

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 11/12/2014
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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 the Post Certification Revisit (PCR) to the extended recertification and state licensure survey completed on 9/23/14.</p> <p>Survey Dates: November 10 and 12, 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 11/20/14 by Ruth Shackelford, QIDP.</p>	W000000		
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 record review and interview for 6 of 11 incident/investigative reports reviewed affecting clients #2, #3 and #5, the facility neglected to implement its policies and procedures to prevent client to client abuse, corrective actions as</p>	W000149	<p>W 149 483.420(d)(1)Staff Treatment of Clients</p> <p>1. Plan of correction: Stone Belt policy was followed and client was reimbursed \$39.72(attachment a).</p>	12/05/2014

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>recommended, ensure staff immediately reported an allegation of neglect to the administrator, and ensure staff provided supervision to client #3 while at the facility-operated day program.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/10/14 at 12:33 PM and indicated the following:</p> <p>1. On 10/30/14 at 4:45 PM, client #2 and staff were at a store so client #2 could purchase a new box fan. Staff was holding client #2's wallet, which contained \$39.72, in her back pocket. Client #2 was screaming and trying to pinch staff while sliding out of his wheelchair. When staff went to assist client #2 with purchasing his fan, staff discovered his wallet was no longer in her back pocket. Client #2 wrote a check for his fan and another staff came to get him so the staff could search extensively for his wallet. After multiple searches and several discussions with customer service, as well as the lost and found, staff left contact information with the store's employees and returned to the group home without the wallet. The BDDS report, dated 10/31/14, indicated, "Stone Belt will reimburse [client #2] his</p>		<p>Plan of Prevention: Facility Coordinator has been trained that lost money due to fault of staff will immediately be reimbursed.</p> <p>Quality Monitoring: Client finances will be reviewed daily by house manager or associate manager.</p> <p>2. Plan of Correction: Client injury was investigated and it was determined cause of injury was wheelchair.</p> <p>Plan of Prevention: Facility staff were trained on 11/14/14 to prevent client #3 from injury her finger (attachment c).</p> <p>Quality Monitoring: Facility coordinators and director monitoring day program daily (attachment d).</p> <p>3. Plan of Correction: Allegation was immediately investigated by facility director.</p> <p>Plan of Prevention: Facility staff have been trained on preventing and reporting allegations of abuse in a timely manner (attachment e).</p> <p>Quality Monitoring: Facility manager will conduct daily observations and facility coordinator will conduct weekly observations.</p> <p>4. Plan of Correction: Staff #3 was suspended and investigation was conducted.</p> <p>Plan of Prevention: Staff #3 returned to duty with retraining on client #3's risk plan, active treatment and not putting documentation ahead of client safety and support (attachment f).</p>				

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	<p>missing \$39.72." There was no documentation client #2 received reimbursement.</p> <p>On 10/30/14 at 8:44 PM, staff #3 sent an email to the staff at the group home indicating, "Earlier today I took [client #2] to [name of store] to purchase a replacement box fan as the one in his bedroom was broken. [Client #2] was very unhappy with the disruption in his routine and even though I tried to be as quick as possible he became quite upset and was pinching, sliding down in his chair, and screaming. When we finally found the fan and got in line and up to pay I discovered his wallet was no longer in my back pocket. He used a check to pay for the fan and another staff came and got him so that I could search for his wallet. After scouring [name of store] and several discussions with Customer Service, the wallet was not located. I left contact information with them incase (sic) the wallet is found and turned in. The wallet contained \$39.72, but thankfully his ID (identification) was in his checkbook which is safe and sound at [name of group home]."</p> <p>On 11/10/14 at 4:07 PM, a review of client #2's Client Finances for November 2014 indicated client #2 had a balance of zero.</p>		<p>Quality Monitoring: Facility coordinators and director monitoring day program daily (attachment d).</p> <p>5. Plan of Correction: Client #5 behavior plan has been trained to facility-operated day program staff (attachment g).</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 h)</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 d).</p> <p>6. Plan of Correction: Client #5 behavior plan has been trained to facility-operated day program staff (attachment g).</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 h)</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 d).</p>				

