

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2013
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: July 11, 12, 15, and 16, 2013</p> <p>Facility Number: 000876 Provider Number: 15G362 AIM Number: 100249160</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/19/13 by Ruth Shackelford, QIDP.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000159	<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 4 of 4 clients in the sample (#3, #4, #5 and #6), the Qualified Intellectual Disabilities Professional (QIDP) failed to review the clients' progress toward achieving their training objectives.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 7/15/13 at 11:46 AM. There was no documentation in client #3's record indicating the facility reviewed his progress toward achieving the training objectives outlined in the Individual Support Plan (ISP) dated 3/12/13.</p> <p>A review of client #4's record was conducted on 7/15/13 at 12:20 PM. There was no documentation in client #4's record indicating the facility reviewed her progress toward achieving the training objectives outlined in the ISP dated 10/19/12.</p> <p>A review of client #5's record was conducted on 7/15/13 at 12:34 PM. There was no documentation in client #5's record indicating the facility reviewed his</p>	W000159	<p>W 159</p> <p>QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will ensure that each client's active treatment program is integrated, coordinated and monitored by the House Program Coordinator.</p> <p>Person Responsible:</p> <p>Miller Program Coordinator</p> <p>Date of Completion:</p> <p>August 10, 2013</p>	08/10/2013			

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	<p>progress toward achieving the training objectives outlined in the ISP dated 6/6/12 since 7/30/12.</p> <p>A review of client #6's record was conducted on 7/15/13 at 12:51 PM. There was no documentation in client #6's record indicating the facility reviewed his progress toward achieving the training objectives outlined in the ISP dated 7/6/12 since 7/30/12.</p> <p>An interview with the Director was conducted on 7/15/13 at 1:37 PM. The Director indicated the QIDP should have conducted quarterly reviews to ensure the clients were achieving their training objectives. The Director indicated the previous QIDP and the Director failed to ensure this was completed quarterly.</p> <p>9-3-3(a)</p>		<p>Plan of Prevention:</p> <p>House Coordinator will ensure that all quarterly reviews are completed for each client.</p> <p>Quality Assurance Monitoring:</p> <p>A monthly checklist will be completed by the House Coordinator or designee and will include the review of quarterly program plans. This will also be reviewed by SGL Director.</p> <p>The SGL Director will review and sign off on monthly progress reports as well as quarterly reviews.</p>		

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 4 clients in the sample (#3), the facility failed to ensure client #3's risk plan for diabetes indicated the guidelines for direct care staff contacting the nurse and the action staff should take when client #3's blood sugar was high during the morning blood sugar test.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 7/15/13 from 5:15 AM to 5:47 AM. At 5:27 AM, client #3 tested his blood sugar (272). Client #3 indicated he was to receive Novolog 13 units per his sliding scale. Staff #7 prepared the shot after reviewing the sliding scale and client #3 gave himself the shot in his stomach.</p> <p>A review of client #3's record was conducted on 7/15/13 at 11:46 AM. Client #3's risk plan for diabetes, dated 6/3/13, indicated, in part, "[Client #3's] blood sugar level is very difficult to control... When his blood sugar is high (above 240) he needs to drink plenty of water and walk." The plan indicated the actions staff were to take at 9:30 AM,</p>	W000240	<p>W 240</p> <p>PROGRAM IMPLEMENTATION</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that each client's individual program plan describes relevant interventions to support the individual toward independence.</p> <p>Specifically, a client's risk plan regarding diabetes indicates guidelines for staff contacting nurse and action staff take during morning hours.</p> <p>Date of Completion:</p> <p>August 2, 2013</p>	08/02/2013			

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	<p>lunch, and 5:00 PM. There was no documentation in client #3's plan indicating staff were to check his blood sugar at 5:30 AM. There was no documentation in the plan indicating the actions staff were to take at 5:30 AM and 8:00 PM blood sugar checks. There was no documentation in client #3's plan indicating when the direct care staff were to contact the nurse with the exception of if his sugar was high at lunch (over 400). Staff were to contact the nurse if medication administered and a recheck of his blood sugar one hour later was still over 400. This was not part of the plan for the 9:30 AM and 5:00 PM blood sugar checks. There was no plan for staff to contact the nurse when client #3's blood sugar was low (not defined in the plan). Client #3's Medication Information Sheet (MIS), dated 7/10/13, indicated client #3 tested his blood sugar 5 times per day at 6:00 AM, 9:30 AM, 11:30 AM, 5:00 PM and 8:00 PM. The MIS indicated the Novolog Sliding Scale was to be used at 6:00 AM, 12:00 PM and 5:00 PM immediately after each meal unless his blood sugar was over 260 then give the Novolog with the meal (within 15 minutes). The MIS did not indicate when the direct care staff should contact the nurse.</p> <p>A review of client #3's Blood Sugar Log</p>		<p>Person Responsible:</p> <p>Miller Program Coordinator/ Miller House Nurse</p> <p>Plan of Prevention:</p> <p>Medication Administration Information Sheet addresses changes in diabetes risk plan for specific client. Staff were trained on these aspects on 7/19/2013. (Attachment # 1)</p> <p>Quality Assurance Monitoring:</p> <p>House Coordinator and House Nurse will monitor client's diabetes plan and assure that staff are following given protocol. <i>On a monthly basis the Nurse reviews the Medication Administration Record which includes the clients Blood Sugar Reading in at 6 am. This was not previously being recorded. (Attachment # A)</i></p>		

