

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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W000000	<p>This visit was for a Post Certification Revisit (PCR) to the investigation of complaint #IN00159056 completed on 11/24/14.</p> <p>Complaint #IN00159056: Not corrected.</p> <p>This visit was in conjunction to the PCR to the full recertification and state licensure survey completed on 10/22/14. This visit included the PCR to the investigation of complaint #IN00156855.</p> <p>This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN00151850 completed on 10/22/14.</p> <p>Survey Dates: January 12, 13, 14 and 15, 2015</p> <p>Facility Number: 001209 Provider Number: 15G634 AIM Number: 100240160</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/21/15 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 The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 4 of 4 clients living in the group home (B, C, D and E), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the couch in the living room was in good repair and 2) the common area floors not covered by carpet were free of dirt and debris.</p> <p>Findings include:</p> <p>On 1/12/15 from 3:02 PM to 5:37 PM, an observation was conducted at the group home and indicated the following:</p> <p>1) On 1/12/15 during the observation at the group home, the living room couch located near the dining room had a piece of the frame sticking out from underneath the couch. The couch's frame was broken and the springs were exposed on the right hand side of the couch. The right front leg was missing causing the couch to sit crooked. There was no new furniture at the group home in the living room since the last survey completed on 10/22/14.</p>	W000104	<p>1. Plan of correction: Coach was replaced with a new one (attachment a). 2. Plan of prevention: Facility house manager will complete maintenance request when an item is in need of replacement (attachment b). 3. Quality monitoring: Facility coordinator – QDIP will complete weekly supervisions and monitor condition of the home and furnishings (attachment b). 4. Plan of correction: Floors were stripped and waxed 2/4/15 by Laurie Best Cleaning (attachment c). Plan of prevention: Facility house manager will complete maintenance request when an item is in need of replacement (attachment b). Quality monitoring: Facility coordinator – QDIP will complete weekly supervisions and monitor condition of the home and furnishings (attachment b).</p>	02/04/2015

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	<p>This affected clients B, C, D and E.</p> <p>On 1/12/15 at 1:29 PM, a receipt indicated two couches were purchased for the group home. The receipt indicated, in part, "Est. (estimated) Ship Date: 6-8 weeks."</p> <p>On 1/12/15 at 11:27 AM, the Group Home Director (GHD) indicated two new couches were ordered but have not been received yet.</p> <p>2) On 1/12/15 during the observation at the group home, the common area floors not covered by carpet (kitchen, dining room, entrance and hallways) were discolored, marked, scuffed and dull. This affected clients B, C, D and E.</p> <p>On 1/12/15 at 4:46 PM, the GHD indicated the issue with the floors not covered by carpet was the staff were using too much cleaner on the floors. The GHD indicated the group home ran out of cleaner due to the staff using too much. The GHD indicated the cleaner needed to be used sparingly however the staff were using too much. The GHD stated the home was scheduled to be "deep-cleaned" soon including a waxing of the floors.</p> <p>This deficiency was cited on 10/22/14.</p>						

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W000149	<p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-1(a)</p> <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 4 of 29 incident/investigative reports reviewed affecting clients B, C and E, the facility neglected to implement its policies and procedures to prevent client to client abuse and take appropriate corrective action to address a medication error.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/12/15 at 12:10 PM and indicated the following:</p> <p>1) On 1/4/15 at 4:30 PM clients B and E were watching television in the living</p>	W000149	<p>1. Plan of correction: Client B is scheduled to transition to ResCare SLP setting closer to guardian date is set for 3/1/15. Historically conflicts between these clients are frequent and numerous plans have been attempted (attachment d). Plan of prevention: Staff completed comprehensive Crisis Prevention Intervention 2/6/15. Quality monitoring: Facility coordinator – QDIP or Facility director will provide daily supervisions and support staff in providing safe environment for clients (attachment b).</p> <p>2. Plan of correction: Staff #7 received written warning for medication error. Plan of prevention: Facility house manager and day aide will</p>	02/04/2015

