STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	4417 BLACKSTONE CT BLOOMINGTON, IN 47401

(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
W 000 Bldg. 00	This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00162031. Complaint #IN00162031: Substantiated. Federal/state deficiencies related to the allegations are cited at W149, W154 and W156. Survey Dates: January 22, 23, 27, 28, 29 and 30, 2015 Facility Number: 000704 Provider Number: 15G170 AIM Number: 100234540 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/6/15 by Ruth Shackelford, QIDP.	W 000		
W 104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	the facility. Based on observation and interview for 1 of 3 clients in the sample (D), the governing body failed to exercise operating direction over the facility by failing to ensure the facility-operated day program had a refrigerator available for client D to store her lunchbox. Findings include: On 1/27/15 at 10:40 AM to 10:50 AM, an observation was conducted at the facility-operated day program classroom where client D was attending class. During the observation, client D's lunchbox was stored outside the building on the sidewalk. Client D's lunchbox was inside a cooler on the ground to the right of the exit door. On 1/27/15 at 10:42 AM, the Instructor of the classroom where client D attended during the day program indicated she obtained a cooler on 1/26/15 to store the clients' lunchboxes. The Instructor stated the cooler was "more sanitary and safe" than what the client was doing which was sitting her lunchbox on the ground outside the exit door to the classroom. The Instructor indicated client D's lunchbox had been stored on the ground outside the classroom for the past 3 weeks. The Instructor stated the	W 104	**Plan ofCorrection: Facility purchased a refrigerator for the room to store client d'slunch was purchased.** **Plan of Prevention:Facility staff trained on storing lunches in refrigerator not outside. Icepacks in lunches may also be used in lieu of refrigeration (attachment a).** **Plan ofMonitoring: Facility LL coordinator / QIDP-D will ensure lunches are stored appropriately and not kept outside.**	02/01/2015

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	classroom was "supposed" to get a refrigerator "soon". The Instructor indicated there was no room in the other classroom refrigerators to store client D's lunchbox. On 1/27/15 at 11:10 AM, the Day Program Coordinator indicated the day program was in the process of getting a refrigerator for the classroom where client D attended. The Coordinator indicated the facility was using a cooler. The Coordinator indicated client D had the option to put her lunchbox in the other classroom refrigerators. The Coordinator indicated obtaining a refrigerator was taking longer than expected. The Coordinator indicated the facility ordered the refrigerator and was waiting for it to be delivered. On 1/27/15 at 1:42 PM, the Group Home Coordinator (GHC) indicated client D's lunchbox should not be stored outside. The GHC indicated client D's lunchbox had an ice pack in it so her lunchbox did not need to be refrigerated. 9-3-1(a)			
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS,			

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Bldg. 00	PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Based on record review and interview for 1 of 3 clients in the sample (D), the facility failed to ensure client D's guardian was notified in regard to a change of client D's program room at the facility-operated day program. Findings include: On 1/23/15 at 2:44 PM, client D's guardian indicated client D's program room at the facility-operated day program recently changed. Client D indicated she was not notified or consulted about the change in the program rooms. Client D's guardian indicated she wanted to be notified when there were changes to client D's program. Client D's guardian indicated she found out about the change when she visited client D at the day program. On 1/27/15 at 10:42 AM, the Instructor for client D's day program indicated the Day Program Coordinators decided to change client D's program room. The Instructor indicated she did not contact the guardian prior to or after the change.	W 148	**Plan ofCorrection: LL coordinator trained on communicating changes in programing toguardians and primary coordinator (attachment b).** **Plan ofPrevention: Facility house manager trained to notify promptly the client'sparents or guardian of any significant incidents, or changes in the client'scondition including, but not limited to, serious illness, accident, death,abuse, or unauthorized absence (attachment c).** **Plan ofMonitoring: Facility coordinators will meet monthly to discuss their role tonotify promptly the client's parents or guardian of any significant incidents,or changes in the client's condition including, but not**	02/01/2015

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	The Instructor indicated client D's guardian found out about the change while visiting the day program. The Instructor stated she "passed along" the guardian's concerns about not being notified to the Day Program Coordinator. On 1/27/15 at 11:10 AM, the Day Program Coordinator (DPC) indicated the day program used to do Leadership Class two days per week. The DPC indicated the day program had the guardian's approval for client D to be in the class at the time. The DPC stated the Leadership Class went to 5 days per week and client D's "homeroom" was changed at that time. The DPC indicated she did not contact client D's guardian. The DPC stated, "I didn't see it as necessary" since the day program had approval for client D previously. The DPC indicated the clients have a choice about which classes at the day program to attend. The DPC stated this particular classroom was client D's "homeroom." On 1/27/15 at 1:45 PM, the Group Home Coordinator (GHC) indicated he found out about the change in client D's day programming the day the change occurred. The GHC indicated the explanation he received was client D attended the class in the past, the previous instructor quit so the class and		**limited to, seriousillness, accident, death, abuse, of unauthorized absence.**	

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	the clients in the class were moved to other program rooms. Once a new instructor was hired client D was moved back to the classroom. The GHC indicated the guardian should have been notified of the change. On 1/27/15 at 12:40 PM, a review of client D's record indicated there was no documentation of client D's guardian being notified of the change in programming at the facility-operated day program. 9-3-2(a)			
W 149 Bldg. 00	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 20 of 48 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility neglected to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations and report the results of investigations to the administrator within 5 working days. Findings include:	W 149	**Plan ofCorrection: Facility coordinator / QIDP trained on following written policies and procedures that prohibit mistreatment, neglect or abuse of the client(attachment d).** **Plan ofPrevention: Facility has introduced an electronic alert system that will ensure that investigations are completed and followed in a timely manner (attachment f).** **Plan ofmonitoring: Facility quality assurance team meet bi weekly to discuss each**	02/01/2015

