

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2014
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3502 FESTIVE DR BLOOMINGTON, IN 47401
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W000000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Survey Dates: September 16, 17, 18, 19, 22 and 23, 2014</p> <p>Facility Number: 000872 Provider Number: 15G357 AIM Number: 100239670</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/30/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 5 of 5 clients living at the group home (#1, #2, #3, #4 and #5), the governing body failed to exercise operating direction over the facility by failing to have the group home van assessed for roadworthiness following an accident on 9/15/14.</p>	W000104	<p>W 104 483.410 GoverningBody</p> <p>1) Planof Correction: The facility's van was inspected by the maintenance departmenton 9/17/2014 and the COO 9/15/2014. It was sent to a body shop and a van wasrented to transport clients safely.</p>	10/17/2014

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>An observation was conducted at the group home on 9/16/14 from 4:06 PM to 5:54 PM. At 4:06 PM, the clients returned home from the day program using the group home van. The left rear door of the van was dented in several inches. The rear bumper was sticking out on the right rear side of the van. The middle of the bumper was pushed underneath the van causing the spare tire (located under the van) to deflate.</p> <p>An observation was conducted at the group home on 9/17/14 from 5:47 AM to 7:53 AM. At 7:46 AM, clients #1, #3, #4 and #5 entered the van to go to the day program. Client #2 rode to the day program in staff #7's car.</p> <p>On 9/19/14 at 11:22 AM, the facility's Bureau of Developmental Disabilities Services (BDDS) incident reports for clients #1, #3 and #5 were reviewed (clients #2 and #4 were not in the van during the accident). The reports, dated 9/16/14, indicated, in part, "On 09/15/2014 at 4:00pm, [clients #3, #5, and #1] and staff were driving home, in the rain, from Stone Belt Day Program on Hwy (highway) [name/Hwy name](sic) under the [name of street] Street overpass when the cars in front of them stopped.</p>		<p>Planof Prevention: The facility staffs have been trained to contact the director orCOO when accidents happen. This is Stone Belt policy and it will be reviewedduring orientation training and annually (AttachmentA).</p> <p>Planof Monitoring: The director or COO will determine, depending on the severity ofthe accident, rather the van is to be inspected by either the maintenancedepartment of a professional prior to transporting clients.</p>	

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	<p>Staff applied the brakes, and then the vehicle was rear ended, pushing the vehicle into the other lane. Coordinator was contacted at 4:06pm, 911 was called directly after. Another staff member took over responsibility for clients and the vehicle, while staff member, who had been driving at the time of the accident, was transported to the [name of hospital]. All clients were taken in the van to [name of hospital] and guardian's (sic) met them there. After examination by ER (emergency room) physician, all clients were released and no follow up was recommended. Support team will review."</p> <p>On 9/17/14 at 11:58 AM, an interview with the Chief Operating Officer (COO) was conducted. The COO indicated he was unsure if the group home van was checked out following the accident on 9/15/14. The COO indicated the Coordinator informed him the van was safe to drive. The COO indicated he had not assessed the damage to the van until the time of the interview (interview held while in the day program parking lot observing the van). The COO indicated the van needed to be assessed for roadworthiness.</p> <p>On 9/17/14 at 12:02 PM, the Coordinator indicated she told the COO the staff told</p>				

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W000122	<p>her the van was safe to drive. The Coordinator indicated the van had not been taken to a mechanic as far as she knew. The Coordinator indicated she was told by the direct care staff the van was safe to drive since it was not shaking or showing signs of issues.</p> <p>On 9/17/14 at 12:43 PM, maintenance staff (MS) #1 indicated he just finished checking the van on this date. MS #1 stated the damage "looks gnarly." MS #1 indicated the van's wheelchair lift was operating appropriately. MS #1 indicated he took the van for a drive. He indicated the brakes worked appropriately. There were no squeaks or unusual bumps. MS #1 indicated he looked at the bushings, suspension and brakes and there was no damage. MS #1 indicated there were no leaks underneath the van. MS #1 indicated the bumper, rear door and spare tire were damaged. MS #1 stated the van was "roadworthy until they can get in to the body shop."</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for</p>	W000122	W122	10/17/2014

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	<p>26 of 65 incident/investigative reports reviewed affecting clients #1, #2, #4, #5 and #6, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations of client to client abuse and staff neglect, prevent further abuse while an investigation was in progress, and ensure staff immediately reported an allegation of abuse to the administrator involving client #6. The facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) an incident of client to client abuse, within 24 hours, in accordance with state law. The facility failed to ensure staff implemented client #3's risk plan for falls to ensure client #3 did not fall.</p> <p>Findings include:</p> <p>1. Please refer to W149. For 26 of 65 incident/investigative reports reviewed affecting clients #1, #2, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations of client to client abuse and staff neglect, prevent further abuse while an investigation was in progress, and ensure staff immediately reported an</p>		<p>483.420 Client Protections</p> <p>1) Plan ofCorrection: Staff have been training on following the fall plan for client #3 (Attachment B).</p> <p>Plan ofPreventing: LL coordinator have been trained on supporting day program staff.Along with training on preventing falls and the definition of what are fallsand what are behaviors.</p> <p>Plan ofMonitoring: Agency coordinator and director along with LL coordinator willconduct daily visits throughout the day to provide training and support toclient #3. These visits may taper down when falls decrease. See attachedobservation visits for client #3 classroom (AttachmentC).</p> <p>2) Plan ofCorrection: Staff have been training on staff immediately reporting allegationsof abuse to administrator(s) and forwarding report the BDDS within in 24 hours. (AttachmentA).</p> <p>Plan ofPreventing: LL coordinator have been trained on supporting day program staff.Along with training on ensuring that staff immediately report allegations toadministrator(s) and / or emergency pager (AttachmentA).</p> <p>Plan ofMonitoring: Agency coordinator and director along with LL coordinator will conductdaily visits throughout the day to provide training and</p>				

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	<p>allegation of abuse to the administrator involving client #6. The facility neglected to report to the Bureau of Developmental Disabilities Services (BDDS) an incident of client to client abuse, within 24 hours, in accordance with state law. The facility neglected to ensure staff implemented client #3's risk plan for falls to ensure client #3 did not fall.</p> <p>2. Please refer to W153. For 3 of 65 incident/investigative reports reviewed affecting clients #5 and #6, the facility failed to ensure staff immediately reported an allegation of abuse to the administrator involving client #6 and the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) an incident of client to client abuse, within 24 hours, in accordance with state law.</p> <p>3. Please refer to W154. For 3 of 65 incident/investigative reports reviewed affecting clients #1, #2, #3 and #5, the facility failed to conduct thorough investigations of client to client abuse and client #3's incident in which she fell out of her wheelchair.</p> <p>4. Please refer to W155. For 2 of 65 incident/investigative reports reviewed affecting client #6, the facility-operated</p>		<p>support to clients # 5and #6. These visits may taper down when falls decrease. See attachedobservation schedule (Attachment C).</p> <p>3) Planof Correction: Investigation was completed and it was determined that client #3.... (Attachment D). Plan ofPreventing: LL Coordinator along with facility Coordinators have been trainedon conducting thorough investigations (AttachmentE). Plan ofMonitoring: Agency coordinator and director along with LL coordinator willconduct daily visits throughout the day to provide training and support toclient #3. These visits may taper down when falls decrease. See attachedobservation visits for client #3 classroom (AttachmentC).</p> <p>4) Planof Correction: Facility director during time of these incidents are no longerwith the agency. Current facilitydirector conducts daily observations and is contacted immediately followingincidents and allegations occurring at LL. She then along with LL director willdetermine course of action. Plan ofPreventing: LL Coordinator along with facility Coordinators have been trainedon ensuring that clients are safe and potential abuse is prevented duringinvestigation process</p>				

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	<p>day program failed to prevent further abuse while an investigation was in progress.</p> <p>5. Please refer to W240. For 1 of 3 clients in the sample (#3), the facility failed to have written instructions to staff to: 1) keep the day program door closed to the outside following two incidents in which client #3 fell out of her wheelchair and 2) specify the positioning of the staff in order to assist client #3 to ensure she did not fall.</p> <p>6. Please refer to W249. For 1 of 3 clients in the sample (#3), the facility failed to ensure staff implemented the clients' program plans as written as evidenced by client #3's risk plan for falls was not implemented as written.</p> <p>9-3-2(a)</p>		<p>(Attachment E). Plan ofMonitoring: Agency coordinator and director along with LL coordinator willconduct daily visits throughout the day to provide training and support toclient #3. These visits may taper down when incidents of abuse and neglectdecrease. See attached observationvisits for client #3 classroom (AttachmentC).</p> <p>5) Planof Correction: Client #3 fall plan was revised and trained to staff (Attachment B). Plan ofPreventing: LL coordinator has been trained on supporting day program staffwith client #3. Along with training on preventing falls and the definition ofwhat are falls and what are behaviors. Plan ofMonitoring: Agency coordinator and director along with LL coordinator willconduct daily visits throughout the day to provide training and support toclient #3. These visits may taper down when falls decrease. See attachedobservation visits for client #3 classroom (AttachmentC).</p> <p>6) Plan ofCorrection: Client #3 fall plan was revised and trained to staff (Attachment B). Plan ofPreventing: LL coordinator has been trained on supporting day program staffwith client #3. Along with training on preventing falls and the definition ofwhat are falls and what are behaviors.</p>		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 26 of 65 incident/investigative reports reviewed affecting clients #1, #2, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations of client to client abuse and staff neglect, prevent further abuse while an investigation was in progress, and ensure staff immediately reported an allegation of abuse to the administrator involving client #6. The facility neglected to report to the Bureau of Developmental Disabilities Services (BDDS) an incident of client to client abuse, within 24 hours, in accordance with state law. The facility neglected to ensure staff implemented client #3's risk</p>	W000149	<p>Plan ofMonitoring: Agency coordinator and director along with LL coordinator willconduct daily visits throughout the day to provide training and support toclient #3. These visits may taper down when falls decrease. See attachedobservation visits for client #3 classroom (AttachmentC).</p> <p>W149 483.420(d)(1)Staff Treatment of Clients</p> <p>1. Plan ofcorrection: Stone Belt policy was followed immediately after the accusation ofabuse was made on 11/18/2014. Stone Belt has a policy that prohibitsmistreatment, neglect, or abuse of a client. This policy was broken by accusedstaff therefore suspended following accusation of abuse of client #6 andterminated after it was substantiated. Plan of Prevention: Facility day program staff andStone Belt SGL staff will be trained on prevention of mistreatment, neglect,and abuse each month at Shiloh and LL meetings (Attachment A). LL staffhave been trained on following client #6's BSP</p>	10/17/2014

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	<p>plan for falls to ensure client #3 did not fall.</p> <p>Findings include:</p> <p>On 9/16/14 at 11:27 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>1) On 11/18/13 (no time indicated) while at the facility-operated day program, former staff #8 neglected to provide appropriate supervision to client #6. The investigation, dated 11/21/13, indicated the incident was substantiated (the findings support the event as described/allegation). The summary indicated, "The incident was verified by two different staff that indeed [client #6] was unsupervised in the restroom and likely ate toilet paper from the toilet. His BSP (behavior support plan) includes information about food seeking and discusses eating inedible items under the food seeking section of the plan. The plan includes a need for increased supervision when [client #6] is agitated including attention to distance between staff and client and utilizing environmental reorganization for client safety. This is included in the general proactive strategies of the plan. It is indicated in the BSP that [client #6] will eat paper from the trashcan and food</p>		<p>(Attachment B). Quality Monitoring: Facility coordinator / dayprogram coordinator will provide daily monitoring to ensure staff are followingclient's BSP and preventing potential abuse and neglect (Attachment C). 2. Plan of Correction: The SGL director at time of mistreatment, neglect, or abuse of a client is no longer in this position. Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on the BSPs of clients #6's and #8 (Attachment B). Quality Monitoring: Facility coordinator / dayprogram coordinator will provide daily monitoring to ensure staff are followingclient's BSP and preventing potential abuse and neglect (Attachment C). 3. Plan of Correction: Client #3's BSP and fall plan have been trained with facility staff (Attachment B). Plan of Prevention: During visits from guardians staffs to walk the visitors to the door and ensure the door is secured (Attachment F). Quality Monitoring: Facility manager will conduct daily observations and facility coordinator will conduct weekly observations (Attachment</p>				

