

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/09/2016
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 214 E SOUTHERN DR BLOOMINGTON, IN 47401
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: March 3, 4, 7, 8 and 9, 2016</p> <p>Facility Number: 001210 Provider Number: 15G637 AIM Number: 100240200</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/15/16.</p>	W 0000		
W 0149 Bldg. 00	<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 18 of 29 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and former client #6, the facility neglected to implement its policies and procedure to prevent client to client abuse, staff to client neglect, take appropriate corrective actions to address medication errors, conduct an investigation of an incident of client #2</p>	W 0149	<p>W 149 Staff Treatment of Clients The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Corrective action for resident(s) found to have been affected The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including client to client abuse, including the need to report and investigate</p>	04/08/2016

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>choking, conduct an investigation to determine where client #3 obtained medication found in her room, submit the results of an investigation to the administrator within 5 working days, and submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>On 3/3/16 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 3/14/15 at 6:00 PM, client #1 hit client #2 on the side of the face. Client #2's ear was swollen and bruised after the incident.</p> <p>On 3/4/16 at 2:50 PM, the Group Home Director (GHD) indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure</p>		<p>promptly and follow-through until issue is resolved. QIDP will be trained on investigations policy and procedure, including completing the investigation within five business days. Training for QIDP and staff about immediate reporting for allegations of abuse, neglect and exploitation. QIDP and staff will be trained on medication error reporting to agency and state as well as corrective action. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff training will be conducted. How corrective actions will be monitored to ensure no recurrence The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>				

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	<p>prohibiting abuse of the clients.</p> <p>2) On 3/22/15 at 3:30 PM, client #1 kicked client #4 on the leg. Client #4 was not injured.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>3) On 4/5/15 at 5:50 PM, client #5 pushed client #1. Client #1 was not injured.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent</p>			

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	<p>abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>4) On 4/12/15 at 5:15 PM, client #1 kicked former client #6 on the shin and hit her on the head. Client #6 was not injured.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>5) On 5/10/15 at 8:00 PM, client #1 kicked client #2 on the leg. Client #2 was not injured.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p>			

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	<p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>6) On 6/22/15 at 1:00 PM, client #1 was being supervised by a facility-operated day program staff (day program staff #1) at her group home. At 1:00 PM when the former Coordinator and staff #1 returned to the group home, day program staff #1 was asleep on the couch. Day program staff #1 was terminated on 6/23/15. The Stone Belt ARC Inc. Incident Report indicated, "Investigation completed. [Day program staff #1] was terminated on 6/23/15. [Coordinator and staff #1] cared for [client #1] and provided support to her. They prepared [client #1] a new lunch since it was unknown how long the other lunch had been in the microwave." The 6/25/15 investigation indicated, in part, "Allegation substantiated. It was determined that [day program staff #1's] sleeping resulted in [client #1] not changing into appropriate clothing, eating lunch, or following her daily schedule. Therefore, [day program staff #1] neglected to care for [client #1]."</p> <p>On 3/8/16 at 8:52 AM, the Assistant Group Home Director indicated the staff</p>				

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	<p>was terminated due to neglect.</p> <p>7) On 7/3/15 at 2:30 PM, client #1 hit client #2 on the right shoulder. Client #2 was not injured.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>8) On 7/17/15 at 11:05 AM at the facility-operated day program, client #3 was grabbed by a peer on her upper right arm. Client #3 was not injured.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was</p>				

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	<p>abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>9) On 7/27/15 at 11:00 AM at the facility-operated day program, client #5's hair was pulled by a peer. Client #5 was not injured.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>10) On 9/29/15 at 2:00 PM while on an outing with the facility-operated day program, the 10/26/15 BDDS report indicated, in part, "...[client #3] and [client #2] went to the restroom at the [name of public building]. Staff, [day program staff #2], stood outside of the restroom while they were inside. After exiting, [client #2] acted upset: pointing, rocking back and forth, and making 'mad</p>			

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	<p>face.' [Client #3] was not sure why [client #2] was upset. [Client #3] is verbal and [client #2] is non-verbal. On 10/19/2015, [client #3] told her [day program] instructor, [day program staff #3], that while in the restroom on 09/29/2015, [client #3] had told [client #2] she could not leave the restroom until she showed [client #3] that she did not have any items she would throw. [Client #2] has a history of stashing throwables in her bra and underwear. [Client #3] checked [client #2's] bra and underwear for items, and then dismissed [client #2] from the restroom. When [name of day program] Coordinator, [day program staff #4], learned about the 09/29/2015 challenge of two male staff on community activity, coordinator talked with [names of day program staff #2 and #5] about asking female clients to go in one at a time, and not send in two together. When coordinator learned of [client #3's] story on 10/29/2015, coordinator spoke with [name of day program Director]. Originally, it was unclear how to categorize event, but after Director spoke with the SGL Director [name], it was decided that this would be classified as client to client aggression and be reported to BDDS/state, and APS (Adult Protective Services)."</p> <p>The facility failed to submit the incident</p>			