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	On 1/23/15 at 12:20 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 1/21/15 at 2:30 PM at the facility-operated workshop, client C smacked a peer on the left arm. The peer was not injured. 2) On 1/15/15 at 4:00 PM at the facility-operated day program, client A told client E to not do something and client E hit client A in the upper stomach. Client A was not injured. 3) On 1/8/15 at 7:00 PM, client C grabbed a stack of envelopes. Client E attempted to grab the stack from client C. Client C hit client E on the upper left arm. There was no visible injury. The investigation, dated 1/12/15, indicated client C, client E and staff #7 were interviewed during the investigation. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 1/9/15, indicated there was another staff (report indicated first name only) present during the incident. The investigation did not include an interview with the 2nd staff. The investigation was not thorough. 4) On 12/29/14 at 4:15 PM, when client		**investigation. Team will provide oversight to ensure that facility staff and QDIP are implementing Stone Belt policies and procedures to prevent client to client abuse, conduct thorough investigations, and recommendations are appropriate**	

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	C returned home from the workshop, she slammed cabinet doors and turned over 2 dining room chairs. Client C attempted to grab client E who was eating a snack. Client C ran across the room and grabbed client D's shirt. Staff used a bear hug for 1 minute on client C. Client C tore client D's shirt and her finger brace came off while trying to pull client C off of her. The investigation, dated 1/12/15 (should have been completed by 1/6/15), included an interview with client C, client D and staff #1. There was no documentation in the investigation of an interview with the 2nd staff. The BDDS report, dated 12/30/14, indicated, in part, "Other clients left the house with another staff...." The BDDS report, investigation and Stone Belt ARC, Inc. Incident Report did not indicate the identity of the second staff. The investigation was not thorough. 5) On 11/19/14 at 7:50 AM, client C punched client D in the face on the same side as client D's shunt. Client D did not have visible injuries. Client D was taken to her physician to ensure there was no damage to her shunt. There was no damage. The investigation, dated 12/1/14 (due 11/26/14), indicated the Coordinator interviewed client C, client D and one staff. The BDDS incident report, dated 11/19/14, indicated there			

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	were three staff present at the time of the incident (staff #4 was outside assisting others into the van for transport, staff #1 was in the medication room passing medications to a client, and staff #6 was upstairs with clients C and D). Staff #6 was not interviewed during the investigation. The investigation included an interview with staff #2 who was not present during the incident based on the BDDS report and Stone Belt ARC, Inc. Incident Report. The investigation was not thorough. 6) On 11/4/14 at 5:30 PM, client B informed staff she had found a bruise (1.5 inches by 3 inches) on the inside of her right thigh while using the restroom. The BDDS report, dated 11/5/14, indicated, in part, "Staff talked to [client B] who reported that the bruise was swollen and that she didn't know where or how she got it." The investigation, dated 12/1/14 (should have been completed by 11/11/14), indicated the Coordinator interviewed staff #1. There were no interviews with additional staff who worked at the home, client B or her peers. The investigation was not thorough. 7) On 10/15/14 at 7:15 AM, client C punched client D on the upper right thigh two times. Client D was not injured. The BDDS report, dated 10/15/14,			

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	indicated there were two staff present at the time of the incident (the report did not identify the staff). The investigation, dated 12/1/14, indicated client C, client D and staff #1 were interviewed. There was no documentation of an interview with the second staff. The investigation was not thorough. 8) On 10/7/14 at 7:15 PM during a tornado warning, client E yelled and banged on doors. Client E attempted to open the fire door to the upstairs however client D's legs were in the way. Client E kicked client D's legs several times. Client E kicked client A (did not indicate where client A was kicked). Clients D and A were not injured. The investigation was reviewed by the administrator on 12/8/14. 9) On 9/27/14 at 4:00 PM, client C was prompted to get her laundry to take downstairs. Client C agreed and asked staff to assist her. As client C started to walk down the hallway, she punched client D, who was lying on a couch, in the head as she walked by client D. The Stone Belt ARC, Inc. Incident Report, dated 9/27/14, indicated, in part, "Completely unprovoked and out of the blue... [client C] became very upset and started to cry hysterically... [Client D] requested an ice pack and stated she had			

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	a minor headache." 10) On 9/24/14 at 3:00 PM at the facility-operated workshop, client C hit a peer in the back after the peer told client C to go back to work. Client C and the peer were asked to talk. Client C reached past the staff and hit the peer on the arm. 11) On 9/21/14 at 3:30 PM while at a store in the community, client C kicked client D after being asked to tie her shoe. Client D was not injured. Once in the van, client C was informed the group was not going into another store due to the incident. Client C banged her head repeatedly on the window in the van and verbally threatened to harm, stab and kill client D. Client C yelled at client D for 15 minutes while in the van. The investigation was reviewed by the administrator on 12/5/14. 12) On 9/8/14 at 4:00 PM at the facility-operated day program, client C scratched client D's upper right arm. 13) On 9/5/14 at 1:00 AM, client C woke up upset about her boyfriend. Client C pulled client A's hair. Client A had been sleeping on the couch. The investigation was reviewed by the administrator on 12/9/14.			

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	14) On 8/18/14 at 7:20 AM, client C ate a large breakfast and was prompted to not eat another client's meal. Client C yelled, cursed, kicked, pushed, pinched and grabbed staff before biting the staff's breast. Second staff and client D went into the office to contact the emergency pager. The staff locked the office door. Client C shoved open the office door. Client C grabbed client D's hair with both hands and pulled client D to the floor. Client C kicked client D in the face. Client D did not have visible injuries. Client D's glasses were broken during the incident. The investigation, dated 8/18/14, indicated, in part, "Door has been repaired. [Client D] was seen by a physician. Shunt determined to be intact and functioning." 15) On 8/14/14 at 3:30 PM at the facility-operated day program, client D was hit by a peer with his belt on her right shoulder and right side of her head. Client D had a welt on her right shoulder and the base of her neck. 16) On 8/11/14 at 8:30 AM at the facility-operated day program, client C ran up the ramp and hit client E on the left arm and shoulder with her lunch box. 17) On 6/13/14 at 3:19 PM, client C yelled at her former housemate (client F).			

