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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G374 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/30/2012 |
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| W0000 | <p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: May 23, 24, 25, 29 and 30, 2012.</p> <p>Facility Number: 000888 Provider Number: 15G374 AIM Number: 100239700</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/6/12 by Ruth Shackelford, 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>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the governing body failed to exercise operating direction over the facility by not ensuring 1) a kitchen drawer was repaired/replaced and a hole in the kitchen wall was repaired and 2) the clients' (#2, #3 and #5) checking accounts were not incurring service charges.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 5/24/12 from 2:59 PM to 6:27 PM and 5/25/12 from 6:00 AM to 7:38 AM. During the observations, a kitchen drawer to the right of the stove was missing. The area where the drawer was supposed to be was empty. There was a hole in the wall (4 inches by 3 inches) near the fire alarm panel located in the kitchen area. Visible in the hole were electrical wires. This affected clients #1, #2, #3, #4 and #5.</p> <p>An email from the Director was received on 5/29/12 at 1:29 PM. The Director indicated in regards to the hole in the wall, "...that was done over a year ago</p> | W0104 | <p>W 104 GOVERNING BODY</p> <p>Plan of Correction:</p> <p>Stone Belt exercises general policy, budget, and operating direction over the facility.</p> <p>Date of Completion:</p> <p>June 29, 2012</p> <p>Person Responsible:</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention:</p> <p>1) A Maintenance request (Attachment # 1) was sent to the Maintenance Supervisor on June 18, 2012 requesting that the kitchen drawer be repaired or replaced and the hole in the wall be patched. 2) Stone Belt staff continue to account for services charges by recording them on each individual client check registrar. Stone Belt is in the process of moving the client's checking accounts to a bank that does not have service charges. Establishing new accounts has been a lengthy process due to changes in the banking industry.</p> | 06/29/2012 | | | |

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| | <p>when [alarm company] had to repair the alarm panel and [home manager] does not think a maintenance request was sent in since [maintenance worker] was assisting [alarm company] on it."</p> <p>An interview with the Assistant Home Manager (AHM) was conducted on 5/24/12 at 3:05 PM. The AHM indicated the missing drawer was due to damage. The AHM indicated it was a known issue. The AHM indicated the facility was working on getting all new cabinets for the kitchen.</p> <p>An interview with the Program Coordinator (PC) was conducted on 5/29/12 at 9:58 AM. The PC indicated he was not aware of the missing kitchen drawer. The PC indicated he was aware the drawer was broken however he did not know it was not in the cabinet. The PC indicated the home was getting estimates for new cabinets. The PC indicated he was aware of the hole in the wall in the kitchen. The PC indicated he thought maintenance had repaired the hole. The PC indicated the hole needed to be repaired.</p> <p>2) A review of the clients' finances was conducted on 5/24/12 at 10:44 AM. -Client #2: On 2/13/12, 3/13/12 and 4/13/12, his checking account incurred</p> | | <p>Quality Assurance Monitoring:</p> <p>1) Coordinator will complete a quarterly report detailing any maintenance needs in the home. New kitchen cabinets are scheduled for after 7/1/2012. 2) Stone Belt is in the process of moving accounts to bank without service charges. This is a long process due to bank requirements. Until this is completed, staff will counsel clients on services fees and document accordingly.</p> | | | | |

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| | <p>\$1.95 service charges.</p> <p>-Client #3: On 1/22/12, 2/20/12, 3/19/12, and 4/18/12, his checking account incurred \$1.95 service charges.</p> <p>-Client #5: On 1/23/12 and 2/21/12 his checking account incurred \$3.95 service charges. On 3/20/12 and 4/19/12 his checking account incurred \$1.95 service charges.</p> <p>An interview with the Program Coordinator (PC) was conducted on 5/29/12 at 9:58 AM. The PC indicated the issues with the clients incurring service charges should have been addressed. The PC indicated the facility should ensure the clients were not incurring service charges if changing banks met the clients' needs.</p> <p>9-3-1(a)</p> | | | | |

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| W0149 | <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 6 investigations and 36 Bureau of Developmental Disability Services (BDDS) incident reports affecting 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 5/23/12 at 12:03 PM and 5/24/12 at 10:07 AM.</p> <p>Investigative reports: -On 6/30/11 at 8:00 AM, client #3 opened the sharps container (by breaking it) located in the restroom and used a discarded disposable razor to shave his eyebrows, resulting in several cuts. The investigation, undated, indicated client #3 was independent in personal hygiene and did not usually keep the bathroom door open while he took care of his personal needs.</p> <p>-On 7/3/11 at 6:00 PM, staff #8 (substitute) working at the group home</p> | W0149 | <p>W149</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt has policies and procedures that address mistreatment, neglect and abuse of clients.</p> <p>House Staff will be retrained on Stone Belt Prevention of Abuse and Neglect/Client Rights and Incident Reporting (Attachment # 2).</p> <p>Responsible Person:</p> <p>Coordinator</p> <p>Date of Completion:</p> <p>June 29, 2012</p> <p>Plan of Prevention:</p> <p>House Staff will be retrained on Stone Belt Prevention of Abuse and Neglect/Client Rights and Incident Reporting (Attachment # 2).</p> <p>All Stone Belt staff working in a group home are trained on the Stone Belt Prevention of Abuse and Neglect/Client Rights and</p> | 06/29/2012 | | | |

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| | told the assistant home manager (AHM) she was trained to flush client #4's G-tube. Staff #8 took client #4 into the restroom. The AHM went into the office to get dressings and when she went into the restroom staff #8 was having difficulty getting the syringe to dispense into the G-tube. The AHM told staff #8 not to force it. The AHM then noticed staff #8 had the syringe in the wrong port of the G-tube. The AHM removed the syringe and showed staff #8 the correct port and flushed the G-tube. Later, at 6:00 PM, the AHM was assisting client #4 with his shower and his G-tube fell out. Client #4 was taken to the emergency room where a Foley catheter was inserted until his next scheduled appointment on 7/8/11 for a button procedure. The physician indicated the G-tube had been deflated causing it to fall out. The conclusion of the investigation, dated 7/8/11, indicated staff #8 "made a medical error when she attempted to flush [client #4's] g-tube port without being trained, on his type of specific apparatus." The facility did not substantiate abuse and neglect. The report indicated, "It is concerning however, that this DSP (staff #8) staff seemed to over estimate her abilities to perform this procedure. She did not consider the possible consequences of 'a trial and error' approach on the client's health and safety. | | Incident Reporting policy and procedure during orientation training and annually. It is also done on an "as needed" basis, such as this situation. In addition, staff will be retrained on 1) Location of sharps, 2) G-tube care, 3) overnight responsibilities, 4) client elopement protocol, 5) incident reporting and investigation. Quality Assurance Monitoring: Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed. The 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>There is a clear concern related to the judgment and maturity level of these actions."</p> <p>-On 7/18/11 at 10:30 AM, former staff #9 was cleaning out the refrigerator and found a small cup with a lid and a straw behind frozen vegetables. The incident report indicated the contents smelled like whiskey. The investigative report, dated 7/21/11, concluded, "It is concluded that someone put a bottle containing liquor in the freezer in Maxwell House. The person is most likely a staff member working at the house. Five staff members interviewed identified [staff #10], week day night aide, as the person suspected of bringing this into the house. Staff members reported that she had been discovered sleeping on at least three occasions when they arrived in the morning, and they questioned whether she has been administering [client #2's] breathing treatments correctly. [Staff #10] describes the procedure of [client #2's] breathing treatment in a way that is not consistent with the recommendation that staff monitor him throughout the treatment to assure that he had the face mask in the right position that he is getting complete medication. There is a clear question as to whether [staff #10] is adequately monitoring, [client #2], and evidence that she had been found sleeping</p> | | | | | | |