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	<p>On 11/10/14 at 12:58 PM, the Fiscal Coordinator indicated she was aware client #2 needed to be reimbursed however she had not reimbursed client #2's lost money yet.</p> <p>On 11/10/14 at 1:04 PM, the Group Home Director indicated she was not aware client #2 was not reimbursed. The Director indicated client #2's money needed to be reimbursed.</p> <p>On 11/10/14 at 4:07 PM, the Residential Coordinator (RC) indicated the staff was carrying client #2's wallet and lost it. The RC indicated a purchase request was submitted to reimburse client #2's money. The RC indicated she was unsure if client #2's money was reimbursed. The RC indicated client #2 lost all of his money.</p> <p>2. On 10/28/14 at 8:30 AM at the facility-operated day program, staff #3 noted client #3's left thumb was bruised and swollen. The nurse was contacted and assessed her thumb. The nurse indicated client #3 needed to go to the walk-in clinic. A typed note with the incident report, undated and unsigned, indicated, "[Client #3] was taken to the [name of clinic] where her mother/guardian met the staff and [client #3]. [Client #3] was seen by [name of</p>			

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	<p>doctor] who ordered an x-ray of the thumb. [Client #3's] mother received a call later in the afternoon with the results of the x-ray. It was determined that there is ligament damage to her thumb as well as a small chip on the end of the bone. [Name of doctor] suggested that [client #3] be referred to a Hand Surgeon to determine the next steps in treatment of the injury to her thumb. [Client #3's] Residential Coordinator conducted an inquiry into the origin of the injury to [client #3's] thumb. The Residential Coordinator spoke with all staff that had worked with [client #3] that morning. The residential staff stated that they did not see any incidents which could have caused the injury to the thumb. The Day Program staff also stated that they did not see an incident in which the injury could have occurred. [Client #3] utilized a wheelchair for (sic) during transportation to and from her house. [Client #3] typically will propel the wheelchair independently with her hands and has a history of getting her fingers and thumb stuck in the wheel of the chair. It appears that this is what occurred to cause the injury to [client #3's] thumb, though no staff actually saw this occur."</p> <p>The Injuries of Unknown Origin Inquiry, dated 10/29/14, indicated, "It appears that the possible cause of the injury is that</p>			

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	<p>[client #3] may have got (sic) her thumb stuck in the wheel of her chair. Staff will be trained at the next house meeting (11/14/14) on ensuring and reminding [client #3] to keep her hands in her lap when staff are assisting her in moving her chair, and to encourage her to be careful when she is wheeling herself." There was no documentation provided for review indicating the staff received training or corrective action was taken to prevent a similar incident from recurring. There was no documentation the facility implemented corrective action to address client #3's continued use of the wheelchair.</p> <p>On 11/12/14 at 12:07 PM, the Residential Coordinator (RC) indicated the staff have not been trained yet. The RC indicated the training was scheduled to be provided at the next house meeting on 11/14/14.</p> <p>3. On 10/28/14 at 7:34 AM (staff #4 reported the allegation to the administrator on 10/29/14), group home staff #4 reported staff #5 left client #5 in staff #5's car alone, without staff supervision. The investigation, dated 10/30/14, indicated regarding staff #6, "[Client #5] was left in the car while [staff #5] was trying to figure out if [client #4] was leaving with her or not. [Staff #4] said that she came in twice. I</p>			

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	do not know if the car was running. Just long enough to find out what was going on and tell us we needed to go. I'm not sure." Staff #4 indicated in the investigation, "[Client #5] was left in the car unsupervised. I do not know if the car was running the first time she was left out there but it was the second time. 3 to 4 minutes the first time and 2 to 3 minutes the second time. Staff could not visibly see her from the house." Staff #5 indicated in the investigation, "I stepped out of my car with the keys out of the ignition and parking break (sic) was on long enough to use the phone to call my [name of supervisor] to tell her we were going to be late. She told me to run inside and tell [client #4] that it was time to go. [Client #5] was buckled into the car and was not going anywhere. So I ran to the door, opened it up and told them that [clients #4 and #5] were leaving. I assisted [client #4] into the car and we left." The investigation indicated, "[Staff #5] did leave [client #5] in the car but it was not running. She was seatbelted in her seat. [Staff #5] did not walk inside the house but spoke to [client #4] and staff from the door way." The Recommendations section indicated, "[Staff #4 and #6] trained on reporting allegations in a timely manner. [Staff #5] will receive a performance review to not leave clients in vehicles."				

