

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 07/16/2012
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 MAXWELL ST BLOOMINGTON, IN 47401
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W0000	<p>This visit was for a post certification revisit (PCR) to the recertification and state licensure survey completed on 5/30/12.</p> <p>Survey Dates: July 12, 13 and 16, 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 7/19/12 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 record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the governing body failed to ensure the clients' personal possessions were recorded on a Personal Inventory Form.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/12/12 at 1:59 PM. On 6/18/12 (no time), staff #8 discovered a DVD player and a DVD/VHS player were missing from the group home (items the facility purchased). During the investigation, dated 6/26/12, it was also discovered client #4's digital camera was missing from the group home. The investigative report indicated staff #2 reported during her interview client #4's digital camera was missing. The report indicated in the summary, "The house Associate Manager [staff #2] and house day aide [staff #6] both are suspicious that [staff #9] may be responsible for both missing DVD/VCR units and other items missing from the house. This is no direct evidence that [staff #9] has taken any items... It is concluded that there is likely</p>	W0104	<p>W 104</p> <p>GOVERNING BODY</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that specific governing body and management requirements are met. Specifically, Stone Belt will ensure that clients personal possessions are recorded on a Personal Inventory Form.</p> <p>Responsible Person:</p> <p>Maxwell House Coordinator</p> <p>Date of Completion:</p> <p>August 8, 2012</p> <p>Plan of Prevention:</p> <p>House Staff were trained on Stone Belt policy regarding Consumer Personal Possessions (Attachment # 1 and # 2). Inventories were completed on all clients at Maxwell House. (Attachment # 3).</p> <p>Quality Assurance Monitoring:</p> <p>Coordinator will audit with House</p>	08/08/2012			

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	<p>a pattern of minor and major thefts occurring at [name of group home]." The investigative report did not address client #4's missing camera. The report did not indicate when client #4 purchased the camera, the cost and when it was discovered missing. The report did not indicate if the facility reimbursed client #4 the cost of the camera or purchased a new camera for client #4. The report did not address the lack of staff documentation of client #4's Personal Inventory Form.</p> <p>A review of client #1's record was conducted on 7/13/12 at 11:09 AM. There was no documentation in his record indicating a Personal Inventory Form was completed.</p> <p>A review of client #2's record was conducted on 7/13/12 at 11:09 AM. There was no documentation in his record indicating a Personal Inventory Form was completed.</p> <p>A review of client #3's record was conducted on 7/13/12 at 11:09 AM. There was documentation in his record indicating a Clothing Inventory Sheet was completed on 11/18/10. There was no documentation it was updated annually and there was no documentation a Personal Inventory Form was completed.</p>		<p>Manager on an annual basis the updated Personal Inventory Form and also confirm that new purchases are added at the time of purchase.</p>				

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	<p>A review of client #4's record was conducted on 7/13/12 at 11:09 AM. There was no documentation in his record indicating a Personal Inventory Form was completed.</p> <p>A review of client #5's record was conducted on 7/13/12 at 11:09 AM. There was no documentation in his record indicating a Personal Inventory Form was completed.</p> <p>A review of the facility's policy on conducting inventories on the clients' possessions, dated 7/28/10, was conducted on 7/13/12 at 11:34 AM. The policy indicated, "In group homes all personal items must be recorded on a Personal Inventory Form. Once a year, the House Manager shall perform an audit of personal possessions and update the Client's (sic) inventory form."</p> <p>An interview with the Director was conducted on 7/13/12 at 11:12 AM. The Director indicated the clients' personal possessions should be inventoried once per year.</p> <p>This deficiency was cited on 5/30/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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	9-3-1(a)			

