

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND ST BEDFORD, IN47421
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W0000	<p>This visit was for the investigation of complaint #IN00096692.</p> <p>Complaint #IN00096692 - Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149, W153, W154 and W157.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: October 7, 11, and 12, 2011.</p> <p>Facility Number: 001094 Provider Number: 15G653 AIM Number: 100235630</p> <p>Survey Team: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/25/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0125	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (B), the facility failed to ensure the clients' rights by implementing the use of a Merry Walker.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/11/11 from 4:12 PM to 5:17 PM. At 4:16 PM, client B exited the van and was immediately assisted into a merrywalker by staff #2. Client B remained in the merrywalker for the remainder of</p>	W0125	<p>PROTECTION OF CLIENT RIGHTS</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure the rights of the clients served. Stone Belt will allow and encourage clients to exercise their rights and have the right to due process.</p> <p>Date of Completion:</p>	11/11/2011

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>the observation.</p> <p>An interview with staff #3 was conducted on 10/11/11 at 4:16 PM. Staff #3 indicated client B was not able to exit the Merry Walker independently. Staff #3 indicated client B was not being taught how to exit the Merry Walker.</p> <p>An interview with staff #2 was conducted on 10/11/11 at 4:42 PM. Staff #2 indicated client B was not able to exit the Merry Walker independently. Staff #2 indicated client B was not being taught how to exit the Merry Walker independently. Staff #2 indicated she had been employed at the facility for 6 years and the facility had not tried the use of a gait belt and knee pads. Staff #2 indicated a regular walker was attempted earlier in the year however client B refused to use it. Staff #2 indicated she thought the use of a gait belt and knee pads would be sufficient to prevent falls.</p> <p>A review of client B's record was conducted on 10/12/11 at 8:03 AM. Client B had a doctor's order, dated 8/22/11, indicating an order for a merry PVC walker or merry motivator due to frequent falls. A Support Team Review Form, dated 8/24/11, indicated the following, "Numerous falls over last month. Merry walker will be purchased today, 8/24/11. Dr. [physician's name] order just received on 8/23/11. Seeing Dr. [physician's name] 8/31/11, due to falls and increased swatting." A Nurse Quarterly Physical, dated 8/29/11, indicated the following, "Increase in falls - some are related to behaviors ([client B] just drops to her knees during a behavior). New orders: To use PVC Merry Walker for all mobility while at home or community outings. To use Merry Motivator when at [day program] to help prevent falls." The record did not indicate the</p>		<p>November 11, 2011</p> <p>Person Responsible:</p> <p>Elliott Coordinator/Support Team</p> <p>Plan of Prevention:</p> <p>The Stone Belt Support Team will ensure that the use of restrictive devices receive appropriate approvals when using such devices.</p> <p>Quality Assurance Monitoring:</p> <p>Support Team meeting will be reviewed by Coordinator and SGL Director to assure proper approvals are given for restrictive devices.</p>		

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W0149	<p>guardian or the specially constituted committee consented to the use of the Merry Walker. Client B's ISP, dated 6/29/11, indicated she had a guardian.</p> <p>An interview with client B's guardian was conducted on 10/12/11 at 8:23 AM. Client B's guardian indicated she did not recall giving consent for the use of the Merry Walker. Client B's guardian indicated she would prefer to see less restrictive measures taken prior to using the Merry Walker such as knee pads and gait belt. Client B's guardian indicated client B did not like the Merry Walker and did not seem comfortable in it. The guardian indicated client B was not able to exit the Merry Walker by herself. Client B's guardian indicated she was not contacted prior to the Merry Walker being implemented. Client B's guardian stated she didn't know why they "put her in this silly thing." She was told the doctor prescribed it.</p> <p>9-3-2(a)</p> <p>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 1 of 3 investigations affecting 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to implement its policies and procedures to prevent abuse at the group home.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was</p>	W0149	<p>STAFF TREATMENT OF CLIENTS Plan of Correction: Stone Belt has policies and procedures that address mistreatment, neglect and abuse of clients. House Staff will retrained on Stone Belt Prevention of Abuse and Neglect/Client Rights and Incident Reporting (Attachment # 1 and 1a) at the SGL Inservice on November 4, 2011. Responsible Person: Elliott Coordinator Date of Completion: November 4,</p>	11/11/2011	