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	<p>items that are unattended. There has been no historical information regarding him eating toilet paper out of the toilet at day program or otherwise. Trash cans had been adapted at day program to have lids that he could not lift and that he does not attempt to get into. [Staff #8] reports that he was trying to give [client #6] space in the restroom. He left him alone for 'one minute.' He indicates that [client #6] will get anxious with him while he is in the restroom with [client #6]. [Staff #8] thought it would be safe as the trashcans were covered as he had no historical behaviors of eating out of the toilet. He had had success giving him space in this way the day before as [client #6] came out of the restroom on his own with a smile. [Staff #9] indicates she did see a conversation regarding what type of supervision was needed for the restroom.</p> <p>Given that the behavior plan states that [client #6] is to have increased supervision during times of agitation, and that it is important to utilize environmental reorganization to ensure his safety, it is clear that this part of the BSP was not followed by [staff #8's] admission. Due to the report from [staff #10], as well as the day program coordinator [Day Program Coordinator #2's] report of other instances that [staff #8] has refused to follow</p>		<p>G). 4. Plan of Correction: Client #5's BSP has been trained with facility staff (Attachment G). Plan of Prevention: Prevention of abuse and neglect is trained with SGL staff each month at Shiloh meeting (Attachment A). Quality Monitoring: Facility manager will conduct daily observations and facility coordinator will conduct weekly observations (Attachment G). 5. Plan of Correction: The SGL director at time of mistreatment, neglect, or abuse of a client is no longer in this position. Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on the BSPs of clients #5 (Attachment B). Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C). 6. Plan of Correction: The SGL director at time of mistreatment, neglect, or abuse of a client is no longer in this position. Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and</p>		

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	<p>recommendations of instructors and supervisors, this incident is substantiated. It is apparent per the interviews that [staff #8] had had clear guidance about this plan and refused to follow the plan and staff direction. Neglect is defined by Stone Belt policy as: Neglect: any action or behavioral interventions that risk 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. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan.</p> <p>[Staff #8] did fail to provide a safe, clean and sanitary environment for [client #6] due to the lack of appropriate supervision during the time of this incident. He did not follow recommendations of instructor staff, nor recommendations of the BSP. [Staff #8] was unaware of the BSP recommendations for supervision when asked."</p> <p>The investigation indicated, "Staff was</p>		<p>abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on the BSP and Fall Plan of client #3 (Attachment B).</p> <p>Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect. They will also make certain door is closed unless client(s) and staff are outside with client #3 per her fall plan to gain exercise and movement in the afternoon (Attachment C).</p> <p>7. Plan of Correction: The incident was investigated and it was determined to not be a client on client but merely a bump into one another while walking by one another.</p> <p>Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on the BSPs of clients #5 (Attachment B).</p> <p>Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p> <p>8. Plan of Correction: Peer who hit client 3's helmet has a</p>		

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	<p>suspended immediately and ultimately terminated on 11/25/13."</p> <p>The Incident/Investigation Committee Report, dated 12/10/13, indicated "No" to the following question: "Was the Report timely?"</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director (GHD) indicated the facility should prevent client abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients.</p> <p>2) On 11/19/13 at 10:00 AM at the facility-operated day program, client #6 sat down on the floor. Staff (did not indicate the staff) noticed staff #8 seemed frustrated with client #6 and told client #6, "That is not a good place to sit." Client #6 began taking off his shoes. Staff #8 "grabbed [client #6's] right hand angrily" and yelled, "No!" and then threw client #6's shoe across the room into the coat closet. The plan to resolve section of the BDDS report indicated, "Taking proactive measures in order to ensure the safety and well being of [client #6], [staff #8] was suspended on 11/20/13. An investigation into this incident has been started on 11/20/13." The investigative report, dated 11/22/13, indicated, "Date/time incident report was filed: It is</p>		<p>BSP and it has been trained to LL staff.</p> <p>Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on all client BSPs (Attachment B).</p> <p>Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p> <p>9. Plan of Correction: Incident was reviewed and outcome was that client #3 dumping her wheelchair was a behavior that staff attempted to prevent (Attachment J).</p> <p>Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on all client BSPs (Attachment B).</p> <p>Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p> <p>10. Plan of Correction: Facility client #5 BSP was trained and will be followed by LL staff to prevent future aggressive incidents.</p>		

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	<p>unclear what time the report was filed." The investigation's Immediate safety measure put into place following event/alleged event was blank. The Findings section of the investigation indicated, "Inconclusive (the information from sources examined is incomplete, and/or contradictory)." The summary indicated, "This investigation has two reports which match up on details of time, place and people present. They do not match up on the facts including details about whether the client was grabbed by the arm and whether a shoe was thrown in anger across the room. The only witness to the event, [staff #9] indicates those two things did happen, and [staff #8] indicates that they did not happen. The only other witnesses were clients who are non-verbal or without the cognitive ability to replay reliable details of this nature after an event. This is one person's word against another person's word... There is no conclusive evidence that abuse happened in this incident." The Resulting Corrective Action section indicated, "Employee [staff #8] was immediately suspended and mandated to report to EAP (Employee Assistance Program). He was then terminated on 11/25/13."</p> <p>The 12/10/13 Quality Assurance Team Meeting notes, reviewed on 9/18/14 at</p>		<p>Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on all client BSPs(Attachment B). Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p> <p>11. Plan of Correction: Facility client #2 and #1 BSP were trained and will be followed by LL staff to prevent future aggressive incidents.</p> <p>Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on all client BSPs(Attachment B). Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p> <p>Facility coordinator was trained on ensuring that investigations are completed by LL coordinator and to follow up with them within 5 day deadline (Attachment H).</p> <p>12. Plan of Correction: Facility client #3 fall plan was followed</p>		

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	<p>2:55 PM, indicated, in part, "[Name of Chief Executive Officer] reviewed 2 investigations in the [name of day program] in the Central Region. Both investigations involved the same staff and client 1 day apart from each other. The investigation on the 18 involved an allegation of neglect which was substantiated. The staff was not suspended until the next day as it was being reviewed by the Director if neglect had taken place. The staff was suspended as soon as it was determined that neglect may have taken place. The staff was working with a client and had been told to keep the client in line of sight. The staff allowed the client to wander away from line of sight. The staff was talked to by the classroom instructor and informed again to make sure the client was within the line of sight. The staff purposefully allowed the client to go to the bathroom by himself for 'privacy' and did not keep the client within line of sight. The client was found to have eaten toilet paper with feces on it. As it was being determined the staff was alleged to have forcibly taken the same client's shoe and thrown it across the room. This investigation was inconclusive. The staff was terminated from employment due to the initial investigation of neglect. The client's behavior plan was reviewed and revised to include a 'line of sight'</p>		<p>and no injuries weresustained by "fall". Since the "fall" did not result in injuries policies werefollowed and an internal report submitted. No follow up or monitoring required.</p> <p>13. Plan ofCorrection: Facility client #3 fall plan was followed and no injuries weresustained by "fall". Since the "fall" did not result in injuries policies werefollowed and an internal report submitted. No follow up or monitoring required.</p> <p>14. Plan ofCorrection: Facility client #3 fall plan was followed and no injuries weresustained by "fall". Since the "fall" did not result in injuries policies werefollowed and an internal report submitted. No follow up or monitoring required.</p> <p>15. Plan ofCorrection: Facility client #3 fall plan was followed and no injuries weresustained by "fall". Since the "fall" did not result in injuries policies werefollowed and an internal report submitted. No follow up or monitoring required.</p> <p>16. Plan ofCorrection: Facility client #3 fall plan was followed and no injuries weresustained by "fall". Since the "fall" did not result in injuries policies werefollowed and an internal report submitted. No follow up or monitoring required.</p> <p>17. Plan ofCorrection: Facility client #3 fall plan was followed and no injuries weresustained by "fall". Since the "fall" did not result</p>	

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	<p>necessity and retrained all staff working with client to be sure the client was within line of sight at all times. The report was not filed in a timely manner but all individuals involved were interviewed. Recommendations addressed causal individual and systemic factors and recommendations were implemented. The second report was timely and all individuals involved were interviewed."</p> <p>The Employee Warning documentation for staff #8, dated 11/25/13, indicated, in part, "Employee was suspended on 11/20/13 due to (sic) allegation of neglect. An investigation was completed and the allegation was substantiated. Based on the substantiated allegation of neglect, employee is terminated as of 11/25/13."</p> <p>On 9/22/14 at 1:07 PM, the Director of Lifelong Learning (day program - DLL) indicated the incidents occurred close together. The DLL indicated she recalled the first incident was not immediately reported. The DLL indicated the first incident was reported after the second incident on 11/19/13. The DLL indicated staff #8 did not report the incident of client #6 eating feces off of toilet paper. The DLL indicated administrative staff were not informed of the incident on</p>		<p>in injuries policies were followed and an internal report submitted. No follow up or monitoring required.</p> <p>18. Plan of Correction: Facility client #3 fall plan was followed and no injuries were sustained by "fall". Since the "fall" did not result in injuries policies were followed and an internal report submitted. No follow up or monitoring required.</p> <p>19. Plan of Correction: Facility client #3 fall plan was followed and no injuries were sustained by "fall". Since the "fall" did not result in injuries policies were followed and an internal report submitted. No follow up or monitoring required.</p> <p>20. Plan of Correction: Facility client #3 fall plan was followed and no injuries were sustained by "fall". Since the "fall" did not result in injuries policies were followed and an internal report submitted. No follow up or monitoring required.</p> <p>21. Plan of Correction: Facility client #3 fall plan was followed and no injuries were sustained by "fall". Since the "fall" did not result in injuries policies were followed and an internal report submitted. No follow up or monitoring required.</p> <p>22. Plan of Correction: Facility client #3 fall plan was followed and no injuries were sustained by "fall". Since the "fall" did not result in injuries policies were followed and an internal report submitted.</p>				

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	<p>11/18/13 until after the incident on 11/19/13. The DLL indicated the 11/18/13 incident should have been reported immediately so action could have been taken to increase client #6's supervision level. The DLL indicated the policy and procedure for preventing abuse/neglect during an investigation was to suspend staff.</p> <p>3) On 5/31/14 at 2:15 PM, client #3 exited the front door in her wheelchair and waited in the driveway for her mother to arrive. No staff members witnessed her exiting the group home. Client #3's mother arrived and assisted client #3 into the group home. Client #3 was outside for no more than 5 minutes. Client #3 was not injured. The BDDS report, dated 6/1/14, indicated, in part, "The parent of another client had been visiting, walking in and out of the house to transport various items from her car. When finished, this parent exited the house but failed to ensure the front door had latched when closed." The investigation's Conclusion, dated 6/1/14, indicated, "After talking with all staff members who were present in the home at the time that the incident occurred and talking with [client #5's guardian], who was also present in the home at the time of the incident, it is concluded that the front door was not shut and latched all</p>		<p>No follow up or monitoring required.</p> <p>23. Plan of Correction: Facility client #3 fall plan was followed and no injuries were sustained by "fall". Since the "fall" did not result in injuries policies were followed and an internal report submitted. No follow up or monitoring required.</p> <p>24. Plan of Correction: Facility client #3 fall plan was followed and no injuries were sustained by "fall". Since the "fall" did not result in injuries policies were followed and an internal report submitted. No follow up or monitoring required.</p> <p>25. Plan of Correction: Facility client #3 fall plan was followed and no injuries were sustained by "fall". Since the "fall" did not result in injuries policies were followed and an internal report submitted. No follow up or monitoring required.</p> <p>26. Plan of Correction: Facility client #3 fall plan was followed and no injuries were sustained by "fall". Since the "fall" did not result in injuries policies were followed and an internal report submitted. No follow up or monitoring required.</p>	

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	<p>the way and that is how [client #3] was able to get out of the front door and down the sidewalk without making enough noise for staff to hear her. [Client #3] is physically unable to open the door herself and does not have a history of attempting to elope. In all probability, [client #3] was headed out the front driveway to meet her mom, who she knew was coming. Staff had just put her shoes on in anticipation of this arrival, [client #3] had been informed that her mother was coming and there was another guest in the home at the time. At no time did [client #3] leave the property, nor was she near the road."</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director (GHD) indicated neglect should be prevented by the facility. The GHD indicated the facility had a policy and procedure prohibiting neglect of the clients.</p> <p>4) On 6/1/14 at 1:19 PM, client #3 was standing at the counter dividing the kitchen and dining room. Client #5 was standing next to her. Client #5 turned to client #3 and pushed her over. Client #3 was caught and lowered to the ground.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director (GHD) indicated client to client aggression was considered abuse</p>			

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	<p>and should be prevented by the facility. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>5) On 6/4/14 at 10:30 AM at the facility-operated day program, client #5 was walking into the classroom as a peer was walking out. Client #5 reached around staff and grabbed her peer's hair. Client #5 released her grip after approximately 7 seconds. There was no documentation an investigation was completed.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director indicated an investigation should have been conducted.</p> <p>6) On 6/16/14 at 2:15 PM at the facility-operated day program, client #3 was rolling in her wheelchair. Client #3 rolled out the door to the outside and her wheelchair tipped over the sidewalk edge. Client #3 came out of the wheelchair and was lying on the ground. Client #3 received a scrape on her right knee. The incident report, dated 6/16/14, indicated, "Possible scrapes on arm." The Review and Corrective Action for fall incident regarding client #3 on June 16, 2014 indicated, "[Client #3] is in group service during her day program, per the support team, and the classroom</p>						