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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 observation, record review and interview for injuries noted to client #2's face and client #4's missing camera, the facility failed to implement its policies and procedures in regard to: 1) reporting injuries to client #2's face to administrative staff, in accordance with State law and 2) conducting a thorough investigation of client #4's missing camera.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 7/13/12 from 6:19 AM to 7:53 AM. An observation was conducted at the facility operated day program on 7/13/12 from 9:25 AM to 9:52 AM. During the observations, client #2 had a red, swollen right cheek and a 2 inch red and swollen area on his right chin.</p> <p>A review of the facility's incident/investigative reports was conducted on 7/12/12 at 1:59 PM. There were no incident reports addressing injuries noted to client #2's face during observations on 7/13/12.</p> <p>A review of an email received from the</p>	W0149	<p>W 149</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt has and implements written policies and procedures that prohibit mistreatment, neglect or abuse of a client.</p> <p>Date of Completion:</p> <p>August 15, 2012</p> <p>Responsible Person:</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention:</p> <p>House Staff were retrained on Stone Belt's policy of Incident Reporting Procedure (Attachment # 4 and # 5). In addition, staff reviewed the Stone Belt policy on Prevention of Abuse and Neglect. (Attachment # 6). Specifically, the CD Player that is in the client's BSP has been replaced. (Attachment # 7) and the client's camera has been replaced. (Attachment # 8)</p>	08/15/2012			

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	<p>Director on 7/16/12 at 10:23 AM was conducted. The email indicated, "since he opened up an old injury an IR (incident report) was not completed....only tracked..... That is also the time he put the hole in the wall across from his room.....". In an email on 7/16/12 at 10:32 AM, the Director indicated there should be an incident report for the original injuries and for re-opening the wounds.</p> <p>A review of client #2's Daily Body Exam Sheet, not dated, was conducted on 7/16/12 at 10:23 AM. The sheet indicated the following for the 13th in the AM, "bruise on L (left) hip & abrasions on jaw/cheek." This same information was documented for the 13th in the PM and the 14th for both the AM and PM. The Individualized Behavior Tracking Form, dated July 2012, indicated on 7/12/12 there were 4 incidents of low intensity self-injurious behavior (SIB) and 3 incidents of high intensity SIB.</p> <p>A review of client #2's Behavioral Intervention Plan (BIP), dated 6/25/12, was conducted on 7/13/12 at 9:52 AM. The BIP indicated client #2 had a targeted behavior of SIB. SIB was defined as, "any aggression [client #2] displays towards himself, such as hitting, kicking, biting, pinching and head-banging."</p>		<p>Quality Assurance Monitoring:</p> <p>Maxwell Coordinator and SGL Director will monitor for possible abuse and exploitation during scheduled and unscheduled site visits. All incident reports will be reviewed to assure timeliness and accuracy.</p>				

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	<p>A review of the facility's abuse and neglect policy, dated 10/17/12, was conducted on 7/16/12 at 10:44 AM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any 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,</p>			

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	<p>or other involved party."</p> <p>An interview was conducted with day program (DP) staff #1 on 7/13/12 at 9:37 AM. DP #1 indicated either on 7/9/12 or 7/10/12, client #2 engaged in self-injurious behavior at the group home causing the injuries to his face. DP staff #1 indicated he was not present, he was verbally informed of the incident.</p> <p>An interview with the Director was conducted on 7/13/12 at 10:28 AM. The Director indicated there should be an incident report (documentation) regarding the injuries to client #2's face. On 7/16/12 at 9:46 AM, the Director indicated he spoke to staff #6 regarding the injuries to client #2's face. Staff #6 indicated to the Director the injuries were sustained (from self-injurious behavior) on 7/12/12 during the evening shift. The Director indicated he was unable to locate an incident report addressing the cause of the injuries.</p> <p>2) A review of the facility's incident/investigative reports was conducted on 7/12/12 at 1:59 PM. On 6/18/12 (no time), staff #8 discovered a DVD player and a DVD/VHS player were missing from the group home (items the facility purchased). During the investigation, dated 6/26/12, it was also</p>				

