

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 08/29/2013
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3502 FESTIVE DR BLOOMINGTON, IN 47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: August 26, 27, 28, and 29, 2013.</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 9/10/13 by Ruth Shackelford, QIDP.</p>	W000000			

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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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the facility notified the Bureau of Developmental Disabilities Services (BDDS) of client #6 moving into the group home due to mold being found at his previous group home and 2) the common areas of the group home were repainted.</p> <p>Findings include:</p> <p>1) A review of the facility's incident/investigative reports was conducted on 8/26/13 at 12:01 PM. On 6/15/13 at 12:00 PM, while a new floor was being installed on 6/14/13 at client #6's previous group home, mold was found. An Industrial Hygienist (IH) appointment was scheduled on 6/15/13. Client #6 was moved, temporarily, to another group home due to his "Severely compromised respiratory system" at the recommendation of the IH. The report indicated, "[IH] felt that the other clients (#1, #3, #4, #5 and #6) are safe to remain in the home with the use of an air</p>	W000104	<p>W104 GOVERNING BODY</p> <p>Plan of Correction: Stone Belt Arc, Inc. will exercise general policy, budget and operating direction over the facility. Specifically, BDDS will be notified formally if any movement of a client takes place within the group homes. The common areas of the group home will be painted. Person Responsible: Festive Program Coordinator/SGL Director Date of Completion: September 28, 2013 Plan of Prevention: Program Coordinator and SGL Director will formally notify BDDS if the situation arises once again within Stone Belt group homes. In regard to the specific individual at Festive house, he will be moving back to his home once remediation work is completed. Social Worker began process of getting temporary nursing home placement for client. (Attachment # 1) Program Coordinator awaiting estimate to repaint the common areas at Festive House. Quality Assurance Monitoring: Prior to any future moves of clients, the SGL Director will contact BDDS Service Coordinator to begin the process. Program Coordinator and House Manager conduct a quarterly house inspection (Attachment #</p>	09/28/2013			

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	<p>scrubber and 3 dehumidifiers. In addition, the affected area has been contained and a piece of detached ductwork has been reconnected."</p> <p>A review of client #6's record was conducted on 8/27/13 at 8:57 AM. There was no documentation in client #6's record indicating the facility contacted, by phone, letter or in person, BDDS to notify them of client #6's move from his former group home to this group home. There was no documentation the facility received approval for the move.</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/26/13 at 3:38 PM. The PC indicated the group home was licensed for 5 but currently have 6 clients living at the home. The PC stated, "it's a 5 bed home." The PC indicated client #6's former group home had mold causing client #6 to have to move due to respiratory issues.</p> <p>An interview with the Director was conducted on 8/27/13 at 11:50 AM. The Director indicated client #6 was moved to this group home for health and safety reasons. The Director indicated the move was temporary while remediation work was completed at client #6's former group home. The Director indicated an air quality test was conducted 2 weeks ago</p>		2) that will identify environmental work needed in the homes.				

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	<p>and there was no change from the first test completed in June 2013. The Director indicated BDDS was notified however the Director did not have documentation indicating they agreed with the move. The Director indicated the BDDS Service Coordinator was aware of the move. The Director indicated no one had questioned the move.</p> <p>On 8/28/13 at 10:59 AM, the BDDS Service Coordinator (SC) was interviewed. The SC indicated BDDS did not give the facility permission for client #6 to move into the group home. The SC indicated Stone Belt did not have permission to move client #6 into a home with no open beds. The SC indicated the BDDS Central Office was notified however she had not received a response from Central Office. The SC indicated Stone Belt was asked for additional information about the move however Stone Belt did not supply the requested information. The SC indicated the BDDS office was not aware client #6's bedroom was located in the formal living room. The SC stated although Stone Belt submitted a BDDS report, the SC found out about move "in passing." The SC indicated she did not receive a call or any communication from Stone Belt about the move.</p>				

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	<p>On 8/28/13 at 11:46 AM, the BDDS Field Service Director (FSD) was interviewed. The FSD indicated BDDS did not give Stone Belt permission to move client #6 to this group home. The FSD stated client #6, "Can't be maintained at the current house." The FSD indicated Stone Belt needed to make repairs to client #6's former group home. The FSD indicated BDDS was not informed of the move until client #6 was moved. The FSD indicated she was not sure what occurred at client #6's former group home but she needed to find out from Stone Belt. The FSD indicated BDDS did not tell Stone Belt to move client #6 or that client #6 could stay at the group home. The FSD stated a "transition" was not completed. The FSD indicated she was not aware if BDDS staff had been to the group home to check on client #6. The FSD was informed client #6's bedroom was in the formal living room. The FSD stated, "That's not okay, not okay. We will address with Stone Belt." The FSD indicated the repair work should have been completed by now. The FSD stated, "We will follow up on that. He (client #6) can't continue to live at [name of group home]."</p> <p>2) Observations were conducted at the group home on 8/26/13 from 4:16 PM to 5:49 PM and 8/27/13 from 5:52 AM to</p>			