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| | <p>which would place all the residents of Maxwell House at high risk due to lack of supervision. It is not clear whether these events of sleeping while at work have been reported as incidents, or addressed as a supervisory issue." The investigative report indicated, "This situation meets the criteria for neglect i.e., Neglect: any action or behavioral interventions that risks the physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. The social worker substantiates neglect on the part of [staff #10] with the information that she was found sleeping on at least 3 different occasions at Maxwell House, by staff who were concerned that she was not adequately monitoring [client #2's] nebulizer treatments." Staff #10 resigned from the facility on 7/27/11.</p> <p>-On 10/18/11 at 3:00 AM, client #4 eloped from the group home. Staff #2 (the only staff present) located client #4 one block north of the group home (she left the other 4 clients in the home while running down the street trying to find client #4). The investigative report indicated, "A review of the incident which occurred at 3:00 AM on 10/18/11 in which [client #4] eloped from Maxwell</p> | | | | | | |

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| | <p>House through the rear door of the house, while Associate Manager [staff #2] was occupied with resident [client #2's] oxygen treatment does not meet the criteria for neglect. [Staff #2] was using the alarms as needed, and she did hear the alarm, albeit poorly, and then quickly went to look for [client #4] both in the house and out of the house, eventually finding him. While [staff #2] did not follow protocol in calling the pager during the event, this is a supervisory issue and not indicative of neglect. While the criteria for neglect was not met, it is still concerning for this reviewer that many staff were not aware of the change in protocol requiring the use of alarms for [client #4]. This indicates a systemic breakdown in communication and procedure within the team that must be addressed."</p> <p>-On 12/17/11 at 2:00 PM, client funds were discovered missing. Client #1 was missing \$13.00. Client #2 was missing \$25.00. Client #3 was missing \$35.00. Client #5 was missing \$7.00. The investigative report indicated, "It is determined that Maxwell House clients experienced an event of exploitation when an individual, most likely a Stone Belt staff member who had access to client cash on hand at Maxwell House took these funds without authorization.</p> | | | | | | |

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| | <p>This is an event of suspected theft, as well as exploitation of disabled adults. It is recommended that his (sic) situation be referred to appropriate law enforcement for investigation...".</p> <p>-On 2/16/12 at 7:00 AM, staff #2, #11 and #12 arrived to work to find all clients at Maxwell House, sleeping and awake, in the living room. Client #5 was soiled with feces and urine and client #2 was incontinent, including his clothes and blanket. It did not appear the clients had been changed as needed through the night. There was question as to whether client #2 received oxygen. Client #3 was in his bedroom hitting himself in the head with a toy vacuum. The overnight staff indicated she observed a bed bug in the bed of client #2 and she reported her concern to the pager at 1:30 AM. Staff #13 indicated she had not received training to check and change clients #2 and #4 every hour. The Maxwell Training Checklist did not indicate any training concerning how frequently to check and change the clients. Staff #13 indicated she was trained to check client #5 hourly, but had chosen not to because of the bed bugs she had seen. She indicated she had not checked client #2 due to fear of bed bugs. The report indicated there was no documentation to support client #2, client #5 and client #4</p> | | | | | | |

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| | <p>were checked or changed during the night of 2/11/12. The report indicated, "It is substantiated that the night aide working the evening of 2/11/12 did not check or change the soiled and wet diapers, and clothing of [clients #5, #4 and #2] during the night as is procedure for these clients. The result of failure to check and change these clients was that [client #5] was found to have dried feces, on his body and red irritated skin caused by this. [Client #2] was found to be wet, as were his bed clothing, and blankets. This finding is consistent with an event of neglect of a client... Thus the findings in this circumstance is consistent with a finding of neglect, as the night aide chose not to check and change the clients during the night of 2/11/12 because of her concern that she would be exposed to bed bugs by close contact with the clients in their rooms...". The staff was terminated.</p> <p>BDDS reports: -On 7/28/11 at 8:05 AM, client #5 ran outside, opened the passenger door to the van and struck, open-handed, client #6 on the head. -On 8/4/11 at 9:15 AM, client #5 struck client #1 on the chest. -On 1/6/12 at 7:15 AM (reported to BDDS on 1/9/12) when client #4 arrived to school and stepped off the bus, his G-tube fell out. The group home staff</p> | | | | | | |

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| | <p>picked client #4 up from school and transported to the emergency room. His G-tube was replaced with a temporary catheter.</p> <p>-On 4/5/12 at 3:45 PM, client #1 punched client #4 in the stomach as he walked past him in the hallway.</p> <p>-On 5/12/12 at 8:00 PM, client #1 indicated to staff #2, "Cause you know your (sic) not suppose (sic) to." Staff #2 asked client #1, "Not suppose (sic) to what?" Client #1 indicated, "Not touch him, not touch [client #4], just leave him alone." Staff #2 asked client #1 where he touched client #4 and client #1 indicated, "the feet" and then client #1 pointed to his chest. Staff #2 asked client #1 if he touched client #4 anywhere else and client #1 indicated, "You shouldn't lie cuz (sic) I didn't touch his privates. Yes, yes he did touch his privates. You know your not suppose (sic) to." Staff #2 documented on the incident report it was unclear if client #1 touched client #4 or was thinking about it. There was no documentation an investigation was conducted.</p> <p>A review of the facility's Behavioral Intervention Policy, dated 10/2010, was conducted on 5/23/12 at 12:13 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, "Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over consumer support; misuse of consumer or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct." The policy indicated Events Requiring Investigations included, "Situations involving suspected or alleged abuse, neglect or exploitation of consumers or any rights issue as described in agency policies will be investigated by staff designated and trained by the agency for this role."</p> <p>An interview was conducted with the Program Coordinator (PC) on 5/24/12 at 12:31 PM. The PC indicated staff should immediately report abuse and neglect to the administrator. The PC indicated</p> | | | | |

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| | <p>clients #1, #3 and #5 were verbal and able to provide information for an investigation. The PC indicated the facility prohibited abuse and neglect of the clients.</p> <p>An interview was conducted with the Director on 5/24/12 at 12:31 PM. The Director indicated staff should immediately report abuse and neglect to the administrator. The Director indicated investigations should include interviews or attempted interviews with everyone involved, including the clients. The Director indicated clients #1 and #3 were verbal and able to provide information for an investigation. The Director indicated client #1's allegation of touching client #4 in his private area should have been investigated. The Director indicated the facility prohibited abuse and neglect of the clients.</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.</p> <p>Based on record review and interview for 2 of 42 incident/investigative reports reviewed affecting 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure staff immediately reported their allegations of abuse and neglect to the administrator and incidents reportable to the Bureau of Developmental Disability Services (BDDS) within 24 hours, in accordance with State Law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 5/23/12 at 12:03 PM and 5/24/12 at 10:07 AM.</p> <p>-On 1/6/12 at 7:15 AM (reported to BDDS on 1/9/12) when client #4 arrived to school and stepped off the bus, his G-tube fell out. The group home staff picked client #4 up from school and transported to the emergency room. His G-tube was replaced with a temporary catheter.</p> | W0153 | <p>W153</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</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>Person Responsible:</p> <p>Coordinator</p> <p>Date of Completion:</p> <p>June 22, 2012</p> <p>Plan of Prevention:</p> <p>Staff will be retrained to report immediately to the Coordinator and/or Director of Group Homes. is who will immediately place the staff person in question on Investigative suspension. (Attachment # 3)</p> <p>Quality Assurance Monitoring:</p> | 06/22/2012 | | | |