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	<p>to BDDS in a timely manner. The results of the 10/27/15 investigation were not submitted to the administrator for review within 5 working days.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours. The Coordinator indicated the results of investigations should be reported to the administrator within 5 working days. The Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated BDDS reports should be submitted within 24 hours. The GHD indicated the results of investigations should be reported to the administrator within 5 working days. The GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>11) On 10/2/15 at 11:40 AM at the facility-operated day program, client #3 hit client #5 on the back. Client #5 was not injured.</p>			

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	<p>On 3/4/16 at 2:50 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>12) On 12/5/15 at 7:45 AM, staff did not properly administer client #1's multivitamin (supplement). The 12/5/15 Medication Error Form indicated, in part, "Staff gave [client #1] a medication either at the wrong time or at the wrong dosage. It was found in the evening buddy check." The 2/25/16 BDDS Incident Follow-Up Report indicated, "The medication was passed during her evening med pass, as well as in the morning. [Client #1] received an extra dose... Staff will be disciplined per Stone Belt's Medication Error and Progressive Disciplinary Action Policies and Procedures."</p> <p>The 1/18/16 Medication Error Report (MER) indicated staff #3 was responsible</p>			

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	<p>for the medication error. The Document Action Taken section of the MER was blank. There was no documentation staff #3 received corrective action.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated the staff should have received corrective action.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated the staff should have received corrective action.</p> <p>13) On 12/10/15 at 12:00 PM at the facility-operated day program, staff did not administer client #5's Risperidone (psychosis). The 12/11/15 BDDS report indicated, in part, "The med error was discovered when (sic) remembered a couple of hours later that no one had been contacted to administer the medication... There was no effect to [client #5] due to this med error. Staff will be disciplined as per Stone Belt's med error policy." There was no documentation the staff involved received disciplinary action as indicated.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated corrective action should have been implemented.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated corrective action should have</p>			

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	<p>been implemented.</p> <p>14) On 12/17/15 at 7:10 AM, client #2 was finished with her breakfast. Client #2 took her last swallow of water and choked on the water. The 12/17/15 BDDS report indicated, "[Staff #4, #1 and #11] encouraged [client #2] to cough. [Client #2] couldn't catch her breath so [staff #1] performed the Heimlich on [client #2]. [Client #2] then jumped and was finally able to catch her breath. [Client #2] appeared to be a little horse (sic) for a few minutes, but continued clearing her throat. After a few minutes, [client #2] continued with her morning routine... [Staff #1] spoke directly with nurse who informed staff that [client #2] could have pocketed foot (sic) in her mouth, and that it was unclear why she choked... DSGL (Director Supervised Group Living) is conducting an inquiry into the choking incident."</p> <p>There was no documentation an inquiry (investigation) was conducted.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated an inquiry was not completed as indicated. The Coordinator indicated an inquiry should have been conducted. The Coordinator indicated a Choking Checklist was completed after he realized an inquiry had not been completed.</p>			

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	<p>On 3/4/16 at 2:50 PM, the GHD indicated an inquiry was not completed as indicated. The GHD indicated an inquiry should have been conducted. The GHD indicated a Choking Checklist was completed once she realized an inquiry was not completed. The GHD indicated client #2 had a Dining Plan at the time of the incident and the Choking Checklist addressed whether or not staff implemented the plan as written. The GHD indicated client #2's Dining Plan was implemented as written.</p> <p>15) On 1/15/16 at 5:07 PM, staff administered medication to client #3 at the wrong time. The physician's order was for client #3 to receive Polyethylene Glycol powder (constipation) every day as needed. Client #3 was administered the medication during the morning medication pass and a second dose in the afternoon. The two doses were administered within a 10-hour period. The 1/18/16 BDDS report indicated, "On 01/18/2016, this med error was found while staff was looking over the MARs (Medication Administration Records). Nurse was notified; there was no noticeable effect to [client #3] due to this med error. Staff will be disciplined as per Stone Belt's med error policy."</p>			

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	<p>The 1/18/16 Medication Error Report (MER) indicated staff #3 was responsible for the medication error. The Document Action Taken section of the MER was blank. There was no documentation the staff was disciplined as indicated in the BDDS report.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated corrective action should have been implemented.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated corrective action should have been implemented.</p> <p>16) The 1/3/16 Stone Belt ARC Inc. Incident Report indicated, "[Client #3] went to her mothers (sic) for a family visit. [Client #3] was gone from 12-22-15 through 1-3-16. [Client #3's] bubble packs were sent with her and (sic) was explained to when to take her Diflucan (antifungal). I asked [client #3] if she had any questions or concerns. [Client #3] told me no that it was fine that she had no questions (sic). [Client #3] was gone for 12 days. During this time frame [client #3] had medication that was scheduled for her to take at certain times. Which [client #3] missed several doses... [Client #3] took an extra does (sic) of the Diflucan and we followed up with the nurse practitioner</p>			