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	Client C was asked to take a break in the office. Clients E and F were sitting on a bench outside of the office when client C ran out of the office and smacked client F's shoulder causing a red mark. 18) On 5/5/14 at 6:00 PM, client C slapped former housemate (client F) on the chest when she was not the first in line to make her lunch. Client F put ice on the area where she was hit although there was no apparent injury. The results of the investigation were reviewed by the administrator on 5/13/14 (due on 5/12/14). 19) On 4/24/14 at 5:30 PM, client C pushed client A in the back to get client A to move so she could get a snack. Client A yelled and began to cry. Client A was not injured. 20) On 3/24/14 at 7:15 AM, client C hit former housemate (client F) twice on the arm. Client F was not injured. On 1/22/15 at 3:39 PM, the Group Home Director (GHD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The GHD indicated the facility had a policy/procedure prohibiting abuse of the clients. The GHD indicated the results of investigations should be			

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	reported to the administrator within 5 working days of the incident. On 1/29/15 at 12:39 PM, the GHD indicated the Coordinator needed to interview all staff and peers present during an incident. The GHD indicated the facility needed to conduct thorough investigations. The GHD stated the Coordinator "was struggling" to keep up with completing investigations. The GHD stated the investigations, "They were not as timely as they should be." On 1/22/15 at 3:08 PM, the Coordinator indicated the incidents between clients C and D were related to client D dating client C's ex-boyfriend as soon as she moved into the home 2-3 years ago. Client D, when upset, blamed client C for everything. Client C antagonized client D verbally. Client C would not stay away when client D was upset. The Coordinator stated, "Sometimes it's just [client D] being in the wrong place at the wrong time." On 1/27/15 at 1:45 PM, the Coordinator indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy/procedure prohibiting abuse of the clients. The Coordinator indicated the results of investigations should be reported to the administrator within 5 working days of			

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	the incident. On 1/29/15 at 12:46 PM, the Coordinator indicated although there were incidents with client to client aggression and he spoke to both staff present, he documented one of his interviews with the staff. The Coordinator indicated the facility should conduct thorough investigations. The Coordinator indicated for client B's injury of unknown origin, he interviewed one staff. The Coordinator indicated he should have interviewed the staff who had worked with her prior to the injury being discovered. On 1/22/15 at 11:48 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 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	4417 BLACKSTONE CT BLOOMINGTON, IN 47401

(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
	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. Events Requiring Investigations. Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over client support; misuse of client or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct. This does not replace the obligation of employees to report immediately to supervisors, directors or to write incident reports. This provides for another level of notification beyond, and in addition to, incident reporting. The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days... Investigations must be started within 24 hours.			

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	ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events." The Human Rights Policy, dated 2/17/14, indicated, in part, "Physical abuse: Consists of any intentional and/or punitive physical action or motion by which physical harm or emotional trauma may occur." The policy indicated, in part, "Neglect: Any action or behavioral interventions that risks the physical or emotional safety and wellbeing of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care, or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide			

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	medical supplies or safety equipment as indicated in the individualized support plan." This federal tag relates to complaint #IN00162031. 9-3-2(a)			
W 154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 5 of 48 incident/investigative reports reviewed affecting clients B, C, D and E, the facility failed to conduct thorough investigations. Findings include: On 1/23/15 at 12:20 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 1/8/15 at 7:00 PM, client C grabbed a stack of envelopes. Client E attempted to grab the stack from client C. Client C hit client E on the upper left arm. There was no visible injury. The investigation, dated 1/12/15, indicated	W 154	**Plan Correction: Facility QIDP trained on interviewing each staff and client present during an incident Plan of Prevention: Facility QIDP trained on completing** thoroughly **investigations per facility and state regulations Plan ofMonitoring: Facility director will review investigations with investigators and team members to create effective outcomes and that investigation was completed correctly**	02/01/2015

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	client C, client E and staff #7 were interviewed during the investigation. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 1/9/15, indicated there was another staff (report indicated first name only) present during the incident. The investigation did not include an interview with the 2nd staff. The investigation was not thorough. 2) On 12/29/14 at 4:15 PM, when client C returned home from the workshop, she slammed cabinet doors and turned over 2 dining room chairs. Client C attempted to grab client E who was eating a snack. Client C ran across the room and grabbed client D's shirt. Staff used a bear hug for 1 minute on client C. Client C tore client D's shirt and her finger brace came off while trying to pull client C off of her. The investigation, dated 1/12/15, included an interview with client C, client D and staff #1. There was no documentation in the investigation of an interview with the 2nd staff. The BDDS report, dated 12/30/14, indicated, in part, "Other clients left the house with another staff...." The BDDS report, investigation and Stone Belt ARC, Inc. Incident Report did not indicate the identity of the second staff. The investigation was not thorough.			

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	3) On 11/19/14 at 7:50 AM, client C punched client D in the face on the same side as client D's shunt. Client D did not have visible injuries. Client D was taken to her physician to ensure there was no damage to her shunt. There was no damage. The investigation, dated 12/1/14, indicated the Coordinator interviewed client C, client D and one staff. The BDDS incident report, dated 11/19/14, indicated there were three staff present at the time of the incident (staff #4 was outside assisting others into the van for transport, staff #1 was in the medication room passing medications to a client, and staff #6 was upstairs with clients C and D). Staff #6 was not interviewed during the investigation. The investigation included an interview with staff #2 who was not present during the incident based on the BDDS report and Stone Belt ARC, Inc. Incident Report. The investigation was not thorough. 4) On 11/4/14 at 5:30 PM, client B informed staff she had found a bruise (1.5 inches by 3 inches) on the inside of her right thigh while using the restroom. The BDDS report, dated 11/5/14, indicated, in part, "Staff talked to [client B] who reported that the bruise was swollen and that she didn't know where or how she got it." The investigation, dated 12/1/14 (should have been completed by			

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	11/11/14), indicated the Coordinator interviewed staff #1. There were no interviews with additional staff who worked at the home, client B or her peers. The investigation was not thorough. 5) On 10/15/14 at 7:15 AM, client C punched client D on the upper right thigh two times. Client D was not injured. The BDDS report, dated 10/15/14, indicated there were two staff present at the time of the incident (the report did not identify the staff). The investigation, dated 12/1/14, indicated client C, client D and staff #1 were interviewed. There was no documentation of an interview with the second staff. The investigation was reviewed by the administrator on 12/5/14. The investigation was not thorough. On 1/29/15 at 12:39 PM, the Group Home Director (GHD) indicated the Coordinator needed to interview all staff and peers present during an incident. The GHD indicated the facility needed to conduct thorough investigations. The GHD stated the Coordinator "was struggling" to keep up with completing investigations. On 1/29/15 at 12:46 PM, the Coordinator indicated although there were incidents with client to client aggression and he spoke to both staff present, he			