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| | <p>-On 10/18/11 at 3:00 AM, client #4 eloped from the group home. Staff #2 (the only staff present) located client #4 one block north of the group home (she left clients #1, #2, #3 and #5 unsupervised) in the home while running down the street trying to find client #4). The investigative report indicated, "A review of the incident which occurred at 3:00 AM on 10/18/11 in which [client #4] eloped from Maxwell House through the rear door of the house, while Associate Manager [staff #2] was occupied with resident [client #2's] oxygen treatment does not meet the criteria for neglect. [Staff #2] was using the alarms as needed, and she did hear the alarm, albeit poorly, and then quickly went to look for [client #4] both in the house and out of the house, eventually finding him. While [staff #2] did not follow protocol in calling the pager during the event, this is a supervisory issue and not indicative of neglect. While the criteria for neglect was not met, it is still concerning for this reviewer that many staff were not aware of the change in protocol requiring the use of alarms for [client #4]. This indicates a systemic breakdown in communication and procedure within the team that must be addressed."</p> <p>-On 7/18/11 at 10:30 AM, former staff #9</p> | | <p>The Stone Belt Staff receive training during new hire orientation and annually on The Stone Belt Abuse, Mistreatment, Neglect and Incident Report Policies.</p> <p>Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed.</p> <p>The Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents.</p> | | | | |

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| | <p>was cleaning out the refrigerator and found a small cup with a lid and a straw behind frozen vegetables. The incident report indicated the contents smelled like whiskey. This affected clients #1, #2, #3, #4 and #5. The investigative report, dated 7/21/11, concluded, "It is concluded that someone put a bottle containing liquor in the freezer in Maxwell House. The person is most likely a staff member working at the house. Five staff members interviewed identified [staff #10], week day night aide, as the person suspected of bringing this into the house. Staff members reported that she had been discovered sleeping on at least three occasions when they arrived in the morning, and they questioned whether she has been administering [client #2's] breathing treatments correctly. [Staff #10] describes the procedure of [client #2's] breathing treatment in a way that is not consistent with the recommendation that staff monitor him throughout the treatment to assure that he had the face mask in the right position that he is getting complete medication. There is a clear question as to whether [staff #10] is adequately monitoring, [client #2] and evidence that she had been found sleeping which would place all the residents of Maxwell House at high risk due to lack of supervision. It is not clear whether these events of sleeping while at work have</p> | | | | |

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| | <p>been reported as incidents, or addressed as a supervisory issue." The investigative report indicated, "This situation meets the criteria for neglect i.e., Neglect: any action or behavioral interventions that risks the physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. The social worker substantiates neglect on the part of [staff #10] with the information that she was found sleeping on at least 3 different occasions at Maxwell House, by staff who were concerned that she was not adequately monitoring [client #2's] nebulizer treatments." Staff #10 resigned from the facility on 7/27/11.</p> <p>An interview was conducted with the Program Coordinator (PC) on 5/24/12 at 12:31 PM. The PC indicated staff should immediately report abuse and neglect to the administrator. The PC indicated BDDS reports should be submitted within 24 hours.</p> <p>An interview was conducted with the Director on 5/24/12 at 12:31 PM. The Director indicated staff should immediately report abuse and neglect to the administrator.</p> | | | |

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| W0154 | <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 7 of 42 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility failed to ensure thorough investigations were conducted.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 5/23/12 at 12:03 PM and 5/24/12 at 10:07 AM.</p> <p>-On 6/30/11 at 8:00 AM, client #3 opened the sharps container located in the restroom and used a discarded disposable razor to shave his eyebrows, resulting in several cuts. The three staff present during the incident were interviewed however there was no documentation client #3 was interviewed or attempted to be interviewed.</p> <p>-On 7/3/11 at 6:00 PM, staff #8 (substitute) working at the group home told the assistant home manager (AHM) she was trained to flush client #4's G-tube. Staff #8 took client #4 into the restroom. The AHM went into the office to get dressings and when she went into</p> | W0154 | <p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will ensure any incidents of Abuse, Neglect, and/or mistreatment are investigated thoroughly and will include clients at the home.</p> <p>Person Responsible:</p> <p>SGL Director & Coordinator</p> <p>Date of Completion:</p> <p>June 22, 2012</p> <p>Plan of Prevention:</p> <p>Social Workers and Coordinators will be trained investigate thoroughly as indicated in the Stone Belt Investigation Protocols. (Attachment # 4)</p> <p>Quality Assurance Monitoring:</p> <p>Stone Belt Director of Group Homes will review all incidents and investigation reports to assure policy is being followed.</p> | 06/22/2012 | | | |

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| | <p>the restroom staff #8 was having difficulty getting the syringe to dispense into the G-tube. The AHM told staff #8 not to force it. The AHM then noticed staff #8 had the syringe in the wrong port of the G-tube. The AHM removed the syringe and showed staff #8 the correct port and flushed the G-tube. Later, at 6:00 PM, the AHM was assisting client #4 with his shower and his G-tube fell out. Client #4 was taken to the emergency room where a foley catheter was inserted until his next scheduled appointment on 7/8/11 for a button procedure. The physician indicated the G-tube had been deflated causing it to fall out. The conclusion of the investigation, dated 7/8/11, indicated staff #8 "made a medical error when she attempted to flush [client #4's] g-tube port without being trained, on his type of specific apparatus." The facility did not substantiate abuse and neglect. The report indicated, "It is concerning however, that this DSP (staff #8) staff seemed to over estimate her abilities to perform this procedure. She did not consider the possible consequences of 'a trial and error' approach on the client's health and safety. There is a clear concern related to the judgment and maturity level of these actions." The investigation did not include an interview or attempted interview with client #4.</p> | | | |

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| | -On 7/18/11 at 10:30 AM, former staff #9 was cleaning out the refrigerator and found a small cup with a lid and a straw behind frozen vegetables. The incident report indicated the contents smelled like whiskey. The investigative report, dated 7/21/11, concluded, "It is concluded that someone put a bottle containing liquor in the freezer in Maxwell House. The person is most likely a staff member working at the house. Five staff members interviewed identified [staff #10], week day night aide, as the person suspected of bringing this into the house. Staff members reported that she had been discovered sleeping on at least three occasions when they arrived in the morning, and they questioned whether she has been administering [client #2's] breathing treatments correctly. [Staff #10] describes the procedure of [client #2's] breathing treatment in a way that is not consistent with the recommendation that staff monitor him throughout the treatment to assure that he had the face mask in the right position that he is getting complete medication. There is a clear question as to whether [staff #10] is adequately monitoring, [client #2] and evidence that she had been found sleeping which would place all the residents of Maxwell House at high risk due to lack of supervision. It is not clear whether these | | | | | | |

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| | <p>events of sleeping while at work have been reported as incidents, or addressed as a supervisory issue." The investigative report indicated, "This situation meets the criteria for neglect ie., Neglect: any action or behavioral interventions that risks the physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. The social worker substantiates neglect on the part of [staff #10] with the information that she was found sleeping on at least 3 different occasions at Maxwell House, by staff who were concerned that she was not adequately monitoring [client #2's] nebulizer treatments." There was no documentation the 5 clients (#1, #2, #3, #4 and #5) were interviewed or attempted to be interviewed during the investigation.</p> <p>-On 10/18/11 at 3:00 AM, client #4 eloped from the group home. Staff #2 (the only staff present) located client #4 one block north of the group home (she left the other 4 clients in the home while running down the street trying to find client #4). The investigative report indicated, "A review of the incident which occurred at 3:00 AM on 10/18/11 in which [client #4] eloped from Maxwell House through the rear door of the house,</p> | | | | | | |