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	<p>today. The nurse practitioner said to continue the Diflucan. [Client #3] reported to myself and our nurse that she had taken 60 units of Lantus (diabetes) at one setting (sic) on a few occasions." An attachment to the incident report indicated client #3 took 9 of 12 doses of Escitalopram (depression), 16 of 24 doses of Naltrexone (trauma/weight loss), 9 of 13 doses of Trajenta (diabetes), 5 of 12 doses of Melatonin (sleep), 18 of 24 doses of Metoprolol (hypertension), an extra weekly dose of Diflucan, and 18 units of Lantus over a 12 day span.</p> <p>On 3/4/16 at 1:17 PM, a review of client #3's record was conducted. A 1/4/16 Nursing Consultation Note indicated, in part, "This nurse received a text from staff [staff #1] wanting to know if I could stop by the house. [Client #3] had returned from her visit with her mom, and she had several med errors. I stopped by and helped [staff #1] with the med documentation for the IR (incident report)." A 1/5/16 Nursing Consultation Note indicated, in part, "[Client #3] was meeting with [Group Home Director] at [name of counseling center]. She requested that I come and she speak with me as well... Explained in length to her the importance of her taking her medications as directed." A 1/7/16 Nursing Consultation Note indicated, in</p>						

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	<p>part, "This nurse received a call from [name], [client #3's] mother. She had questions and concerns about [client #3's] care. Explained in grave detail why [client #3's] 'yeast infection,' had gotten worse. [Client #3's mother] denied that [client #3's] blood sugars were high during her visit. She also denied that [client #3] gained as much weight as she did...."</p> <p>There was no documentation the facility reported the medication errors to BDDS.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated the medication errors should have been reported to BDDS.</p> <p>On 3/8/16 at 12:14 PM, the Nurse Manager (NM) indicated at the time client #3 was on a home visit, she had an order to receive 17 units of Lantus daily at bedtime.</p> <p>17) On 1/20/16 at 11:15 AM at the facility-operated day program, client #5 hit a peer with an open hand on the upper right shoulder. The peer was not injured.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure prohibiting abuse</p>			

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	<p>of the clients.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients.</p> <p>18) On 1/25/16 at 9:00 AM, the 1/25/16 Stone Belt ARC, Inc. Incident Report indicated, in part, "The previous evening, an email was sent to the [name of group home] about [client #3] hoarding food items from the kitchen without staff knowledge. Per [client #3's] behavior plan, she is not to have kitchen access. Staff involved in this incident, [staff #1 and #8], were concerned about undiscovered food packaging left in [client #3's] room attracting vermin. Involved staff decided to look for food items in [client #3's] room that were either spoiled or in need of disposal. Staff searched [client #3's] room for food items or food packaging. Staff found an empty container of prunes and a jar of plastic spoons. During the search, however, staff also found a plastic baggie in [client #3's] closet that contained 20 blue pills with the number 17 on them. [Staff #1] took these pills to [address] to show to (name of GHD). Staff identified them as Naproxen (anti-inflammatory)</p>			

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	<p>200 mg (milligrams) tablets. Staff sent these into med destruct and wrote an IR (incident report). [GHD] met with [client #3] for [client #3's] counseling session and talked with her about this incident. It was discovered that [client #3] had taken a key to the kitchen from another client. [Client #3] gave [GHD] the key. Further discussion among [client #3's] support team about how best to proceed will occur."</p> <p>There was no documentation the incident was investigated. There was no documentation indicating where client #3 obtained the pills.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated the incident should have been reported to BDDS.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated there was no documentation of an investigation. The GHD indicated the facility looked into the incident. The GHD indicated the pills came from client #3's mother's house. The GHD indicated client #3 did not take any of the pills. The GHD indicated there was no documentation of an investigation.</p> <p>On 3/3/16 at 2:47 PM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated</p>			

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	<p>5/14/13, 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 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...</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</p>			

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	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 policy indicated, "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." The policy indicated, in part, "Review the Incident Report to identify individuals and the nature of their participation, i.e. possible victims, perpetrators and witnesses. If there is an allegation of abuse/neglect or exploitation all staff assigned to the client(s) and present during the event, will be interviewed or asked to provide a written, signed statement. All perpetrators/alleged perpetrators will be interviewed or asked to provide a written, signed statement. All persons who saw the incident and are able to give substantial information are to be interviewed or provide written, signed statements. Those individuals who are not able to provide written or verbal statements due to disability are not required to provide statements. If			

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W 0153 Bldg. 00	<p>statements can be interpreted by staff, or a 'knowledgeable other' familiar with the client's communication style, signed statements from these individuals are to be provided. In a residential setting, all residents present for the incident and able to participate in the interview process must be interviewed to assure they have not been victimized or traumatized by the event."</p> <p>9-3-2(a)</p> <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 2 of 29 incident reports reviewed affecting clients #2 and #3, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include: On 3/3/16 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the</p>	W 0153	<p>W 153 Staff Treatment of Clients(Standard) 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. Corrective action for resident(s) found to have been affected The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including client to client abuse, and injuries of unknown origin,</p>	04/08/2016