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	<p>On 11/10/14 at 1:06 PM, the Group Home Director indicated the staff should have immediately reported the allegation of neglect. The Director indicated the staff reported the allegation the next day.</p> <p>On 11/12/14 at 12:41 PM, the Residential Coordinator (RC) indicated the staff should have immediately reported the allegation of neglect.</p> <p>4. On 10/8/14 at 3:30 PM at the facility-operated day program, client #3 was outside the building in the courtyard. There were 4 clients and 2 staff. Day program staff #2 told day program staff #3 she needed to go inside the classroom. The BDDS report, dated 10/9/14 indicated, "State Surveyor [name] intercepted [client #3] when she rolled around the corner and out of sight of the staff. Staff was working on billing and was unaware that [client #3] was no longer where she could see her. Staff was immediately suspended and investigation will be started."</p> <p>The investigation, dated 10/13/14, indicated the allegation of neglect was substantiated. Day program staff #3 indicated in her statement, "[Staff #3] knew that the reason [name of investigator] was calling was that 'a client</p>			

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	<p>got out of my sight.' [Staff #3] reported that on the afternoon of 10/8/14, she was outside with clients [clients #1, #2 and #3 as well as 3 additional clients]. [Staff #2] was also outside. They were in the courtyard, and it was a little after 3:30pm. [Staff #3] reported that she was doing billing at the picnic table, and that [staff #2] went inside. She did not recall [staff #2] saying anything to her before she went inside... She reported that she was aware that [client #3] had tried to go around the corner two times earlier that day, and that she had been redirected back to the group." The investigation indicated, "[Staff #3] will be returned to duty with retraining on [client #3's] risk plan, active treatment and not putting documentation ahead of client safety and support."</p> <p>On 11/10/14 at 1:06 PM, the Group Home Director indicated the facility had a policy and procedure prohibiting neglect. The Group Home Director indicated the facility should prevent neglect of the client.</p> <p>On 11/12/14 at 12:41 PM, the Residential Coordinator (RC) indicated the facility had a policy and procedure prohibiting neglect. The RC indicated the facility should prevent neglect of the client.</p>						

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	<p>5. On 10/2/14 at 3:45 PM at the facility-operated day program, client #5 asked for a straw and started walking toward the office where the straws were kept. The staff in the staffing office shut the door when client #5 was a few steps away. Client #5 reached out and pulled a peer's hair who was traveling down the hallway. The peer received ice for her head.</p> <p>On 11/10/14 at 1:06 PM, the Group Home Director (GHD) indicated client to client aggression was considered abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 11/12/14 at 12:41 PM, the Residential Coordinator (RC) indicated client to client aggression was considered abuse and the facility should prevent abuse. The RC indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>6. On 9/26/14 at 12:06 PM at the facility-operated day program, client #5 dropped three plastic glasses and staff asked her to pick them up. Client #5 walked over to a peer and pulled her hair on the top of her head. The peer was not injured. The investigation, dated</p>						

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	<p>9/30/14, indicated, "[Day Program Staff #1] & all other Rm (room) 16 regular staff will be retrained on [client #5's] BSP (behavior support plan) and how to properly make requests of her."</p> <p>On 11/10/14 at 1:06 PM, the Group Home Director (GHD) indicated client to client aggression was considered abuse and the facility should prevent abuse. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 11/12/14 at 12:41 PM, the Residential Coordinator (RC) indicated client to client aggression was considered abuse and the facility should prevent abuse. The RC indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 11/10/14 at 11:48 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</p>				

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	<p>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 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</p>			

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W000153	<p>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> <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."</p> <p>This deficiency was cited on 9/23/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 1 of 11 incident/investigative reports reviewed affecting client #5, the facility failed to ensure staff immediately reported an allegation of neglect to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/10/14 at 12:33 PM and indicated the following: On 10/28/14 at 7:34 AM (staff #4 reported the allegation to the administrator on 10/29/14), group home staff #4 reported staff #5 left client #5 in staff #5's car alone, without staff supervision. The investigation, dated 10/30/14, indicated regarding staff #6, "[Client #5] was left in the car while [staff #5] was trying to figure out if [client #4] was leaving with her or not. [Staff #4] said that she came in twice. I do not know if the car was running. Just long enough to find out what was going on and tell us we needed to go. I'm not sure." Staff #4 indicated in the investigation, "[Client #5] was left in the car unsupervised. I do not know if the car was running the first time she was left</p>	W000153	<p>1. Plan of Correction: Allegation was immediately investigated by facility director.</p> <p>Plan of Prevention: Facility staff have been trained on preventing and reporting allegations of abuse in a timely manner (attachment e). SGL staff will continue to receive prevention and reporting abuse and neglect training each month at Shiloh (attachment h)</p> <p>Quality Monitoring: Facility manager will conduct daily observations and facility coordinator will conduct weekly observations.</p>	12/05/2014