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	<p>conducted on 10/7/11 at 1:22 PM. On 9/10/11 at 7:30 PM, staff #5 told staff #7, in front of staff #11, that client B refused to use her merrywalker. Staff #11 said, "I force her into it, I can not stand her and don't care if she sits in it all day." Staff #11 reportedly slept on the couch during his shift on two occasions. At dinner, staff #11 took a picture with his cellphone of client E with ranch dressing dripping down his chin and said, "what does it look like he had been doing?" Staff #11 told client C he did not like her several times and told staff that he showed the clients at the day program naked pictures of women on his cellphone. Staff #11, while client B was eating her lunch, told her not to look at him when she eats because it was disgusting. Staff reported that staff #11 called client C "ferret face" several times. The Conclusion of the investigation indicated staff #11 violated the facility's policy by using his cellphone while working, sleeping during his shifts and not having the required eight hours off between shifts. The report indicated, "While [staff #11] denied the allegations of verbal abuse, he was witnessed by [facility name] staff to have made rude and insolent comments to and about clients. This meets the criteria for verbal abuse."</p> <p>Staff #5 reported in her statement during</p>		<p>2011 Plan of Prevention: Stone Belt Director of Group Homes will review all Incident Reports to assure Consumer to Consumer aggression is being reviewed appropriately. Documentation will be kept to assure all such incidents are addressed within 5 working days. All Stone Belt staff working in a group home are trained on the Stone Belt Prevention of Abuse and Neglect/Client Rights and Incident Reporting policy (Attachment # 1) and procedure during orientation training and annually. Quality Assurance Monitoring: 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>				

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	<p>the investigation:</p> <p>-Staff #11 stated regarding client B's walker, "I force her to use it. She gets babied. I can't stand her. I don't care if she sits in it all damn day."</p> <p>-Staff #11 told client B during lunch, "Don't look at me while eating, it's disgusting."</p> <p>-Staff #11 stated that after observing staff #5 assist client B to the floor during a fall, "I would have let her fall."</p> <p>-Staff #11 called client C "ferret face" several times and when client C said "I don't like that boy", staff #11 told client C, "I don't like you either."</p> <p>-Staff #11 took a picture of client A with a basket on his head. Staff #5 reported that client A refuses to wear hats and did not believe client A put the basket on his own head.</p> <p>-Staff #11 called client E a "prick" during dinner.</p> <p>-Staff #11 took a picture of client E with ranch dressing on his face and stated, "What does it look like he's been doing?"</p> <p>-Staff #11 sent client E away from the table for touching his food. Staff #11 told client E he was done before client E ate dessert. Client E did not receive dessert.</p> <p>-Staff #11 slept 2 times during his shift (affecting clients A, B, C, D, E and F).</p> <p>Staff #7 reported in her statement during the investigation:</p>				

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	<p>-Staff #11 took picture of client A with the basket on his head. Staff #7 indicated client A did not like things on his head</p> <p>-Staff #11 told client B "Don't look at me when you chew."</p> <p>-Staff #11 told clients B and C "I don't like you."</p> <p>-Staff #11 called client C "ferret face" and said, "Doesn't she look like a ferret face?"</p> <p>-Staff #11 sent client E, using a "gruff" tone, to the living room for touching his food.</p> <p>-Staff #11 said "I would have let her fall" when staff #7 assisted client B during a fall.</p> <p>-Staff #11 made a comment about forcing client B to use her walker.</p> <p>-Staff #11 told her, after breakfast, he was going to take a 30 minute nap and he did sit in client C's recliner and was quiet for awhile.</p> <p>-Staff #7 indicated in her statement she was sick to her stomach about the situation. She indicated she took client C to her hair appointment early and then drove around afterward because she did not want to go back to the house around staff #11. She indicated she thought about calling the home manager but did not contact her. Staff #7 took client C to staff #7's house and she knew she shouldn't have taken her to her house.</p> <p>-Staff #7 indicated in her statement if she could do something different, she would</p>				