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	<p>discovered client #4's digital camera was missing from the group home. The investigative report indicated staff #2 reported during her interview client #4's digital camera was missing. The report indicated in the summary, "The house Associate Manager [staff #2] and house day aide [staff #6] both are suspicious that [staff #9] may be responsible for both missing DVD/VCR units and other items missing from the house. There is no direct evidence that [staff #9] has taken any items... It is concluded that there is likely a pattern of minor and major thefts occurring at [name of group home]." The investigative report did not address client #4's missing camera. The report did not indicate when client #4 purchased the camera, the cost and when it was discovered missing. The report did not indicate if the facility reimbursed client #4 the cost of the camera or purchased a new camera for client #4. The report did not address the lack of staff documentation of client #4's Personal Inventory Form.</p> <p>An interview with the Program Director (PD) was conducted on 7/13/12 at 10:24 AM. The PD indicated he should have looked into client #4's missing camera when he read the investigation. The PD indicated he wanted to know more about the camera such as when it was purchased</p>						

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	<p>and by whom and how long it had been missing.</p> <p>An interview with the Director was conducted on 7/16/12 at 9:41 AM. The Director indicated an investigation should have been conducted into client #4's missing camera. The Director indicated it was not clear if the facility or client #4 purchased the camera.</p> <p>This deficiency was cited on 5/30/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 observation, record review and interview for injuries noted to client #2's face, the facility failed to document the incident and report the injuries to administrative staff, in accordance with State law.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 7/13/12 from 6:19 AM to 7:53 AM. An observation was conducted at the facility operated day program on 7/13/12 from 9:25 AM to 9:52 AM. During the observations, client #2 had a red, swollen right cheek and a 2 inch red and swollen area on his right chin.</p> <p>A review of the facility's incident/investigative reports was conducted on 7/12/12 at 1:59 PM. There were no incident reports addressing injuries noted to client #2's face during observations on 7/13/12.</p> <p>A review of an email received from the Director on 7/16/12 at 10:23 AM was</p>	W0153	<p>W153</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt ensures that all allegations of mistreatment, abuse or neglect are reported immediately to the administrator or other officials. Stone Belt will report the incident within 24 hours.</p> <p>Date of Completion</p> <p>August 15, 2012</p> <p>Responsible Person</p> <p>Maxwell Coordinator and SGL Director</p> <p>Plan of Prevention</p> <p>House Staff were retrained on Stone Belt's policy of Incident Reporting Procedure (Attachment # 4 and # 5). In addition, staff reviewed the Stone Belt policy on Prevention of Abuse and Neglect. (Attachment # 6).</p>	08/15/2012	

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	<p>conducted. The email indicated, "since he opened up an old injury an IR (incident report) was not completed....only tracked..... That is also the time he put the hole in the wall across from his room.....". In an email on 7/16/12 at 10:32 AM, the Director indicated there should be an incident report for the original injuries and for re-opening the wounds.</p> <p>A review of client #2's Daily Body Exam Sheet, not dated, was conducted on 7/16/12 at 10:23 AM. The sheet indicated the following for the 13th in the AM, "bruise on L (left) hip & abrasions on jaw/cheek." This same information was documented for the 13th in the PM and the 14th for both the AM and PM. The Individualized Behavior Tracking Form, dated July 2012, indicated on 7/12/12 there were 4 incidents of low intensity self-injurious behavior (SIB) and 3 incidents of high intensity SIB.</p> <p>A review of client #2's Behavioral Intervention Plan (BIP), dated 6/25/12, was conducted on 7/13/12 at 9:52 AM. The BIP indicated client #2 had a targeted behavior of SIB. SIB was defined as, "any aggression [client #2] displays towards himself, such as hitting, kicking, biting, pinching and head-banging."</p>		<p>Quality Assurance Monitoring</p> <p>The SGL Director and House Coordinator will review all incident reports and assure they are reported within the 24 hour period.</p>	