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| | <p>while Associate Manager [staff #2] was occupied with resident [client #2's] oxygen treatment does not meet the criteria for neglect. [Staff #2] was using the alarms as needed, and she did hear the alarm, albeit poorly, and then quickly went to look for [client #4] both in the house and out of the house, eventually finding him. While [staff #2] did not follow protocol in calling the pager during the event, this is a supervisory issue and not indicative of neglect. While the criteria for neglect was not met, it is still concerning for this reviewer that many staff were not aware of the change in protocol requiring the use of alarms for [client #4]. This indicates a systemic breakdown in communication and procedure within the team that must be addressed." The investigative packet did not include interviews with client #4.</p> <p>-On 12/17/11 at 2:00 PM, client funds were discovered missing. Client #1 was missing \$13.00. Client #2 was missing \$25.00. Client #3 was missing \$35.00. Client #5 was missing \$7.00. The investigative report indicated, "It is determined that Maxwell House clients experienced an event of exploitation when an individual, most likely a Stone Belt staff member who had access to client cash on hand at Maxwell House took these funds without authorization.</p> | | | |
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| | <p>This is an event of suspected theft, as well as exploitation of disabled adults. It is recommended that his (sic) situation be referred to appropriate law enforcement for investigation...". There was no documentation in the investigative packet clients #1, #2, #3, #4 and #5 were interviewed or attempted to be interviewed.</p> <p>-On 2/16/12 at 7:00 AM, staff #2, #11 and #12 arrived to work to find all clients at Maxwell House, sleeping and awake, in the living room. Client #5 was soiled with feces and urine and client #2 was incontinent, including his clothes and blanket. It did not appear the clients had been changed as needed through the night. There was question as to whether client #2 received oxygen. Client #3 was in his bedroom hitting himself in the head with a toy vacuum. The overnight staff indicated she observed a bed bug in the bed of client #2 and she reported her concern to the pager at 1:30 AM. Staff #13 indicated she had not received training to check and change clients #2 and #4 every hour. The Maxwell Training Checklist did not indicate any training concerning how frequently to check and change the clients. Staff #13 indicated she was trained to check client #5 hourly, but had chosen not to because of the bed bugs she had seen. She</p> | | | | |

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| | <p>indicated she had not checked client #2 due to fear of bed bugs. The report indicated there was no documentation to support client #2, client #5 and client #4 were checked or changed during the night of 2/11/12. The report indicated, "It is substantiated that the night aide working the evening of 2/11/12 did not check or change the soiled and wet diapers, and clothing of clients [#5, #4 and #2] during the night as is procedure for these clients. The result of failure to check and change these clients was that [client #5] was found to have dried feces, on his body and red irritated skin caused by this. [Client #2] was found to be wet, as were his bed clothing, and blankets. This finding is consistent with an event of neglect of a client... Thus the findings in this circumstance is consistent with a finding of neglect, as the night aide chose not to check and change the clients during the night of 2/11/12 because of her concern that she would be exposed to bed bugs by close contact with the clients in their rooms...". The staff was terminated. There was no documentation an interview with the clients was conducted or attempted in the investigative report.</p> <p>-On 5/12/12 at 8:00 PM, client #1 indicated to staff #2, "Cause you know your (sic) not suppose (sic) to." Staff #2 asked client #1, "Not suppose (sic) to</p> | | | |

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| | <p>what?" Client #1 indicated, "Not touch him, not touch [client #4], just leave him alone." Staff #2 asked client #1 where he touched client #4 and client #1 indicated, "the feet" and then client #1 pointed to his chest. Staff #2 asked client #1 if he touched client #4 anywhere else and client #1 indicated, "You shouldn't lie cuz (sic) I didn't touch his privates. Yes, yes he did touch his privates. You know your not suppose (sic) to." Staff #2 documented on the incident report it was unclear if client #1 touched client #4 or was thinking about it. There was no documentation an investigation was conducted.</p> <p>An interview was conducted with the Program Coordinator (PC) on 5/24/12 at 12:31 PM. The PC indicated clients #1, #3 and #5 were verbal and able to provide information for an investigation.</p> <p>An interview was conducted with the Director on 5/24/12 at 12:31 PM. The Director indicated investigations should include interviews or attempted interviews with everyone involved, including the clients. The Director indicated clients #1 and #3 were verbal and able to provide information for an investigation. The Director indicated client #1's allegation of touching client #4 in his private area should have been</p> | | | | | | |

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| | <p>investigated.</p> <p>An interview with the Social Worker (SW) who conducted the facility's investigations was completed on 5/29/12 at 4:32 PM. The SW indicated clients #2, #4 and #5 were non-verbal. The SW indicated the clients were not cognizant of the alcohol found in the freezer and would not have knowledge of it being in there. The SW indicated client #4 was not interviewed for the investigations due to being non-verbal and not having a communication device. The SW indicated the incident in which the clients (#2, #4 and #5) were found soiled by the day shift staff were non-verbal; the SW indicated clients #1 and #3 were not direct witnesses and not soiled. The SW indicated she interviewed client #1 regarding his statements about touching client #4's private area; she indicated he touched his belly and feet. The SW did not provide documentation she interviewed client #1. The SW indicated she interviewed client #3 about him breaking into the sharps container; the SW did not provide documentation she interviewed client #3.</p> <p>9-3-2(a)</p> | | | | | | |

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| W0159 | <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#3), the Qualified Mental Retardation Professional (QMRP) failed to ensure client #3's quarterly reviews of his program plans were conducted.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 5/29/12 at 9:06 AM. Client #3 had quarterly reviews of his program plans on 9/14/11 and 5/23/12. His Individual Support Plan (ISP) annual review was conducted on 12/20/11. There was no documentation in client #3's record indicating a quarterly review was conducted in June 2011 and March 2012.</p> <p>An interview with the Program Coordinator (PC) was conducted on 5/29/12 at 9:58 AM. The PC indicated the reviews of client #3's program plans should have been conducted quarterly.</p> <p>9-3-3(a)</p> | W0159 | <p>W 159</p> <p>QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will ensure that each client's active treatment program is integrated, coordinated and monitored by the House Coordinator.</p> <p>Person Responsible:</p> <p>Maxwell Coordinator</p> <p>Date of Completion:</p> <p>June 29, 2012</p> <p>Plan of Prevention:</p> <p>QMRP/Coordinator will ensure that all quarterly reviews are completed for each client.</p> <p>Quality Assurance Monitoring:</p> <p>A monthly checklist will be completed by the House Coordinator or designee and will include the review of quarterly program plans. This will also be</p> | 06/29/2012 | |

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| | | | reviewed by SGL Director. | |

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| W0189 | <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure staff received training to implement the clients' plans.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 5/23/12 at 12:03 PM and 5/24/12 at 10:07 AM.</p> <p>-On 7/3/11 at 6:00 PM, staff #8 (substitute) working at the group home told the assistant home manager (AHM) she was trained to flush client #4's G-tube. Staff #8 took client #4 into the restroom. The AHM went into the office to get dressings and when she went into the restroom staff #8 was having difficulty getting the syringe to dispense into the G-tube. The AHM told staff #8 not to force it. The AHM then noticed staff #8 had the syringe in the wrong port of the G-tube. The AHM removed the syringe and showed staff #8 the correct port. and flushed the G-tube. Later, at 6:00 PM, the AHM was assisting client</p> | W0189 | <p>W 189 STAFF TRAINING PROGRAM Plan of Correction: Stone Belt will ensure that all staff are provided with initial and continuing training that enables the employee to perform their duties effectively, efficiently ad competently. Date of Completion: June 29, 2012 Person Responsible: Coordinator & House Manager Plan of Prevention: Staff receive initial training prior to working at this particular home. (Attachment # 5) In addition, staff will be retrained on 1) Location of sharps, 2) G-tube care, 3) overnight responsibilities, 4) client elopement protocol, 5) incident reporting and investigation.</p> | 06/29/2012 | | | |