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	<p>have contacted the pager and asked to have staff #11 removed. Staff #7 indicated staff #11 was verbally and emotionally abusive.</p> <p>A review of the facility's policy, dated 9/27/10, was conducted on 10/7/11 at 1:13 PM. The policy indicated all consumers served through programs provided by the facility shall have the following rights: "11. To be free from mental, verbal, sexual and physical abuse; and chemical, mechanical, and physical restraints shall be employed only when absolutely necessary to protect the consumer from injury to self and others and when all other less restrictive measures have been attempted and fail."</p> <p>An interview with the Social Worker (SW) was conducted on 10/11/11 at 10:58 AM. The SW indicated the staff should have ensured the clients were safe and immediately contacted the Coordinator or the Director. The SW indicated the HM should have immediately notified the Coordinator or the Director upon being notified of the incidents. The SW indicated the facility prohibited abuse and neglect.</p> <p>An interview with administrative staff (AS) #1 was conducted on 10/11/11 at 11:41 AM. AS #1 indicated the staff did</p>				

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W0153	<p>not implement the facility's policy for notifying administrative staff of suspected abuse and neglect. AS #1 indicated the staff should have immediately notified the Coordinator or the Director. The AS #1 indicated the facility prohibited abuse and neglect.</p> <p>This federal tag relates to complaint #IN00096692.</p> <p>9-3-2(a)</p> <p>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.</p> <p>Based on record review and interview for 1 of 3 investigations affecting 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to ensure staff immediately reported abuse to the administrator, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/7/11 at 1:22 PM. On 9/10/11 at 7:30 PM (reported to</p>	W0153	<p>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: Elliott Coordinator Date of Completion: November 11, 2011 Plan of Prevention: Staff will be trained to report Immediately to the Coordinator and/or Director of Group Homes who will immediately place the staff person in question on Investigative suspension. (Attachment 2 & 1A) Quality</p>	11/11/2011	

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	<p>administrative staff on 9/12/11), staff #5 told staff #7, in front of staff #11, that client B refused to use her merrywalker. Staff #11 said, "I force her into it, I can not stand her and don't care if she sits in it all day." Staff #11 reportedly slept on the couch during his shift on two occasions. At dinner, staff #11 took a picture with his cellphone of client E with ranch dressing dripping down his chin and said, "what does it look like he had been doing?" Staff #11 told client C he did not like her several times and told staff that he showed the clients at the day program naked pictures of women on his cellphone. Staff #11, while client B was eating her lunch, told her not to look at him when she eats because it was disgusting. Staff reported that staff #11 called client C "ferret face" several times. Staff #5 indicated in her statement in the investigative report that if she could do it over again, she would have called the home manager or the Qualified Mental Retardation Professional and had staff #11 removed from the home. Staff #5 indicated in her statement that she notified the home manager the day after the incidents. The Conclusion of the investigation indicated staff #11 violated the facility's policy by using his cellphone while working, sleeping during his shifts and not having the required eight hours off between shifts. The report indicated,</p>		<p>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. (Attachment 1)</p>	

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	<p>"While [staff #11] denied the allegations of verbal abuse, he was witnessed by [facility name] staff to have made rude and insolent comments to and about clients. This meets the criteria for verbal abuse." The investigation recommended that the staff working in clients B, C and E's group home be retrained on the facility's policy of reporting suspected abuse, neglect and exploitation.</p> <p>Staff #5 reported in her statement during the investigation:</p> <ul style="list-style-type: none"> -Staff #11 stated regarding client B's walker, "I force her to use it. She gets babied. I can't stand her. I don't care if she sits in it all damn day." -Staff #11 told client B during lunch, "Don't look at me while eating, it's disgusting." -Staff #11 stated that after observing staff #5 assist client B to the floor during a fall, "I would have let her fall." -Staff #11 called client C "ferret face" several times and when client C said "I don't like that boy", staff #11 told client C, "I don't like you either." -Staff #11 took a picture of client A with a basket on his head. Staff #5 reported that client A refuses to wear hats and did not believe client A put the basket on his own head. -Staff #11 called client E a "prick" during dinner. 				