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	<p>out there but it was the second time. 3 to 4 minutes the first time and 2 to 3 minutes the second time. Staff could not visibly see her from the house." Staff #5 indicated in the investigation, "I stepped out of my car with the keys out of the ignition and parking break (sic) was on long enough to use the phone to call my [name of supervisor] to tell her we were going to be late. She told me to run inside and tell [client #4] that it was time to go. [Client #5] was buckled into the car and was not going anywhere. So I ran to the door, opened it up and told them that [clients #4 and #5] were leaving. I assisted [client #4] into the car and we left." The investigation indicated, "[Staff #5] did leave [client #5] in the car but it was not running. She was seatbelted in her seat. [Staff #5] did not walk inside the house but spoke to [client #4] and staff from the door way." The Recommendations section indicated, "[Staff #4 and #6] trained on reporting allegations in a timely manner. [Staff #5] will receive a performance review to not leave clients in vehicles."</p> <p>On 11/10/14 at 1:06 PM, the Group Home Director indicated the staff should have immediately reported the allegation of neglect. The Director indicated the staff reported the allegation the next day.</p>						

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W000157	<p>On 11/12/14 at 12:41 PM, the Residential Coordinator (RC) indicated the staff should have immediately reported the allegation of neglect.</p> <p>This deficiency was cited on 9/23/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 11 incident/investigative reports reviewed affecting clients #2 and #3, the facility failed to take appropriate corrective actions following an incident of staff losing client #2's wallet and client #3 sustaining an injury of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/10/14 at 12:33 PM and indicated the following:</p>	W000157	<p>1. Plan of correction: Stone Belt policy was followed and client was reimbursed \$39.72(attachment a). Plan of Prevention: Facility Coordinator has been trained that lost money due to fault of staff will immediately be reimbursed. Quality Monitoring: Client finances will be reviewed daily by house manager or associate manager.</p> <p>2. Plan of Correction: Client injury was investigated and it was determined cause of injury was wheelchair. Plan of Prevention: Facility staff were trained on 11/14/14 to prevent client #3 from injury her</p>	11/14/2014	

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	<p>1) On 10/30/14 at 4:45 PM, client #2 and staff were at a store so client #2 could purchase a new box fan. Staff was holding client #2's wallet, which contained \$39.72, in her back pocket. Client #2 was screaming and trying to pinch staff while sliding out of his wheelchair. When staff went to assist client #2 with purchasing his fan, staff discovered his wallet was no longer in her back pocket. Client #2 wrote a check for his fan and another staff came to get him so the staff could search extensively for his wallet. After multiple searches and several discussions with customer service, as well as the lost and found, staff left contact information with the store's employees and returned to the group home without the wallet. The BDDS report, dated 10/31/14, indicated, "Stone Belt will reimburse [client #2] his missing \$39.72." There was no documentation client #2 received reimbursement.</p> <p>On 10/30/14 at 8:44 PM, staff #3 sent an email to the staff at the group home indicating, "Earlier today I took [client #2] to [name of store] to purchase a replacement box fan as the one in his bedroom was broken. [Client #2] was very unhappy with the disruption in his routine and even though I tried to be as</p>		<p>finger (attachment c). Quality Monitoring: Facility coordinators and director monitoring day program daily (attachment d).</p>				

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	<p>quick as possible became quite upset and was pinching, sliding down in his chair, and screaming. When we finally found the fan and got in line and up to pay I discovered his wallet was no longer in my back pocket. He used a check to pay for the fan and another staff came and got him so that I could search for his wallet. After scouring [name of store] and several discussions with Customer Service, the wallet was not located. I left contact information with them incase (sic) the wallet is found and turned in. The wallet contained \$39.72, but thankfully his ID (identification) was in his checkbook which is safe and sound at [name of group home]."</p> <p>On 11/10/14 at 4:07 PM, a review of client #2's Client Finances for November 2014 indicated client #2 had a balance of zero.</p> <p>On 11/10/14 at 12:58 PM, the Fiscal Coordinator indicated she was aware client #2 needed to be reimbursed however she had not reimbursed client #2's lost money yet.</p> <p>On 11/10/14 at 1:04 PM, the Group Home Director indicated she was not aware client #2 was not reimbursed. The Director indicated client #2's money needed to be reimbursed.</p>			