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	<p>An interview was conducted with day program (DP) staff #1 on 7/13/12 at 9:37 AM. DP #1 indicated either on 7/9/12 or 7/10/12, client #2 engaged in self-injurious behavior at the group home causing the injuries to his face. DP staff #1 indicated he was not present, he was verbally informed of the incident.</p> <p>An interview with the Director was conducted on 7/13/12 at 10:28 AM. The Director indicated there should be an incident report (documentation) regarding the injuries to client #2's face. On 7/16/12 at 9:46 AM, the Director indicated he spoke to staff #6 regarding the injuries to client #2's face. Staff #6 indicated to the Director the injuries were sustained (from self-injurious behavior) on 7/12/12 during the evening shift. The Director indicated he was unable to locate an incident report addressing the cause of the injuries.</p> <p>This deficiency was cited on 5/30/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</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 1 of 3 incident/investigative reports reviewed affecting client #4, the facility failed to conduct a thorough investigation into client #4's digital camera being stolen from the group home.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 7/12/12 at 1:59 PM. On 6/18/12 (no time), staff #8 discovered a DVD player and a DVD/VHS player were missing from the group home (items the facility purchased). During the investigation, dated 6/26/12, it was also discovered client #4's digital camera was missing from the group home. The investigative report indicated staff #2 reported during her interview client #4's digital camera was missing. The report indicated in the summary, "The house Associate Manager [staff #2] and house day aide [staff #6] both are suspicious that [staff #9] may be responsible for both missing DVD/VCR units and other items missing from the house. There is no direct evidence that [staff #9] has taken any items... It is concluded that there is</p>	W0154	<p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that all allegations are investigated thoroughly.</p> <p>Date of Completion</p> <p>August 15, 2012</p> <p>Responsible Person</p> <p>Deckard Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>The Coordinator and Social Worker reviewed and completed training on Stone Belt investigation procedures. This included how to conduct proper investigations and who should be interviewed. (Attachment # 9)</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure, after reviewing the incident, that investigations will be completed thoroughly.</p>	08/15/2012			

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	<p>likely a pattern of minor and major thefts occurring at [name of group home]." The investigative report did not address client #4's missing camera. The report did not indicate when client #4 purchased the camera, the cost and when it was discovered missing. The report did not indicate if the facility reimbursed client #4 the cost of the camera or purchased a new camera for client #4. The report did not address the lack of staff documentation of client #4's Personal Inventory Form.</p> <p>An interview with the Program Director (PD) was conducted on 7/13/12 at 10:24 AM. The PD indicated he should have looked into client #4's missing camera when he read the investigation. The PD indicated he wanted to know more about the camera such as when it was purchased and by whom and how long it had been missing.</p> <p>An interview with the Director was conducted on 7/16/12 at 9:41 AM. The Director indicated an investigation should have been conducted into client #4's missing camera. The Director indicated it was not clear if the facility or client #4 purchased the camera.</p> <p>This deficiency was cited on 5/30/12. The facility failed to implement a</p>						

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	systemic plan of correction to prevent recurrence. 9-3-2(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, interview and record review for 2 of 3 clients in the sample (#1 and #2), the facility failed to ensure their program plans were implemented as written for 1) client #1's use of a CD player and 2) client #2's plan for putting his arms through his sleeves during a snack at the facility-operated day program.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 7/12/12 from 3:17 PM to 4:39 PM and 7/13/12 from 6:19 AM to 7:53 AM. On 7/12/12 at 3:31 PM, client #1 yelled and cursed about client #5 "stealing" the television (client #1 wanted to use the DVD and television to listen to CDs). Client #1 exited the living room area and went to his bedroom, slamming his door. During the observation of 7/13/12, client #1 did not have a CD player to listen to. On 7/13/12 at 7:35 AM, client #1 was using the DVD and television in the living room to listen to</p>	W0249	<p>W249</p> <p>PROGRAM IMPLEMENTATION</p> <p>Plan of Correction</p> <p>The Stone Belt interdisciplinary team formulates a client's individual program plan, each client receives a continuous active treatment program consisting of needed interventions and services sufficient in number and frequency to support the achievements and objectives of the individual.</p> <p>Date of Completion</p> <p>August 15, 2012</p> <p>Responsible Person</p> <p>Maxwell Coordinator</p> <p>Plan of Prevention</p> <p>House staff were retrained on clients BSP regarding the use of the CD player. (Attachment # 10).</p>	08/15/2012			