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	<p>had 3 staff for 6 clients at the time of her fall. All 3 staff were engaged in supporting other clients at the time [client #3] went to the ramp to go into the court yard. [Client #3's] doctor and support team have agreed she can have use of the wheelchair in the afternoon to give her the movement she desires. Her mother does not want [client #3] to be belted in the wheelchair. She often goes down the short ramp to the courtyard independently, but the soil next to the ramp has eroded over the winter and [client #3] got one wheel off the ramp causing the accident. The following corrective action is in response to this incident. 1. Train Room 16 staff - keep the door closed to the courtyard from Room 16, unless being used to get clients in/out, until the changes are made to the ramp to ensure safety. [Chief Operating Officer] has requested that the maintenance staff make the physical changes to the ramp. [Day Program Coordinator] will train staff and document by 6/20/14. 2. Support Team will review the number and type of falls and make any needed recommendations at the the next support team meeting on July 14th. [Day Program Coordinator] will bring the fall tracking from the last 6 months to assess trends."</p> <p>7) On 7/11/14 at 9:00 AM at the</p>			

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	<p>facility-operated day program, client #3 was sitting in a rocking chair and stood up. As client #3 walked away from the rocking chair a peer began walking toward the rocking chair. The peer stepped in front of staff and pushed client #3's upper arm. Client #3 fell over. Client #3 was not injured.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director (GHD) indicated client to client aggression was considered abuse and should be prevented by the facility. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>8) On 7/11/14 at 9:00 AM at the facility-operated day program, client #3 was walking around. A peer jumped out of a rocking chair and hit client #3 open handed on the top of her head (she was wearing a helmet).</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director (GHD) indicated client to client aggression was considered abuse and should be prevented by the facility. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>9) On 8/21/14 at 12:15 PM at the facility-operated day program, client #3</p>				

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	<p>was rolling around in the wheelchair and listening to music. Staff put another client's chair outside while getting ready to bring the other client outside. The outside door was open. Client #3 backed up in her wheelchair quickly, fell down stairs in the doorway to the outside, rolled backwards, and flipped out of her wheelchair. Client #3 had scrapes on her hands, arms, chin and cheeks. The Bureau of Developmental Disabilities Services (BDDS) follow-up report, dated 8/25/14, indicated, in part, "[Client #3's] Day Program Coordinator completed an inquiry regarding this incident and talked with the staff that were involved. All staff will review [client #3's] risk plans and sign off on training. Staff will also be mindful of client location in proximity to outside doorways or other surface changes that can prove challenging for [client #3]. Doors to outside will remain closed unless a transition to outside or inside is occurring and door will be shut immediately afterward. Staff will continue to implement strategies outlined in [client #3's] plans to ensure her health and safety at all times." There was no documentation an investigation or inquiry was conducted into the incident.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director indicated the incident should have been investigated.</p>			

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	<p>On 9/16/14 at 12:58 PM, the Coordinator indicated she requested the day program coordinator to conduct a review of the incident. The Coordinator indicated the incident should have been investigated.</p> <p>10) On 8/26/14 at 3:00 PM at the facility-operated day program, client #5 pulled a female peer's hair when the peer entered the classroom. The BDDS report, dated 8/26/14, indicated, "...[client #5] pulled [peer's name] hair in two different places and would not let go. It took time for staff to remove [client #5's] hands holding on tightly to [peer's] hair. After a struggle, staff was able to release [client #5's] grasp of [peer's] hair, which included a hand full of hair. Staff gently laid [peer] on the floor, and staff removed [client #5] from the room. [Client #5] pulled on [peer's] hair for about 5 minutes, and during that time [peer] screamed from the pain. Staff from all over the building came to help; [peer] was sobbing hysterically as [client #5] pulled her hair."</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director (GHD) indicated client to client aggression was considered abuse and should be prevented by the facility. The GHD indicated the facility had a policy and procedure prohibiting abuse of</p>			

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	<p>the clients.</p> <p>11) On 9/3/14 at 2:15 PM at the facility-operated day program, client #2 was upset while walking in his walker. Client #1 was walking in her walker. Clients #1 and #2 met while walking and smiled. The report indicated, "After a while [client #2] became unhappy again but he didn't scream or walk away. [Client #2] reached over and started grabbing at [client #1's] arm. He made pinching motions with his hand and began to pinch her. Staff stopped his hand and moved [client #1] away. [Client #1] looked unhappy and staff checked her for marks or bruises on arm. There were no injuries or treatment needed." There was no documentation the facility conducted an investigation.</p> <p>On 9/16/14 at 12:58 PM, the Coordinator indicated an inquiry should have been completed.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director indicated an investigation should have been completed.</p> <p>Client #3's falls while at the facility-operated day program (15 total in the past 6 months):</p> <p>12) On 4/2/14 at 8:20 AM at the</p>						

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	<p>facility-operated day program, client #3 was walking near a table with other clients. A staff stood up with client #3 near him and bumped into client #3. Client #3 fell backward and hit her head (she was wearing a helmet) on a chair. Client #3 was not injured.</p> <p>13) On 4/8/14 at 10:00 AM at the facility-operated day program, client #3 began to fall. Staff caught her as she was hitting the ground. Client #3 was not injured.</p> <p>14) On 5/7/14 at 3:04 PM at the facility-operated day program, client #3 stood up, took three steps and fell on her right hip as she was trying to turn. The Incident Report, dated 5/7/14, indicated, "No clients were around. Did not stub toe. No visible reason for fall. Staff was in arm reach (sic)." Client #3 was not injured.</p> <p>15) On 5/27/14 at 8:15 AM at the facility-operated day program, client #3 was walking around the table after exiting her wheelchair. Client #3 lost her balance and fell backward. Staff put arms out but was unable to slow her fall. Client #3 landed on her buttocks and rolled onto her back. Client #3 was not injured.</p>						

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	<p>16) On 6/9/14 at 10:30 AM at the facility-operated day program, client #3 was walking around the gym. Client #3 was near the restroom exit when a peer came out. Client #3 fell landing on her buttocks after being startled. Client #3 was not injured.</p> <p>17) On 6/16/14 at 8:15 AM at the facility-operated day program, client #3 fell backward while waiting for staff to give her a radio. Client #3 was not injured.</p> <p>18) On 6/30/14 at 8:45 AM at the facility-operated day program, client #3 was walking to the restroom. Client #3 walked to the doorway, got startled and fell backward. The report indicated staff was within arm's length but was not able to catch her. Client #3 was not injured.</p> <p>19) On 7/7/14 (no time) at the facility-operated day program, client #3 walked behind a peer who was sitting in a chair. The peer moved her chair backward and knocked client #3 down. Client #3 was not injured.</p> <p>20) On 7/8/14 at 10:20 AM at the facility-operated day program, client #3 was walking while a peer played basketball in the gym. The ball bounced toward client #3 but did not hit her.</p>			

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	<p>Client #3 was startled and fell on her buttocks. Client #3 was not injured.</p> <p>21) On 7/14/14 at 12:00 PM at the facility-operated day program, client #3 was walking to the restroom with staff. A peer bumped into the staff, the staff turned and client #3 fell onto her buttocks. Client #3 was not injured.</p> <p>22) On 7/24/14 at 10:20 AM at the facility-operated day program, client #3 was listening to music and walking. Client #3 dropped to the ground and landed on her right side. The Incident Report, dated 7/24/14, indicated, in part, "[Client #3] dropped w/ (with) no known antecedent to fall." Client #3 was not injured.</p> <p>23) On 8/11/14 at 9:15 AM at the facility-operated day program, client #3 wanted her music changed and pulled down her pants while staff was changing her music. Client #3 fell backward. Staff was unable to slow down the fall or catch her. Client #3 landed on her buttocks and rolled onto her back. Client #3 hit her head, with helmet on, on another client's walker. Client #3 was not injured.</p> <p>24) On 8/12/14 at 2:30 PM at the facility-operated day program, client #3 was in the restroom stall. Client #3 got</p>			

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	<p>startled when staff opened the stall door. Client #3 fell backward onto her buttocks and hit her head (with helmet on) on the toilet. Client #3 was not injured.</p> <p>25) On 8/13/14 at 8:40 AM at the facility-operated day program, client #3 was in the restroom. The Incident Report indicated, in part, "Staff made sure [client #3] was stable and moved to put down clothes and wipes away from [client #3]. [Client #3] became unstable and fell back on butt and possibly hit her head (with helmet on) on either the toilet or the stall wall. Staff didn't see [client #3] fall, she heard it." Client #3 was not injured.</p> <p>26) On 9/2/14 at 11:20 AM at the facility-operated day program, client #3 was walking with her speaker on her ear. Client #3 stopped walking and fell onto the ground on her right side. Client #3 was not injured.</p> <p>An observation was conducted at the facility-operated day program on 9/17/14 from 10:35 AM to 11:51 AM. During the observation, client #3 was walking around the classroom with day program staff #1's assistance. Client #3 was holding onto staff #1's hand while she walked. At 10:40 AM, client #3 almost fell after lifting staff #1's hand up to the top of her head. Client #3 leaned</p>			

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	<p>backward onto staff to prevent the fall. The staff assisted client #3 by standing on client #3's left side, holding client #3's hand with her left hand and staff having her right hand near client #3's gait belt in case she fell.</p> <p>A review of client #3's record was conducted on 9/18/14 at 11:14 AM. Client #3's risk plan for falls, included in the Medication Information Sheet, dated 9/9/14, indicated, in part, "[Client #3] is at risk for falls due to her history and her diagnosis. [Client #3] is easily startled and may fall in reaction to a loud noise or sudden movement. These falls are quick. She appears to simply drop to the floor or onto an immediately close by surface - furniture, staff, and roommates. Some of [client #3's] falls occur without any evident cause. Some of [client #3's] falls are due to bumping into something or being bumped into by someone else. These falls can be quick or slow resulting in her landing on her side, back, or seated depending on the contact that initiated the fall. Sometimes [client #3] chooses to sit down; this should not be documented as a fall, but as a 'sit down.' [Client #3] walks slowly. She had difficulty changing surfaces, and even this may resulting (sic) in falls. Getting too close to furniture, walls or other people can cause her to lose her balance and fall. In the past,</p>				

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	<p>[client #3] has fallen out of chairs onto the ground or missed a chair she appeared to be attempting to sit on and fall, but this does not appear to be of issue at this time. [Client #3's] falls are not seizure related.</p> <p>Due to a history of head trauma resulting from these falls, [client #3] wears a soft helmet when she is out of bed. [Client #3] can refrain from wearing her helmet during late night or early morning hours when she is transitioning from her bedroom to the bathroom with 1:1 (one on one) assistance. Her helmet may also be removed for lunch at SBC (Stone Belt Center) when staff is with in arms (sic) length of [client #3].</p> <p>Staff will be with in arms (sic) length of [client #3] when ambulating at [name of day program], and she will wear a gait belt during [name of day program]. This is due to the numerous falls she has had during [name of day program].</p> <p>Staff will assist [client #3] when she is walking outside, or inside if needed, by gently taking her arm or walking behind her and guiding her with their hands. [Client #3] will reach for staff's hand when she wants assistance. Attention should be paid when [client #3] is walking on uneven surfaces or transitions</p>						

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	<p>of different type of surfaces. Staff will apply [client #3's] helmet correctly and assure that she wears her helmet at all times when she is awake (this from BDDS - Bureau of Developmental Disabilities Services). The exception to this is at SBC lunch time, late at night, or early in the morning as stated above. Staff will assure that [client #3] is seated securely and correctly in her chair when sitting. When [client #3] goes to sit in a chair, staff will offer assistance if [client #3] indicates she wants help by reaching for staff's hand."</p> <p>Client #3's Individual Support Plan, dated 3/6/14, indicated, in part, "[Client #3] continues to fall on a regular basis due to an ataxic (loss of coordination of the muscles, especially of the extremities) form of cerebral palsy which causes her walk to be unsteady and her legs to be wide spread which affects her balance. Her mother wants her to stay out of the wheelchair as much as possible. [Client #3] is to use the wheel chair for transport over long distances, in crowded situations, during emergency evacuations and drills and for transport to and from the van. [Client #3] may also use the chair in the Stone Belt group home van to assist in transportation. [Client #3] has two separate wheelchairs, one 'transport' wheelchair that is used indoors for [client</p>			

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	<p>#3] to freely use at her discretion, if she does not want to walk somewhere (sic). [Client #3] used the transport chair both at home and at day program. The second chair is a regular wheelchair that has a footbox attached to the leg rests. The chair is to be used when [client #3] is being transported in the group home van, for safety reason...".</p> <p>Client #3's Support Team Review Forms were reviewed and indicated the following:</p> <p>-On 10/14/13, there were no changes recommended for client #3's fall risk plan at the time.</p> <p>-On 3/10/14, the form indicated, "Falls still being monitored, discussed changing 1:1 (one on one) at [day program] during annual. Had annual 3/6/14. Support team agrees to discontinue 1:1 holding on to gait belt while at [day program]. [Client #3] will have a staff w/in (within) arm's reach while at [day program]. [Client #3] will still wear gait belt at [day program]."</p> <p>-On 4/14/14, the form indicated, "Has been doing well since discontinuing the 'hands on' 1:1 at day program, 1 fall and a significant decrease in sit downs. Continue with 'arms length' at day program."</p> <p>-On 5/12/14, the form indicated, "Has had 1 fall, risk plan was being followed.</p>						