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	<p>for May and June 2013 indicated the following:</p> <p>On 5/7/13 at 11:30 AM client #3's blood sugar was 264. At 1:30 PM it was 270.</p> <p>On 5/14/13 at 9:30 AM client #3's blood sugar was 45. At 11:30 AM it was 299.</p> <p>On 5/17/13 at 9:30 AM client #3's blood sugar was 265.</p> <p>On 5/20/13 at 11:30 AM client #3's blood sugar was 297.</p> <p>On 5/22/13 at 11:30 AM client #3's blood sugar was 267. At 1:30 PM it was 313.</p> <p>On 5/28/13 at 9:30 AM client #3's blood sugar was 408. At 11:30 AM it was 352. At 1:30 PM it was 295.</p> <p>On 5/30/13 at 11:30 AM client #3's blood sugar was 271.</p> <p>On 5/31/13 at 11:30 AM client #3's blood sugar was 265.</p> <p>On 6/5/13 at 11:30 AM client #3's blood sugar was 464.</p> <p>On 6/10/13 at 11:30 AM client #3's blood sugar was 287.</p> <p>On 6/17/13 at 1:30 PM client #3's blood sugar was 264.</p> <p>On 6/24/13 at 11:30 AM client #3's blood sugar was 301.</p> <p>An interview with the Director was conducted on 7/15/13 at 1:37 PM. The Director indicated client #3's risk plan should include guidelines for staff to contact the nurse.</p>						

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	<p>An interview with the Licensed Practical Nurse (LPN) was conducted on 7/15/13 at 2:26 PM. The LPN indicated client #3's risk plan for diabetes was reviewed and approved by client #3's primary care physician. The LPN indicated the staff were to contact her if the plan was ineffective. The LPN indicated she reviewed the blood sugar logs monthly. The LPN stated client #3 was "Not a normal diabetic" and "He doesn't have a normal range." The LPN indicated blood sugar above 240 was high for client #3. The LPN stated "His blood sugar is everywhere." The LPN indicated client #3 had a sliding scale for every meal. The staff check his blood sugar 5 times per day. The LPN indicated the staff knew when to call her but when to call the LPN was not part of the plan. The LPN stated, "I can revise to call the nurse."</p> <p>9-3-4(a)</p>				

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 4 clients in the sample (#5), the facility failed to ensure his comprehensive functional assessment (CFA) was reviewed and updated as needed annually.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 7/15/13 at 12:34 PM. Client #5's most recent CFA was dated 6/6/12. There was no documentation in client #5's record indicating the CFA was reviewed and updated since 6/6/12.</p> <p>An interview with the Director was conducted on 7/15/13 at 1:37 PM. The Director indicated client #5's CFA should be reviewed and updated annually.</p> <p>9-3-4(a)</p>	W000259	<p>W 259</p> <p>PROGRAM MONITORING AND CHANGE</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that each client's comprehensive functional assessment will be reviewed by the interdisciplinary team for relevancy and updated as needed at least annually.</p> <p>Date of Completion:</p> <p>August 10, 2013</p> <p>Person Responsible:</p>	08/10/2013			

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			<p>Miller Program Coordinator</p> <p>Plan of Prevention:</p> <p>Miller Program Coordinator is completing/scheduling annual reviews for all clients at Maxwell to ensure that the annual information is complete, including the functional assessment.</p> <p>Quality Assurance Monitoring:</p> <p>House Coordinator and SGL Director will review annual meetings to ensure that the comprehensive assessment is completed as part of the annual review. <i>The House Manager and Coordinator review the Group Home File Checklist (Attachment # B) on a monthly basis to ensure that all necessary documents are current in the system. The Checklist includes the Program Assessment/Comprehensive Functional Assessment.</i></p>		