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	<p>room. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 1/5/15, indicated, "[Client B] began harassing [client E] by following him around the house, entering [client E's] room without permission, and shouting 'no' at [client E]. [Client E] pushed [client B] into a wall. [Client B] stayed on his feet, and staff ensured he had no injuries. Five minutes later while [client B] continued to pester [client E], [client E] smacked [client B] on top of the head three times...."</p> <p>On 1/12/15 at 11:55 AM, 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 in place prohibiting abuse of the clients.</p> <p>2) On 12/21/14 at 8:00 AM, staff #7 administered client B a medication prescribed for client E. The Medication Error Report, dated 12/21/14, indicated, "Accidentally gave [client E's] Lorazepam 2 mg (milligram) in place of [client B's] Alprazolam 2 mg." The Supervisor: Document action taken section was not marked (verbal discussion/training, performance review given, written warning, retake med (medication) admin (administration))</p>		<p>continue to providedaily observations during medication administration. A new medication storagebox was introduced in the home to allow staff the ability to better see pillpacks (attachment b).</p> <p>Planof monitoring: Facility coordinator – QDIP will provide weekly medicationobservations (attachment b).</p> <p>3. Planof correction: Staff were training on LL program client that 'poked client btwice with a plastic fork (attachment e).</p> <p>Planof prevention: Client was also moved to a different program away from client b(attachment f).</p> <p>Planof monitoring: LL program coordinator will continue to offer training, monitoring, and support to LL direct care staff.</p> <p>4. Planof correction: Client B is scheduled to transition to ResCare SLP settingcloser to guardian. Historically conflicts between these clients are frequentand numerous plans have been attempted (attachment d).</p> <p>Planof prevention: Staff completed comprehensive Crisis Prevention Intervention2/6/15.</p> <p>Qualitymonitoring: Facility coordinator – QDIP or Facility director will provide dailysupervisions and support staff in providing safe environment for clients(attachment b).</p>	

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	<p>course plus 3 passes, or written warning with termination of employment). The report was not signed by staff #7's supervisor. The facility did not provide documentation staff #7 received a verbal warning for the medication error.</p> <p>On 1/13/15 at 12:32 PM, the Group Home Director (GHD) indicated there was no documentation of corrective action taken with staff #7. The GHD indicated it was a verbal warning. The GHD indicated this was staff #7's first medication error and the first error was a verbal warning. The GHD indicated the Home Manager should have documentation of the verbal warning and training.</p> <p>3) On 12/16/14 at 2:25 PM at the facility-operated day program, client B was poked on the arm and stomach with a plastic fork by a peer.</p> <p>On 1/12/15 at 11:55 AM, 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 in place prohibiting abuse of the clients.</p> <p>4) On 12/2/14 at 7:20 AM, client B refused to return staff #10's cellphone he</p>				

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	<p>took from the staff. Staff #10 got the phone back from client B and prepared to leave the group home. Staff #9 and client C were walking around the house. When client C and staff #9 stopped by the office door, client B walked up and pushed client C's head down onto staff #9's arm. Client C bit staff #9's arm and would not let go. Staff #9 yelled for assistance and staff #10 arrived to assist. The other staff moved client B away and asked client B to go to a quiet area. Staff #9 cleaned the wound on her arm. Staff #10 left the home. The BDDS report, dated 12/2/14, indicated, in part, "Directly after [staff #10's] departure at end of shift (sic), [client B] became angry and threw things at [staff #4]. [Staff #4] asked [client B] to calm down, take deep breaths, and count to 10; [client B] tried to hit, kick, and spit at [staff #4]. [Staff #4] asked [client B] to go to a quiet place to calm, but [client B] refused and continued his aggressive behavior. [Staff #4] and [staff #5] attempted to do a two-person transport to a quiet place, and in response to this, [client B] sat on the living room floor. After a five minute interval, [staff #4] and [staff #5] assisted [client B] back to his feet. [Client B] then sat down again in the hallway, where staff waited another five minutes before assisting [client B] to his feet; each transport lasted 3 seconds. Once standing, [client B] ran</p>			

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	to his bedroom, and [staff #4] followed after retrieving the blocking pad. [Staff #4] used the pad to block items [client B] was throwing and aggressive behavior, each time suggesting a calming technique. [Client B's] aggression continued by hitting windows, walls, and slamming door repeatedly. At 8:00 AM when [staff #11] arrived, he walked in to [name of group home] and to the end of the hall where [client B's] room is located, and attempted to switch places with [staff #4]. [Staff #4] was blocking [client B] from aggressive behavior per [client B's] behavior plan. [Staff #11] attempted to relieve [staff #4] with blocking pads. As the switch was happening [client B] lunged at [staff #11] knocking off his glasses and grabbing his shirt. [Staff #4] assisted [staff #11] by removing [client B] off of [staff #11]. [Staff #4] then used a one-person transport to assist [client B] back in (sic) to his room. [Client B's] aggressive behavior continued and proceeded for approximately five minutes. [Client B] then started showing signs of calming, deep breathing, and counting. [Staff #4 and #11] again attempted to switch positions, and in response, [client B] lunged and grabbed [staff #11's] eyeglasses. [Client B] attempted to bend the glasses before deciding to throw them down the hallway. As a result, [staff			