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	<p>No changes needed to plan. Staff within arms reach at day program is going well."</p> <p>-On 6/11/14, the form indicated, "Discussed newest physicians (sic) recommendation of only utilizing transport chair in the afternoons/after lunch. Behaviorist to talk to day program to ensure that they are not restricting her. Wheelchair should be kept in plain sight so that [client #3] has the choice of when she utilizes the chair and client rights are being followed and she has a choice to refuse."</p> <p>-On 7/14/14, the form indicated, "Increase in falls since Physician ordered that she only use transport chair after lunch, at day program. Staff will continue to prompt [client #3] to follow Physicians (sic) order of not using chair until after lunch. Staff will document any refusals to follow order of not using chair. Day Program staff felt (increase) in falls is due to change in Physicians (sic) order. Team does not recommend any changes to fall risk plan at this time. Day program to continue to monitor falls."</p> <p>-On 8/19/14, the form indicated, "Reviewed recent (increase) in falls. Team feels that the (increase) is due to lack of consistency w/ new day program staff, moved classroom with a different flooring surface; room is set up differently with different clients. Team</p>						

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	<p>will continue to monitor falls, no changes necessary at this time. Coord (Coordinator) to consult with day prog (program) Coord about falls."</p> <p>-On 9/8/14, the form indicated, "Falls are still increased at Day Program. Day Program reports that falls are due to changes in wheelchair routine per Physicians (sic) order (only using chair after lunch). [Client #3] has also changed classrooms at Day Program which has different flooring which may also be a factor in the (increase) in falls. [Client #3] will be in this room for the foreseeable (sic) future. The team is hoping this will lessen the falls since it is more consistent. No changes to fall risk plan at this time. Team will continue to monitor falls."</p> <p>On 9/17/14 at 11:22 AM, the Day Program Instructor indicated client #3 should not be falling at the day program if staff were implementing her plan as written. The instructor indicated the risk plan was appropriate. The instructor stated, "No reason she should fall if plan implemented."</p> <p>On 9/16/14 at 12:49 PM, the Coordinator indicated the majority of client #3's falls occurred at the facility-operated day program. The Coordinator indicated client #3 switched rooms due to the day program being short-staffed. The</p>			

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	Coordinator indicated while client #3 was at the day program, staff were to be within arm's reach of client #3. The Coordinator indicated client #3 wore a gait belt to the day program to assist her to prevent falls. The Coordinator client #3 was easily startled and at times, she just dropped to the ground. The Coordinator indicated client #3 was in a new environment with new peers in the area. The Coordinator indicated client #3 was being given her wheelchair to use all day at the day program. Client #3 was sitting in her chair and getting stiff from being in her wheelchair. Client #3 was falling more due to sitting all the time and getting stiff. The doctor was presented the information and ordered she not use her wheelchair until after lunch. The Coordinator stated there had "always been a struggle with falls at the day program." The day program was crowded and she startled easily. The Coordinator indicated there was a lot of staff turnover at the day program. The Coordinator indicated the quality of services dropped with short staffing. The Coordinator indicated the day program staff were not implementing the risk plan for falls as written. The Coordinator indicated when this was discussed with the day program management, the group home was told the day program was short staffed. The Coordinator stated client			

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	<p>#3's falls at the day program were "out of control."</p> <p>On 9/16/14 at 5:14 PM, the Nurse Manager (NM) indicated there had been no recent change in client #3's risk plan for falls. The NM indicated he did make a change to include the use of client #3's gait belt while at the day program. The NM indicated the plan was effective however the day program staff were not implementing the plan as written. The NM indicated some of the staff implement the plan as written but most did not implement the plan as written.</p> <p>On 9/16/14 at 11:17 AM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue</p>			

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	<p>about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law. Events Requiring Investigations. 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 client support; misuse of client or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct. This does not replace the obligation of employees to report immediately to supervisors, directors or to write incident reports. This provides for another level of notification beyond, and in addition to, incident reporting. The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days... Investigations must be started within 24 hours.</p>			

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W000153	<p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events." The Human Rights Policy, dated 9/14, indicated, in part, "Emotional/Verbal abuse: Consists of the intentional use of actions, words, or activities where an individual suffers emotional/psychological harm or trauma."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations</p>				

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	<p>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 3 of 65 incident/investigative reports reviewed affecting clients #5 and #6, the facility failed to ensure staff immediately reported an allegation of abuse to the administrator involving client #6 and the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) an incident of client to client abuse, within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 9/16/14 at 11:27 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>1) On 11/18/13 (no time indicated) while at the facility-operated day program, former staff #8 neglected to provide appropriate supervision to client #6. The investigation, dated 11/21/13, indicated the incident was substantiated (the findings support the event as described/allegation). The summary indicated, "The incident was verified by two different staff that indeed [client #6] was unsupervised in the restroom and likely ate toilet paper from the toilet. His</p>	W000153	<p>W153 483.420(d)(2)Staff Treatment of Clients</p> <p>1. Plan of correction: Stone Belt policy was followed immediately after the accusation of abuse was made on 11/18/2014. Stone Belt has a policy that prohibits mistreatment, neglect, or abuse of a client. This policy was broken by accused staff therefore suspended following accusation of abuse of client #6 and terminated after it was substantiated.</p> <p>Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on following client #6's BSP (Attachment B).</p> <p>Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p> <p>2) Plan of Correction: Staff have been training on staff immediately reporting allegations of abuse to administrator(s) and forwarding report the BDDS within</p>	10/17/2014

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	BSP (behavior support plan) includes information about food seeking and discusses eating inedible items under the food seeking section of the plan. The plan includes a need for increased supervision when [client #6] is agitated including attention to distance between staff and client and utilizing environmental reorganization for client safety. This is included in the general proactive strategies of the plan. It is indicated in the BSP that [client #6] will eat paper from the trashcan and food items that are unattended. There has been no historical information regarding him eating toilet paper out of the toilet at day program or otherwise. Trash cans had been adapted at day program to have lids that he could not lift and that he does not attempt to get into. [Staff #8] reports that he was trying to give [client #6] space in the restroom. He left him alone for 'one minute.' He indicates that [client #6] will get anxious with him while he is in the restroom with [client #6]. [Staff #8] thought it would be safe as the trashcans were covered as he had no historical behaviors of eating out of the toilet. He had had success giving him space in this way the day before as [client #6] came out of the restroom on his own with a smile. [Staff #9] indicates she did see a conversation regarding what type of supervision was needed for the restroom.		in 24 hours. (Attachment A). Plan of Preventing: LL coordinator have been trained on supporting day program staff. Along with training on ensuring that staff immediately report allegations to administrator(s) and / or emergency pager (Attachment A). Plan of Monitoring: Agency coordinator and director along with LL coordinator will conduct daily visits throughout the day to provide training and support to clients # 5 and #6. (Attachment C). 1. Plan of Correction: Client #5's BSP has been trained with facility staff (Attachment G). Plan of Prevention: Reporting of abuse and neglect is trained with SGL staff each month at Shiloh meeting (Attachment A). Quality Monitoring: Facility manager will conduct daily observations and facility coordinator will conduct weekly observations to ensure BSPs are followed and incidents are being reported timely (Attachment C).	

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	<p>Given that the behavior plan states that [client #6] is to have increased supervision during times of agitation, and that it is important to utilize environmental reorganization to ensure his safety, it is clear that this part of the BSP was not followed by [staff #8's] admission. Due to the report from [staff #10], as well as the day program coordinator [Day Program Coordinator #2's] report of other instances that [staff #8] has refused to follow recommendations of instructors and supervisors, this incident is substantiated. It is apparent per the interviews that [staff #8] had had clear guidance about this plan and refused to follow the plan and staff direction. Neglect is defined by Stone Belt policy as: Neglect: any action or behavioral interventions that risk 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. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated</p>			

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	<p>in the individualized support plan.</p> <p>[Staff #8] did fail to provide a safe, clean and sanitary environment for [client #6] due to the lack of appropriate supervision during the time of this incident. He did not follow recommendations of instructor staff, nor recommendations of the BSP. [Staff #8] was unaware of the BSP recommendations for supervision when asked."</p> <p>The investigation indicated, "Staff was suspended immediately and ultimately terminated on 11/25/13."</p> <p>The Incident/Investigation Committee Report, dated 12/10/13, indicated "No" to the following question: "Was the Report timely?"</p> <p>2) On 11/19/13 at 10:00 AM at the facility-operated day program, client #6 sat down on the floor. Staff (did not indicate the staff) noticed staff #8 seemed frustrated with client #6 and told client #6, "That is not a good place to sit." Client #6 began taking off his shoes. Staff #8 "grabbed [client #6's] right hand angrily" and yelled, "No!" and then threw client #6's shoe across the room into the coat closet. The plan to resolve section of the BDDS report indicated, "Taking proactive measures in order to ensure the</p>			

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	<p>safety and well being of [client #6], [staff #8] was suspended on 11/20/13. An investigation into this incident has been started on 11/20/13. The investigative report, dated 11/22/13, indicated, "Date/time incident report was filed: It is unclear what time the report was filed."</p> <p>The investigation's Immediate safety measure put into place following event/alleged event was blank. The Findings section of the investigation indicated, "Inconclusive (the information from sources examined is incomplete, and/or contradictory)." The summary indicated, "This investigation has two reports which match up on details of time, place and people present. They do not match up on the facts including details about whether the clients was grabbed by the arm and whether a shoe was thrown in anger across the room. The only witness to the event, [staff #9] indicates those two things did happen, and [staff #8] indicates that they did not happen. The only other witnesses were clients who are non-verbal or without the cognitive ability to replay reliable details of this nature after an event. This is one person's word against another person's word... There is no conclusive evidence that abuse happened in this incident."</p> <p>The Resulting Corrective Action section indicated, "Employee [staff #8] was immediately suspended and mandated to</p>			

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	<p>report to EAP (Employee Assistance Program). He was then terminated on 11/25/13."</p> <p>The 12/10/13 Quality Assurance Team Meeting notes, reviewed on 9/18/14 at 2:55 PM, indicated, in part, "[Name of Chief Executive Officer] reviewed 2 investigations in the [name of day program] in the Central Region. Both investigations involved the same staff and client 1 day apart from each other. The investigation on the 18 involved an allegation of neglect which was substantiated. The staff was not suspended until the next day as it was being reviewed by the Director if neglect had taken place. The staff was suspended as soon as it was determined that neglect may have taken place. The staff was working with a client and had been told to keep the client in line of sight. The staff allowed the client to wander away from line of sight. The staff was talked to by the classroom instructor and informed again to make sure the client was within the line of sight. The staff purposefully allowed the client to go to the bathroom by himself for 'privacy' and did not keep the client within line of sight. The client was found to have eaten toilet paper with feces on it. As it was being determined the staff was alleged to have forcibly taken the same client's shoe</p>			

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	<p>and thrown it across the room. This investigation was inconclusive. The staff was terminated from employment due to the initial investigation of neglect. The client's behavior plan was reviewed and revised to include a 'line of sight' necessity and retrained all staff working with client to be sure the client was within line of sight at all times. The report was not filed in a timely manner but all individuals involved were interviewed. Recommendations addressed causal individual and systemic factors and recommendations were implemented. The second report was timely and all individuals involved were interviewed."</p> <p>On 9/22/14 at 1:07 PM, the Director of Lifelong Learning (day program - DLL) indicated the incidents (11/18/13 and 11/19/13) occurred close together. The DLL indicated she recalled the first incident was not immediately reported. The DLL indicated the first incident was reported after the second incident on 11/19/13. The DLL indicated staff #8 did not report the incident of client #6 eating feces off of toilet paper. The DLL indicated administrative staff were not informed of the incident on 11/18/13 until after the incident on 11/19/13. The DLL indicated the 11/18/13 incident should have been reported immediately</p>						

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W000154	<p>so action could have been taken to increase client #6's supervision level.</p> <p>3) On 6/4/14 at 10:30 AM at the facility-operated day program, client #5 was walking into the classroom as a peer was walking out. Client #5 reached around staff and grabbed her peer's hair. Client #5 released her grip after approximately 7 seconds. There was no documentation the incident was reported to BDDS.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director indicated the incident should have been reported to BDDS.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 3 of 65 incident/investigative reports reviewed affecting clients #1, #2, #3 and #5, the facility failed to conduct thorough investigations of client to client abuse and client #3's incident in which she fell</p>	W000154	<p>W154 483.420(d)(3)Staff Treatment of Clients</p> <p>1. Plan of Correction: Investigation was completed and aggression is included in client's BSP. Client #5's BSP has</p>	10/17/2014