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| | <p>#4 with his shower and his G-tube fell out. Client #4 was taken to the emergency room where a Foley catheter was inserted until his next scheduled appointment on 7/8/11 for a button procedure. The physician indicated the G-tube had been deflated causing it to fall out. The conclusion of the investigation, dated 7/8/11, indicated staff #8 "made a medical error when she attempted to flush [client #4's] g-tube port without being trained, on his type of specific apparatus." The facility did not substantiate abuse and neglect. The report indicated, "It is concerning however, that this DSP (staff #8) staff seemed to over estimate her abilities to perform this procedure. She did not consider the possible consequences of 'a trial and error' approach on the client's health and safety. There is a clear concern related to the judgment and maturity level of these actions."</p> <p>-On 10/18/11 at 3:00 AM, client #4 eloped from the group home. Staff #2 (the only staff present) located client #4 one block north of the group home (she left the other 4 clients in the home while running down the street trying to find client #4). The investigative report indicated, "A review of the incident which occurred at 3:00 AM on 10/18/11 in which [client #4] eloped from Maxwell</p> | | <p>Quality Assurance Monitoring:</p> <p>Staffing office and Coordinator will ensure that all staff are properly trained before working at this particular site.</p> | | | | |

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| | <p>House through the rear door of the house, while Associate Manager [staff #2] was occupied with resident [client #2's] oxygen treatment does not meet the criteria for neglect. [Staff #2] was using the alarms as needed, and she did hear the alarm, albeit poorly, and then quickly went to look for [client #4] both in the house and out of the house, eventually finding him. While [staff #2] did not follow protocol in calling the pager during the event, this is a supervisory issue and not indicative of neglect. While the criteria for neglect was not met, it is still concerning for this reviewer that many staff were not aware of the change in protocol requiring the use of alarms for [client #4]. This indicates a systemic breakdown in communication and procedure within the team that must be addressed."</p> <p>-On 2/16/12 at 7:00 AM, staff #2, #11 and #12 arrived to work to find all clients at Maxwell House, sleeping and awake, in the living room. Client #5 was soiled with feces and urine and client #2 was incontinent, including his clothes and blanket. It did not appear the clients had been changed as needed through the night. There was question as to whether client #2 received oxygen. Client #3 was in his bedroom hitting himself in the head with a toy vacuum. The overnight staff</p> | | | | | | |

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| | <p>indicated she observed a bed bug in the bed of client #2 and she reported her concern to the pager at 1:30 AM. Staff #13 indicated she had not received training to check and change clients #2 and #4 every hour. The Maxwell Training Checklist did not indicate any training concerning how frequently to check and change the clients. Staff #13 indicated she was trained to check client #5 hourly, but had chosen not to because of the bed bugs she had seen. She indicated she had not checked client #2 due to fear of bed bugs. The report indicated there was no documentation to support client #2, client #5 and client #4 were checked or changed during the night of 2/11/12. The report indicated, "It is substantiated that the night aide working the evening of 2/11/12 did not check or change the soiled and wet diapers, and clothing of clients [#5, #4 and #2] during the night as is procedure for these clients. The result of failure to check and change these clients was that [client #5] was found to have dried feces, on his body and red irritated skin caused by this. [Client #2] was found to be wet, as were his bed clothing, and blankets. This finding is consistent with an event of neglect of a client... Thus the findings in this circumstance is consistent with a finding of neglect, as the night aide chose not to check and change the clients during the</p> | | | |

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| | <p>night of 2/11/12 because of her concern that she would be exposed to bed bugs by close contact with the clients in their rooms...". The staff was terminated.</p> <p>An interview with the Program Director (PD) was conducted on 5/30/12 at 9:59 AM. The PD indicated the staff should receive training prior to working with the clients unsupervised. The PD indicated the staff should not be assigned/partnered with a group until the staff had been trained to work at the home.</p> <p>9-3-3(a)</p> | | | |

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| W0227 | <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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.</p> <p>Based on observation, record review and interview for 2 of 3 clients in the sample (#1 and #3), the facility failed to ensure: 1) clients #1 and #3 had plans addressing a physician's recommendation and 2) client #3 had a plan to encourage him to drink six 8 ounce glasses of fluids per day.</p> <p>Findings include:</p> <p>1) A review of client #1's record was conducted on 5/25/12 at 11:21 AM. Client #1's record had a letter from his primary care physician, dated 4/3/12, indicating, "To enforce good eating habits and avoid food hoarding, please prompt [client #1] to slow down when eating too fast and remind him not to fill his mouth full of food." There was no documentation there was a plan in client #1's record addressing this recommendation from the physician.</p> <p>A review of client #3's record was conducted on 5/29/12 at 9:06 AM. Client #3's record had a letter from his primary care physician, dated 4/3/12, indicating,</p> | W0227 | <p>W 227 INDIVIDUAL PROGRAM PLAN</p> <p>Plan of Correction: Stone Belt will ensure that specific objectives necessary to meet the client's needs are identified by the client's comprehensive assessment.</p> <p>Date of Completion: June 29, 2012</p> <p>Person Responsible: Maxwell Coordinator & Nursing Services Manager</p> <p>Plan of Prevention: 1) Nursing Services Manager will create dining plans that will address the request from the physician's recommendation. 2) Staff will be trained to encourage client to drink six 8 ounce glasses of fluids per day per the client's plan.</p> <p>Quality Assurance Monitoring:</p> | 06/29/2012 | |

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| | <p>"To enforce good eating habits and avoid food hoarding, please prompt [client #3] to slow down when eating too fast and remind him not to fill his mouth full of food." There was no documentation there was a plan in client #3's record addressing this recommendation from the physician.</p> <p>2) A review of client #3's record was conducted on 5/29/12 at 9:06 AM. His dietary consult, dated 4/29/12, indicated a recommendation for staff to encourage client #3 to drink six 8 ounce glasses of fluids per day. Client #3's Physician's Orders, dated 3/12/12, indicated "encourage 6/8 oz (ounces) fluids daily." There was no documentation of a plan in client #3's record addressing this recommendation from the dietician.</p> <p>An interview with the Program Coordinator (PC) was conducted on 5/29/12 at 9:58 AM. The PC indicated there should be plans addressing the physician and dietician's recommendations. The PC indicated the recommendations were discussed at a team meeting and should be addressed with plans to ensure staff received training on the recommendations. The PC indicated client #3 should have documentation of the amount of fluids he consumed each day; the PC indicated this data was not being collected since there</p> | | Coordinator will review documentation to ensure that all client plans are being followed. This MAR will provide the necessary documentation that indicates the staff are encouraging staff to drink the fluids. | | |

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| | was no plan. 9-3-4(a) | | | | |