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	<p>following:</p> <p>1) On 9/29/15 at 2:00 PM while on an outing with the facility-operated day program, the 10/26/15 BDDS report indicated, in part, "...[client #3] and [client #2] went to the restroom at the [name of public building]. Staff, [day program staff #2], stood outside of the restroom while they were inside. After exiting, [client #2] acted upset: pointing, rocking back and forth, and making 'mad face.' [Client #3] was not sure why [client #2] was upset. [Client #3] is verbal and [client #2] is non-verbal. On 10/19/2015, [client #3] told her [day program] instructor, [day program staff #3], that while in the restroom on 09/29/2015, [client #3] had told [client #2] she could not leave the restroom until she showed [client #3] that she did not have any items she would throw. [Client #2] has a history of stashing throwables in her bra and underwear. [Client #3] checked [client #2's] bra and underwear for items, and then dismissed [client #2] from the restroom. When [name of day program] Coordinator, [day program staff #4], learned about the 09/29/2015 challenge of two male staff on community activity, coordinator talked with [names of day program staff #2 and #5] about asking female clients to go in one at a time, and not send in two</p>		<p>including the need to report and investigate promptly and follow-through until issue is resolved. QIDP will be trained on investigations policy and procedure, including completing the investigation within five business days. Training for QIDP and staff about immediate reporting for allegations of abuse, neglect and exploitation. QIDP and staff will be trained on medication error reporting to agency and state as well as corrective action. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff training will be conducted. How corrective actions will be monitored to ensure no recurrence The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>together. When coordinator learned of [client #3's] story on 10/29/2015, coordinator spoke with [name of day program Director]. Originally, it was unclear how to categorize event, but after Director spoke with the SGL Director [name], it was decided that this would be classified as client to client aggression and be reported to BDDS/state, and APS (Adult Protective Services)."</p> <p>The facility failed to submit the incident to BDDS in a timely manner.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated BDDS reports should be submitted within 24 hours.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated BDDS reports should be submitted within 24 hours.</p> <p>2) On 1/25/16 at 9:00 AM, the 1/25/16 Stone Belt ARC, Inc. Incident Report indicated, in part, "The previous evening, an email was sent to the [name of group home] about [client #3] hoarding food items from the kitchen without staff knowledge. Per [client #3's] behavior plan, she is not to have kitchen access. Staff involved in this incident, [staff #1 and #8], were concerned about undiscovered food packaging left in [client #3's] room attracting vermin.</p>			

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	<p>Involved staff decided to look for food items in [client #3's] room that were either spoiled or in need of disposal. Staff searched [client #3's] room for food items or food packaging. Staff found an empty container of prunes and a jar of plastic spoons. During the search, however, staff also found a plastic baggie in [client #3's] closet that contained 20 blue pills with the number 17 on them. [Staff #1] took these pills to [address] to show to (name of GHD). Staff identified them as Naproxen (anti-inflammatory) 200 mg (milligrams) tablets. Staff sent these into med destruct and wrote an IR (incident report). [GHD] met with [client #3] for [client #3's] counseling session and talked with her about this incident. It was discovered that [client #3] had taken a key to the kitchen from another client. [Client #3] gave [GHD] the key. Further discussion among [client #3's] support team about how best to proceed will occur."</p> <p>There was no documentation the incident was investigated. There was no documentation indicating where client #3 obtained the pills.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated the incident should have been reported to BDDS.</p>			

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W 0154 Bldg. 00	<p>On 3/4/16 at 2:50 PM, the GHD indicated there was no documentation of an investigation. The GHD indicated the facility looked into the incident. The GHD indicated the pills came from client #3's mother's house. The GHD indicated client #3 did not take any of the pills. The GHD indicated there was no documentation of an investigation.</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 2 of 29 incident/investigative reports reviewed affecting clients #2 and #3, the facility failed to conduct thorough investigations. Findings include: On 3/3/16 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 12/17/15 at 7:10 AM, client #2 was finished with her breakfast. Client</p>	W 0154	<p>W 154 Staff Treatment of Clients(Standard) The facility must have evidence that all alleged violations are thoroughly investigated. Corrective action for resident(s) found to have been affected The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including the need to follow-through until issue is resolved. QIDP and staff will be trained on reporting all incidents that involve choking, falling or other potential risk. How facility will identify other residents potentially affected & what measures taken All</p>	04/08/2016

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	<p>#2 took her last swallow of water and choked on the water. The 12/17/15 BDDS report indicated, "[Staff #4, #1 and #11] encouraged [client #2] to cough. [Client #2] couldn't catch her breath so [staff #1] performed the Heimlich on [client #2]. [Client #2] then jumped and was finally able to catch her breath. [Client #2] appeared to be a little horse (sic) for a few minutes, but continued clearing her throat. After a few minutes, [client #2] continued with her morning routine... [Staff #1] spoke directly with nurse who informed staff that [client #2] could have pocketed foot (sic) in her mouth, and that is was unclear why she choked... DSGL (Director Supervised Group Living) is conducting an inquiry into the choking incident."</p> <p>There was no documentation an inquiry (investigation) was conducted.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated an inquiry was not completed as indicated. The Coordinator indicated an inquiry should have been conducted. The Coordinator indicated a Choking Checklist was completed after he realized an inquiry had not been completed.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated an inquiry was not completed as indicated. The GHD indicated an</p>		<p>residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff training will be conducted. How corrective actions will be monitored to ensure no recurrence The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>				