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W000260	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 4 of 7 clients living in the group home (#1, #5, #6 and #7), the facility failed to ensure the clients' Individual Support Plans (ISPs) were revised annually.</p> <p>Findings include:</p> <p>On 7/15/13 at 1:23 PM, client #1's record was reviewed. Client #1's ISP was dated 6/21/12. There was no documentation in client #1's record indicating the facility revised her ISP since 6/21/12.</p> <p>On 7/15/13 at 12:34 PM, client #5's record was reviewed. Client #5's ISP was dated 6/6/12. There was no documentation in client #5's record indicating the facility revised his ISP since 6/6/12.</p> <p>On 7/15/13 at 12:51 PM, client #6's record was reviewed. Client #6's ISP was dated 7/6/12. There was no documentation in client #6's record indicating the facility revised his ISP since 7/6/12.</p> <p>On 7/15/13 at 11:25 AM, client #7's</p>	W000260	<p>W 260 PROGRAM MONITORING AND CHANGE Plan of Correction: Stone Belt will ensure that each client's individual program plan will be reviewed and revised, as needed, on an annual basis. Date of Completion: August 10, 2013 Person Responsible: Miller Program Coordinator Plan of Prevention: Miller Program Coordinator is completing/scheduling annual reviews for all clients at Miller to ensure that the annual information is complete, including the individual program plan Quality Assurance Monitoring: House Coordinator and SGL Director will review annual meetings to ensure that the individual program plan is completed as part of the annual review. The House Manager and Coordinator review the Group Home File Checklist (Attachment # B) on a monthly basis to ensure that all necessary documents are current in the system. The Checklist includes the Individual Support Plan and all documents that apply to the annual. This is also reviewed by the SGL Director monthly.</p>	08/10/2013	

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	<p>record was reviewed. Client #7's ISP was dated 6/15/12. There was no documentation in client #7's record indicating the facility revised his ISP since 6/15/12.</p> <p>An interview with the Director was conducted on 7/15/13 at 1:37 PM. The Director indicated the clients' ISPs should be revised annually.</p> <p>9-3-4(a)</p>			

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 2 of 4 clients in the sample (#3 and #5), the facility failed to ensure the clients' hearing was evaluated annually.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 7/15/13 at 11:46 AM. Client #3's most recent hearing examination was conducted on 1/5/12. Client #3's most recent physical examination conducted by his primary care physician was conducted on 12/19/12. The annual physical examination did not include an evaluation of client #3's hearing.</p> <p>A review of client #5's record was conducted on 7/15/13 at 12:34 PM. Client #5's most recent hearing examination was conducted on 1/10/12. Client #5's most recent physical examination conducted by his primary care physician was conducted on 6/5/13. The annual physical examination did not include an evaluation of client #5's hearing.</p>	W000323	<p>W 323 PHYSICIAN SERVICES Plan of Correction: Stone Belt will provide or obtain annual physical examinations of each client that includes at a minimum an evaluation of vision and hearing. Date of Completion: August 10, 2013 Person Responsible: House Program Coordinator Plan of Prevention: The hearing exams have been scheduled. House staff discussing with personal care physician regarding the reason for not conducting the screenings during the annual physical exam. Quality Assurance Monitoring: House Program Coordinator will review, on a monthly basis, all required physical exams, including hearing, to ensure that they are completed in a timely manner. This review is also seen by the SGL Director. <i>The House Manager and Coordinator review the Group Home File Checklist (Attachment # B) on a monthly basis to ensure that all necessary documents are current in the system. The Checklist includes the annual hearing and vision. This document is also reviewed by the SGL Director. Specifically,</i></p>	08/10/2013			

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	An interview with the Licensed Practical Nurse (LPN) was conducted on 7/15/13 at 2:26 PM. The LPN indicated the clients' hearing should be evaluated annually at their physical examination. 9-3-6(a)		the two clients primary physicians did not document on the 450B the hearing or vision section. That is being corrected by the physicians. (Attachment # C)		

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W000346	<p>483.460(d)(4) NURSING STAFF</p> <p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Based on observation, record review and interview for 7 of 7 clients living at the group home (#1, #2, #3, #4, #5, #6 and #7), the facility failed to ensure there was a Registered Nurse (RN) available to the Licensed Practical Nurse (LPN) for consultation.</p> <p>Findings include:</p> <p>The facility was unable to provide documentation of a formal contract between the facility and a RN to be available for consultation for the group home's LPN. The information was requested on 7/15/13 at 1:37 PM. This affected clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>An interview with the LPN was conducted on 7/15/13 at 2:26 PM. The LPN indicated the facility did not have a RN for her to consult.</p> <p>An interview with the Director was conducted on 7/15/13 at 1:37 PM. The Director indicated the facility did not have</p>	W000346	<p>W 346</p> <p>NURSING STAFF</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that a formal arrangement with a registered nurse is provided for verbal or onsite consultation to the licensed practical nurses providing health services.</p> <p>Date of Completion:</p> <p>July 31, 2013</p> <p>Person Responsible:</p>	08/10/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/16/2013
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	a RN for the LPN to consult. 9-3-6(a)		<p>Milestones Director</p> <p>Plan of Prevention:</p> <p>At the time of the survey, Stone Belt did not have a Registered Nurse as the previous RN resigned her position on July 1, 2013. The hiring process had begun to replace the RN and a new RN has been hired and begins with Stone Belt on August 12, 2013.. However, during the interim period Stone Belt nursing staff had immediate access to Milestones Dr.'s Kettnis and Weakley for consultation.</p> <p>Quality Assurance Monitoring:</p> <p>RN has been hired and begins August 12, 2013. In the interim, the LPN's have access to Dr.'s Kettnis and Weakley at Milestones.</p>		