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| W0249 | <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 4 of 5 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure the direct care staff implemented: 1) client #2's plan for having his arms in his sleeves during meals, 2) client #4's plan to feed himself during meals and 3) clients #1 and #3's medication administration training.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 5/24/12 from 2:59 PM to 6:27 PM. At 6:13 PM, client #2 started eating dinner (mandarin chicken, rice, broccoli, tea, water and milk). Client #2 ate with both of his arms coming out from underneath the bottom of his shirts (wearing more than one shirt). Client #2 was not prompted to have his arms through the sleeves of his shirt during the meal. Client #2 ate leaning to the side and bent over during dinner.</p> <p>A review of client #2's record was</p> | W0249 | <p>W 249</p> <p>PROGRAM IMPLEMENTATION</p> <p>Plan of Correction:</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>Date of Completion:</p> <p>June 29, 2012</p> <p>Person Responsible:</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention:</p> <p>The Stone Belt Support Team will ensure that behavior and active treatment plans are followed in general and specifically as follows</p> | 06/29/2012 | | | |

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| | <p>conducted on 5/29/12 at 9:49 AM. His Behavioral Intervention Plan (BIP), dated 2/2/12, indicated the following was added to the plan on 4/28/11: "During meal times, staff should cue [client #2] to put his arms in his sleeves, allowing him to have a more erect posture while eating, and keeping him from having to bend down and to the side for each bite. Staff should praise [client #2] initially, even, if [client #2] attempts this for a few moments without self-injurious behavior, the goal being that eventually [client #2] can have his arms through his sleeves for the duration of the meal." The plan indicated, "Wrapping is self-calming technique. [Client #2] is learning to wrap himself. If [client #2] asks to be wrapped, encourage him to wrap himself. If [client #2] is not able to wrap/swaddle himself, staff may assist him with removing his arms from his sleeves. [Client #2] is especially likely to ask to be wrapped at bedtime. Staff will encourage [client #2] to wrap himself but may assist [client #2] if needed."</p> <p>An interview with the Program Coordinator (PC) was conducted on 5/29/12 at 9:58 AM. The PC indicated the staff should have implemented client #2's plan for putting his arms through the sleeves of his shirt.</p> | | <p>1) client will be encourage to eat with his arms outside of his sleeves, 2) client will be prompted to feed himself during meal time and all adaptive equipment will be made available 3) clients will be encouraged to participate in medication administration as outlined in their specific plan. Goals for med administration will be reviewed at Support Team meeting and adjusted accordingly. Training will occur as necessary in applicable areas.</p> <p>Quality Assurance Monitoring:</p> <p>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>2) An observation was conducted at the facility-operated day program on 5/24/12 from 11:22 AM to 12:03 PM. At 11:22 AM, client #4 was sitting at a table with day program staff #1 (DPS #1) and one staff from his school (transitioning from school to day program). The school staff was placing client #4's food on his spoon and placing the spoon into client #4's mouth. Client #4's arms were both raised above his head during this time. The school staff continued feeding client #4 throughout client #4's lunch. At 11:38 AM, DPS #1 poured client #4's juice into a cup with a straw while the school staff fed client #4 his lunch. At 11:43 AM, DPS #1 held client #4's cup and straw up to client #4's mouth; client #4 did not request the drink and was not prompted to request a drink. The school staff then wiped off client #4's face with client #4's napkin. At 11:45 AM, DPS #1 threw away client #4's trash. At 11:49 AM, DPS #1 washed client #4's food processor. During the observation, neither the school staff nor the day program staff prompted client #4 to feed or take a drink himself.</p> <p>A review of client #4's record was conducted on 5/25/12 at 10:13 AM. His Individual Support Plan (ISP), dated 4/17/12, indicated the following, "As [client #4's] appetite and interest in food</p> | | | | | | |

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| | <p>has continued to increase over time, he will continue his program with self feeding and drinking. He had made considerable progress with this goal in the last several months and is now feeding himself for the majority of his meal." His ISP indicated he had a formal goal to request a drink.</p> <p>An interview with the Director was conducted on 5/24/12 at 11:31 AM. The Director indicated the staff who was feeding client #4 was staff from the school. The Director indicated he wondered why the staff was feeding client #4. The Director indicated client #4 could feed himself.</p> <p>An interview with day program staff #1 (DPS #1) was conducted on 5/24/12 at 11:47 AM. DPS #1 indicated client #4 was able to feed himself. DPS #1 indicated client #4 was missing his adaptive equipment of a weighted spoon so the staff fed him since the day program had not received the adaptive equipment.</p> <p>An interview with the Program Director (PD) was conducted on 5/24/12 at 12:24 PM. The PD indicated client #4 should be encouraged to feed himself during meals.</p> <p>3) An observation was conducted at the</p> | | | | | | |

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| | <p>group home on 5/25/12 from 6:00 AM to 7:38 AM. At 6:01 AM, client #1 received his medications from staff #2. Client #1 received Tab-a-vite (supplement), Lorazepam (psychosis), Lithium Carbonate (mood stabilizer), Quetiapine (psychosis), Cetirizine (allergies), Seroquel (psychosis) and Clindamycin (acne). Staff #2 did not prompt or inform client #1 of the dose or side effects of his medications. Staff #2 asked client #1 to name his medications and staff #2 told client #1 the purpose of the medications without prompting him to state the purpose. At 6:22 AM, client #3 received his medications from staff #2. The medications were Abilify (depression), Clonidine (anxiety), Polyethylene Glycol (constipation), Reguloid powder (constipation), Lamotrigine (mood), Docusate Sodium (constipation), Escitalopram (obsessive compulsive disorder/anxiety), Deep Sea nasal spray (dry sinus), Clindamycin phosphate (acne), Hydrocortisone cream (eczematous), and Fluocinoride cream (topical steroid). Staff #2 prompted client #3 to name the medications. Staff #2 did not prompt client #3 to name the dosage, purpose and two side effects.</p> <p>A review of client #1's record was conducted on 5/25/12 at 11:21 AM. His Individual Support Plan (ISP), dated</p> | | | |

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| | <p>3/6/12, indicated he had a training goal to tell staff when it was med time, names meds, purpose and side effects.</p> <p>A review of client #3's record was conducted on 5/29/12 at 9:06 AM. His ISP, dated 12/30/11, indicated he had a training goal to tell staff the name of his medications, dosage, purpose and 2 side effects.</p> <p>An interview with staff #2 was conducted on 5/25/12 at 7:31 AM. Staff #2 indicated she did not prompt or inform clients #1 and #3 of their dose and side effects of the medications she administered and she should have. Staff #2 indicated she did not implement the clients med goals as written.</p> <p>An interview with the Program Coordinator (PC) was conducted on 5/29/12 at 9:58 AM. The PC indicated the staff should implement the clients' med training goals as written.</p> <p>9-3-4(a)</p> | | | | |

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| W0331 | <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 3 of 5 clients living in the group home (#1, #2 and #4), the facility's nursing services failed to ensure the direct care staff administered the clients' medications per Physician's Orders.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 5/23/12 at 12:03 PM and 5/24/12 at 10:07 AM.</p> <p>-On 2/3/12 at 5:00 PM, client #4 was not administered his medications (Simethicone, Lactase, Eryped, and Domperidone - all for gastrointestinal symptoms).</p> <p>-On 3/5/12 at 7:00 AM, client #2 failed to receive his morning medications from staff #3.</p> <p>-On 4/1/12 at 4:00 PM, client #1 received one pill of Seroquel (mood disorder) instead of two pills.</p> <p>-On 4/22/12 at 3:00 PM, client #2 received a double-dose of Bzntropine (EPS - extrapyramidal symptoms) due to staff #11 failing to initial the Medication Administration Record when he passed the first dose.</p> | W0331 | <p>W 331</p> <p>NURSING SERVICES</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that clients will receive nursing services consistent with their needs. Specifically, medication administration protocol will be followed at this particular home.</p> <p>Date of Completion:</p> <p>June 22, 2012</p> <p>Person Responsible:</p> <p>Coordinator and Nursing Services Manager</p> <p>Plan of Prevention:</p> <p>Training on Medication Administration was completed on April 27, 2012 by the Nursing Services Manager. This included review of three point check system, medication storage, identification of individual med boxes, etc. (Attachment # 6)</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator and Nursing Services</p> | 06/22/2012 | | | |