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	<p>inquiry should have been conducted. The GHD indicated a Choking Checklist was completed once she realized an inquiry was not completed. The GHD indicated client #2 had a Dining Plan at the time of the incident and the Choking Checklist addressed whether or not staff implemented the plan as written. The GHD indicated client #2's Dining Plan was implemented as written.</p> <p>2) On 1/25/16 at 9:00 AM, the 1/25/16 Stone Belt ARC, Inc. Incident Report indicated, in part, "The previous evening, an email was sent to the [name of group home] about [client #3] hoarding food items from the kitchen without staff knowledge. Per [client #3's] behavior plan, she is not to have kitchen access. Staff involved in this incident, [staff #1 and #8], were concerned about undiscovered food packaging left in [client #3's] room attracting vermin. Involved staff decided to look for food items in [client #3's] room that were either spoiled or in need of disposal. Staff searched [client #3's] room for food items or food packaging. Staff found an empty container of prunes and a jar of plastic spoons. During the search, however, staff also found a plastic baggie in [client #3's] closet that contained 20 blue pills with the number 17 on them. [Staff #1] took these pills to [address] to</p>			

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W 0156	<p>show to (name of GHD). Staff identified them as Naproxen (anti-inflammatory) 200 mg (milligrams) tablets. Staff sent these into med destruct and wrote an IR (incident report). [GHD] met with [client #3] for [client #3's] counseling session and talked with her about this incident. It was discovered that [client #3] had taken a key to the kitchen from another client. [Client #3] gave [GHD] the key. Further discussion among [client #3's] support team about how best to proceed will occur."</p> <p>There was no documentation the incident was investigated. There was no documentation indicating where client #3 obtained the pills.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated there was no documentation of an investigation. The GHD indicated the facility looked into the incident. The GHD indicated the pills came from client #3's mother's house. The GHD indicated client #3 did not take any of the pills. The GHD indicated there was no documentation of an investigation.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p>				

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Bldg. 00	<p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 1 of 29 incident/investigative reports reviewed affecting clients #2 and #3, the facility failed to submit the results of an investigation to the administrator within 5 working days.</p> <p>Findings include:</p> <p>On 3/3/16 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 9/29/15 at 2:00 PM while on an outing with the facility-operated day program, the 10/26/15 BDDS report indicated, in part, "...[client #3] and [client #2] went to the restroom at the [name of public building]. Staff, [day program staff #2], stood outside of the restroom while they were inside. After exiting, [client #2] acted upset: pointing, rocking back and forth, and making 'mad face.' [Client #3] was not sure why [client #2] was upset. [Client #3] is verbal and [client #2] is non-verbal. On 10/19/2015, [client #3] told her [day program] instructor, [day program staff #3], that while in the restroom on 09/29/2015, [client #3] had told [client #2] she could not leave the restroom until</p>	W 0156	<p>W 156 Staff Treatment of Clients(Standard) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Corrective action for resident(s) found to have been affected The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including the need to report findings to SGL Director within five working days. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP training will be conducted. How corrective actions will be monitored to ensure no recurrence The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at</p>	04/08/2016

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	<p>she showed [client #3] that she did not have any items she would throw. [Client #2] has a history of stashing throwables in her bra and underwear. [Client #3] checked [client #2's] bra and underwear for items, and then dismissed [client #2] from the restroom. When [name of day program] Coordinator, [day program staff #4], learned about the 09/29/2015 challenge of two male staff on community activity, coordinator talked with [names of day program staff #2 and #5] about asking female clients to go in one at a time, and not send in two together. When coordinator learned of [client #3's] story on 10/29/2015, coordinator spoke with [name of day program Director]. Originally, it was unclear how to categorize event, but after Director spoke with the SGL Director [name], it was decided that this would be classified as client to client aggression and be reported to BDDS/state, and APS (Adult Protective Services)."</p> <p>The results of the 10/27/15 investigation were not submitted to the administrator for review within 5 working days.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated the results of investigations should be reported to the administrator within 5 working days.</p>		resurvey.		

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W 0157 Bldg. 00	<p>On 3/4/16 at 2:50 PM, the GHD indicated the results of investigations should be reported to the administrator within 5 working days.</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 3 of 5 clients living in the group home (#1, #3 and #5), the facility failed to implement appropriate corrective actions to address medication errors.</p> <p>Findings include:</p> <p>On 3/3/16 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 12/5/15 at 7:45 AM, staff did not properly administer client #1's multivitamin (supplement). The 12/5/15 Medication Error Form indicated, in part, "Staff gave [client #1] a medication either at the wrong time or at the wrong dosage. It was found in the evening buddy check." The 2/25/16 BDDS Incident Follow-Up Report indicated,</p>	W 0157	<p>W 157 Staff Treatment of Clients(Standard) If the alleged violation is verified, appropriate corrective action must be taken. Corrective action for resident(s) found to have been affected A new procedure will be developed to ensure that the agency's disciplinary and corrective actions for medication errors is being followed by the QIDP, and the QIDP will be trained on the new procedure. The QIDP will be trained on the agency's abuse, neglect and exploitation policy, including the need to follow-through until issue is resolved. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence A new procedure will be</p>	04/08/2016