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	<p>-Staff #11 took a picture of client E with ranch dressing on his face and stated, "What does it look like he's been doing?"</p> <p>-Staff #11 sent client E away from the table for touching his food. Staff #11 told client E he was done before client E ate dessert. Client E did not receive dessert.</p> <p>-Staff #11 slept 2 times during his shift (affecting clients A, B, C, D, E and F).</p> <p>-Staff #5 indicated in her statement she reported the incidents to the home manager on 9/11/11. The home manager recommended to her to call the anonymous reporting line.</p> <p>Staff #7 reported in her statement during the investigation:</p> <p>-Staff #11 took picture of client A with the basket on his head. Staff #7 indicated client A did not like things on his head</p> <p>-Staff #11 told client B "Don't look at me when you chew."</p> <p>-Staff #11 told clients B and C "I don't like you."</p> <p>-Staff #11 called client C "ferret face" and said, "Doesn't she look like a ferret face?"</p> <p>-Staff #11 sent client E, using a "gruff" tone, to the living room for touching his food.</p> <p>-Staff #11 said "I would have let her fall" when staff #7 assisted client B during a fall.</p> <p>-Staff #11 made a comment about forcing client B to use her walker.</p>				

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	<p>-Staff #11 told her, after breakfast, he was going to take a 30 minute nap and he did sit in client C's recliner and was quiet for awhile.</p> <p>-Staff #7 indicated in her statement she was sick to her stomach about the situation. She indicated she took client C to her hair appointment early and then drove around afterward because she did not want to go back to the house around staff #11. She indicated she thought about calling the home manager but did not contact her. Staff #7 took client C to staff #7's house and she knew she shouldn't have taken her to her house.</p> <p>-Staff #7 indicated in her statement if she could do something different, she would have contacted the pager and asked to have staff #11 removed. Staff #7 indicated staff #11 was verbally and emotionally abusive.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/7/11 at 1:52 PM. The QMRP indicated she was notified of the incident on 9/12/11. The QMRP indicated she was not clear on when the home manager was notified of the incident however she thought the home manager was aware of the incident on 9/11/11. The QMRP indicated the home manager did not immediately report the incidents to her.</p>				

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W0154	<p>An interview with administrative staff (AS) #1 was conducted on 10/11/11 at 11:41 AM. AS #1 indicated the staff did not implement the facility's policy for notifying administrative staff of suspected abuse and neglect. AS #1 indicated the staff should have immediately notified the Coordinator or the Director.</p> <p>This federal tag relates to complaint #IN00096692.</p> <p>9-3-2(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 investigations affecting 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to conduct a thorough investigation.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/7/11 at 1:22 PM. On 9/10/11 at 7:30 PM, staff #5 told staff #7, in front of staff #11, that client B refused</p>	W0154	<p>STAFF TREATMENT OF CLIENTS Investigation/Interview Plan of Correction: Stone Belt will assure that all alleged violations are investigated thoroughly and staff will follow Stone Belt procedure of Investigation Protocol. (Attachment 3 & 3A))Responsible Person: Director of Group Homes/ Social Work Manager Date of Completion: November 11, 2011 Plan of Prevention: Stone Belt staff, responsible for investigations, will be retrained on Investigation</p>	11/11/2011	

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	<p>to use her walker. Staff #11 said, "I force her into it, I can not stand her and don't care if she sits in it all day." Staff #11 reportedly slept on the couch during his shift on two occasions. At dinner, staff #11 took a picture with his cellphone of client E with ranch dressing dripping down his chin and said, "what does it look like he had been doing?" Staff #11 told client C he did not like her several times and told staff that he showed the clients at the day program naked pictures of women on his cellphone. Staff #11, while client B was eating her lunch, told her not to look at him when she eats because it was disgusting. Staff reported that staff #11 called client C "ferret face" several times. The Conclusion of the investigation indicated staff #11 violated the facility's policy by using his cellphone while working, sleeping during his shifts and not having the required eight hours off between shifts. The report indicated, "While [staff #11] denied the allegations of verbal abuse, he was witnessed by [facility name] staff to have made rude and insolent comments to and about clients. This meets the criteria for verbal abuse." The investigation did not include interviews with the home manager and clients A, D and F.</p> <p>Staff #5 reported in her statement during the investigation:</p>		<p>Protocol. This will involved the Director, Social Worker and Coordinators at Stone Belt group homes. Training will be completed by November 11, 2011. Quality Assurance Monitoring: Stone Belt Director of Group Homes will review all incident reports and investigations to assure protocol is being followed and all parties are being interviewed for the particular incident.</p>		