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	15G170		01/30/2015

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	documented one of his interviews with the staff. The Coordinator indicated the facility should conduct thorough investigations. The Coordinator indicated for client B's injury of unknown origin, he interviewed one staff. The Coordinator indicated he should have interviewed the staff who had worked with her prior to the injury being discovered. This federal tag relates to complaint #IN00162031. 9-3-2(a)			
W 156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 8 of 48 incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to report the results of investigations to the administrator within 5 working days. Findings include: On 1/23/15 at 12:20 PM, a review of the facility's incident/investigative reports	W 156	**Plan ofCorrection: Facility coordinator / QIDP trained on investigations reported tothe administrator or designated representative or to other officials inaccordance with State law within five working days of the incident (attachmente). Plan ofPrevention: Facility introduced electronic alert system that prompts facilitycoordinator / QIDP and**	02/01/2015

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	was conducted and indicated the following: 1) On 12/29/14 at 4:15 PM, when client C returned home from the workshop, she slammed cabinet doors and turned over 2 dining room chairs. Client C attempted to grab client E who was eating a snack. Client C ran across the room and grabbed client D's shirt. Staff used a bear hug for 1 minute on client C. Client C tore client D's shirt and her finger brace came off while trying to pull client C off of her. The investigation, dated 1/12/15 (should have been completed by 1/6/15), included an interview with client C, client D and staff #1. There was no documentation in the investigation of an interview with the 2nd staff. The BDDS report, dated 12/30/14, indicated, in part, "Other clients left the house with another staff...." The BDDS report, investigation and Stone Belt ARC, Inc. Incident Report did not indicate the identity of the second staff. 2) On 11/19/14 at 7:50 AM, client C punched client D in the face on the same side as client D's shunt. Client D did not have visible injuries. Client D was taken to her physician to ensure there was no damage to her shunt. There was no damage. The investigation, dated 12/1/14 (should have been completed by		**DSGL to review incident. Plan ofMonitoring: Facility director will ensure that the outcome of investigation is reviewed within five working days of the incident.**	

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	11/26/14), indicated the Coordinator interviewed client C, client D and one staff. The BDDS incident report, dated 11/19/14, indicated there were three staff present at the time of the incident (staff #4 was outside assisting others into the van for transport, staff #1 was in the medication room passing medications to a client, and staff #6 was upstairs with clients C and D). Staff #6 was not interviewed during the investigation. The investigation included an interview with staff #2 who was not present during the incident based on the BDDS report and Stone Belt ARC, Inc. Incident Report. 3) On 11/4/14 at 5:30 PM, client B informed staff she had found a bruise (1.5 inches by 3 inches) on the inside of her right thigh while using the restroom. The BDDS report, dated 11/5/14, indicated, in part, "Staff talked to [client B] who reported that the bruise was swollen and that she didn't know where or how she got it." The investigation, dated 12/1/14 (should have been completed by 11/11/14), indicated the Coordinator interviewed staff #1. There were no interviews with additional staff who worked at the home, client B or her peers. 4) On 10/15/14 at 7:15 AM, client C punched client D on the upper right thigh two times. Client D was not injured.			

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	The BDDS report, dated 10/15/14, indicated there were two staff present at the time of the incident (the report did not identify the staff). The investigation, dated 12/1/14 (should have been completed by 10/22/14), indicated client C, client D and staff #1 were interviewed. There was no documentation of an interview with the second staff. 5) On 10/7/14 at 7:15 PM during a tornado warning, client E yelled and banged on doors. Client E attempted to open the fire door to the upstairs however client D's legs were in the way. Client E kicked client D's legs several times. Client E kicked client A (did not indicate where client A was kicked). Clients D and A were not injured. The investigation was reviewed by the administrator on 12/8/14 (should have been completed by 10/14/14). 6) On 9/21/14 at 3:30 PM while at a store in the community, client C kicked client D after being asked to tie her shoe. Client D was not injured. Once in the van, client C was informed the group was not going into another store due to the incident. Client C banged her head repeatedly on the window in the van and verbally threatened to harm, stab and kill client D. Client C yelled at client D for 15 minutes while in the van. The			

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	15G170		01/30/2015

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	investigation was reviewed by the administrator on 12/5/14 (should have been completed by 9/26/14). 7) On 9/5/14 at 1:00 AM, client C woke up upset about her boyfriend. Client C pulled client A's hair. Client A had been sleeping on the couch. The investigation was reviewed by the administrator on 12/9/14 (should have been completed by 9/12/14). 8) On 5/5/14 at 6:00 PM, client C slapped former housemate (client F) on the chest when she was not the first in line to make her lunch. Client F put ice on the area where she was hit although there was no apparent injury. The results of the investigation were reviewed by the administrator on 5/13/14 (should have been completed by 5/12/14). This federal tag relates to complaint #IN00162031. 9-3-2(a)			
W 159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must			

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	be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 3 of 3 clients in the sample (B, C and D) and two additional clients (A and E), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' active treatment programs to ensure: 1) client D's lunch was not being stored outside the building during the day program, 2) client D's guardian was notified when a change in her day program room was implemented, 3) client D had written instructions to staff in regard to the implementation of client D's physical therapy (PT) exercises, 4) client D's risk plan for UTIs (Urinary Tract Infections) indicated the procedure staff was to implement to check her urine weekly, 5) staff implemented client D's risk plan for UTIs (Urinary Tract Infections) as written, 6) at least annually, the clients' comprehensive functional assessments were reviewed for relevancy and updated as needed, 7) client B had an individualized program plan developed and implemented since her admission on 7/26/14, 8) furnish, maintain in good repair and teach client C to use and make an informed choice about the use of her glasses and 9) quarterly evacuation drills were conducted for each shift.	W 159	**1) Plan ofCorrection: Facility purchased a refrigerator for the room to store client d'slunch was purchased.** **Plan ofPrevention: Facility staff trained on storing lunches in refrigerator notoutside. Ice packs in lunches may also be used in lieu of refrigeration(attachment a).** **Plan ofMonitoring: Facility LL coordinator / QIDP-D will ensure lunches are stored appropriately and not kept outside.** **2) Plan ofCorrection: Facility coordinator trained on communicating changes in programingto guardians and primary coordinator (attachment b).** **Plan ofPrevention: Facility house manager trained to notify promptly the client'sparents or guardian of any significant incidents, or changes in the client'scondition including, but not limited to, serious illness, accident, death,abuse, or unauthorized absence**	02/01/2015