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| | <p>-On 4/16/12, 4/17/12, 4/18/12 and 4/19/12 at bedtime, client #2's 3:00 PM dose of Benztropine (EPS) was administered at bedtime in addition to the 3:00 PM dose (he received an extra dose for 4 days).</p> <p>An interview with the Program Director (PD) was conducted on 5/29/12 at 9:58 AM. The PD indicated the facility was addressing med errors with disciplinary action, written warning and suspended med passes.</p> <p>An interview with the Nursing Services Administrator (NSA) was conducted on 5/30/12 at 9:50 AM. The NSA indicated the group home had their own way of organizing the medication bubble packs which was not part of the facility's system to pass meds. The NSA indicated the med cabinets were reorganized and staff were retrained. The NSA indicated the staff had their own way to organize the meds which caused issues. The NSA indicated the staff were not paying attention. The NSA indicated staff in the home were retrained on conducting med passes.</p> <p>9-3-6(a)</p> | | <p>Manager will conduct unannounced visits in order to observe medication administration in the home. Stone Belt Medication Administration protocol will be followed.</p> | | |

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| W0436 | <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 1 of 3 clients in the sample (#4), the facility failed to ensure client #4 had his adaptive equipment during lunch at the facility-operated day program.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated day program on 5/24/12 from 11:22 AM to 12:03 PM. At 11:22 AM, client #4 was sitting at a table with day program staff #1 (DPS #1) and one staff from his school (transitioning from school to day program). The school staff was placing client #4's food on his spoon and placing the spoon into client #4's mouth. Client #4's arms were both raised above his head during this time. The school staff continued feeding client #4 throughout client #4's lunch. At 11:38 AM, DPS #1 poured client #4's juice into a cup with a straw while the school staff fed client #4 his lunch. At 11:43 AM, DPS #1 held client #4's cup and straw up to client #4's mouth; client #4 did not</p> | W0436 | <p>W 436</p> <p>SPACE AND EQUIPMENT</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that proper adaptive equipment is furnished, in good repair and training is conducted to teach clients the use of the particular devices. These devices are identified by the Support Team and needed by the client.</p> <p>Date of Completion:</p> <p>June 22, 2012</p> <p>Person Responsible:</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention:</p> <p>Adaptive equipment for the particular client was delivered to Stone Belt and was in use on 5/25/2012. Staff were trained that the particular client can feed himself using the proper adaptive equipment.</p> | 06/22/2012 | | | |

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| | <p>request the drink and was not prompted to request a drink. The school staff then wiped off client #4's face with client #4's napkin. At 11:45 AM, DPS #1 threw away client #4's trash. At 11:49 AM, DPS #1 washed client #4's food processor. During the observation, neither the school staff nor the day program staff prompted client #4 to feed or take a drink himself. The staff did not prompt client #4 to clean up after his lunch.</p> <p>A review of client #4's record was conducted on 5/25/12 at 10:13 AM. Client #4's Medication Information Sheet (MIS), dated 5/24/12, indicated client #4 had a weighted spoon as adaptive equipment; no documentation of a divided plate was mentioned on the MIS. His Individual Support Plan (ISP), dated 4/17/12, indicated the following, "As [client #4's] appetite and interest in food has continued to increase over time, he will continue his program with self feeding and drinking. He had made considerable progress with this goal in the last several months and is now feeding himself for the majority of his meal." His ISP indicated he had a formal goal to request a drink. The ISP indicated client #4 had a divided plate; the ISP did not indicate a weighted spoon was needed for meals. An Occupational Therapy</p> | | <p>Quality Assurance Monitoring:</p> <p>Coordinator will make unannounced observations to ensure that the client is using the necessary adaptive equipment.</p> | | | | |

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| | <p>evaluation, dated 3/22/12, indicated the following, "[Client #4] will self feed with use of weighted spoon and divided plate."</p> <p>An interview with the Director was conducted on 5/24/12 at 11:31 AM. The Director indicated the staff who was feeding client #4 was staff from the school. The Director indicated he wondered why the staff was feeding client #4. The Director indicated client #4 could feed himself.</p> <p>An interview with day program staff #1 (DPS #1) was conducted on 5/24/12 at 11:47 AM. DPS #1 indicated client #4 was able to feed himself. DPS #1 indicated client #4 was missing his adaptive equipment of a weighted spoon so the staff fed him since the day program had not received the adaptive equipment.</p> <p>An interview with the Program Director (PD) was conducted on 5/24/12 at 12:24 PM. The PD indicated client #4 should have his adaptive equipment with him at the home, school and day program.</p> <p>9-3-7(a)</p> | | | | | | |

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| W0440 | <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure quarterly evacuation drills were conducted for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 5/23/12 at 12:21 PM and 5/24/12 at 9:59 AM. This affected clients #1, #2, #3, #4 and #5. -Day shift (6:00 AM to 2:00 PM): There were no drills conducted from 5/23/11 to 2/25/12. -Night shift (10:00 PM to 6:00 AM): There were no drills conducted from 5/23/11 to 11/30/11 and 12/2/11 to 5/23/12.</p> <p>An interview with the Director was conducted on 5/23/12 at 12:26 PM. The Director indicated there should be one drill per shift per quarter.</p> <p>9-3-7(a)</p> | W0440 | <p>W 440</p> <p>EVACUATION DRILLS</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that evacuation drills will be conducted at least quarterly for each shift.</p> <p>Date of Completion:</p> <p>June 22, 2012</p> <p>Person Responsible:</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention:</p> <p>House Manager and other designees will be trained to conduct drills in accordance with the requirement of one drill per shift, per quarter.</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator or Designee will track drills to ensure compliance.</p> | 06/22/2012 | |

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| W0448 | <p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills, including accidents.</p> <p>Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), 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 5/23/12 at 12:21 PM and 5/24/12 at 9:59 AM. The following drills took over 2 minutes to conduct.</p> <p>This affected clients #1, #2, #3, #4 and #5. There was no documentation on the forms indicating investigations into the issues during the drills were conducted:</p> <p>-On 7/31/11 at 9:00 PM, a fire drill was conducted. The duration of the drill was 2.5 minutes.</p> <p>-On 9/4/11 at 6:00 PM, a fire drill was conducted. The duration of the drill was 4 minutes.</p> <p>-On 11/5/11 at 5:50 PM, a fire drill was conducted. The duration of the drill was 4 minutes.</p> <p>-On 4/26/12 at 6:00 PM, a fire drill was conducted. The duration of the drill was 3 minutes.</p> <p>-On 2/29/12 at 7:00 AM, a fire drill was conducted. The drill took 10 minutes to</p> | W0448 | <p>W 448</p> <p>EVACUATION DRILLS</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that evacuation drills will be conducted at least quarterly for each shift and that any problems will be investigated and addressed by the Support Team.</p> <p>Date of Completion:</p> <p>June 22, 2012</p> <p>Person Responsible:</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention:</p> <p>House Manager and other designees will be trained to conduct drills in accordance with the requirement of one drill per shift, per quarter and will investigate as to why problems occurred when drills are not completed within the proper time frame of two minutes.</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator or Designee will</p> | 06/22/2012 | | | |