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	<p>7:50 AM. During the observations, the common area walls (kitchen, dining room, bathrooms, hallways, and living room) were scuffed, marked, discolored and missing paint in areas. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>A review of the facility's Internal Inspection, dated 8/20/13, was conducted on 8/28/13 at 12:14 PM. The inspection indicated, in part, "Paint on walls are (sic) getting worn and dirty. Wallpaper and border are peeling off."</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/26/13 at 4:16 PM. The PC indicated the group home's common areas needed to be repainted. The PC indicated she had worked at the group home for 2 years and the common areas had not been repainted during that time.</p> <p>An interview with the Home Manager (HM) was conducted on 8/27/13 at 6:13 AM. The HM indicated she had worked at the group home for 4 years and the common areas had not been repainted. The HM stated, "Definitely could use a facelift." The HM indicated she recently completed a home assessment indicating the walls needed to be repainted.</p> <p>9-3-1(a)</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 record review and interview for 14 of 42 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse and report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/26/13 at 12:01 PM.</p> <p>1) On 8/20/13 at 6:00 PM, client #6 was struck by a peer from another group home in the back right shoulder blade.</p> <p>2) On 8/5/13 at 4:00 PM while in the van, client #4 took off his seatbelt and began to hit, kick and grab at client #3 who was in the front seat. The BDDS report, dated 8/6/13, indicated, in part, "Staff was able to block all but two grabs and 3 kicks."</p> <p>3) On 8/4/13 at 5:50 PM, client #6 was headbutted by a peer from another group</p>	W000149	<p>W149 STAFF TREATMENT OF CLIENTS Plan of Correction: Stone Belt has policies and procedures that address mistreatment, neglect and abuse of clients. In particular, client-to-client aggression. Responsible Person: Festive Program Coordinator Date of Completion: September 28, 2013 Plan of Prevention: Festival House staff were retrained on the Stone Belt policy of the prevention of abuse, mistreatment and neglect. (Attachment # 3 and # 3A). This includes the Stone Belt policy on incident reporting within 24 hours. Quality Assurance Monitoring: The Stone Belt Staff receive training during new hire orientation and annually on The Stone Belt Abuse, Mistreatment, Neglect and Incident Report Policies. Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed. The Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents.</p>	09/28/2013			

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	<p>home.</p> <p>4) On 8/4/13 at 1:50 PM (reported to BDDS on 8/6/13), client #2 was kicked in the buttocks by client #4 as client #2 was on the floor. The BDDS report indicated, in part, "Staff intervened and stood between the two clients. Staff made sure [client #2] was okay, and no injuries were found. Staff talked to [client #4] about how it is not okay to touch other people in such a manner. Staff will continue to implement [client #4's] plan and monitor for signs of aggression."</p> <p>5) On 7/31/13 at 5:45 PM, client #1 was walking around in the dining room. Client #4 was pacing in the dining room. Client #4 walked up to client #1 and pushed her to the floor.</p> <p>6) On 7/25/13 at 3:45 PM at the facility-operated day program, client #3 walked past client #2 and grabbed her hair and pulled. Client #3 released her grip when prompted but then pulled client #2's hair again. Client #3 attempted to bite client #2. Client #3 had a mouth full of client #2's hair but did not make contact with her skin.</p> <p>7) On 7/23/13 at 4:15 PM at the facility-operated day program, client #3 reached back while in the van and</p>				

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	<p>grabbed client #4's hair.</p> <p>8) On 7/19/13 at 8:00 AM while in the van, client #3 grabbed client #4's hair and began pulling. The staff stopped the van and removed client #3's hands from client #4's hair.</p> <p>9) On 7/11/13 at 7:00 AM, client #3 grabbed client #1's hand and yelled for a prolonged period of time in a "forceful negative manner." The report indicated, "The hand holding did not appear friendly." The Incident Report, dated 7/11/13, indicated, in part, "There was no way to interpret the action as a friendly hand-hold."</p> <p>10) On 7/10/13 at 10:55 AM, client #4 was at the facility-operated day program. Client #4 attempted to leave the program area but was redirected. Client #4 yelled "no" as he walked back into the program area. Client #4 punched a peer in the stomach as he passed the peer. The peer began to cry.</p> <p>11) On 7/9/13 at 4:30 PM, client #3 was prompted to put her lunchbox in the kitchen. Client #3 grabbed client #2's hair. The Incident Report, dated 7/9/13, indicated, in part, "Staff had to release [client #3's] hand from [client #2's] hair."</p>						