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	Findings include: 1) Please refer to W104. For 1 of 3 clients in the sample (D), the governing body failed to exercise operating direction over the facility by failing to ensure the facility-operated day program had a refrigerator available for client D to store her lunchbox. 2) Please refer to W148. For 1 of 3 clients in the sample (D), the facility failed to ensure client D's guardian was notified in regard to a change of client D's program room at the facility-operated day program. 3) Please refer to W210. For 1 of 3 clients in the sample (B), the facility failed to ensure, within 30 days after admission, the client's comprehensive functional assessment was completed. 4) Please refer to W226. For 1 of 3 clients in the sample (B), the facility failed to ensure client B had an individualized program plan developed and implemented since her admission on 7/26/14. 5) Please refer to W227. For 1 of 3 clients in the sample (D), the facility failed to ensure client D had written instructions to staff in regard to the		**(attachment c).** **Plan ofMonitoring: Facility coordinators will meet monthly to discuss their role tonotify promptly the client's parents or guardian of any significant incidents,or changes in the client's condition including, but not limited to, seriousillness, accident, death, abuse, of unauthorized absence.** **3) Plan ofCorrection: Client B's assessment completed 8/13/2014 within 30 days of intake(attachment e).** **Plan ofPrevention: Facility LL coordinator / QIDP-D will ensure forms are turned into AA to have scanned into Fortisdatabase (attachment f).** **Plan ofMonitoring: Electronic alerts will be sent out to notify Facility LLcoordinator / QIDP-D and director whenassessments have not been completed or turned into AA to scan into**	

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	implementation of client D's physical therapy (PT) exercises. 6) Please refer to W240. For 1 of 3 clients in the sample (D), the facility failed to ensure client D's risk plan for UTIs (Urinary Tract Infections) indicated the procedure staff was to implement to check her urine weekly. 7) Please refer to W249. For 1 of 3 clients in the sample (D), the facility failed to ensure staff implemented client D's risk plan for UTIs (Urinary Tract Infections) as written. 8) Please refer to W259. For 1 of 3 clients in the sample (C), the facility failed to ensure, at least annually, the client's comprehensive functional assessment was reviewed for relevancy and updated as needed. 9) Please refer to W436. For 1 of 3 clients in the sample (C), the facility failed to furnish, maintain in good repair and teach client C to use and make an informed choice about the use of her glasses. 10) Please refer to W440. For 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to ensure quarterly evacuation drills were		**Fortisdatabase (attachment f).** **4) Plan ofCorrection: Client B's ISP was completed (attachment g).** **Plan ofPrevention: Facility coordinator / QIDP-D trained on completing ISP within 30 days of intake (attachment h).** **Plan ofMonitoring: Electronic alerts will be sent out to notify Facility LLcoordinator / QIDP-D and director whenassessments have not been completed or turned into AA to scan into Fortisdatabase.** **5) Plan ofCorrection: Facility nurse ensured client D had written instructions to staffin regard to the implementation of client D's physical therapy (PT) exercises(attachment h).** **Plan ofprevention: Facility nurse trained staff on client D HRP that includes written instructionsto staff in regard**	

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4417 BLACKSTONE CT BLOOMINGTON, IN 47401	

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	conducted for each shift. 9-3-3(a)		**to the implementation of client D's physical therapy (PT)exercises (attachment i).** **Plan ofMonitoring: Facility LL coordinator / QIDP-D trained on ensuring that HRP are in place for diagnosis and that staffare trained to follow plans. Tracking implemented to monitor the completion ofthese exercises included on informal goal tracking.** **6)Plan ofCorrection: Facility nurse ensured client D's risk plan for UTIs (Urinary TractInfections) complete with the procedures for staff to implement and to check her urine weekly (attachment j).** **Plan ofprevention: Facility nurse trained staff on client D's risk plan for UTIs(Urinary Tract Infections) complete with the procedures for staff to implement and to check her urineweekly (attachment k).** **Plan ofMonitoring: Facility LL**	

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			coordinator / QIDP-D trained on ensuring that D's risk plan for UTIs (Urinary TractInfections) complete with the procedures for staff to implement and to check her urine weekly. Tracking implemented tomonitor the completion of this procedure (l). **7)Plan ofCorrection: Facility nurse ensured client D's risk plan for UTIs (Urinary TractInfections) complete with the procedures for staff to implement and to check her urine weekly (attachment j).** **Plan ofprevention: Facility nurse trained staff on client D's risk plan for UTIs(Urinary Tract Infections) complete with the procedures for staff to implement and to check her urineweekly (attachment k).** **Plan ofMonitoring: Facility coordinator / QIDP-D trained on ensuring that D's risk plan**	

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			for UTIs (Urinary TractInfections) complete with the procedures for staff to implement and to check her urine weekly. Tracking implementedto monitor the completion of this procedure (I). **.** **8) Plan ofCorrection: Client B's assessment completed 8/13/2014 within 30 days of intake(attachment e).** **Plan ofPrevention: Facility coordinator / QIDP-D will ensure forms are turned into AA to have scanned into Fortisdatabase (attachment f).** **Plan ofMonitoring: Electronic alerts will be sent out to notify Facility LLcoordinator / QIDP-D and director whenassessments have not been completed or turned into AA to scan into Fortisdatabase (attachment f).** **9) Plan ofCorrection: Client C team determined to**	

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			introduce a goal to her plan to trainher to wear her glasses as ordered by physican (attachment m). **Plan ofPrevention: Facility staff trained on importance of training client C on neweye glass goal (attachment n).** **Plan ofMonitoring: Facility day aid and coordinator / QIDP-D was trained on ensuringthat adaptive equipment including glasses; are furnished, maintained, and ingood repair along with teachingclient(s) to use and make an informedchoice about the use of her glasses (attachment o).** **10) Plan ofCorrection: Facility created drill schedule to ensure quarterly evacuationdrills are conducted for each shift (attachment p).** **Plan ofPrevention: Facility staff trained to follow schedule to ensure quarterlyevacuation drills are**	