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	<p>out of her wheelchair.</p> <p>Findings include:</p> <p>On 9/16/14 at 11:27 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>1) On 6/4/14 at 10:30 AM at the facility-operated day program, client #5 was walking into the classroom as a peer was walking out. Client #5 reached around staff and grabbed her peer's hair. Client #5 released her grip after approximately 7 seconds. There was no documentation an investigation was completed.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director indicated an investigation should have been conducted.</p> <p>2) On 8/21/14 at 12:15 PM at the facility-operated day program, client #3 was rolling around in the wheelchair and listening to music. Staff put another client's chair outside while getting ready to bring the other client outside. The outside door was open. Client #3 backed up in her wheelchair quickly, fell down stairs in the doorway to the outside, rolled backwards, and flipped out of her wheelchair. Client #3 had scrapes on her hands, arms, chin and cheeks. The</p>		<p>been trained with facility staff (Attachment G).</p> <p>Plan of Prevention: Ensuring that LL coordinator has completed investigations of abuse and neglect has been trained with SGL coordinator (Attachment I).</p> <p>QualityMonitoring: Facility manager will conduct daily observations and facility coordinator will conduct weekly observations to ensure BSPs are followed and incidents are being reported and investigated timely (Attachment C).</p> <p>2. Plan of Correction: Investigation was completed and aggression is included in client's BSP. Client #3's BSP and Fall plan have been trained with facility staff (Attachment G).</p> <p>Plan of Prevention: Ensuring that LL coordinator has completed investigations of abuse and neglect has been trained with SGL coordinator (Attachment I).</p> <p>QualityMonitoring: Facility manager will conduct daily observations and facility coordinator will conduct weekly observations to ensure BSPs are followed and incidents are being reported and investigated timely (Attachment C).</p>				

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	<p>Bureau of Developmental Disabilities Services (BDDS) follow-up report, dated 8/25/14, indicated, in part, "[Client #3's] Day Program Coordinator completed an inquiry regarding this incident and talked with the staff that were involved. All staff will review [client #3's] risk plans and sign off on training. Staff will also be mindful of client location in proximity to outside doorways or other surface changes that can prove challenging for [client #3]. Doors to outside will remain closed unless a transition to outside or inside is occurring and door will be shut immediately afterward. Staff will continue to implement strategies outlined in [client #3's] plans to ensure her health and safety at all times." There was no documentation an inquiry was conducted into the incident.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director indicated the incident should have been investigated.</p> <p>On 9/16/14 at 12:58 PM, the Coordinator indicated she requested the day program coordinator to conduct a review of the incident. The Coordinator indicated the incident should have been investigated.</p> <p>3) On 9/3/14 at 2:15 PM at the facility-operated day program, client #2 was upset while walking in his walker.</p>			

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W000155	<p>Client #1 was walking in her walker. Clients #1 and #2 met while walking and smiled. The report indicated, "After a while [client #2] became unhappy again but he didn't scream or walk away. [Client #2] reached over and started grabbing at [client #1's] arm. He made pinching motions with his hand and began to pinch her. Staff stopped his hand and moved [client #1] away. [Client #1] looked unhappy and staff checked her for marks or bruises on arm. There were no injuries or treatment needed." There was no documentation the facility conducted an investigation.</p> <p>On 9/16/14 at 12:58 PM, the Coordinator indicated an inquiry should have been completed.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director indicated an investigation should have been completed.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 2 of 65 incident/investigative reports reviewed affecting client #6, the</p>	W000155	<p>W155 483.420(d)(3)Staff Treatment of Clients</p>	10/17/2014

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	<p>facility-operated day program failed to prevent further abuse while an investigation was in progress.</p> <p>Findings include:</p> <p>On 9/16/14 at 11:27 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>1) On 11/18/13 (no time indicated) while at the facility-operated day program, former staff #8 neglected to provide appropriate supervision to client #6. The investigation, dated 11/21/13, indicated the incident was substantiated (the findings support the event as described/allegation). The summary indicated, "The incident was verified by two different staff that indeed [client #6] was unsupervised in the restroom and likely ate toilet paper from the toilet. His BSP (behavior support plan) includes information about food seeking and discusses eating inedible items under the food seeking section of the plan. The plan includes a need for increased supervision when [client #6] is agitated including attention to distance between staff and client and utilizing environmental reorganization for client safety. This is included in the general proactive strategies of the plan. It is indicated in the BSP that [client #6] will</p>		<p>1. Plan of correction: Stone Belt policy was followed immediately after the accusation of abuse was made on 11/18/2014. Stone Belt has a policy that prohibits mistreatment, neglect, or abuse of a client. This policy was broken by accused staff therefore suspended following accusation of abuse of client #6 and terminated after it was substantiated.</p> <p>Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on following client #6's BSP (Attachment B). Coordinator was trained to follow up to make certain that staff are immediately suspended following allegation of abuse and neglect.</p> <p>Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p> <p>2. Plan of correction: Stone Belt policy was followed immediately after the accusation of abuse was made on 11/18/2014. Stone Belt has a policy that prohibits mistreatment, neglect, or abuse of a client. This policy was broken by accused staff therefore suspended following accusation of abuse of client #6 and</p>				

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	<p>eat paper from the trashcan and food items that are unattended. There has been no historical information regarding him eating toilet paper out of the toilet at day program or otherwise. Trash cans had been adapted at day program to have lids that he could not lift and that he does not attempt to get into. [Staff #8] reports that he was trying to give [client #6] space in the restroom. He left him alone for 'one minute.' He indicates that [client #6] will get anxious with him while he is in the restroom with [client #6]. [Staff #8] thought it would be safe as the trashcans were covered as he had no historical behaviors of eating out of the toilet. He had had success giving him space in this way the day before as [client #6] came out of the restroom on his own with a smile. [Staff #9] indicates she did see a conversation regarding what type of supervision was needed for the restroom.</p> <p>Given that the behavior plan states that [client #6] is to have increased supervision during times of agitation, and that it is important to utilize environmental reorganization to ensure his safety, it is clear that this part of the BSP was not followed by [staff #8's] admission. Due to the report from [staff #10], as well as the day program coordinator [Day Program Coordinator #2's] report of other instances that [staff</p>		<p>terminated after it was substantiated. Staff #8 was not suspended immediately following the accusation due to the director not making the decision in a timely manner. The program coordinators have been trained to make this decision in their absence.</p> <p>Plan of Prevention: Facility day program staff and Stone Belt SGL staff will be trained on prevention of mistreatment, neglect, and abuse each month at Shiloh and LL meetings (Attachment A). LL staff have been trained on following client #6's BSP (Attachment B). Coordinator was trained to follow up to make certain that staff are immediately suspended following allegation of abuse and neglect.</p> <p>Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p>		

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	<p>#8] has refused to follow recommendations of instructors and supervisors, this incident is substantiated. It is apparent per the interviews that [staff #8] had had clear guidance about this plan and refused to follow the plan and staff direction. Neglect is defined by Stone Belt policy as: Neglect: any action or behavioral interventions that risk 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. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan.</p> <p>[Staff #8] did fail to provide a safe, clean and sanitary environment for [client #6] due to the lack of appropriate supervision during the time of this incident. He did not follow recommendations of instructor staff, nor recommendations of the BSP. [Staff #8] was unaware of the BSP recommendations for supervision when asked."</p>			

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	<p>The investigation indicated, "Staff was suspended immediately and ultimately terminated on 11/25/13."</p> <p>The Incident/Investigation Committee Report, dated 12/10/13, indicated "No" to the following question: "Was the Report timely? Filed on 11/20/13."</p> <p>2) On 11/19/13 at 10:00 AM at the facility-operated day program, client #6 sat down on the floor. Staff (did not indicate the staff) noticed staff #8 seemed frustrated with client #6 and told client #6, "That is not a good place to sit." Client #6 began taking off his shoes. Staff #8 grabbed client #6's right hand angrily and yelled, "No!" and then threw client #6's shoe across the room into the coat closet. The plan to resolve section of the BDDS report indicated, "Taking proactive measures in order to ensure the safety and well being of [client #6], [staff #8] was suspended on 11/20/13. An investigation into this incident has been started on 11/20/13. The investigative report, dated 11/22/13, indicated, "Date/time incident report was filed: It is unclear what time the report was filed." The investigation's Immediate safety measure put into place following event/alleged event was blank. The Findings section of the investigation indicated, "Inconclusive (the information</p>			

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	<p>from sources examined is incomplete, and/or contradictory)." The summary indicated, "This investigation has two reports which match up on details of time, place and people present. They do not match up on the facts including details about whether the clients was grabbed by the arm and whether a shoe was thrown in anger across the room. The only witness to the event, [staff #9] indicates those two things did happen, and [staff #8] indicates that they did not happen. The only other witnesses were clients who are non-verbal or without the cognitive ability to replay reliable details of this nature after an event. This is one person's word against another person's word... There is no conclusive evidence that abuse happened in this incident." The Resulting Corrective Action section indicated, "Employee [staff #8] was immediately suspended and mandated to report to EAP (Employee Assistance Program). He was then terminated on 11/25/13."</p> <p>The 12/10/13 Quality Assurance Team Meeting notes, reviewed on 9/18/14 at 2:55 PM, indicated, in part, "[Name of Chief Executive Officer] reviewed 2 investigations in the [name of day program] in the Central Region. Both investigations involved the same staff and client 1 day apart from each other.</p>						

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	The investigation on the 18 involved an allegation of neglect which was substantiated. The staff was not suspended until the next day as it was being reviewed by the Director if neglect had taken place. The staff was suspended as soon as it was determined that neglect may have taken place. The staff was working with a client and had been told to keep the client in line of sight. The staff allowed the client to wander away from line of sight. The staff was talked to by the classroom instructor and informed again to make sure the client was within the line of sight. The staff purposefully allowed the client to go to the bathroom by himself for 'privacy' and did not keep the client within line of sight. The client was found to have eaten toilet paper with feces on it. As it was being determined the staff was alleged to have forcibly taken the same client's shoe and thrown it across the room. This investigation was inconclusive. The staff was terminated from employment due to the initial investigation of neglect. The client's behavior plan was reviewed and revised to include a 'line of sight' necessity and retrained all staff working with client to be sure the client was within line of sight at all times. The report was not filed in a timely manner but all individuals involved were interviewed. Recommendations			

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	<p>addressed causal individual and systemic factors and recommendations were implemented. The second report was timely and all individuals involved were interviewed."</p> <p>The Employee Warning documentation for staff #8, dated 11/25/13, indicated, in part, "Employee was suspended on 11/20/13 due to (sic) allegation of neglect. An investigation was completed and the allegation was substantiated. Based on the substantiated allegation of neglect, employee is terminated as of 11/25/13."</p> <p>On 9/22/14 at 1:07 PM, the Director of Lifelong Learning (day program - DLL) indicated the incidents occurred close together. The DLL indicated she recalled the first incident was not immediately reported. The DLL indicated the first incident was reported after the second incident on 11/19/13. The DLL indicated staff #8 did not report the incident of client #6 eating feces off of toilet paper. The DLL indicated administrative staff were not informed of the incident on 11/18/13 until after the incident on 11/19/13. The DLL indicated the 11/18/13 incident should have been reported immediately so action could have been taken to increase client #6's supervision level. The DLL indicated the</p>				

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W000189	<p>policy and procedure for preventing abuse/neglect during an investigation was to suspend staff.</p> <p>9-3-2(a)</p> <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. Based on observation, interview and record review for 1 of 3 clients in the sample (#3), the facility failed to provide each day program employee with continuing training to enable the employees to perform his or her duties effectively, efficiently and competently in regard to keeping the day program door to the outside closed.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated day program on 9/17/14 from 10:35 AM to 11:51 AM. The door to the outside remained open throughout the observation.</p> <p>On 9/16/14 at 11:27 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p>	W000189	<p>W189 483.430(e)(1)Staff Training Program</p> <p>1. Plan of Correction: LL staff have been trained on client #3 BSP and fall plan. Plan of Prevention: LL Coordinator has been trained on providing support and staff training to staff on a continuous basis. Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p> <p>2. Plan of Correction: LL staff have been trained on client #3 BSP and fall plan. Plan of Prevention: LL Coordinator has been trained on providing support and staff training to staff on a continuous basis.</p>	10/17/2014

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	<p>1) On 6/16/14 at 2:15 PM at the facility-operated day program, client #3 was rolling in her wheelchair. Client #3 rolled out the door to the outside and her wheelchair tipped over the sidewalk edge. Client #3 came out of the wheelchair and was lying on the ground. Client #3 received a scrape on her right knee. The incident report, dated 6/16/14, indicated, "Possible scrapes on arm." The Review and Corrective Action for fall incident regarding client #3 on June 16, 2014 indicated, "[Client #3] is in group service during her day program, per the support team, and the classroom had 3 staff for 6 clients at the time of her fall. All 3 staff were engaged in supporting other clients at the time [client #3] went to the ramp to go into the court yard. [Client #3's] doctor and support team have agreed she can have use of the wheelchair in the afternoon to give her the movement she desires. Her mother does not want [client #3] to be belted in the wheelchair. She often goes down the short ramp to the courtyard independently, but the soil next to the ramp has eroded over the winter and [client #3] got one wheel off the ramp causing the accident. The following corrective action is in response to this incident. 1. Train Room 16 staff - keep the door closed to the courtyard from</p>		<p>Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect. They will also ensure door is closed unless client and staff are outside (Attachment C).</p>				