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	<p>music.</p> <p>A review of client #1's record was conducted on 7/13/12 at 9:46 AM. Client #1's Behavioral Intervention Plan (BIP), dated 5/23/12, indicated the following, "[Client #1] has become obsessed with electronic equipment in the past. Staff should set clear boundaries regarding electronic equipment in the house; those boundaries being that [client #1] is not to have, use, or purchase any electronic equipment not pre-approved by his parents. Additionally, he should not be left unsupervised if using the VCR/DVD, television or CD player. His CD player should not be permitted in his room. It is for use only in common areas of the house. At this time, the only electronic device permitted in [client #1's] room is his piano keyboard. Staff should continue to engage many alternate activities so as to wean him from the development of any obsessions with electronic equipment. a. [Client #1's] CD player may be added to his daily schedule during the following times: 7:00 - 8:00 AM; 3:00 - 4:00 PM; 7:00 -8:00 PM. If [client #1] misses an outing or refuses to participate in an activity, he may not replace the scheduled activity with CD time. If [client #1] has difficulty complying with the rules of his CD times, his CD player may be removed until the next scheduled CD time. Be</p>		<p>The CD player was purchased. (Attachment # 7). Day Programming staff will be retrained on clients BSP regarding the prompting of having the clients arms through his sleeves.</p> <p>Quality Assurance Monitoring</p> <p>House Coordinator will ensure the BSP is being implemented during announced and unannounced visits to the home and at day programming.</p>				

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	<p>aware that this is likely to upset [client #1]. b. Staff must make an effort to allow [client #1] to finish his CD player time before scheduling an outing. He should not be put in a lose-lose situation by having to choose between a desired outing and his CD time. c. If there is an uncontrollable disruption in his CD time, [client #1] should be given his hour of CD time when he returns to the group home."</p> <p>An interview with the home manager (HM) was conducted on 7/12/12 at 3:31 PM. The HM indicated client #1 broke his CD player earlier in the week during a behavior. The HM indicated part of client #1's program plan was to have CD time. The HM indicated the broken CD player had not been replaced. At 3:47 PM, the HM indicated client #1 had a plan for the use of his CD player. The HM indicated client #1 had been agitated since he broke his CD player.</p> <p>An interview with the Director on 7/13/12 at 10:28 AM was conducted. The Director indicated client #1 should have a CD player available to him to listen to music.</p> <p>2) An observation was conducted at the facility operated day program on 7/13/12 from 9:25 AM to 9:55 AM. At 9:32 AM, client #2 got a container of pudding and</p>			

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	<p>sat down at a table to eat his snack. Client #2's arms were out of the sleeves and down by his waist. Client #2 ate the pudding with his arms out of his sleeves. The bottom of his shirt was pulled up as client #2 ate his pudding. Client #2 was bent forward and leaning to the left as he ate. Client #2 was not prompted to put his arms through the sleeves of his shirt while eating his snack.</p> <p>A review of client #2's record was conducted on 7/13/12 at 9:52 AM. His Behavioral Intervention Plan (BIP), dated 6/25/12, indicated the following: "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 regularly 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. If [client #2] begins to continuously self-injure, he may be offered his wrap." 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</p>				

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W9999	<p>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 7/13/12 at 10:24 AM. The PC indicated the staff at the facility operated day program should have implemented client #2's plan for putting his arms through his sleeves during his snack.</p> <p>An interview with the Director was conducted on 7/13/12 at 10:24 AM. The Director indicated client #2's plan for putting his arms through his sleeves should have been implemented as written.</p> <p>This deficiency was cited on 5/30/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>	W9999	No deficiency statement for W9999	08/15/2012	