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| | <p>complete.</p> <p>-On 5/20/12 (no time of day documented but day shift box checked), the fire drill took 3 minutes to complete.</p> <p>An interview with the Program Director (PD) was conducted on 5/29/12 at 9:58 AM. The PD indicated the targeted time for completing drills was 2 minutes. The PD indicated anything over 2 minutes should be reviewed and discussed at a team meeting for the client to decrease the time to evacuate.</p> <p>An interview with the Director was conducted on 5/23/12 at 12:26 PM. The Director indicated 4 minutes was too long to complete a drill.</p> <p>9-3-7(a)</p> | | <p>review all drills to ensure they are being completed timely and, if not, review with Support Team any problems.</p> | | |

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| W0460 | <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</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 followed his diet orders during dinner.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 5/24/12 from 2:59 PM to 6:27 PM. At 6:13 PM, client #1 started eating dinner (mandarin chicken, rice, broccoli, tea, water and milk). Client #1 served himself a double portion of mandarin chicken. Staff #2, #5, #6, #7 and the behavior consultant were present; none of the staff prompted client #1 to follow the menu or his diet. At 6:22 PM, client #1 served himself another serving of the mandarin chicken. The staff did not prompt or encourage client #1 to follow his diet or the menu serving sizes; none of the staff prompted client #1 to have seconds on vegetables only.</p> <p>A review of the menu, dated 2012 Spring - Summer Week 4 was conducted on 5/24/12 at 5:23 PM. The menu indicated the followed serving sizes: 4 ounces of chicken with green peppers and onion, 1/3 cup of rice, 1/2 cup of broccoli, low</p> | W0460 | <p>W 460 FOOD AND NUTRITION SERVICES Plan of Correction: Stone Belt will ensure that each client will receive a nourishing, well-balanced diet including modified and specifically-prescribed diets. Date of Completion: June 29, 2012 Person Responsible: Maxwell Coordinator Plan of Prevention: Coordinator and/or Nursing Services Manager will train staff to following clients diets as instructed, including additional servings if applicable. Quality Assurance Monitoring: Coordinator will make announced and unannounced visits to observe that all dietary plans are being implemented.</p> | 06/29/2012 | | | |

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| | <p>calorie ice cream bar, beverage of choice and 1 cup of skim milk.</p> <p>A review of client #1's record was conducted on 5/25/12 at 11:21 AM. His dietary consultation, dated 4/29/12, indicated client #1 was on an 1800 calorie diet due to his weight (189). Ideal weight was listed as 135 - 170. His Physician's Orders, dated 3/12/12, indicated client #1 was on an 1800 calorie diet with double portion of vegetables.</p> <p>An interview with the Program Coordinator (PC) was conducted on 5/29/12 at 9:58 AM. The PC indicated client #1 should have been prompted by staff to follow his diet.</p> <p>9-3-8(a)</p> | | | | |

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| W0488 | <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4 assisted with breakfast prep.</p> <p>Findings include:</p> <p>An observation was conducted on 5/25/12 from 6:00 AM to 7:38 AM. At 6:52 AM, staff #4 was in the kitchen preparing client #4's breakfast. Staff #4 poured milk into the food processor and then staff #4 turned on the processor while client #4 stood behind him not engaged in an activity. At 6:55 AM, staff #4 continued to prepare cereal in the food processor. At 6:57 AM, staff #4 poured applesauce onto a plate; client #4 was standing next to him but not asked to assist. At 7:12 AM, staff #4 added soymilk to client #4's food being processed. Client #4 was not asked to assist to pour or turn on the processor.</p> <p>An interview with the Program Director (PD) was conducted on 5/29/12 at 9:58 AM. The PD indicated client #4 should have been prompted to assist with breakfast preparation including stirring, pouring and turning on the food</p> | W0488 | <p>W 488</p> <p>DINING AREAS AND SERVICES</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that each client eats in a manner consistent with his developmental level. This specifically includes preparing food if possible.</p> <p>Date of Completion:</p> <p>June 22, 2012</p> <p>Person Responsible:</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention:</p> <p>House staff will be retrained on engaging clients during meal preparation time.</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator will make announced and unannounced visits to the home to ensure that clients are engaged in meal preparation.</p> | 06/22/2012 | | | |

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| | processor, with assistance as needed. 9-3-8(a) | | | | |

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| W9999 | <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 #5), the facility failed to ensure</p> | W9999 | <p>W 9999</p> <p>FINAL OBSERVATIONS</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that each residential staff shall submit written evidence that a Mantoux tuberculosis skin test or chest x-ray is completed.</p> <p>Date of Completion:</p> <p>June 18, 2012</p> <p>Person Responsible:</p> <p>Coordinator & House Manager</p> <p>Plan of Prevention:</p> <p>The House Manager will review on a monthly basis all staff trainings and testings to ensure that staff working in the home have the proper training and testing. The individual involved specifically with this citation received a TB Screening on May 23, 2012. (Attachment # 7)</p> <p>Quality Assurance Monitoring:</p> <p>The Coordinator and House Manager will review records provided by the Stone Belt Human Resource Department on</p> | 06/18/2012 | | | |

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| | <p>an annual Mantoux (5TU, PPD) tuberculosis screening was conducted.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 5/23/12 at 11:50 AM. Direct Care Staff #5 had a negative PPD on 9/24/10. There was no documentation in her file indicating she had a Mantoux since 9/24/10.</p> <p>An interview with the Director was conducted on 5/23/12 at 12:19 PM. The Director indicated Direct Care Staff #5 should have an annual Mantoux and she was past due.</p> <p>2) 431 IAC 1.1-3-1 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.</p> <p>This state rule was not met as evidenced by:</p> <p>A review of the facility's incident/investigative reports was conducted on 5/23/12 at 12:03 PM and 5/24/12 at 10:07 AM.</p> | | a quarterly basis to ensure that all staff have necessary training and testing, including Mantoux test. | | | | |

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| | <p>Med errors:</p> <p>-On 2/3/12 at 5:00 PM, client #4 was not administered his medications (Simethicone, Lactase, Eryped, and Domperidone - all for gastrointestinal symptoms).</p> <p>-On 3/5/12 at 7:00 AM, client #2 failed to receive his morning medications from staff #3.</p> <p>-On 4/1/12 at 4:00 PM, client #1 received one pill of Seroquel (mood disorder) instead of two pills.</p> <p>-On 4/22/12 at 3:00 PM, client #2 received a double-dose of Benztropine (EPS - extrapyramidal symptoms) due to staff #11 failing to initial the Medication Administration Record when he passed the first dose.</p> <p>-On 4/16/12, 4/17/12, 4/18/12 and 4/19/12 at bedtime, client #2's 3:00 PM dose of Benztropine (EPS) was administered at bedtime in addition to the 3:00 PM dose (he received an extra dose for 4 days).</p> <p>As needed psychotropic medication administration:</p> <p>-On 4/29/12 at 2:00 PM, client #1 received an as needed (PRN) medication (Zyprexa) due to self-injurious behavior. The facility did not provide documentation the incident was reported to BDDS.</p> | | | | | | |

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| | <p>A review of the facility's Behavioral Intervention Policy, dated 10/2010, was conducted on 5/23/12 at 12:13 PM. The policy indicated, "An agency report, as well as a state incident report must be completed whenever the PRN medication is administered."</p> <p>An interview was conducted with the Program Coordinator (PC) on 5/24/12 at 12:31 PM. The PC indicated BDDS reports should be submitted within 24 hours. The PC indicated the use of psychotropic medication for behavior should be reported to BDDS.</p> <p>9-3-3(e) 9-3-1(b)</p> | | | | |