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	<p>Room 16, unless being used to get clients in/out, until the changes are made to the ramp to ensure safety. [Chief Operating Officer] has requested that the maintenance staff make the physical changes to the ramp. [Day Program Coordinator] will train staff and document by 6/20/14. 2. Support Team will review the number and type of falls and make any needed recommendations at the the next support team meeting on July 14th. [Day Program Coordinator] will bring the fall tracking from the last 6 months to assess trends."</p> <p>2) On 8/21/14 at 12:15 PM at the facility-operated day program, client #3 was rolling around in the wheelchair and listening to music. Staff put another client's chair outside while getting ready to bring the other client outside. The outside door was open. Client #3 backed up in her wheelchair quickly, fell down stairs in the doorway to the outside, rolled backwards, and flipped out of her wheelchair. Client #3 had scrapes on her hands, arms, chin and cheeks. The Bureau of Developmental Disabilities Services (BDDS) follow-up report, dated 8/25/14, indicated, in part, "All staff will review [client #3's] risk plans and sign off on training. Staff will also be mindful of client location in proximity to outside doorways or other surface changes that</p>			

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	<p>can prove challenging for [client #3]. Doors to outside will remain closed unless a transition to outside or inside is occurring and door will be shut immediately afterward. Staff will continue to implement strategies outlined in [client #3's] plans to ensure her health and safety at all times."</p> <p>On 9/17/14 at 2:45 PM, a Staff Training Form, dated 7/8/14, indicated the day program staff were informed to keep the door closed closed unless client and staff going out. A Staff Training Form, dated 9/15/14, indicated, "keep outside door closed due to her leaving & falling out the door."</p> <p>On 9/17/14 at 2:45 PM, Day Program Coordinator #2 indicated the door to the outside should not have been open unless a client or staff was going in or out of the door. Coordinator #2 indicated the staff received training to keep the door closed due to the two incidents involving client #3 falling while going out the doors.</p> <p>On 9/17/14 at 2:45 PM, the Coordinator indicated the door to the outside should have been closed during the observation. The Coordinator indicated the door should have been closed due to the two incidents of client #3 falling out of her wheelchair.</p>			

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W000240	<p>9-3-3(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility failed to have written instructions to staff to: 1) keep the day program door closed to the outside following two incidents in which client #3 fell out of her wheelchair and 2) specify the positioning of the staff in order to assist client #3 to ensure she did not fall.</p> <p>Findings include:</p> <p>1) An observation was conducted at the facility-operated day program on 9/17/14 from 10:35 AM to 11:51 AM. The door to the outside remained open throughout the observation.</p> <p>On 9/16/14 at 11:27 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>a) On 6/16/14 at 2:15 PM at the facility-operated day program, client #3</p>	W000240	<p>W240 483.440(c)(6)Individual Program Plan</p> <p>1. Plan of Correction: LL staff have been trained on client #3 BSP and fall plan. Plan of Prevention: LL Coordinator has been trained on providing support and staff training to staff on a continuous basis. Client #3 has a new behavior consultant who has been consulted concerning the frequent "falls" and "startling" behaviors at LL day program (Attachment J). Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p>	10/17/2014

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	<p>was rolling in her wheelchair. Client #3 rolled out the door to the outside and her wheelchair tipped over the sidewalk edge. Client #3 came out of the wheelchair and was lying on the ground. Client #3 received a scrape on her right knee. The incident report, dated 6/16/14, indicated, "Possible scrapes on arm." The Review and Corrective Action for fall incident regarding client #3 on June 16, 2014 indicated, "[Client #3] is in group service during her day program, per the support team, and the classroom had 3 staff for 6 clients at the time of her fall. All 3 staff were engaged in supporting other clients at the time [client #3] went to the ramp to go into the courtyard. [Client #3's] doctor and support team have agreed she can have use of the wheelchair in the afternoon to give her the movement she desires. Her mother does not want [client #3] to be belted in the wheelchair. She often goes down the short ramp to the courtyard independently, but the soil next to the ramp has eroded over the winter and [client #3] got one wheel off the ramp causing the accident. The following corrective action is in response to this incident. 1. Train Room 16 staff - keep the door closed to the courtyard from Room 16, unless being used to get clients in/out, until the changes are made to the ramp to ensure safety. [Chief Operating</p>			

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	<p>Officer] has requested that the maintenance staff make the physical changes to the ramp. [Day Program Coordinator] will train staff and document by 6/20/14. 2. Support Team will review the number and type of falls and make any needed recommendations at the the next support team meeting on July 14th. [Day Program Coordinator] will bring the fall tracking from the last 6 months to assess trends."</p> <p>b) On 8/21/14 at 12:15 PM at the facility-operated day program, client #3 was rolling around in the wheelchair and listening to music. Staff put another client's chair outside while getting ready to bring the other client outside. The outside door was open. Client #3 backed up in her wheelchair quickly, fell down stairs in the doorway to the outside, rolled backwards, and flipped out of her wheelchair. Client #3 had scrapes on her hands, arms, chin and cheeks. The Bureau of Developmental Disabilities Services (BDDS) follow-up report, dated 8/25/14, indicated, in part, "All staff will review [client #3's] risk plans and sign off on training. Staff will also be mindful of client location in proximity to outside doorways or other surface changes that can prove challenging for [client #3]. Doors to outside will remain closed unless a transition to outside or inside is</p>			

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	<p>occurring and door will be shut immediately afterward. Staff will continue to implement strategies outlined in [client #3's] plans to ensure her health and safety at all times."</p> <p>A review of client #3's record was conducted on 9/18/14 at 11:14 AM. There were no written instructions to staff in client #3's risk plan for falls to keep the outside doors closed following the incidents on 6/16/14 and 8/21/14. Client #3's record did not contain written instructions to staff to keep the outside doors closed at the day program.</p> <p>On 9/17/14 at 2:45 PM, a Staff Training Form, dated 7/8/14, indicated the day program staff were informed to keep the door closed unless client and staff going out. A Staff Training Form, dated 9/15/14, indicated, "keep outside door closed due to her leaving & falling out the door."</p> <p>On 9/17/14 at 2:45 PM, Day Program Coordinator #2 indicated there were no written instructions to staff to keep the door to the outside closed while client #3 was at the day program.</p> <p>On 9/17/14 at 2:45 PM, the Coordinator indicated there were no written instructions to staff to keep the door to</p>			

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	<p>the outside closed while client #3 was at the day program.</p> <p>On 9/19/14 at 1:47 PM, the Nurse Manager (NM) indicated client #3 did not have written instructions to staff to keep the day program doors closed. The NM indicated he was not informed of the day program's corrective action plan to keep the doors closed therefore the corrective action was not included in client #3's risk plan for falls. The NM indicated he should have been informed of the day program's plan of correction to address the falls on 6/16/14 and 8/21/14 since he was responsible for updating and revising client #3's risk plan for falls.</p> <p>2) On 9/16/14 at 11:27 AM, the facility's incident/investigative reports were reviewed and indicated client #3 fell 23 times since March 2014 while at the facility-operated day program.</p> <p>A review of client #3's record was conducted on 9/18/14 at 11:14 AM. Client #3's risk plan for falls, included in the Medication Information Sheet, dated 9/9/14, indicated, in part, "[Client #3] is at risk for falls due to her history and her diagnosis. [Client #3] is easily startled and may fall in reaction to a loud noise or sudden movement. These falls are quick. She appears to simply drop to the floor or</p>			

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	<p>onto an immediately close by surface - furniture, staff, and roommates. Some of [client #3's] falls occur without any evident cause. Some of [client #3's] falls are due to bumping into something or being bumped into by someone else. These falls can be quick or slow resulting in her landing on her side, back, or seated depending on the contact that initiated the fall. Sometimes [client #3] chooses to sit down; this should not be documented as a fall, but as a 'sit down.' [Client #3] walks slowly. She had difficulty changing surfaces, and even this may resulting (sic) in falls. Getting too close to furniture, walls or other people can cause her to lose her balance and fall. In the past, [client #3] has fallen out of chairs onto the ground or missed a chair she appeared to be attempting to sit on and fall, but this does not appear to be of issue at this time. [Client #3's] falls are not seizure related.</p> <p>Due to a history of head trauma resulting from these falls, [client #3] wears a soft helmet when she is out of bed. [Client #3] can refrain from wearing her helmet during late night or early morning hours when she is transitioning from her bedroom to the bathroom with 1:1 (one on one) assistance. Her helmet may also be removed for lunch at SBC (Stone Belt Center) when staff is with in arms (sic)</p>				

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	<p>length of [client #3].</p> <p>Staff will be with in arms (sic) length of [client #3] when ambulating at [name of day program], and she will wear a gait belt during [name of day program]. This is due to the numerous falls she has had during [name of day program].</p> <p>Staff will assist [client #3] when she is walking outside, or inside if needed, by gently taking her arm or walking behind her and guiding her with their hands. [Client #3] will reach for staff's hand when she wants assistance. Attention should be paid when [client #3] is walking on uneven surfaces or transitions of different type of surfaces. Staff will apply [client #3's] helmet correctly and assure that she wears her helmet at all times when she is awake (this from BDDS - Bureau of Developmental Disabilities Services). The exception to this is at SBC lunch time, late at night, or early in the morning as stated above. Staff will assure that [client #3] is seated securely and correctly in her chair when sitting. When [client #3] goes to sit in a chair, staff will offer assistance if [client #3] indicates she wants help by reaching for staff's hand.</p> <p>The risk plan did not indicate how staff were to position themselves in order to be</p>				

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W000249	<p>able to assist client #3 in case of a fall. The plan did not indicate if staff were to be on her left or right side. The plan did not indicate which hand should be offered to client #3. The plan did not indicate the staff should have a hand close to her gait belt in order to assist her when needed. The plan indicated the staff needed to be within arm's length of client #3 but did not specify the staff need to keep her in their sight at all times to observe her in case she started to fall.</p> <p>On 9/19/14 at 2:33 PM, the Nurse Manager (NM) indicated the risk plan could have additional instructions to staff to specify the way the staff were to assist her. The NM indicated he thought the day program staff were not implementing the plan as written but indicated the plan could be more specific.</p> <p>On 9/22/14 at 1:07 PM, the Director of Lifelong Learning (day program - DLL) indicated client #3's risk plan for falls needed to be revised to indicate the staff's positioning while assisting client #3.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p>				

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	<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 3 of 3 clients in the sample (#2, #3 and #5), the facility failed to ensure staff implemented the clients' program plans as written as evidenced by: a) client #3's risk plan for falls was not implemented as written, and b) client #2, #3 and #5's medication administration training objectives were not implemented as written.</p> <p>Findings include:</p> <p>a) On 9/16/14 at 11:27 AM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>-On 4/2/14 at 8:20 AM at the facility-operated day program, client #3 was walking near a table with other clients. A staff stood up with client #3 near him and bumped into client #3. Client #3 fell backward and hit her head (she was wearing a helmet) on a chair. Client #3 was not injured.</p> <p>-On 4/8/14 at 10:00 AM at the</p>	W000249	<p>W249 483.440(d)(1)Program Implementation</p> <p>1. Plan of Correction: LL staff have been trained on client #3 BSP and fall plan. Plan of Prevention: LL Coordinator has been trained on providing support and staff training to staff on a continuous basis. Client #3 has a new behavior consultant who has been consulted concerning the frequent "falls" and "startling" behaviors at LL day program (Attachment J). Quality Monitoring: Facility coordinator / day program coordinator will provide daily monitoring to ensure staff are following client's BSP and preventing potential abuse and neglect (Attachment C).</p> <p>2. Plan of Correction: Facility staff have been trained on medication procedures and completing goals / IPPs with clients (Attachment K). Quality Monitoring: House manager will review goals/IPP daily to monitor that staff are completing them as written.</p>	10/17/2014

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	<p>facility-operated day program, client #3 began to fall. Staff caught her as she was hitting the ground. Client #3 was not injured.</p> <p>-On 5/7/14 at 3:04 PM at the facility-operated day program, client #3 stood up, took three steps and fell on her right hip as she was trying to turn. The Incident Report, dated 5/7/14, indicated, "No clients were around. Did not stub toe. No visible reason for fall. Staff was in arm reach (sic)." Client #3 was not injured.</p> <p>-On 5/27/14 at 8:15 AM at the facility-operated day program, client #3 was walking around the table after exiting her wheelchair. Client #3 lost her balance and fell backward. Staff put arms out but was unable to slow her fall. Client #3 landed on her buttocks and rolled onto her back. Client #3 was not injured.</p> <p>-On 5/31/14 at 2:15 PM, client #3 exited the front door in her wheelchair and waited in the driveway for her mother to arrive. No staff members witnessed her exiting the group home. Client #3's mother arrived and assisted client #3 into the group home. Client #3 was outside for no more than 5 minutes. Client #3 was not injured. The BDDS report, dated</p>						

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	<p>6/1/14, indicated, in part, "The parent of another client had been visiting, walking in and out of the house to transport various items from her car. When finished, this parent exited the house but failed to ensure the front door had latched when closed." The investigation's Conclusion, dated 6/1/14, indicated, "After talking with all staff members who were present in the home at the time that the incident occurred and talking with [client #5's guardian], who was also present in the home at the time of the incident, it is concluded that the front door was not shut and latched all the way and that is how [client #3] was able to get out of the front door and down the sidewalk without making enough noise for staff to hear her. [Client #3] is physically unable to open the door herself and does not have a history of attempting to elope. In all probability, [client #3] was headed out the front driveway to meet her mom, who she knew was coming. Staff had just put her shoes on in anticipation of this arrival, [client #3] had been informed that her mother was coming and there was another guest in the home at the time. At no time did [client #3] leave the property, nor was she near the road."</p> <p>-On 6/9/14 at 10:30 AM at the facility-operated day program, client #3</p>				

