

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/08/2015
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND ST BEDFORD, IN 47421
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W 0000  Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey dates: July 6, 7 and 8, 2015</p> <p>Facility Number: 001094 Provider Number: 15G653 AIM Number: 100235630</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0125  Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS 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 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients had the right to due process in regard to the unnecessary restriction of a front door alarm.</p>	W 0125	<p><b>W 125483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</b> Plan of Correction: Alarm was removed from doors by maintenance coordinator 7/13/15. Plan of Prevention: Support teams discussed door alarm and determine it was not needed.</p>	07/13/2015

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>Findings include:</p> <p>On 7/6/15 from 4:20 PM to 6:18 PM and 7/7/15 from 6:00 AM to 7:47 AM, observations were conducted at the group home. During the observations, the front door to the group home had an audible alarm that sounded when the front door was opened. The door alarm sounded each time the door was opened. This affected clients #1, #2, #3, #4, #5 and #6. The door leading to the outside in the hallway where the bedrooms were located did not have an alarm. The door leading to the backyard did not have an alarm.</p> <p>On 7/7/15 at 6:35 AM, staff #10 indicated he was not sure why the front door had an alarm and the other doors did not have alarms. Staff #10 indicated the alarm might be for clients #2 and #5 who had the potential for elopement.</p> <p>On 7/7/15 at 6:47 AM, staff #6 stated the front door had "always been like that" with the alarm when asked why only the front door had an alarm and the other two exit doors did not. Staff #6 indicated clients #2, #3 and #5 had the potential to elope.</p> <p>On 7/7/15 at 7:14 AM, staff #2 indicated she was not sure why the front door had</p>		<p>Copy of support team note is in Fortis. Staff training that when there is arestriction such as a door alarm that is not is a plan approved by HRC it is tobe immediately reported to DSGL (attachment a). Plan of Monitoring: Coordinator / Q will complete monthly observations to ensure that thereare no HRC issues (attachment b).</p>	

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	<p>an alarm and the other two doors did not have an alarm.</p> <p>On 7/8/15 at 12:48 PM, a review of client #1's record indicated no documentation of the need for a door alarm on the front door. There was no documentation of the use of a door alarm in her 7/9/14 Individual Support Plan (ISP) and 7/1/14 Behavior Support Plan (BSP).</p> <p>On 7/7/15 at 10:11 AM, a review of client #2's record indicated no documentation of the need for a door alarm on the front door. There was no documentation of the use of a door alarm in his 8/26/14 ISP or 5/29/15 BSP.</p> <p>On 7/8/15 at 12:50 PM, a review of client #3's record indicated no documentation of the need for a door alarm on the front door. There was no documentation of the use of a door alarm in her 7/1/15 ISP or 7/9/14 BSP.</p> <p>On 7/8/15 at 12:52 PM, a review of client #4's record indicated no documentation of the need for a door alarm on the front door. There was no documentation of the use of a door alarm in his 9/17/14 ISP or 9/17/14 BSP.</p> <p>On 7/7/15 at 10:50 AM, a review of client #5's record indicated there was no</p>			

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W 0153  Bldg. 00	<p>documentation for the use of a front door alarm. Client #5's 8/1/14 ISP and 2/26/15 BSP did not include the use of a door alarm.</p> <p>On 7/7/15 at 11:53 AM, a review of client #6's record indicated there was no documentation for the use of a front door alarm. Client #6's 6/11/15 ISP and 5/14/14 BSP did not include the use of a door alarm.</p> <p>On 7/7/15 at 12:48 PM, the Program Coordinator (PC) indicated there was no reason for the front door alarm to be on. The PC indicated she thought the alarm was turned off. The PC indicated if the alarm was on, it did not sound an alarm every time the door was opened. The PC indicated she need to check to ensure the batteries were out of the alarm. The PC indicated there was no documentation in any of the clients' plans requiring the use of the door alarm.</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</p>						

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	<p>through established procedures.</p> <p>Based on record review and interview for 1 of 14 incident/investigative reports reviewed affecting client #5, the facility failed to ensure staff immediately reported an incident of elopement to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 7/6/15 at 1:57 PM, a review of the facility's incident reports was conducted and indicated the following: On 7/7/15 at 10:50 AM, a review of client #5's record was conducted. In a note to the psychiatrist from the Behavior Consultant, dated 2/27/15, the note indicated, "Recently (the weekend of 2/14), [client #5] has also left the house through the side door without staff knowing and he has re-entered the house on his own. Staff have implemented behavioral interventions to teach and train [client #5] about the safety of keeping doors shut, especially given the dangerously cold conditions outside." Upon request, the Program Coordinator provided a communication from staff #5 to the other group home staff. The note, dated 2/14/15, indicated, "[Client #5] elopement. Hello all. I wanted to let</p>	W 0153	<p><b>W 153483.420(d)(2) STAFF TREATMENT OF CLIENTS</b></p> <p>Plan of correction: Support team met 7/15/15 and determined that staff was trained on bsp /hrp and no other concerns have been reported (attachment a). Plan of prevention: Elliott staff was trained on reporting mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator. (attachment a). Staff who failed to report fall to pager and administrator received an employee warning notice (attachment c). Plan of monitoring: Coordinator / Q will immediately report mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator (attachment b).</p>	07/15/2015			