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	<p>12) On 7/9/13 at 12:20 PM while at the facility-operated day program, client #6 attempted to grab staff's arm. Staff redirected client #6. Client #6 slapped a peer and the staff on their arms.</p> <p>13) On 6/14/13 at 8:00 AM, client #3 grabbed client #4's hair and pulled it while riding in the van.</p> <p>14) On 5/29/13 at 10:45 AM, client #4 was at the facility-operated day program dancing. Staff observed a peer "looking angry" and heard the peer say, "I'm not going to put up with your sh-- any longer [client #4] you pis--- me off." The peer took off running and "rammed" client #4 in the back with his head.</p> <p>A review of the facility's abuse and neglect policy, dated 10/17/11, was conducted on 8/26/13 at 11:39 AM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of</p>				

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	<p>physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a client, parent/guardian, advocate, staff member, or other involved party."</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/26/13 at 1:18 PM. The PC indicated incident reports should be submitted to BDDS within 24 hours. The PC indicated client to client aggression was considered abuse.</p> <p>An interview with the Director was conducted on 8/27/13 at 11:50 AM. The Director indicated incident reports should be submitted to BDDS within 24 hours. The Director indicated client to client aggression was considered abuse and</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 42 incident/investigative reports reviewed affecting clients #2 and #4, the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/26/13 at 12:01 PM.</p> <p>On 8/4/13 at 1:50 PM (reported to BDDS on 8/6/13), client #2 was kicked in the buttocks by client #4 as client #2 was on the floor. The BDDS report indicated, in part, "Staff intervened and stood between the two clients. Staff made sure [client #2] was okay, and no injuries were found. Staff talked to [client #4] about how it is not okay to touch other people in such a manner. Staff will continue to implement [client #4's] plan and monitor for signs of aggression."</p>	W000153	<p>W153 STAFF TREATMENT OF CLIENTS Plan of Correction: Stone Belt Arc, Inc. will ensure any incidents of Abuse, Neglect, and/or mistreatment of the consumers will be reported immediately. Person Responsible: Festive Program Coordinator Date of Completion: September 28, 2013 Plan of Prevention: Staff will be retrained to report immediately to the Coordinator and/or Director of Group Homes. (Attachment # 3 and # 3A) Quality Assurance Monitoring: The Stone Belt Staff receive training during new hire orientation and annually on The Stone Belt Abuse, Mistreatment, Neglect and Incident Report Policies. Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed. The Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents.</p>	09/28/2013	

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	<p>An interview with the Program Coordinator (PC) was conducted on 8/26/13 at 1:18 PM. The PC indicated incident reports should be submitted to BDDS within 24 hours.</p> <p>An interview with the Director was conducted on 8/27/13 at 11:50 AM. The Director indicated incident reports should be submitted to BDDS within 24 hours.</p> <p>9-3-2(a)</p>			

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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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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (#4 and #5), the facility failed to ensure client #4 had an annual eye exam and client #5's hearing was evaluated annually.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 8/27/13 at 9:32 AM. An Outside Services Report for Vision, dated 9/27/12, indicated, in part, "Unable to assess fundus and refractive error. External ocular health WNL (within normal limits)." The report indicated to follow up in 2 weeks. The Nursing Consultation form, dated 9/27/12, indicated, in part, "[Client #4] is to f/u (follow up) in two weeks and at that time the fundus will be examined/assessed - new rx (prescription) for 5% Homatropine ophthalmic solution two drops to be instilled in each eye eight hours before the exam." The Outside Services Report for Vision dated 10/11/12 indicated, in part, "Examination of eyes and vision - unable to get views of fundus - pt (patient) very resistant to any testing. Recommend eye exam under sedation if PCP (primary care</p>	W000323	<p>W 323 PHYSICIAN SERVICES</p> <p>Plan of Correction: Stone Belt will provide or obtain annual physical examinations of each client that includes at a minimum an evaluation of vision and hearing. Date of Completion: September 28, 2013 Person Responsible: Festive Program Coordinator Plan of Prevention: The specific hearing test was completed on 9/25/13. (Attachment # 4). Regarding the specific eye exam the guardian has indicated that he does not want the client to undergo a sedated eye exam. Other option are being explored for the particular client. House staff will discuss with personal care physician regarding the reason for not conducting the screenings during the annual physical exam.</p> <p>Quality Assurance Monitoring: House Program Coordinator will review, on a monthly basis, all required physical exams, including hearing, to ensure that they are completed in a timely manner. This review is also seen by the SGL Director. The House Manager and Coordinator review the Group Home File Checklist (Attachment # 5) on a monthly basis to ensure that all necessary documents are current in the</p>	09/28/2013			