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	15G170		01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	4417 BLACKSTONE CT BLOOMINGTON, IN 47401

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			conducted for each shift (attachment q). **Plan ofMonitoring: Facility house managers trained to follow schedule to ensure quarterlyevacuation drills are conducted for each shift (attachment r).**	
W 210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3 clients in the sample (B), the facility failed to ensure, within 30 days after admission, the client's comprehensive functional assessment was completed. Findings include: On 1/27/15 at 10:58 AM, client B's record was reviewed. Client B was admitted to the group home on 7/26/14. There was no documentation in client B's record indicating the facility completed a comprehensive functional assessment since her admission.	W 210	**Plan ofCorrection: Client B's assessment completed 8/13/2014 within 30 days of intake(attachment e).** **Plan ofPrevention: Facility LL coordinator / QIDP-D will ensure forms are turned into AA to have scanned into Fortisdatabase (attachment f).** **Plan ofMonitoring: Electronic alerts will be sent out to notify Facility LL coordinator/ QIDP-D and director when**	02/01/2015

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	15G170		01/30/2015

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	On 1/27/15 at 1:46 PM, the Coordinator indicated client B's functional assessment was completed however the assessment was not in the electronic record for review. The Coordinator indicated the facility's records department would not scan the client's assessment into the record until all the required documentation for the client's annual was completed. 9-3-4(a)		**assessmentshave not been completed or turned into AA to scan into Fortis database(attachment f).**	
W 226 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on observation, record review and interview for 1 of 3 clients in the sample (B), the facility failed to ensure client B had an individualized program plan developed and implemented since her admission on 7/26/14. Findings include: An observation was conducted at the group home on 1/26/15 from 5:58 AM to 7:48 AM. At 7:20 AM, client B received	W 226	**Plan ofCorrection: Client B's ISP was completed (attachment g).** **Plan ofPrevention: Facility coordinator / QIDP-D trained on completing ISP within 30 days of intake (attachment h).** **Plan ofMonitoring: Electronic**	02/01/2015

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	15G170		01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	4417 BLACKSTONE CT BLOOMINGTON, IN 47401

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	her medications from the Home Manager (HM). At the completion of the medication pass to client B at 7:33 AM, the HM indicated, when asked what client B's medication training objectives were, indicated client B did not have a medication training objective. At 7:26 AM, the HM indicated client B did not have training objectives addressing anything since she was admitted to the group home. On 1/27/15 at 10:58 AM, client B's record indicated she was admitted to the group home on 7/26/14. There was no documentation in her record indicating the facility developed and implemented an individualized program plan since her admission to the group home. On 1/27/15 at 1:46 PM, the Coordinator stated, when told the surveyor was unable to locate a program plan in her record, "I know she doesn't." The Coordinator indicated client B did not have any current training objectives and nothing was being documented. The Coordinator indicated he just finished getting all the elements together to complete her program plan. 9-3-4(a)		**alerts will be sent out to notify Facility LLcoordinator / QIDP-D and director when planshave not been completed or turned into AA to scan into Fortis database.**	

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W 227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 3 clients in the sample (D), the facility failed to ensure client D had written instructions to staff in regard to the implementation of client D's physical therapy (PT) exercises. Findings include: On 1/26/15 from 5:58 AM to 7:48 AM, an observation was conducted at the group home. At 6:33 AM when client D exited her bedroom and entered the office area for her medication pass, client D informed the Home Manager (HM) the HM could mark down client D completed her PT exercises. The HM documented client D completed her PT exercises. On 1/26/15 at 7:07 AM, client D indicated she completed her PT exercises in her room without staff supervision. Client D stated she "sometimes" completed her exercises twice a day but "usually" one time per day.	W 227	**Plan ofCorrection: Facility nurse ensured client D had written instructions to staffin regard to the implementation of client D's physical therapy (PT) exercises(attachment h).** **Plan ofprevention: Facility nurse trained staff on client D HRP that includes writteninstructions to staff in regard to the implementation of client D's physicaltherapy (PT) exercises (attachment i).** **Plan ofMonitoring: Facility LL coordinator / QIDP-D trained on ensuring that HRP are in place for diagnosis and that staffare trained to follow plans. Tracking implemented to monitor the completion ofthese exercises included on informal goal tracking.**	02/01/2015

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	On 1/27/15 at 12:40 PM a review of client D's record indicated on her Medication Information Sheet, dated 1/20/15, she was to complete her PT exercises twice daily at 7:00 AM and 4:00 PM. Client D's Outside Services Report (OSR), dated 1/15/14, indicated she was seen by the Physical Therapist for gait instability. The Treatments/Test Ordered section indicated, "Physical Therapy - Therapeutic exercise home exercise program." There were several exercises in the home exercise program client D was to complete. An OSR, dated 1/22/14, indicated, "Gait Instability. Physical Therapy - therapeutic exercises." Additional exercises were added during the 1/22/14 for her home exercise program. Client D's 2/6/14 Individual Support Plan did not include PT exercises. On 1/28/15 at 1:56 PM, the Nurse Manager (NM) indicated the staff should observe client D completing her exercises. The NM indicated the staff should not document the PT exercises as completed unless the staff observed her completing the exercises. On 1/27/15 at 1:46 PM, the Coordinator indicated client D had her PT exercise program book in her bedroom. The Coordinator indicated the staff did not			

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	15G170		01/30/2015

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	observe client D as she completed her PT exercises. The Coordinator indicated the staff should ensure client D completed her exercises as indicated in the home program. The Coordinator indicated the staff initialed the Medication Administration Record indicating client D completed her exercises even though the staff did not observe the completion of the exercises. The Coordinator indicated client D's PT exercises were not part of her program plan. 9-3-4(a)			
W 240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 clients in the sample (D), the facility failed to ensure client D's risk plan for UTIs (Urinary Tract Infections) indicated the procedure staff was to implement to check her urine weekly. Findings include: On 1/27/15 at 12:40 PM, client D's record was reviewed. Client D had a risk plan addressing UTIs. The plan, dated 12/30/14, indicated, in part, "[Client D]	W 240	**Plan ofCorrection: Facility nurse ensured client D's risk plan for UTIs (Urinary TractInfections) complete with the procedures for staff to implement and to check her urine weekly (attachment j). Plan ofprevention: Facility nurse trained staff on client D's risk plan for UTIs(Urinary Tract Infections) complete with the procedures for staff to implement and to check her urineweekly (attachment k). Plan of Monitoring: Tracking implemented to monitor the**	02/01/2015