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	<p>everyone know that [client #5] left the building this afternoon. He had been listening to music in the Living Room, and pacing around the house as he normally does. He all of a sudden ran down the hallway and ran out the side door. I ran after him and first looked out into the parking lot to make sure first that he hadn't ran (sic) toward the road. He had went (sic) around the other side of the house. He fortunately came back in on his own while I was out looking for him. I reviewed with him the red sign on the back door, and that it was not safe to go outside with out (sic) staff. I also let him know that it was dangerously cold out and that was also not safe. I did fill out an incident report, and will do ABC (antecedent/behavior/consequence) tracking as well."</p> <p>There was no documentation the staff reported the incident to the administrator. There was no documentation the incident was reported to BDDS.</p> <p>On 7/8/15 at 1:02 PM, the Group Home Director (GHD) indicated the incident was not reported to the administrator. The GHD indicated the staff should have immediately reported the incident to the administrator. The GHD indicated, after checking the on-call records on her phone, the staff failed to report the</p>			

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W 0154 Bldg. 00	<p>incident to the administrator.</p> <p>On 7/7/15 at 12:54 PM, the Program Coordinator (PC) indicated she was aware of the incident. The PC indicated the facility did not submit an incident report to BDDS. The PC indicated the incident should have been reported to BDDS.</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.</p> <p>Based on record review and interview for 2 of 14 incident/investigative reports reviewed affecting clients #3 and #5, the facility failed to conduct thorough investigations for an incident of elopement and a fall with injury.</p> <p>Findings include:</p> <p>1) On 7/7/15 at 10:50 AM, a review of client #5's record was conducted. In a note to the psychiatrist from the Behavior Consultant, dated 2/27/15, the note indicated, "Recently (the weekend of 2/14), [client #5] has also left the house through the side door without staff</p>	W 0154	<p><b>W 154483.420(d)(3) STAFF TREATMENT OF CLIENTS</b> The facility must have evidence that all alleged violations are thoroughly investigated. Plan of correction: Support team met 7/15/15 to discuss investigation and determined that staff was trained on bsp /hrp and reporting abuse and neglect immediately so administrator could start investigation (attachment a). Plan of prevention: Facility staff was trained on reporting mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator so investigation can be initiated (attachment a). Staff #f received a written warning</p>	07/15/2015

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	<p>knowing and he has re-entered the house on his own. Staff have implemented behavioral interventions to teach and train [client #5] about the safety of keeping doors shut, especially given the dangerously cold conditions outside." Upon request, the Program Coordinator provided a communication from staff #5 to the other group home staff. The note, dated 2/14/15, indicated, "[Client #5] elopement. Hello all. I wanted to let everyone know that [client #5] left the building this afternoon. He had been listening to music in the Living Room, and pacing around the house as he normally does. He all of a sudden ran down the hallway and ran out the side door. I ran after him and first looked out into the parking lot to make sure first that he hadn't ran (sic) toward the road. He had went (sic) around the other side of the house. He fortunately came back in on his own while I was out looking for him. I reviewed with him the red sign on the back door, and that it was not safe to go outside with out (sic) staff. I also let him know that it was dangerously cold out and that was also not safe. I did fill out an incident report, and will do ABC (antecedent/behavior/consequence) tracking as well." There was no documentation of an investigation regarding client #5 eloping from the group home on 2/14/15.</p>		(attachment c) Plan of monitoring: Coordinator / Q will immediately report mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator (attachment b). Coordinator / Q will undergo investigation training (attachment b).				

