan for each psychotropic medication.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 10/9/12 at 9:14 AM. Client #1's Behavioral Support Plan (BSP), dated 4/12/12, indicated he took Risperdal and Cogentin as psychotropic medications. The plan of reduction for Risperdal indicated, "Risperdal is administered as one component of [client #1's] treatment plan for ADHD (attention deficit hyperactivity disorder) in routine doses. When symptoms of hyperactivity are tracked at three or fewer for six consecutive months, the support team will assess the appropriateness of a medication reduction with [client #1's] psychiatrist." The plan of reduction for Cogentin indicated, "Cogentin is administered as one component of [client #1's] treatment for drug induced EPS (Extrapyramidal</p>	W0312	<p><b>W 312</b>  <b>DRUG USAGE</b></p> <p><b>Plan of Correction:</b>  Stone Belt will ensure that 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.</p> <p><b>Date of Completion:</b>  November 9, 2012</p> <p><b>Person Responsible:</b>  Deckard Program Coordinator /Behavior Specialist</p> <p><b>Plan of Prevention:</b>  The Milestones Psychiatrist meets with clients on a quarterly basis to review psychotropic medications. As necessary the doctor will reduce medications based on the individual plan for</p>	11/09/2012			

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	<p>symptoms). When symptoms of EPS are tracked at zero for six consecutive months, the support team will assess the appropriateness of a medication reduction with [client #1's] psychiatrist." The plan for each psychotropic medication did not indicate a specific plan of reduction to be implemented.</p> <p>A review of client #3's record was conducted on 10/9/12 at 10:36 AM. Client #3's BSP, dated 9/5/12, indicated he took Depakote, Risperdal and Tenex as psychotropic medications. The plan of reduction for Depakote indicated, "Depakote is administered as a component of [client #3's] treatment plan for attention deficit hyperactivity disorder. When episodes of refusal/ignoring behavior have declined to fewer than three episodes per month for 12 consecutive months, [client #3's] team will consider the appropriateness of medication reduction." The plan of reduction for Risperdal indicated, "Risperdal is administered as a component of [client #3's] psychiatric illness. When aggressive behavior has decreased to fewer than two episodes per quarter for four consecutive quarters, [client #3's] team will consider the appropriateness of medication reduction." The plan of reduction for Tenex indicated, "Tenex is a component of [client #3's] attention deficit hyperactivity disorder.</p>		<p>medication reduction. The Milestones Director, Behavioral Specialist Manager and Doctor are reviewing current practices for medication reduction and assess the need to change to be more specific as required within the standard.</p> <p><b>Quality Assurance Monitoring:</b></p> <p>A quarterly review will take place regarding the reduction in psychotropic medications for each Stone Belt client.</p>	

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	<p>When aggressive behavior has decreased to fewer than two episodes per quarter for four consecutive quarters, [client #3's] team will consider the appropriateness of medication reduction." The plan for each psychotropic medication did not indicate a specific plan of reduction to be implemented. The plan did not indicate which medication would be targeted first for reduction.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/9/12 at 11:35 AM. The QMRP indicated the clients' plans needed to have specific plans of reduction for each psychotropic medication.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 10/9/12 at 12:23 PM. The BC indicated the medication reduction plans needed to be specific for the amount of reduction for each medication.</p> <p>9-3-5(a)</p>			