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	<p>-Staff #11 stated regarding client B's walker, "I force her to use it. She gets babied. I can't stand her. I don't care if she sits in it all damn day."</p> <p>-Staff #11 told client B during lunch, "Don't look at me while eating, it's disgusting."</p> <p>-Staff #11 stated that after observing staff #5 assist client B to the floor during a fall, "I would have let her fall."</p> <p>-Staff #11 called client C "ferret face" several times and when client C said "I don't like that boy", staff #11 told client C, "I don't like you either."</p> <p>-Staff #11 took a picture of client A with a basket on his head. Staff #5 reported that client A refuses to wear hats and did not believe client A put the basket on his own head.</p> <p>-Staff #11 called client E a "prick" during dinner.</p> <p>-Staff #11 took a picture of client E with ranch dressing on his face and stated, "What does it look like he's been doing?"</p> <p>-Staff #11 sent client E away from the table for touching his food. Staff #11 told client E he was done before client E ate dessert. Client E did not receive dessert.</p> <p>-Staff #11 slept 2 times during his shift (affecting clients A, B, C, D, E and F).</p> <p>-Staff #5 indicated in her statement she reported the incidents to the home manager on 9/11/11. The home manager recommended to her to call the</p>			

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	<p>anonymous reporting line.</p> <p>Staff #7 reported in her statement during the investigation:</p> <ul style="list-style-type: none"> -Staff #11 took picture of client A with the basket on his head. Staff #7 indicated client A did not like things on his head -Staff #11 told client B "Don't look at me when you chew." -Staff #11 told clients B and C "I don't like you." -Staff #11 called client C "ferret face" and said, "Doesn't she look like a ferret face?" -Staff #11 sent client E, using a "gruff" tone, to the living room for touching his food. -Staff #11 said "I would have let her fall" when staff #7 assisted client B during a fall. -Staff #11 made a comment about forcing client B to use her walker. -Staff #11 told her, after breakfast, he was going to take a 30 minute nap and he did sit in client C's recliner and was quiet for awhile. -Staff #7 indicated in her statement she was sick to her stomach about the situation. She indicated she took client C to her hair appointment early and then drove around afterward because she did not want to go back to the house around staff #11. She indicated she thought about calling the home manager but did not contact her. Staff #7 took client C to 				

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	<p>staff #7's house and she knew she shouldn't have taken her to her house.</p> <p>-Staff #7 indicated in her statement if she could do something different, she would have contacted the pager and asked to have staff #11 removed. Staff #7 indicated staff #11 was verbally and emotionally abusive.</p> <p>The investigative report did not address staff #5's statement that she reported the incidents to the group home manager on 9/11/11 and that the administrative staff of the facility were notified of the incidents on 9/12/11. The investigative report did not include a statement from the home manager.</p> <p>An interview with the Social Worker (SW) was conducted on 10/11/11 at 10:58 AM. The SW indicated client A should have been interviewed for the investigation.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/11/11 at 11:41 AM. AS #1 indicated the home manager and the 3 clients who were not interviewed should have been interviewed. AS #1 indicated the investigation was not thorough.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was</p>			