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	<p>On 7/7/15 at 12:54 PM, the Program Coordinator (PC) indicated she was aware of the incident. The PC indicated the facility did not conduct an investigation into the incident. The PC indicated the facility should have investigated the incident.</p> <p>On 7/8/15 at 1:02 PM, the Group Home Director (GHD) indicated the incident was not reported to the administrator and if it had been reported to her, she would have requested that an investigation was conducted.</p> <p>2) On 7/6/15 at 1:57 PM a review of the facility's incident reports was conducted and indicated the following: On 5/19/15 at 7:00 PM, client #3 was walking with staff #9 (a substitute staff) after putting her clothes away. The Stone Belt ARC, Inc. Incident Report, dated 5/19/15, indicated, in part, "I was walking with her holding onto her gait belt. She tripped over her own feet and went forward to the floor. She apparently bit her lip. Her lip split open a little bit. I cleaned the blood off her face. Her lip was starting to swell..." There was no documentation the incident was investigated to find out how client #3 fell while staff held onto her gait belt. There was no documentation the facility</p>			

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W 0159 Bldg. 00	<p>investigated the incident to determine whether or not staff #9 implemented client #3's fall risk plan as written.</p> <p>On 7/8/15 at 9:21 AM, a review of client #3's Medication Information Sheet, dated 6/26/15, indicated she had a fall risk plan. The plan indicated, "[Client #3] is at risk for falls due to a congenital birth defect in her left hip and her history of seizure disorder... To help prevent falls, DSPs (direct support professionals) will use a gait belt to assist [client #3] when ambulating. Assistance given as needed when in the group home and at all times while out in the community...."</p> <p>On 7/8/15 at 12:59 PM the Program Coordinator (PC) indicated the incident was not investigated. It was not unusual for her to trip over her own feet. The fall risk plan was being followed. The PC indicated the incident should have been investigated. The PC indicated she did not follow up with the staff to find out what occurred.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must</p>						

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	<p>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 (#2, #5 and #6), the Qualified Intellectual Disabilities Professional (QIDP) failed to conduct quarterly reviews of the clients' program plans.</p> <p>Findings include:</p> <p>On 7/7/15 at 10:11 AM a review of client #2's record was conducted. Client #2's record contained a Monthly Review, dated 1/12/15. The document was not a quarterly review. The document discussed a review of emergency drill procedures for August, taking his medications on time in October, maintaining a safe distance in February, identifying money in October and using toilet tissue in September. There were no quarterly reviews in client #2's record for review.</p> <p>On 7/7/15 at 10:50 AM a review of client #5's record was conducted. Client #5's Monthly Review, dated 1/12/15, was not a quarterly review. The document discussed a review of verbalizing choices in October, identifying money in September, completing a side dish in October, oral hygiene in October and learning self-help skills and hygiene</p>	W 0159	<p><b>W 159483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b> Plan of correction: Quarterlies were completed and filed in fortis data base (attachment e). Plan of prevention: Coordinator/Q will undergo training with IT to ensure she is trained on PPS and can submit monthly and quarterlies to fortis (attachment b) Plan of monitoring : Director will ensure that coordinator/Q completes quarterlies in a timely manner and send to fortis. Internal audit will be completed by peer and submitted to the Director each quarter reviewing coordinator/Q is completing QMRP duties as designated (attachment d).</p>	07/15/2015			

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	<p>skills in October. A document titled Quarterly Review, dated 10/1/14, did not include information regarding the progress on client #5's goals and objectives. The document listed the goals and objectives but did not include any information regarding how many trials there were and when client #5 met the goals.</p> <p>On 7/7/15 at 11:53 AM a review of client #6's record was conducted. Client #6's Monthly Review, dated 1/12/15, was not a quarterly review. The document discussed a review of participating in an activity in December 2015 (zero training sessions), signing "stop" in May, increasing communication skills in October, correct amount for an item in October, completing a side dish in October, using a key to open his bedroom and laundry room in October, increasing walker skills in October, and completing a medication pass and adjusting water temperature in October. A document titled Quarterly Review, dated 2/3/15, indicated the review period was 11/1/14 to 2/1/15. The participate in an activity indicated there were no trials in November and December. There was no information indicating how this was addressed. The objective to sign "stop" indicated the review was for April and May. The increase communication skills,</p>			

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W 0440  Bldg. 00	<p>completing a side dish, using a key to access bedroom and laundry room, walker skills, completing a medication pass, adjusting the water temperature and correct amount for an item indicated the review was for August, September and October. There were no quarterly reviews in client #6's record for review covering July 2014 to July 2015.</p> <p>On 7/7/15 at 12:52 PM, the Program Coordinator (QIDP) indicated the clients' records should include a quarterly review of the progress on their training goals and objectives. The QIDP indicated she needed to seek assistance from another QIDP to complete the clients' quarterlies. The QIDP stated she was having a "difficult time" getting the information from another electronic system into the clients' records.</p> <p>9-3-3(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift.</p>	W 0440	<p><b>W 440483.470(i)(1)</b> <b>EVACUATION DRILLS</b> Plan of correction: Facility drill was completed and scanned into Fortis (attachment g). Plan of prevention: House manager will</p>	07/15/2015			