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	<p>was walking around the gym. Client #3 was near the restroom exit when a peer came out. Client #3 fell landing on her buttocks after being startled. Client #3 was not injured.</p> <p>-On 6/16/14 at 8:15 AM at the facility-operated day program, client #3 fell backward while waiting for staff to give her a radio. Client #3 was not injured.</p> <p>-On 6/16/14 at 2:15 PM at the facility-operated day program, client #3 was rolling in her wheelchair. Client #3 rolled out the door to the outside, her wheelchair tipped over the sidewalk edge. Client #3 came out of the wheelchair and was lying on the ground. Client #3 received a scrape on her right knee. The incident report, dated 6/16/14, indicated, "Possible scrapes on arm." The Review and Corrective Action for fall incident regarding client #3 on June 16, 2014 indicated, "[Client #3] is in group service during her day program, per the support team, and the classroom had 3 staff for 6 clients at the time of her fall. All 3 staff were engaged in supporting other clients at the time [client #3] went to the ramp to go into the court yard. [Client #3's] doctor and support team have agreed she can have use of the wheelchair in the afternoon to give her</p>			

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	<p>the movement she desires. Her mother does not want [client #3] to be belted in the wheelchair. She often goes down the short ramp to the courtyard independently, but the soil next to the ramp has eroded over the winter and [client #3] got one wheel off the ramp causing the accident. The following corrective action is in response to this incident. 1. Train Room 16 staff - keep the door closed to the courtyard from Room 16, unless being used to get clients in/out, until the changes are made to the ramp to ensure safety. [Chief Operating Officer] has requested that the maintenance staff make the physical changes to the ramp. [Day Program Coordinator] will train staff and document by 6/20/14. 2. Support Team will review the number and type of falls and make any needed recommendations at the the next support team meeting on July 14th. [Day Program Coordinator] will bring the fall tracking from the last 6 months to assess trends."</p> <p>-On 6/30/14 at 8:45 at the facility-operated day program, client #3 was walking to the restroom. Client #3 walked to the doorway, got startled and fell backward. The report indicated staff was within arm's length but was not able to catch her. Client #3 was not injured.</p>			

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	<p>-On 7/7/14 (no time) at the facility-operated day program, client #3 walked behind a peer who was sitting in a chair. The peer moved her chair backward and knocked client #3 down. Client #3 was not injured.</p> <p>-On 7/8/14 at 10:20 AM at the facility-operated day program, client #3 was walking while a peer played basketball in the gym. The ball bounced toward client #3 but did not hit her. Client #3 was startled and fell on her buttocks. Client #3 was not injured.</p> <p>-On 7/14/14 at 12:00 PM at the facility-operated day program, client #3 was walking to the restroom with staff. A peer bumped into the staff, the staff turned and client #3 fell onto her buttocks. Client #3 was not injured.</p> <p>-On 7/24/14 at 10:20 AM at the facility-operated day program, client #3 was listening to music and walking. Client #3 dropped to the ground and landed on her right side. The Incident Report, dated 7/24/14, indicated, in part, "[Client #3] dropped w/ (with) no known antecedent to fall." Client #3 was not injured.</p> <p>-On 8/11/14 at 9:15 AM at the facility-operated day program, client #3</p>			

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	<p>wanted her music changed and pulled down her pants while staff was changing her music. Client #3 fell backward. Staff was unable to slow down the fall or catch her. Client #3 landed on her buttocks and rolled onto her back. Client #3 hit her head, with helmet on, on another client's walker. Client #3 was not injured.</p> <p>-On 8/12/14 at 2:30 PM at the facility-operated day program, client #3 was in the restroom stall. Client #3 got startled when staff opened the stall door. Client #3 fell backward onto her buttocks and hit her head (with helmet on) on the toilet. Client #3 was not injured.</p> <p>-On 8/13/14 at 8:40 AM at the facility-operated day program, client #3 was in the restroom. The Incident Report indicated, in part, "Staff made sure [client #3] was stable and moved to put down clothes and wipes away from [client #3]. [Client #3] became unstable and fell back on butt and possibly hit her head (with helmet on) on either the toilet or the stall wall. Staff didn't see [client #3] fall, she heard it." Client #3 was not injured.</p> <p>-On 8/21/14 at 12:15 PM at the facility-operated day program, client #3 was rolling around in the wheelchair and listening to music. Staff put another client's chair outside while getting ready</p>			

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	<p>to bring the other client outside. The outside door was open. Client #3 backed up in her wheelchair quickly, fell down stairs in the doorway to the outside, rolled backwards, and flipped out of her wheelchair. Client #3 had scrapes on her hands, arms, chin and cheeks. The Bureau of Developmental Disabilities Services (BDDS) follow-up report, dated 8/25/14, indicated, in part, "[Client #3's] Day Program Coordinator completed an inquiry regarding this incident and talked with the staff that were involved. All staff will review [client #3's] risk plans and sign off on training. Staff will also be mindful of client location in proximity to outside doorways or other surface changes that can prove challenging for [client #3]. Doors to outside will remain closed unless a transition to outside or inside is occurring and door will be shut immediately afterward. Staff will continue to implement strategies outlined in [client #3's] plans to ensure her health and safety at all times." There was no documentation an investigation or inquiry was conducted into the incident.</p> <p>-On 9/2/14 at 11:20 AM at the facility-operated day program, client #3 was walking with her speaker on her ear. Client #3 stopped walking and fell onto the ground on her right side. Client #3 was not injured.</p>			

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	<p>A review of client #3's record was conducted on 9/18/14 at 11:14 AM. Client #3's risk plan for falls, included in the Medication Information Sheet, dated 9/9/14, indicated, in part, "[Client #3] is at risk for falls due to her history and her diagnosis. [Client #3] is easily startled and may fall in reaction to a loud noise or sudden movement. These falls are quick. She appears to simply drop to the floor or onto an immediately close by surface - furniture, staff, and roommates. Some of [client #3's] falls occur without any evident cause. Some of [client #3's] falls are due to bumping into something or being bumped into by someone else. These falls can be quick or slow resulting in her landing on her side, back, or seated depending on the contact that initiated the fall. Sometimes [client #3] chooses to sit down; this should not be documented as a fall, but as a 'sit down.' [Client #3] walks slowly. She had difficulty changing surfaces, and even this may resulting (sic) in falls. Getting too close to furniture, walls or other people can cause her to lose her balance and fall. In the past, [client #3] has fallen out of chairs onto the ground or missed a chair she appeared to be attempting to sit on and fall, but this does not appear to be of issue at this time. [Client #3's] falls are not seizure related.</p>			

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	<p>Due to a history of head trauma resulting from these falls, [client #3] wears a soft helmet when she is out of bed. [Client #3] can refrain from wearing her helmet during late night or early morning hours when she is transitioning from her bedroom to the bathroom with 1:1 (one on one) assistance. Her helmet may also be removed for lunch at SBC (Stone Belt Center) when staff is with in arms (sic) length of [client #3].</p> <p>Staff will be with in arms (sic) length of [client #3] when ambulating at [name of day program], and she will wear a gait belt during [name of day program]. This is due to the numerous falls she has had during [name of day program].</p> <p>Staff will assist [client #3] when she is walking outside, or inside if needed, by gently taking her arm or walking behind her and guiding her with their hands. [Client #3] will reach for staff's hand when she wants assistance. Attention should be paid when [client #3] is walking on uneven surfaces or transitions of different type of surfaces. Staff will apply [client #3's] helmet correctly and assure that she wears her helmet at all times when she is awake (this from BDDS - Bureau of Developmental Disabilities Services). The exception to</p>			

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	<p>this is at SBC lunch time, late at night, or early in the morning as stated above. Staff will assure that [client #3] is seated securely and correctly in her chair when sitting. When [client #3] goes to sit in a chair, staff will offer assistance if [client #3] indicates she wants help by reaching for staff's hand."</p> <p>Client #3's Support Team Review Forms were reviewed and indicated the following: -On 10/14/13, there were no changes recommended for client #3's fall risk plan at the time. -On 3/10/14, the form indicated, "Falls still being monitored, discussed changing 1:1 (one on one) at [day program] during annual. Had annual 3/6/14. Support team agrees to discontinue 1:1 holding on to gait belt while at [day program]. [Client #3] will have a staff w/in (within) arm's reach while at [day program]. [Client #3] will still wear gait belt at [day program]." -On 4/14/14, the form indicated, "Has been doing well since discontinuing the 'hands on' 1:1 at day program, 1 fall and a significant decrease in sit downs. Continue with 'arms length' at day program." -On 5/12/14, the form indicated, "Has had 1 fall, risk plan was being followed. No changes needed to plan. Staff within</p>						

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	<p>arms reach at day program is going well."</p> <p>-On 6/11/14, the form indicated, "Discussed newest physicians (sic) recommendation of only utilizing transport chair in the afternoons/after lunch. Behaviorist to talk to day program to ensure that they are not restricting her. Wheelchair should be kept in plain sight so that [client #3] has the choice of when she utilizes the chair and client rights are being followed and she has a choice to refuse."</p> <p>-On 7/14/14, the form indicated, "Increase in falls since Physician ordered that she only use transport chair after lunch, at day program. Staff will continue to prompt [client #3] to follow Physicians (sic) order of not using chair until after lunch. Staff will document any refusals to follow order of not using chair. Day Program staff fell (increase) in falls is due to change in Physicians (sic) order. Team does not recommend any changes to fall risk plan at this time. Day program to continue to monitor falls."</p> <p>-On 8/19/14, the form indicated, "Reviewed recent (increase) in falls. Team feels that the (increase) is due to lack of consistency w/ new day program staff, moved classroom with a different flooring surface; room is set up differently with different clients. Team will continue to monitor falls, no changes</p>			

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	<p>necessary at this time. Coord (Coordinator) to consult with day prog (program) Coord about falls." -On 9/8/14, the form indicated, "Falls are still increased at Day Program. Day Program reports that falls are due to changes in wheelchair routine per Physicians (sic) order (only using chair after lunch). [Client #3] has also changed classrooms at Day Program which has different flooring which may also be a factor in the (increase) in falls. [Client #3] will be in this room for the foreseeable (sic) future. The team is hoping this will lesson the falls since it is more consistent. No changes to fall risk plan at this time. Team will continue to monitor falls."</p> <p>On 9/17/14 at 11:22 AM, the Day Program Instructor indicated client #3 should not be falling at the day program if staff were implementing her plan as written. The instructor indicated risk plan was appropriate. The instructor stated, "No reason she should fall if plan implemented."</p> <p>On 9/16/14 at 12:49 PM, the Coordinator indicated the majority of client #3's falls occurred at the facility-operated day program. The Coordinator indicated client #3 switched rooms due to the day program being short-staffed. The</p>						

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	Coordinator indicated while client #3 was at the day program, staff were to be within arm's reach of client #3. The Coordinator indicated client #3 wore a gait belt to the day program to assist her to prevent falls. The Coordinator client #3 was easily startled and at times, she just dropped to the ground. The Coordinator indicated client #3 was in a new environment with new peers in the area. The Coordinator indicated client #3 was being given her wheelchair to use all day at the day program. Client #3 was sitting in her chair and getting stiff from being in her wheelchair. Client #3 was falling more due to sitting all the time and getting stiff. The doctor was presented the information and ordered she not use her wheelchair until after lunch. The Coordinator stated there had "always been a struggle with falls at the day program." The day program was crowded and she startled easily. The Coordinator indicated there was a lot of staff turnover at the day program. The Coordinator indicated the quality of services dropped with short staffing. The Coordinator indicated the day program staff were not implementing the risk plan for falls as written. The Coordinator indicated when this was discussed with the day program management, the group home was told the day program was short staffed. The Coordinator stated client			

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	<p>#3's fall at the day program were "out of control."</p> <p>On 9/16/14 at 5:14 PM, the Nurse Manager (NM) indicated there had been no recent change in client #3's risk plan for falls. The NM indicated he did make a change to include the use of client #3's gait belt while at the day program. The NM indicated the plan was effective however the day program staff were not implementing the plan as written. The NM indicated some of the staff implement the plan as written but most did not implement the plan as written.</p> <p>b) An observation was conducted at the group home on 9/17/14 from 5:47 AM to 7:53 AM. Staff #4 did not implement the clients' medication training objectives.</p> <p>-On 9/17/14 at 6:07 AM, client #2 received his medications from staff #4. Staff #4 did not prompt client #2 to assist with preparing his medications. Staff #4 did not hold client #2's medication cup in front of him and encourage him to grab the spoon and feed himself his medications. Staff did not inform client #2 the names of the medications and the purpose of the medications.</p> <p>A review of client #2's record was conducted on 9/18/14 at 1:07 PM. Client</p>						