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W0157	<p>conducted on 10/7/11 at 1:52 PM. The QMRP indicated she was notified of the incident on 9/12/11. The QMRP indicated she was not clear on when the home manager was notified of the incidents. She did not know why the home manager was not interviewed for the investigation.</p> <p>This federal tag relates to complaint #IN00096692.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 1 of 3 investigations affecting 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to take appropriate corrective action.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/7/11 at 1:22 PM. On 9/10/11 at 7:30 PM (reported to the home manager on 9/11/11 and to administrative staff on 9/12/11), staff #5 told staff #7, in front of staff #11, that client B refused to use her merrywalker. Staff #11 said, "I force her into it, I can not stand her and</p>	W0157	<p>STAFF TREATMENT OF CLIENTS Plan of Correction: Stone Belt will assure that when alleged violations are verified, appropriate action will be taken.</p> <p>Date of Completion: November 11, 2011 Person Responsible: Elliott Coordinator/SGL Director</p> <p>Plan of Prevention: Retraining on Incident Reporting and Prevention of Abuse, Neglect and Reporting was completed on November 4, 2011 with house staff. Also, Boundaries training was conducted with all staff on November 4, 2011 (Attachment 4 & 4A) Any further occurrences will result in disciplinary action taken against staff per the Stone Belt Disciplinary Procedures, Quality Assurance Monitoring: Home</p>	11/11/2011	

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	<p>don't care if she sits in it all day." Staff #11 reportedly slept on the couch during his shift on two occasions. At dinner, staff #11 took a picture with his cellphone of client E with ranch dressing dripping down his chin and said, "what does it look like he had been doing?" Staff #11 told client C he did not like her several times and told staff that he showed the clients at the day program naked pictures of women on his cellphone. Staff #11, while client B was eating her lunch, told her not to look at him when she eats because it was disgusting. Staff reported that staff #11 called client C "ferret face" several times. The Conclusion of the investigation indicated staff #11 violated the facility's policy by using his cellphone while working, sleeping during his shifts and not having the required eight hours off between shifts. The report indicated, "While [staff #11] denied the allegations of verbal abuse, he was witnessed by [facility name] staff to have made rude and insolent comments to and about clients. This meets the criteria for verbal abuse." The investigation recommended that the staff working in clients B, C and E's group home be retrained on the facility's policy of reporting suspected abuse, neglect and exploitation. The recommendations section indicated staff #7 should be retrained on Boundaries; there was no documentation this occurred.</p>		<p>Coordinator and SGL Director will review all incident reports to assure that appropriate training and, if necessary, disciplinary actions are taken for staff involved.</p>		

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	<p>Staff #5 reported in her statement during the investigation:</p> <ul style="list-style-type: none"> -Staff #11 stated regarding client B's walker, "I force her to use it. She gets babied. I can't stand her. I don't care if she sits in it all damn day." -Staff #11 told client B during lunch, "Don't look at me while eating, it's disgusting." -Staff #11 stated that after observing staff #5 assist client B to the floor during a fall, "I would have let her fall." -Staff #11 called client C "ferret face" several times and when client C said "I don't like that boy", staff #11 told client C, "I don't like you either." -Staff #11 took a picture of client A with a basket on his head. Staff #5 reported that client A refuses to wear hats and did not believe client A put the basket on his own head. -Staff #11 called client E a "prick" during dinner. -Staff #11 took a picture of client E with ranch dressing on his face and stated, "What does it look like he's been doing?" -Staff #11 sent client E away from the table for touching his food. Staff #11 told client E he was done before client E ate dessert. Client E did not receive dessert. -Staff #11 slept 2 times during his shift (affecting clients A, B, C, D, E and F). 			

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	<p>Staff #7 reported in her statement during the investigation:</p> <ul style="list-style-type: none"> -Staff #11 took picture of client A with the basket on his head. Staff #7 indicated client A did not like things on his head -Staff #11 told client B "Don't look at me when you chew." -Staff #11 told clients B and C "I don't like you." -Staff #11 called client C "ferret face" and said, "Doesn't she look like a ferret face?" -Staff #11 sent client E, using a "gruff" tone, to the living room for touching his food. -Staff #11 said "I would have let her fall" when staff #7 assisted client B during a fall. -Staff #11 made a comment about forcing client B to use her walker. -Staff #11 told her, after breakfast, he was going to take a 30 minute nap and he did sit in client C's recliner and was quiet for awhile. -Staff #7 indicated in her statement she was sick to her stomach about the situation. She indicated she took client C to her hair appointment early and then drove around afterward because she did not want to go back to the house around staff #11. She indicated she thought about calling the home manager but did not contact her. Staff #7 took client C to staff #7's house and she knew she shouldn't have taken her to her house. 			