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	<p>On 11/10/14 at 4:07 PM, the Residential Coordinator (RC) indicated the staff was carrying client #2's wallet and lost it. The RC indicated a purchase request was submitted to reimburse client #2's money. The RC indicated she was unsure if client #2's money was reimbursed. The RC indicated client #2 lost all of his money.</p> <p>2) On 10/28/14 at 8:30 AM at the facility-operated day program, staff #3 noted client #3's left thumb was bruised and swollen. The nurse was contacted and assessed her thumb. The nurse indicated client #3 needed to go to the walk-in clinic. A typed note with the incident report, undated and unsigned, indicated, "[Client #3] was taken to the [name of clinic] where her mother/guardian met the staff and [client #3]. [Client #3] was seen by [name of doctor] who ordered an x-ray of the thumb. [Client #3's] mother received a call later in the afternoon with the results of the x-ray. It was determined that there is ligament damage to her thumb as well as a small chip on the end of the bone. [Name of doctor] suggested that [client #3] be referred to a Hand Surgeon to determine the next steps in treatment of the injury to her thumb. [Client #3's] Residential Coordinator conducted an inquiry into the origin of the injury to</p>			

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	<p>[client #3's] thumb. The Residential Coordinator spoke with all staff that had worked with [client #3] that morning. The residential staff stated that they did not see any incidents which could have caused the injury to the thumb. The Day Program staff also stated that they did not see an incident in which the injury could have occurred. [Client #3] utilized a wheelchair for (sic) during transportation to and from her house. [Client #3] typically will propel the wheelchair independently with her hands and has a history of getting her fingers and thumb stuck in the wheel of the chair. It appears that this is what occurred to cause the injury to [client #3's] thumb, though no staff actually saw this occur."</p> <p>The Injuries of Unknown Origin Inquiry, dated 10/29/14, indicated, "It appears that the possible cause of the injury is that [client #3] may have got (sic) her thumb stuck in the wheel of her chair. Staff will be trained at the next house meeting (11/14/14) on ensuring and reminding [client #3] to keep her hands in her lap when staff are assisting her in moving her chair, and to encourage her to be careful when she is wheeling herself." There was no documentation provided for review indicating the staff received training or corrective action was taken to prevent a similar incident from recurring.</p>				

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W000240	<p>There was no documentation the facility implemented corrective action to address client #3's continued use of the wheelchair.</p> <p>On 11/12/14 at 12:07 PM, the Residential Coordinator (RC) indicated the staff have not been trained yet. The RC indicated the training was scheduled to be provided at the next house meeting on 11/14/14.</p> <p>9-3-2(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 keep the facility-operated day program door closed to the outside following two incidents in which client #3 fell out of her wheelchair.</p> <p>Findings include:</p> <p>On 11/10/14 at 12:33 PM, 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</p>	W000240	<p>1. Plan of Correction: Client #3 HRP was revised to include keeping exterior door closed (attachment f). Plan of Prevention: Facility-operated day program staff have received training on client #3 HRP. Quality Monitoring: Facility coordinators and director monitoring day program daily (attachment d).</p>	11/28/2014

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	<p>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 Room 16, unless being used to get clients in/out, until the changes are made to the</p>			

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	<p>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>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</p>			

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	<p>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>A review of client #3's record was conducted on 11/12/14 at 1:12 PM. 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 facility-operated day program.</p> <p>On 11/12/14 at 1:08 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 11/12/14 at 1:08 PM, the Day Program Coordinator 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 11/12/14 at 1:02 PM, the Residential</p>			

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W009999	<p>Coordinator 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>This deficiency was cited on 9/23/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>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>	W009999	<p>1. Plan of Correction: Facility staff have been trained on preventing and reporting abuse and neglect within 24 hours (attachment h). Plan of Prevention: SGL staff will continue to receive this training each month at Shiloh meeting. Quality Monitoring: Facility manager will conduct daily observations and facility coordinator will conduct weekly observations (attachment e).</p>	12/05/2014

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	<p>by:</p> <p>Based on record review and interview for 1 of 11 incident/investigative reports reviewed affecting client #3, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) for a fall with injury in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/10/14 at 12:33 PM and indicated the following: On 10/11/14 at 6:25 PM (reported to BDDS on 10/14/14), client #3 was walking down the hallway toward her bedroom. Client #3's legs buckled and she fell backward onto her buttocks. Staff was behind client #3 with her wheelchair when client #3 fell. Client #3 hit her right shoulder blade on the wheelchair causing a long scratch on her back from her shoulder blade to the bottom of her ribs. The scratch was cleaned with soap and water.</p> <p>On 11/10/14 at 1:05 PM, the Group Home Director indicated BDDS reports should be submitted within 24 hours for falls with injury.</p> <p>On 11/10/14 at 12:41 PM, the Residential</p>				

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	<p>Coordinator (RC) indicated BDDS reports for a fall with injury should be submitted within 24 hours.</p> <p>This state rule was cited on 9/23/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(b)</p>				