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	<p>physician) feels the need for more detailed exam." Client #4's most recent physical examination conducted by the PCP was dated 1/23/13. Client #4's vision was not assessed. There was no documentation the facility followed up with client #4's PCP regarding the sedated vision exam.</p> <p>A review of client #5's record was conducted on 8/27/13 at 10:25 AM. Client #5's most recent hearing examination was conducted on 2/23/10. Client #5's most recent physical examination, dated 8/27/12, indicated, in part, "Unable to test hearing...". There was no documentation in client #5's record indicating his hearing had been assessed since 2/23/10.</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/27/13 at 11:17 AM. The PC indicated client #4 and #5's vision and hearing should be assessed annually. The PC indicated the checklist the staff who scheduled client #5's hearing test had the wrong date for follow up on it. The PC indicated client #5 was due for a hearing examination in February 2013.</p> <p>An interview with the Director was conducted on 8/27/13 at 11:50 AM. The Director indicated the clients' hearing and</p>		<p>system. The Checklist includes the annual hearing and vision. This document is also reviewed by the SGL Director.</p>		

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	<p>vision should be assessed annually.</p> <p>An interview with the Director of Health Care Services (DHCS) was conducted on 8/27/13 at 12:07 PM. The DHCS indicated the guardian did not want client #4 to have a sedated vision exam. The DHCS indicated there should be documentation in client #4's record.</p> <p>9-3-6(a)</p>			

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W000377	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of sanitation. Based on observation and interview for 1 of 3 clients observed to receive their medications (#4), the facility failed to ensure the clients' internal and external medications were stored separately.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 8/27/13 from 5:52 AM to 7:50 AM. At 6:22 AM, client #4 received his medications from staff #1. Client #4's oral medications (internal) and lotions and creams (external) were stored in the same plastic container.</p> <p>An interview with the Home Manager (HM) was conducted on 8/27/13 at 6:25 AM. The HM indicated she did not know internal and external medications could not be stored together.</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/27/13 at 11:17 AM. The PC indicated internal and external medications should be stored separately.</p> <p>An interview with the Director was conducted on 8/27/13 at 11:50 AM. The Director indicated internal and external</p>	W000377	<p>W 377 DRUG STORAGE & RECORD KEEPING Plan of Correction: Stone Belt will store drugs under proper conditions of sanitation. Date of Completion: September 28, 2013 Person Responsible: Festive Program Coordinator Plan of Prevention: New caddies were purchased to ensure that topical and oral medications are not store in the same container. Quality Assurance Monitoring: Program Coordinator will review medication storage during visits to the house, both announced and unannounced.</p>	09/28/2013			

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	<p>medications should be stored separately.</p> <p>An interview with the Director of Health Care Services (DHCS) was conducted on 8/27/13 at 12:07 PM. The DHCS indicated internal and external medications should be stored in separate containers.</p> <p>9-3-6(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>460 IAC 9-3-1(a) 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: A fall resulting in injury, regardless of the severity of the injury.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 3 of 42 incident reports reviewed affecting clients #1 and #4, the facility failed to ensure falls with injury were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/18/13 at 2:23 PM.</p>	W009999	<p>W 9999 FINAL OBSERVATIONS Plan of Correction: Stone Belt will report falls resulting in injury, regardless of injury in writing within 24 hours of the incident. Date of Completion: September 28, 2013 Person Responsible: Festive Program Coordinator Plan of Prevention: Training on Incident Reporting was conducted on 9/2/9/2013 with house staff (Attachment # 3). Reviewed the types of incidents that are reportable and the timing of the report. Quality Assurance Monitoring: Program Coordinator and SGL Director review all incident reports to ensure they are reported correctly and timely.</p>	09/28/2013			

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	<p>On 8/4/13 at 2:15 PM (reported to BDDS on 8/6/13), staff turned around and observed client #4 on the ground. Client #4 fell causing a scratch on his right knee.</p> <p>On 7/10/13 at 12:50 PM (not reported to BDDS), client #1 walked into client #2's wheelchair and fell down onto client #2's wheelchair. The report indicated, in part, "She looked fine (facial expression) but I noticed the side of her right wrist and a bit of her middle finger was (sic) red." The incident report, dated 7/10/13, indicated in the Physical Condition section, "Apparent injuries on right wrist & middle finger (red marks)."</p> <p>On 6/29/13 at 7:00 AM (reported to BDDS on 7/1/13), client #1 lost her balance and slipped hitting her right side. Client #1 sustained a one and a half inch scrape on her right arm with a bruise around the scrape.</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/26/13 at 1:18 PM. The PC indicated falls with injury should be submitted to BDDS within 24 hours.</p> <p>An interview with the Director was conducted on 8/27/13 at 11:50 AM. The Director indicated falls with injury should</p>			

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	be submitted to BDDS within 24 hours. 9-3-1(b)				