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	<p>-Staff #7 indicated in her statement if she could do something different, she would have contacted the pager and asked to have staff #11 removed. Staff #7 indicated staff #11 was verbally and emotionally abusive.</p> <p>The investigation documentation indicated the home manager and staff #5 and #7 did not receive disciplinary action for failing to immediately report abuse.</p> <p>A review of staff training documentation was conducted on 10/11/11 at 4:29 PM. Staff #5 received training on the prevention of abuse and neglect on 3/18/11. Staff #1 and #7 received training on the prevention of abuse and neglect on 2/11/11.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/11/11 at 10:05 AM. AS #1 indicated the investigation recommendation for staff #7 to have Boundaries training had not been implemented.</p> <p>This federal tag relates to complaint #IN00096692.</p> <p>9-3-2(a)</p>				

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W0262	<p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (B), the facility failed to ensure the specially constituted committee (HRC) reviewed, approved and monitored the use of a Merry Walker.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/11/11 from 4:12 PM to 5:17 PM. At 4:16 PM, client B exited the van and was immediately assisted into a merrywalker by staff #2. Client B remained in the merrywalker for the remainder of the observation.</p> <p>An interview with staff #3 was conducted on 10/11/11 at 4:16 PM. Staff #3 indicated client B was not able to exit the Merry Walker independently. Staff #3 indicated client B was not being taught how to exit the Merry Walker.</p> <p>An interview with staff #2 was conducted on 10/11/11 at 4:42 PM. Staff #2 indicated client B was not able to exit the Merry Walker independently. Staff #2 indicated she had been employed at the facility for 6 years and the facility had not tried the use of a gait belt and knee pads. Staff #2 indicated a regular walker was attempted earlier in the year however client B refused to use it. Staff #2 indicated she thought the use of a gait belt and knee pads would be sufficient to prevent falls.</p>	W0262	<p>PROGRAM MONITORING & CHANGE Plan of Correction: Stone Belt will ensure that a specially constituted committee (HRC) will review, approve and monitor the use of restrictive devices. Stone Belt will allow and encourage clients to exercise their rights and have the right to due process. Date of Completion: November 11, 2011 Person Responsible: Elliott Coordinator/Support Team Plan of Prevention: The Stone Belt Support Team will ensure that the use of restrictive devices receive appropriate approvals by the HRC when using such devices. Support Team will review the Stone Belt Human Rights Policy (Attachment # 5) and the Behavioral Intervention Policy (Attachment # 6) that defines the role of the HRC. Quality Assurance Monitoring: Support Team meeting will be reviewed by Coordinator and SGL Director to assure proper approvals are given for restrictive devices.</p>	11/11/2011	

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W0263	<p>A review of client B's record was conducted on 10/12/11 at 8:03 AM. Client B had a doctor's order, dated 8/22/11, indicating an order for a merry PVC walker or merry motivator due to frequent falls. A Support Team Review Form, dated 8/24/11, indicated the following, "Numerous falls over last month. Merry walker will be purchased today, 8/24/11. Dr. [physician's name] order just received on 8/23/11. Seeing Dr. [physician's name] 8/31/11, due to falls and increased swatting." A Nurse Quarterly Physical, dated 8/29/11, indicated the following, "Increase in falls - some are related to behaviors ([client B] just drops to her knees during a behavior). New orders: To use PVC Merry Walker for all mobility while at home or community outings. To use Merry Motivator when at [day program] to help prevent falls." The record did not indicate the HRC consented to the use of the Merry Walker.</p> <p>An interview with the Director was conducted on 10/12/11 at 8:30 AM. The Director indicated the use of the Merry Walker was not treated as a restrictive intervention. He indicated he did not know if HRC consent was obtained.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/12/11 at 8:46 AM. The QMRP indicated there was no HRC consent for client B's Merry Walker.</p> <p>9-3-4(a)</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p>			