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W 0488  Bldg. 00	<p>Findings include:</p> <p>On 7/6/15 at 4:52 PM a review of the facility's evacuation drills was conducted and indicated the following: During the day shift (6:00 AM to 2:00 PM), the facility failed to conduct evacuation drills from 2/1/15 to 6/15/15 and 8/1/14 to 11/13/14. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 7/6/15 at 5:05 PM, the Home Manager (HM) indicated the facility should conduct quarterly drills for each shift. The HM indicated she had directed staff several times to conduct a drill in April 2015 however the staff failed to conduct the drill until June 2015.</p> <p>On 7/7/15 at 12:46 PM, the Program Coordinator indicated the facility should conduct quarterly drills for each shift.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 6 of 6 clients living in the group home (#1,</p>			W 0488	<p>ensure that drill are completed quarterly for each shift of personnel(attachment h). Plan of monitoring : Coordinator / Qwill ensure monitor and ensure that drills are completed each quarterly foreach shift and personnel (attachment b).</p> <p><b>W 488483.480(d)(4) DINING AREAS AND SERVICE</b> Plan of correction: Facility staff were</p>		07/15/2015

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	<p>#2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved with meal preparation, serving themselves and cutting up their own food.</p> <p>Findings include:</p> <p>On 7/6/15 from 4:20 PM to 6:18 PM an observation was conducted at the group home. At 4:26 PM, staff #3 was in the kitchen preparing dinner with no clients involved. At 5:16 PM, staff #3 was in the kitchen preparing dinner with no clients involved. Clients #1, #2, #3, #4, #5 and #6 were present in the home and available to assist. Staff did not ask or prompt the clients to assist with dinner preparation. At 5:24 PM the Home Manager prompted client #1 to assist with dinner preparation. Client #1 went to the kitchen area but left the kitchen and started talking with staff. Client #1 was not observed to assist with dinner preparation. At 6:07 PM, staff #3 used client #6's rocker knife to cut up his food. Staff #3 used client #3's rocker knife to cut up her chicken. At 6:09 PM, staff #3 served client #6's vegetables and potatoes. Staff #3 served vegetables and potatoes to client #3. At 6:11 PM, staff #3 poured client #3 and #6's milk. Staff #3 added margarine to client #3 and #6's vegetables.</p>		<p>trained on trainingclients on utilizing prescribed adaptive equipment by following plan put into place by coordinator and Q (attachment i). Plan of prevention: House manager will ensure clients plansare being followed per assessed needs of team and physician's' orders. House manager / associate manager will observe each mealtime to monitor (attachment j). Plan of monitoring : Coordinator / Qwill ensure monitor and complete weekly observations of facility to ensure plans are appropriate and being followed by staff (attachment b).</p>	

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W 9999  Bldg. 00	<p>On 7/8/15 at 9:58 AM the Program Coordinator (PC) indicated the clients should be involved either with hand over hand assistance or independently serve themselves. The PC indicated the clients should be taught how to cut up their food and serve themselves. The PC indicated the staff should not serve the clients and cut up their food without providing the clients training. The PC indicated the clients should be involved with the meal preparation.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 15. A fall resulting in injury, regardless</p>	W 9999	<p><b>W 153483.420(d)(2) STAFF TREATMENT OF CLIENTS</b></p> <p>Plan of correction: Support team met 7/15/15 and determined that staff #9 was trained on bsp /hrp and no other concerns have been reported (attachment a). Staff #9 received a warning for not reporting incident regarding client #4 to the emergency pager or administrator (attachment c)</p> <p>Plan of prevention: Elliott staff was trained on reporting mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator. (attachment a). Staff #9 who failed to report fall to</p>	07/15/2015			

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	<p>of the severity of the injury.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 non-sampled clients in the sample (#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, for a fall resulting in an injury.</p> <p>Findings include:</p> <p>On 7/6/15 at 1:57 PM a review of the facility's incident reports was conducted and indicated the following: On 5/19/15 at 7:00 PM, client #3 was walking with staff #9 (a substitute staff) after putting her clothes away. The Stone Belt ARC, Inc. Incident Report, dated 5/19/15, indicated, in part, "I was walking with her holding onto her gait belt. She tripped over her own feet and went forward to the floor. She apparently bit her lip. Her lip split open a little bit. I cleaned the blood off her face. Her lip was starting to swell..." There was no documentation the incident was reported to BDDS.</p> <p>On 7/7/15 at 12:46 PM, the Program</p>		<p>pager and administrator received an employee warning notice (attachment c). Plan of monitoring: Coordinator / Q will immediately report mistreatment, neglect or abuses, as well as injuries of unknown source, are immediately to the administrator (attachment b).</p>				

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	Coordinator indicated the incident, a fall with injury, should have been reported to BDDS.  9-3-1(b)				