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	<p>"The medication was passed during her evening med pass, as well as in the morning. [Client #1] received an extra dose... Staff will be disciplined per Stone Belt's Medication Error and Progressive Disciplinary Action Policies and Procedures."</p> <p>The 1/18/16 Medication Error Report (MER) indicated staff #3 was responsible for the medication error. The Document Action Taken section of the MER was blank. There was no documentation staff #3 received corrective action.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated the staff should have received corrective action.</p> <p>On 3/4/16 at 2:50 PM, the Group Home Director (GHD) indicated the staff should have received corrective action.</p> <p>2) On 12/10/15 at 12:00 PM at the facility-operated day program, staff did not administer client #5's Risperidone (psychosis). The 12/11/15 BDDS report indicated, in part, "The med error was discovered when remembered a couple of hours later that no one had been contacted to administer the medication... There was no effect to [client #5] due to this med error. Staff will be disciplined as per Stone Belt's med error policy."</p>		<p>developed for medication error tracking, and QIDP training will be conducted. How corrective actions will be monitored to ensure no recurrence The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		

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	<p>There was no documentation the staff involved received disciplinary action as indicated.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated corrective action should have been implemented.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated corrective action should have been implemented.</p> <p>3) On 1/15/16 at 5:07 PM, staff administered medication to client #3 at the wrong time. The physician's order was for client #3 to receive Polyethylene Glycol powder (constipation) every day as needed. Client #3 was administered the medication during the morning medication pass and a second dose in the afternoon. The two doses were administered within a 10-hour period. The 1/18/16 BDDS report indicated, "On 01/18/2016, this med error was found while staff was looking over the MARs (Medication Administration Records). Nurse was notified; there was no noticeable effect to [client #3] due to this med error. Staff will be disciplined as per Stone Belt's med error policy."</p> <p>The 1/18/16 Medication Error Report (MER) indicated staff #3 was responsible for the medication error. The Document</p>			

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W 0159 Bldg. 00	<p>Action Taken section of the MER was blank. There was no documentation the staff was disciplined as indicated in the BDDS report.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated corrective action should have been implemented.</p> <p>On 3/4/16 at 2:50 PM, the GHD indicated corrective action should have been implemented.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 clients in the sample (#3, #4 and #5), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' individualized program plans by failing to conduct regular reviews of the clients' progress toward meeting their training objectives.</p> <p>Findings include:</p>	W 0159	<p>W 159 QIDP(Standard) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.</p> <p>Corrective action for resident(s) found to have been affected QIDP will be trained on active treatment programing, development and implementation. QIDP will be trained on quarterly reports, meetings and documentation of ISP progress towards goals set by the IST.</p> <p>How facility will identify other</p>	04/08/2016

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	<p>On 3/4/16 at 1:17 PM, a review of client #3's record was conducted. There was no documentation the QIDP reviewed client #3's progress toward meeting her training goals and objectives from 12/8/15 to 3/4/16. There were regular reviews conducted monthly from 4/23/15 (admission date to the group home) to 12/8/15. Client #3's record contained documentation of quarterly reviews being conducted on 9/9/15 and 12/8/15. There was no quarterly review conducted in July 2015. The quarterly review conducted on 1/7/16 did not include documentation of the goals and objectives being reviewed. The 1/7/16 quarterly was blank in the section for review of the client's goals and objectives.</p> <p>On 3/7/16 at 10:59 AM, a review of client #4's record was conducted. There was no documentation the QIDP reviewed client #4's progress toward meeting her training goals and objectives from 12/8/15 to 3/4/16. There were regular reviews conducted monthly from 3/3/15 to 12/8/15. Client #4 had quarterly reviews conducted on 5/11/15 for February, March and April and 8/10/15 for June and July. There were no additional quarterly reviews in her record.</p>		<p>residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP training will be conducted. How corrective actions will be monitored to ensure no recurrence The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>				

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W 0249 Bldg. 00	<p>On 3/7/16 at 11:54 AM, a review of client #5's record was conducted. There was no documentation the QIDP reviewed client #5's progress toward meeting her training goals and objectives from 12/8/15 to 3/4/16. There were regular reviews conducted monthly from 3/3/15 to 12/8/15. Client #5 had quarterly reviews conducted on 5/11/15 for February, March and April, 7/15/15 for April, May and June, and 10/8/15 for August and September. There were no additional quarterly reviews in her record.</p> <p>On 3/7/16 at 11:52 AM, the Coordinator indicated he thought the reviews were conducted since 12/8/15 however the Coordinator did not provide documentation to review. The Coordinator indicated the old progress he used to write goals and objectives would provide a report monthly once the data was entered. The Coordinator indicated the facility switched forms the facility used to conduct quarterly reviews.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>			