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	has a history of contracting several urinary tract infections. She completes self catheterization 5 times a day for urinary retention related to Spina Bifida (spinal nerves push out of the spinal canal). The plan indicated, "Staff will check [client D's] urine once a week and record results on the MAR (Medication Administration Record). If there are any signs of a (sic) UTI, staff will notify nurse immediately." The plan did not indicate the procedure staff was to implement to check her urine. The plan did not indicate if client D was to urinate into a container or into the toilet, ensure the toilet was clear of urine prior to the start of the check and where to document the notification of the nurse if symptoms were found. Client D's 12/16/14 Physician's Orders indicated, "Check urine weekly, notify nurse if foul odor, cloudiness, dark color." Client D's Medication Information Sheet, dated 1/20/15, indicated, "Check urine weekly for signs of Urinary Tract Infection (foul odor, cloudiness, dark color) Sunday." Client D's December 2014 Medication Administration Record (MAR) indicated there was documentation of one check of		**completion of this procedure (I). Facility coordinator / QIDP-D trained on ensuring that staff is trained on Client D's risk plan for UTIs (Urinary Tract Infections) and tracking is being monitored by nurse and physician as needed**	

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	15G170		01/30/2015

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	her urine on 12/7/14 (little cloudy). There was no documentation the staff checked her urine weekly on 12/14/14, 12/21/14 and 12/28/14. Client D's November 2014 MAR indicated, "Check urine weekly for foul odor, cloudiness, dark color. Notify nurse if (with an arrow to the foul odor, cloudiness, dark color)." The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check (whether or not her urine had a foul odor, cloudiness or dark color). Client D's October 2014 MAR indicated, "Check urine weekly for foul odor, cloudiness, dark color - report to nurse." The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check on 10/12/14 (whether or not her urine had a foul odor, cloudiness or dark color). The checks on 10/5/14, 10/19/14 and 10/26/14 indicated, "clear." Client D's September 2014 MAR indicated, "Check urine weekly (foul odor, cloudiness, dark color." The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check (whether or not her urine had a foul odor, cloudiness or			

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	dark color). Client D's August 2014 MAR indicated, "Check urine weekly - to check for UTI symptoms. Record description of urine on reverse page of MAR (e.g. clear, cloudy, foul odor, etc.). If [client D] has UTI symptoms, she will need to be seen!" The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check (whether or not her urine had a foul odor, cloudiness or dark color) on 8/17/14, 8/24/14 and 8/31/14. On 1/27/15 at 1:46 PM, the Coordinator indicated client D's guardian informed him test strips were to be used and client D should be urinating into a cup once a week to be tested. The Coordinator indicated the facility needed to clarify the risk plan. The Coordinator indicated the facility needed to have written instructions to staff about what is expected to be documented and how the testing would be completed. The Coordinator indicated the plan needed to be implemented as written with documentation of the results of the weekly check of her urine. 9-3-4(a)			

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	15G170		01/30/2015

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W 249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.			
	Based on record review and interview for 1 of 3 clients in the sample (D), the facility failed to ensure staff implemented client D's risk plan for UTIs (Urinary Tract Infections) as written. Findings include: On 1/27/15 at 12:40 PM, client D's record was reviewed. Client D had a risk plan addressing UTIs. The plan, dated 12/30/14, indicated, in part, "[Client D] has a history of contracting several urinary tract infections. She completes self catheterization 5 times a day for urinary retention related to Spina Bifida (spinal nerves push out of the spinal canal). The plan indicated, "Staff will check [client D's] urine once a week and record results on the MAR (Medication Administration Record). If there are any signs of a (sic) UTI, staff will notify nurse immediately." Client D's 12/16/14 Physician's Orders	W 249	**Plan ofCorrection: Facility nurse ensured client D's risk plan for UTIs (Urinary TractInfections) complete with the procedures for staff to implement and to check her urine weekly (attachment j). Plan ofprevention: Facility nurse trained staff on client D's risk plan for UTIs(Urinary Tract Infections) complete with the procedures for staff to implement and to check her urineweekly (attachment k). Plan of Monitoring: Tracking implementedto monitor the completion of this procedure (l). Facility coordinator / QIDP-D trained on ensuring that D's risk plan for UTIs (Urinary TractInfections) complete with the procedures for staff to implement and to check her urine weekly. Tracking will be monitored by QIDP-D to ensure that concerns are relayed to nurse or physician**	02/01/2015

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	15G170		01/30/2015

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	indicated, "Check urine weekly, notify nurse if foul odor, cloudiness, dark color." Client D's Medication Information Sheet, dated 1/20/15, indicated, "Check urine weekly for signs of Urinary Tract Infection (foul odor, cloudiness, dark color) Sunday." Client D's December 2014 Medication Administration Record (MAR) indicated there was documentation of one check of her urine on 12/7/14 (little cloudy). There was no documentation the nurse was notified. There was no documentation the staff checked her urine weekly on 12/14/14, 12/21/14 and 12/28/14. Client D's November 2014 MAR indicated, "Check urine weekly for foul odor, cloudiness, dark color. Notify nurse if (with an arrow to the foul odor, cloudiness, dark color)." The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check (whether or not her urine had a foul odor, cloudiness or dark color). Client D's October 2014 MAR indicated, "Check urine weekly for foul odor, cloudiness, dark color - report to nurse."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/30/2015
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4417 BLACKSTONE CT BLOOMINGTON, IN 47401	