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	<p>Based on observation, interview and record review for 1 of 3 clients in the sample (B), the facility's specially constituted committee (HRC) failed to ensure the use of a Merry Walker was consented to by client B's guardian prior to implementation.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/11/11 from 4:12 PM to 5:17 PM. At 4:16 PM, client B exited the van and was immediately assisted into a merrywalker by staff #2. Client B remained in the merrywalker for the remainder of the observation.</p> <p>An interview with staff #3 was conducted on 10/11/11 at 4:16 PM. Staff #3 indicated client B was not able to exit the Merry Walker independently. Staff #3 indicated client B was not being taught how to exit the Merry Walker.</p> <p>An interview with staff #2 was conducted on 10/11/11 at 4:42 PM. Staff #2 indicated client B was not able to exit the Merry Walker independently. Staff #2 indicated client B was not being taught how to exit the Merry Walker independently. Staff #2 indicated she had been employed at the facility for 6 years and the facility had not tried the use of a gait belt and knee pads. Staff #2 indicated a regular walker was attempted earlier in the year however client B refused to use it. Staff #2 indicated she thought the use of a gait belt and knee pads would be sufficient to prevent falls.</p> <p>A review of client B's record was conducted on 10/12/11 at 8:03 AM. Client B had a doctor's order, dated 8/22/11, indicating an order for a merry PVC walker or merry motivator due to</p>	W0263	<p>PROGRAM MONITORING AND CHANGEPlan of Correction: Stone Belt will ensure that a guardian approve the use of restrictive devices. Stone Belt will allow and encourage clients to exercise their rights and have the right to due process. When a client has a guardian the client's rights also transfer to the guardian. Date of Completion: November 11, 2011 Person Responsible: Elliott Coordinator/Support Team Plan of Prevention: The Stone Belt Support Team will ensure that the use of restrictive devices be approved by the guardian, if applicable, when using such devices. Support Team will review the Stone Belt Human Rights Policy (Attachment # 5) that defines the role of the guardian as a representative of the client. Quality Assurance Monitoring: Support Team meeting will be reviewed by Coordinator and SGL Director to assure proper approvals are given for restrictive devices.</p>	11/11/2011	

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	<p>frequent falls. A Support Team Review Form, dated 8/24/11, indicated the following, "Numerous falls over last month. Merry walker will be purchased today, 8/24/11. Dr. [physician's name] order just received on 8/23/11. Seeing Dr. [physician's name] 8/31/11, due to falls and increased swatting." A Nurse Quarterly Physical, dated 8/29/11, indicated the following, "Increase in falls - some are related to behaviors ([client B] just drops to her knees during a behavior). New orders: To use PVC Merry Walker for all mobility while at home or community outings. To use Merry Motivator when at [day program] to help prevent falls." The record did not indicate the guardian or the HRC consented to the use of the Merry Walker. Client B's ISP, dated 6/29/11, indicated she had a guardian.</p> <p>An interview with client B's guardian was conducted on 10/12/11 at 8:23 AM. Client B's guardian indicated she did not recall giving consent for the use of the Merry Walker. Client B's guardian indicated she would prefer to see less restrictive measures taken prior to using the Merry Walker such as knee pads and gait belt. Client B's guardian indicated client B did not like the Merry Walker and did not seem comfortable in it. The guardian indicated client B was not able to exit the Merry Walker by herself. Client B indicated she was not contacted prior to the Merry Walker being implemented. Client B's guardian stated she didn't know why they "put her in this silly thing." She was told the doctor prescribed it.</p> <p>An interview with the Director was conducted on 10/12/11 at 8:30 AM. The Director indicated the use of the Merry Walker was not treated as a restrictive intervention. He indicated he did not know if guardian consent was obtained.</p>						

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

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND ST BEDFORD, IN47421		
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	An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/12/11 at 8:46 AM. The QMRP indicated she thought the facility's nurse, at the time, received verbal consent from the guardian for the use of the Merry Walker. 9-3-4(a)				