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	<p>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 (#3, #4 and #5), the facility failed to ensure the facility-operated day program implemented the clients' program plans as written during two observations.</p> <p>Findings include:</p> <p>On 3/3/16 from 1:05 PM to 2:24 PM, an observation was conducted at the facility-operated day program. At 1:05 PM, client #5 had her head on the table. Client #3 was playing a game on a tablet. At 1:21 PM, client #5 had her head down and client #3 put her tablet down to use the restroom. At 1:24 PM, client #5 was asked if she wanted her nails done. Client #5 ate a snack. At 1:29 PM, client #3 was playing a game on her tablet. At 1:35 PM, client #4 entered the room. At 1:47 PM, client #3 was not engaged and not offered activities. Client #5 was playing on a tablet. Client #4 had her nails painted. During the observation, client #3 was not engaged in activities, client #5 played on a tablet, and client #4 had her nails painted.</p>	W 0249	<p>W 249 Program Implementation(Standard) Client ISPs must consist of needed interventions and include continuous active treatment. Corrective action forresident(s) found to have been affected QIDP will be trained on active treatment programing, development and implementation. QIDP and staff will be trained on client's ISP and active treatment programing, including use of adaptive equipment(CPAP) and engaging clients in active treatment(money goals, self care) How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff training will be conducted. CPAP machine will be purchased by Stone Belt. How corrective actions will be monitored to ensure no recurrence The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all</p>	04/08/2016

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	<p>On 3/4/16 from 11:46 AM to 12:45 PM, an observation was conducted at the facility-operated day program. At 11:46 AM, clients #3 and #5 were eating their lunches. At 12:04 PM, client #3 put her head down on the table. At 12:07 PM, day program staff (DPS) #6 prompted client #3 to work on her puzzle. Client #3 did not work on a puzzle and continued to have her head on the table. At 12:09 PM, clients #3 and #5 had their heads on the table. At 12:13 PM, clients #3 and #5 were falling asleep. At 12:18 PM, both clients were asleep. At 12:22 PM, client #5 lifted her head up and was asked by DPS #6 if she wanted to watch television. Client #5 did not move and was not offered an alternate activity. At 12:22 PM, client #3 was prompted by DPS #6 to play a game. Client #3 continued to have her head on the table. Client #3 was not offered alternate activities. At 12:26 PM, client #5 was prompted to wake up. No activities were offered to her. At 12:30 PM, client #3 was awake but not engaged in an activity. Client #3 was asleep. At 12:35 PM, client #5 was asked if she wanted her nails painted. Client #5 did not want her nails painted. No additional activities were offered to client #5. At 12:40 PM, clients #3 and #5 were asleep. At 12:45 PM, clients #3 and #5 were asleep.</p>		<p>documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>	

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	<p>On 3/4/16 at 1:17 PM, a review of client #3's record was conducted. Client #3's 4/23/15 Individual Support Plan (ISP) indicated she had the following training objectives: complete a personal schedule each week and give it to her instructor at the facility-operated day program, balance her debit card ledger weekly and assist in meal preparation.</p> <p>On 3/7/16 at 10:59 AM, a review of client #4's record was conducted. Client #4's 4/17/15 ISP indicated she had the following training objectives: maintain her debit card ledger, assist with meal preparation, exercise for 50 minutes or more daily and stay awake during day program hours.</p> <p>On 3/7/16 at 11:54 AM, a review of client #5's record was conducted. Client #5's 4/9/15 ISP indicated she had the following training objectives: use complete sentences, count her bills in her bag, review evacuation drill social story and brush her teeth thoroughly.</p> <p>On 3/4/16 at 2:49 PM, the Coordinator indicated the facility-operated day program should offer activities for the clients to engage in. The Coordinator indicated the clients should be engaged in activities and their program plans</p>			

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W 0436 Bldg. 00	<p>implemented while at the facility-operated day program.</p> <p>On 3/4/16 at 2:49 PM, the Group Home Director (GHD) indicated the facility-operated day program should offer activities for the clients to engage in. The GHD indicated the clients should be engaged in activities and their program plans implemented while at the facility-operated day program.</p> <p>9-3-4(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on record review and interview for 1 of 3 clients in the sample with adaptive equipment (#3), the facility failed to obtain a CPAP (continuous positive airway pressure - a treatment using mild air pressure to keep the airways open) machine for client #3 to use.</p> <p>Findings include:</p> <p>On 3/4/16 at 1:17 PM, a review of client</p>	W 0436	<p>W 436 Space and Equipment(Standard) 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 communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Corrective action for resident(s) found to have been affected QIDP will be trained about client's</p>	04/08/2016

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	<p>#3's record was conducted and indicated the following:</p> <p>-A 9/29/15 Stone Belt Outside Services Report indicated, in part, "Overnight sleep study." There was no additional documentation on the form.</p> <p>-A 10/8/15 SGL (Supervised Group Living) Support Team Review Form indicated, in part, "Had sleep study. Results showed possible sleep apnea (a sleep disorder characterized by pauses in breathing or instances of shallow breathing during sleep) and she had follow up on 11/5/15."</p> <p>-A 11/5/15 Positive Airway Pressure Titration Final Report indicated, in part, "Indications: known sleep apnea, Prader-Willi syndrome (a genetic disorder usually caused by deletion of a part of chromosome 15 passed down by the father. The most common symptoms of Prader-Willi syndrome are behavior problems, intellectual disability, and short stature. Hormonal symptoms include delayed puberty and constant hunger leading to obesity), CPAP titration... [Client #3], who is a 23 year-old female patient, was evaluated for sleep breathing disorders in an all-night polysomnogram (sleep study) on 11/5/2015. The patient's chief</p>		<p>adaptive equipment, use and maintenance. Also trained how to engage clients in using their adaptive equipment How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff training will be conducted. How corrective actions will be monitored to ensure no recurrence The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>				