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	<p>#2's Individual Support Plan (ISP), dated 9/3/14, indicated he had a medication training objective. The objective indicated, in part, "During medication administration staff will assist [client #2] in preparing his meds in applesauce, yogurt or pudding. Hold the cup of meds in front of [client #2] and encourage him to grab the spoon and feed himself his medications. Staff can assist [client #2] in scooping the meds out of the cup as needed. As always, during every med pass, staff must recite the medication and its purpose. Staff should track if [client #2] makes eye contact during the recitation of the medication and its purpose."</p> <p>An interview with staff #4 was conducted on 9/17/14 at 6:43 AM. Staff #4 indicated she did not know client #2's medication administration training objective.</p> <p>-On 9/17/14 at 6:23 AM, client #5 received her medications from staff #4. Staff #4 did not show the sign for medication (medication cup and verbal prompt). Staff #4 did not prompt client #5 to throw away her medication cup after the medication pass. Staff #4 did not inform client #5 of the medications she was taking, what they were for and a possible side effect of the medications.</p>			

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	<p>A review of client #5's record was conducted on 9/18/14 at 12:31 PM. Client #5's ISP, dated 2/24/14, indicated she had a medication training objective. The objective indicated, in part, "Show the sign for medication (med cup & verbal prompt) and cue her to the med administration area. Give [client #5] her meds mixed in applesauce or yogurt. [Client #5] will throw away her med cup when finished. Staff may need to use hand-over-hand assistance. Staff should inform [client #5] of what medications she is taking, what they are for and a possible side effect of the medication."</p> <p>An interview with staff #4 was conducted on 9/17/14 at 6:43 AM. Staff #4 indicated she did not know client #5's medication administration training objective.</p> <p>-On 9/17/14 at 6:35 AM, client #3 received her medications from staff #4. Staff #4 did not show the sign for medication (medication cup and verbal prompt). Staff #4 did not prompt client #3 to throw away her medication cup after the medication pass.</p> <p>A review of client #3's record was conducted on 9/18/14 at 11:14 AM. Client #3's ISP, dated 3/6/14, indicated</p>			

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W000312	<p>she had a medication training objective. The objective indicated, in part, "Show the sign for medication (med cup & verbal prompt) and cue her to the med administration area. Give [client #3] her meds mixed in applesauce or yogurt. [Client #3] will throw away her med cup when finished. Staff may need to use hand-over-hand assistance to complete this goal."</p> <p>An interview with staff #4 was conducted on 9/17/14 at 6:42 AM. Staff #4 indicated she did not know client #3's medication administration training objective.</p> <p>On 9/17/14 at 2:35 PM, the Coordinator indicated the clients' medication training objectives should be implemented at all medication administration times. The Coordinator indicated the staff should know what the clients' medication training objectives were since the staff was trained on their objectives.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan</p>						

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	<p>that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5's medication reduction plan was attainable.</p> <p>Findings include:</p> <p>On 9/18/14 at 12:31 PM, a review of client #5's record was conducted. Client #5's 2/24/14 Behavioral Intervention Plan indicated she took Clonazepam to address anxiety. The Medication Reduction Plan indicated, "Clonazepam is being used as a part of [client #5's] medication regimen for the treatment of anxiety, as expressed as aggression and SIB (self-injurious behavior). When there are zero incidents of aggression and SIB for two consecutive quarters, a possible decrease in Clonazepam will be reassessed."</p> <p>On 9/18/14 at 2:27 PM, the Coordinator indicated client #5's guardian did not want client #5's medications changed. The Coordinator indicated the plan was attainable. The Coordinator indicated client #5 had met the aggression piece a couple of times for a quarter. The Coordinator indicated she did not write the plan.</p>	W000312	<p>W312 483.450(e)(2)Drug Usage</p> <p>Plan ofCorrection: Client #5 reduction plan has been revised to be attainable per thepsychiatric (Attachment L). Plan ofPrevention: Behavior consultant is new and will ensure that reduction plans arecorrectly introduced and implemented. Plan ofMonitoring: Facility coordinator/ QDIP-Dhas been trained on reviewing BSPs to ensure that they contain a reduction plan(Attachment I).</p>	10/17/2014			

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W000436	<p>On 9/22/14 at 10:58 AM, the Manager of Clinical Services (MCS) indicated she thought the plan was attainable for client #5 based on looking at the data. The MCS indicated client #5's medication reduction plan indicated she needed to have 6 months of zero incidents of physical aggression and self-injurious behavior. The MCS indicated, based on reviewing the data, this was attainable for client #5. The MCS indicated client #5 had a recent medication reduction which did not go well and the medication had to be increased (after the decrease) due to increased behaviors.</p> <p>9-3-5(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview and record review for 1 of 2 non-sampled clients with adaptive equipment (#4), the facility failed to ensure the client's hearing aids were furnished, maintained in good repair, and taught client #4 to use</p>	W000436	<p>W436 483.470(e)(2)Space and Equipment</p> <p>Plan ofCorrection: Client #4 hearing aide were located and added to her MAR.</p>	10/17/2014

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	<p>and make informed choices about using her hearing aids.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/16/14 from 4:06 PM to 5:54 PM and 9/17/14 from 5:47 AM to 7:53 AM. During the observations, client #4 was not observed to wear her bilateral hearing aids. During the observations, client #4 was not offered her bilateral hearing aids. During the observations, when staff spoke to client #4, staff raised their voices to ensure client #4 heard what the staff were saying to her.</p> <p>On 9/17/14 at 7:31 AM, staff #4 indicated client #4 was not wearing her hearing aids due to one of them was missing. Staff #4 was asked to show the surveyor the hearing aids. At 7:36 AM, staff #4 showed the hearing aids to the surveyor. Both were present and stored in the medication administration area. Staff #4 indicated she thought one of the hearing aids was missing. Staff #4 indicated client #4 may not be wearing her hearing aids due to the hearing aids needing new batteries. Staff #4 did not offer client #4 her hearing aids. Staff #4 did not attempt to locate batteries for client #4's hearing aids. Staff #4 put the hearing aids away. Staff #4 indicated</p>		<p>Plan ofPrevention: House manager will review MARs and make certain that clients haveaccess of adaptive equipment and that it is in good repair.</p> <p>Plan ofMonitoring: Facility coordinator/ QDIP-Dhas been trained on reviewing MARs and adding an IPP to teach client to make aninformed decision to use adaptive equipment (Attachment I).</p>				

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	<p>client #4 had been refusing to wear her hearing aids. Staff #4 indicated, at times, client #4 will put her hearing aids in her bag she took to the day program but not daily.</p> <p>On 9/17/14 at 7:40 AM, staff #5 indicated client #4, since moving into the group home (on 6/23/14), refused to wear her hearing aids. Staff #5 indicated client #4, at times, would wear them for 10 minutes or so then take them out after making a scene causing them to accidentally fall out.</p> <p>On 9/18/14 at 10:53 AM, a review of client #4's record was conducted. Client #4's most recent hearing assessment, completed on 1/21/14, indicated client #4 had a severe to profound hearing loss in her right ear. Client #4's 8/20/14 Medication Information Sheet indicated she had "bilateral hearing loss (severe)." Client #4's Individual Support Plan, dated 11/1/13, did not include a training objective to increase client #4's use of her hearing aids. Client #4's Behavior Support Plan, dated 7/30/14, did not include a plan to address client #4's refusals to wear her hearing aids. Client #4's Nursing Quarterlies, dated 10/24/13, 1/22/14, 4/29/14, 5/28/14 and 7/28/14, indicated she had bilateral hearing aids. The quarterlies did not address client #4's</p>			

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	<p>refusals to wear her hearing aids. Client #4's interdisciplinary team meeting notes, held monthly from September 2013 to August 2014, did not address client #4's refusals to wear her hearing aids. Client #4's record did not include a plan to teach and train client #4 to wear her hearing aids.</p> <p>On 9/18/14 at 2:21 PM, the Coordinator indicated client #4 claimed she did not hear better with her hearing aids. The Coordinator indicated client #4 would wear them, at times. The Coordinator indicated client #4 liked wearing headphones but she could not wear both (hearing aids and headphones) at the same time. The Coordinator indicated client #4 said she did not want to wear her hearing aids. The Coordinator indicated she thought about getting a discontinue order for client #4's hearing aids but had not done so. The Coordinator indicated the staff should offer and prompt client #4 to wear her hearing aids during the morning medication administration. The Coordinator indicated she needed to add client #4's hearing aid use to client #4's Medication Administration Record. The Coordinator indicated this had been an on-going issue since client #4 moved into the group home.</p>			

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W000488	<p>9-3-7(a)</p> <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. Based on observation and interview for 4 of 5 clients living in the group home (#2, #3, #4 and #5), the facility failed to ensure the clients were involved with preparing their own breakfast.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 9/17/14 from 5:47 AM to 7:53 AM. At 6:50 AM, staff #5 was in the kitchen pouring the clients' drinks. Clients #3 and #5 were given a choice of cereal by staff #5. Staff #5 poured the clients' cereal into their bowls. At 6:52 AM, staff #5 poured cereal into a food processor for client #2. At 6:54 AM, staff #5 added yogurt to the food processor. At 6:55 AM, staff #5 pureed the cereal in the food processor. At 6:57 AM, staff #4 poured the cereal from the food processor into client #2's bowl. At 6:58 AM, staff #5 put toaster strudels into the toaster. Staff #4 poured yogurt on top of client #3 and #5's cereal. At 7:02 AM, staff #4 took the toaster</p>	W000488	<p>W488 483.480(d)(4)Dining Areas and Service</p> <p>Plan ofCorrection: Staff have been trained to provide active treatment to clients atall opportunities. Clients are to be actively engaged in meal preparation. Plan ofPrevention: House manager will conduct daily active treatment observations andprovide training to staff when needed (AttachmentM). Plan ofMonitoring: Facility coordinator/ QDIP-Dwill continue to train with house manager and staff on active treatment eachweek during staff meetings.</p>	10/17/2014
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	<p>strudels out of the toaster and cut them into bite size pieces using scissors for clients #3 and #5. Staff #4 put one of the strudels on client #4's plate. At 7:05 AM, staff #4 stated to client #5, "[Client #5], you're ready, man." Client #5 got up from the dining room table and stood at the pass through window between the kitchen and dining room. At 7:08 AM, staff #4 pureed client #2's strudel. At 7:11 AM, staff #4 poured client #2's strudel from the food processor into his bowl. At 7:14 AM, staff #4 took client #2's bowl and drink to the table. Staff #4 took client #3 and #5's food to the table. At 7:20 AM, staff #5 poured more milk into client #3's cup.</p> <p>On 9/18/14 at 2:14 PM, the Coordinator indicated the clients should be involved with their meal preparation. The Coordinator indicated the staff were trained to assist the clients. The Coordinator stated she thought the staff may be doing too much for the clients due to "burnout." The Coordinator indicated there were three regular staff who work many hours at the home. The Coordinator stated, "Shouldn't mean quality of service goes out the door."</p> <p>9-3-8(a)</p>						

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (staff #5),</p>	W009999	<p>W9999</p> <p>Plan of Correction: Staff received PDD/TB screening</p> <p>Plan of Prevention: HR staff will review and make certain staff and substitutes in a residential group home has been screened per state regulation</p> <p>Plan of Monitoring: HR director will monitor and ensure this is in compliance</p>	10/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2014
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3502 FESTIVE DR BLOOMINGTON, IN 47401		
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	<p>the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 9/16/14 at 1:19 PM. Direct Care Staff #5 had a negative TB test on 6/7/13. There was no documentation in staff #5's personnel file staff #5 had an annual screening or TB test conducted since 6/7/13.</p> <p>On 9/16/14 at 1:33 PM, Human Resources employee #1 indicated the direct care staff working in group homes should have an annual TB test.</p> <p>On 9/16/14 at 3:57 PM, the Coordinator indicated employees should have an annual TB test.</p> <p>2) 460 IAC 9-3-1 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: 15. A fall resulting in injury, regardless of the severity of the injury.</p> <p>This state rule was not met as evidenced</p>				

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	<p>by:</p> <p>Based on record review and interview for 2 of 65 incident/investigative reports reviewed affecting clients #4 and #5, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) for falls with injury in a timely manner.</p> <p>Findings include:</p> <p>On 9/16/14 at 11:27 AM, the facility's incident/investigative reports were reviewed and indicated the following falls with injury were not reported to the (BDDS) within 24 hours:</p> <p>-On 8/6/14 at 9:10 AM at the facility-operated day program, client #5 was walking around and stopped behind a peer. The peer stepped back and landed on client #5's foot. Client #5 stumbled and fell backward landing on her buttocks and left elbow. Client #5 got up and held her left elbow. Client #5 had a red spot from landing on her elbow. There was no documentation the incident was reported to BDDS.</p> <p>-On 5/18/14 at 2:00 PM, client #4 was walking on gravel on her way to the track at a high school. Client #4 fell on one knee. Client #4 scraped her knee. There</p>			

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	<p>was no blood, per the incident report, dated 5/18/14, "just scratches were apparent. First Aide (sic) was given." There was no documentation the incident was reported to BDDS.</p> <p>On 9/16/14 at 12:15 PM, the Group Home Director indicated the falls should have been reported to BDDS.</p> <p>On 9/16/14 at 1:00 PM, the Coordinator indicated falls with injury should be reported to BDDS.</p> <p>9-3-3(e) 9-3-1(b)</p>						