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	<p>#11] sustained a small laceration on the upper right side of his forehead. [Staff #4] again used a one-person transport to assist [client B] to his room; however, [client B] continued to act aggressively for another four to five minutes. [Staff #11] continued to block [client B] in the hallway another eight to ten minutes. [Client B] stopped trying to strike staff and proceeded to sit in the hallway, refusing to move or talk to staff..."</p> <p>The investigation, dated 12/6/14, indicated client B denied pushing client C's head down causing client C to bite staff #9. The Recommendations section of the investigation indicated, "Allegation stating [client B] 'shoved' [client C's] head is inconclusive. There were 5 staff and 4 clients (2 verbal) none of which (sic) witnessed or heard any proof that [client B] 'forced' [client C] into biting [staff #9]. [Staff #5] utilized CPI (Crisis Prevention Institute) bite release to assist [client C] in letting go of staff's arm. [Staff #9] has been transferred to another setting."</p> <p>On 1/12/15 at 11:23 AM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the</p>						

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	<p>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>This deficiency was cited on 10/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-2(a)</p>			

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W000157	<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 1 of 29 incident/investigative reports reviewed affecting client B, the facility failed to take appropriate corrective action to address a medication error.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/12/15 at 12:10 PM and indicated the following: On 12/21/14 at 8:00 AM, staff #7 administered client B a medication prescribed for client E. The Medication Error Report, dated 12/21/14, indicated, "Accidentally gave [client E's] Lorazepam 2 mg (milligram) in place of [client B's] Alprazolam 2 mg." The Supervisor: Document action taken section was not marked (verbal discussion/training, performance review given, written warning, retake med (medication) admin (administration) course plus 3 passes, or written warning with termination of employment). The report was not signed by staff #7's supervisor. The facility did not provide documentation staff #7 received a verbal</p>	W000157	<p>1. Plan of correction: Staff #7 received written warning for medication error. Plan of prevention: Facility house manager and day aide will continue to provide daily observations during medication administration. A new medication storage box was introduced in the home to allow staff the ability to better see pill packs (attachment b). Plan of monitoring: Facility coordinator – QDIP will provide weekly medication observations (attachment b).</p>	02/04/2015

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W000436	<p>warning for the medication error.</p> <p>On 1/13/15 at 12:32 PM, the Group Home Director (GHD) indicated there was no documentation of corrective action taken with staff #7. The GHD indicated it was a verbal warning. The GHD indicated this was staff #7's first medication error and the first error was a verbal warning. The GHD indicated the Home Manager should have documentation of the verbal warning and training.</p> <p>This deficiency was cited on 10/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00159056.</p> <p>9-3-2(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p>			
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	<p>Based on observation, record review and interview for 2 of 4 clients living in the group home with adaptive equipment (D and E), the facility failed to ensure the clients' glasses were in good repair.</p> <p>Findings include:</p> <p>On 1/12/15 from 3:02 PM to 5:37 PM an observation was conducted at the group home. During the observation, clients D and E were not observed to wear glasses.</p> <p>On 1/12/15 at 3:38 PM, the Home Manager (HM) indicated there was a box in the office at the group home with glasses in it. The HM located the box and opened it. There were 5 pairs of glasses in the box. Four of the five pairs of glasses were broken (frames broken or missing lenses). The HM indicated he was not sure if the good pair of glasses was client D or client E's glasses. The HM indicated clients D and E did not have glasses to wear.</p> <p>A review on 1/13/15 at 11:55 AM indicated an email, dated 12/16/14 at 1:48 PM, sent from the Group Home Director (GHD) to the group home staff indicated, in part, "It is the responsibility of the day aid to ensure that adaptive equipment is located in the home and is (sic) good condition. Please let them</p>	W000436	<p>1)Plan of correction: ClientD first available appointment was 2/18/15 for new eye glasses (attachment g).</p> <p>Plan of prevention: Facilityday Aide and house manager have been trained on medical appointment schedulesand ensuring these are appointments occur on time. Facility staff have beentrained on maintain and training clients in wearing / using adaptive equipmentper physician's orders.</p> <p>Plan of monitoring: Facilitycoordinator QDIP has been trained on monitoring that client's adaptiveequipment (attachment b).</p>	02/04/2015

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	<p>know if there is an item listed in a BSP (behavior support plan), ISP (individual support plan), or HRP (health risk plan) that is no longer applicable or has been lost. This includes items such as: helmets, padded gloves, eye glasses, retainers, mouth guards, communication devices, et cetera. This is very important! Not providing this equipment to our SGL (Supervised Group Living) clients is consider (sic) a state and federal violation...."</p> <p>A review on 1/13/15 at 1:25 PM indicated an email, dated 1/13/15 at 1:25 PM, sent from staff #4 to the group home staff indicated, in part, "I'm very happy to tell you all about [client E's] day. He got up and took a shower, brushed his teeth and got dressed with very little prompting. We went to [name] eye center and got his glasses repaired."</p> <p>On 1/13/15 at 12:53 PM, the Group Home Director indicated the clients' adaptive equipment (glasses) should be in good repair and available to the clients.</p> <p>This deficiency was cited on 10/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2015

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/15/2015
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408		
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