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	<p>complaints are known sleep apnea, Prader-Willi syndrome... The patient experienced 11 apneas in total... Recommendations: BIPAP (bilevel positive airway pressure) of 14/8 cm (centimeters) water pressure with a back up of 10/min for Complex Sleep Apnea using a Small ResMed Quattro Air full face mask."</p> <p>-A 2/4/16 Nursing Consultation note indicated, in part, "This nurse spoke with [name] from [name of pharmacy] concerning the Cpap for [client #3]. Insurance is denying because she lives in a group home. This is being categorized as a skilled nursing facility. Waiting on the fax with all the information from [name]. Will contact appropriate staff."</p> <p>On 3/4/16 at 1:56 PM, the Nurse Manager (NM) indicated client #3 did not have a CPAP yet. The NM stated, "Insurance won't pay for it. Being denied." The NM indicated Stone Belt needed to pay for the equipment.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated if insurance did not pay for the machine, Stone Belt should pay for it.</p> <p>On 3/4/16 at 2:50 PM, the Group Home Director indicated the facility should pay for the machine.</p>			

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W 9999 Bldg. 00	<p>On 3/7/16 at 11:33 AM, the nurse indicated authorization for the machine was declined in February 2016. The nurse indicated she requested the physician to resubmit the request. The nurse indicated client #3 had a follow-up appointment scheduled on 5/16/16 with the pulmonologist. The nurse indicated client #3 said she was going to refuse to wear it if it was obtained. The nurse indicated the facility should pay for the device since insurance was denying coverage. The nurse indicated client #3's primary care physician ordered the CPAP after her sleep study in November 2015.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>1) 460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the</p>	W 9999	<p>Corrective action for resident(s) found to have been affected The QIDP and staff will be trained on the agency's medication error reporting policy including the need to follow-through until issue is resolved. QIDP and staff will be trained on reporting all incidents that involve choking, falling or other potential risk. QIDP will be trained on staff need for yearly TB tests How facility will identify</p>	04/08/2016

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	<p>division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>15. A fall resulting in injury, regardless of the severity of the injury. 16. A medication error or medical treatment error as follows: a. wrong medication given; b. wrong medication dosage given; c. missed medication - not given; d. medication given wrong route; or e. medication error that jeopardizes an individual's health and welfare and requires medical attention.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 29 incident reports reviewed affecting client #3, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law.</p> <p>Findings include:</p> <p>On 3/3/16 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>A) The 1/3/16 Stone Belt ARC Inc. Incident Report indicated, "[Client #3]</p>		<p>other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QIDP and staff training will be conducted. How corrective actions will be monitored to ensure no recurrence The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		

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	<p>went to her mothers (sic) for a family visit. [Client #3] was gone from 12-22-15 through 1-3-16. [Client #3's] bubble packs were sent with her and (sic) was explained to when to take her Diflucan (antifungal). I asked [client #3] if she had any questions or concerns. [Client #3] told me no that it was fine that she had no questions (sic). [Client #3] was gone for 12 days. During this time frame [client #3] had medication that was scheduled for her to take at certain times. Which [client #3] missed several doses... [Client #3] took an extra does (sic) of the Diflucan and we followed up with the nurse practitioner today. The nurse practitioner said to continue the Diflucan. [Client #3] reported to myself and our nurse that she had taken 60 units of Lantus (diabetes) at one setting (sic) on a few occasions." An attachment to the incident report indicated client #3 took 9 of 12 doses of Escitalopram (depression), 16 of 24 doses of Naltrexone (trauma/weight loss), 9 of 13 doses of Trajenta (diabetes), 5 of 12 doses of Melatonin (sleep), 18 of 24 doses of Metoprolol (hypertension), an extra weekly dose of Diflucan, and 18 units of Lantus over a 12 day span.</p> <p>There was no documentation the facility reported the medication errors to BDDS.</p>			

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	<p>On 3/4/16 at 2:50 PM, the Coordinator indicated the medication errors should have been reported to BDDS.</p> <p>B) On 1/27/16 at 1:14 PM at the facility-operated day program, client #3 was walking to the restroom and shuffling her feet. Client #3 stumbled and fell forward, catching herself with her hands and knees. Client #3 had a red mark about a half an inch long under her right knee. There was no documentation the fall with injury was reported to BDDS.</p> <p>On 3/4/16 at 2:50 PM, the Coordinator indicated the fall should have been reported to BDDS.</p> <p>On 3/4/16 at 2:50 PM, the Group Home Director indicated the fall should have been reported to BDDS.</p> <p>2) 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</p>						

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	<p>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 #3), the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>On 3/3/16 at 2:54 PM a review of the facility's employee files was conducted. Staff #3's employee file did not contain documentation of a TB test being conducted since she was hired on 6/1/15.</p> <p>On 3/3/16 at 3:17 PM, the Human Resources Director indicated there was no documentation in staff #3's employee file indicating she had a TB test.</p> <p>On 3/4/16 at 2:47 PM, the Coordinator indicated the staff should have an annual TB test.</p>			

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	<p>On 3/4/16 at 2:47 PM, the GHD indicated the staff should have an annual TB test.</p> <p>9-3-3(e) 9-3-1(b)</p>				