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	The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check on 10/12/14 (whether or not her urine had a foul odor, cloudiness or dark color). The checks on 10/5/14, 10/19/14 and 10/26/14 indicated, "clear." Client D's September 2014 MAR indicated, "Check urine weekly (foul odor, cloudiness, dark color)." The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check (whether or not her urine had a foul odor, cloudiness or dark color). Client D's August 2014 MAR indicated, "Check urine weekly - to check for UTI symptoms. Record description of urine on reverse page of MAR (e.g. clear, cloudy, foul odor, etc.). If [client D] has UTI symptoms, she will need to be seen!" The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check (whether or not her urine had a foul odor, cloudiness or dark color) on 8/17/14, 8/24/14 and 8/31/14. On 1/27/15 at 1:46 PM, the Coordinator indicated the staff should document the results on the MAR of the weekly check. The Coordinator indicated the plan			

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	15G170		01/30/2015

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	needed to be implemented as written with documentation of the results of the weekly check of her urine. On 1/28/15 at 1:48 PM, the Nurse Manager (NM) indicated client D's plan for UTIs should be implemented weekly as indicated. The NM indicated the staff should document the outcome of the weekly test. 9-3-4(a)			
W 259 Bldg. 00	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 3 clients in the sample (C), the facility failed to ensure, at least annually, the client's comprehensive functional assessments was reviewed for relevancy and updated as needed. Findings include: On 1/27/15 at 11:51 AM, client C's most recent comprehensive functional assessment was dated 6/24/13. There was no documentation in client C's record indicating the facility reviewed	W 259	**Plan ofCorrection: Client B's assessment completed 8/13/2014 within 30 days of intake(attachment e).** **Plan ofPrevention: Facility coordinator / QIDP-D will ensure forms are turned into AA to have scanned into Fortis database(attachment f).** **Plan ofMonitoring: Electronic alerts will be sent out to**	02/01/2015

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	and updated at least annually. On 1/27/15 at 1:46 PM, the Coordinator indicated client C's functional assessment was completed however the assessment was not in the electronic record for review. The Coordinator indicated the facility's records department would not scan the client's assessments into the record until all the required documentation for the client's annuals was completed. The Coordinator indicated the assessment should be completed at least annually. 9-3-4(a)		**notify Facility LLcoordinator / QIDP-D and director whenassessments have not been completed or turned into AA to scan into Fortisdatabase (attachment f).**	
W 331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (D), the facility's nursing services failed to ensure client D's risk plan for UTIs (Urinary Tract Infections) indicated the procedure staff was to implement to check her urine weekly and the staff implemented the plan as written. Findings include: On 1/27/15 at 12:40 PM, client D's	W 331	**Plan of Correction:Facility nurse ensured client D's risk plan for UTIs (Urinary Tract Infections)complete with the procedures for staffto implement and to check her urine weekly (attachment j). Plan ofprevention: Facility nurse trained staff on client D's risk plan for UTIs(Urinary Tract Infections) complete with the procedures for staff to implement and to check her urineweekly (attachment k).**	02/01/2015

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	record was reviewed. Client D had a risk plan addressing UTIs. The plan, dated 12/30/14, indicated, in part, "[Client D] has a history of contracting several urinary tract infections. She completes self catheterization 5 times a day for urinary retention related to Spina Bifida (spinal nerves push out of the spinal canal). The plan indicated, "Staff will check [client D's] urine once a week and record results on the MAR (Medication Administration Record). If there are any signs of a (sic) UTI, staff will notify nurse immediately." The plan indicated, "[Client D] will use personal hygiene wipes before and after catheterization. [Client D] will wipe from front to back every time." The plan did not indicate the procedure staff was to implement to check her urine. The plan did not indicate if client D was to urinate into a container or into the toilet, ensure the toilet was clear of urine prior to the start of the check and where to document the notification of the nurse if symptoms were found. Client D's 12/16/14 Physician's Orders indicated, "Check urine weekly, notify nurse if foul odor, cloudiness, dark color." Client D's Medication Information Sheet, dated 1/20/15, indicated, "Check urine		**Plan ofMonitoring: Tracking implementedto monitor the completion of this procedure (I). Facility coordinator / QIDP-D trained on ensuring that D's risk plan for UTIs (Urinary TractInfections) complete with the procedures for staff to implement and to check her urine weekly. Tracking will be monitored by QDIP-D and concerns relayed to nurse or physician**	

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	weekly for signs of Urinary Tract Infection (foul odor, cloudiness, dark color) Sunday." A 12/16/14 Outside Services Report (OSR) indicated, in part, "Note: [client D] treated for UTI by [name of clinic] starting 12/1/14 - relayed to [name of physician]." The OSR indicated in the Laboratory tests ordered today section, "Urinary Tract Infection." Client D's December 2014 Medication Administration Record (MAR) indicated there was documentation of one check of her urine on 12/7/14 (little cloudy). There was no documentation the staff checked her urine weekly on 12/14/14, 12/21/14 and 12/28/14. Client D's November 2014 MAR indicated, "Check urine weekly for foul odor, cloudiness, dark color. Notify nurse if (with an arrow to the foul odor, cloudiness, dark color)." The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check (whether or not her urine had a foul odor, cloudiness or dark color). Client D's October 2014 MAR indicated, "Check urine weekly for foul odor, cloudiness, dark color - report to nurse."			

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	The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check on 10/12/14 (whether or not her urine had a foul odor, cloudiness or dark color). The checks on 10/5/14, 10/19/14 and 10/26/14 indicated, "clear." Client D's September 2014 MAR indicated, "Check urine weekly (foul odor, cloudiness, dark color." The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check (whether or not her urine had a foul odor, cloudiness or dark color). Client D's August 2014 MAR indicated, "Check urine weekly - to check for UTI symptoms. Record description of urine on reverse page of MAR (e.g. clear, cloudy, foul odor, etc.). If [client D] has UTI symptoms, she will need to be seen!" The MAR was initialed indicating the staff checked her urine. There was no documentation of the results of the check (whether or not her urine had a foul odor, cloudiness or dark color) on 8/17/14, 8/24/14 and 8/31/14. On 1/27/15 at 1:46 PM, the Coordinator indicated the staff should document the results on the MAR of the weekly check. The Coordinator indicated client D's			

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	guardian informed him test strips were to be used and client D should be urinating into a cup once a week to be tested. The Coordinator indicated the facility needed to clarify the risk plan. The Coordinator indicated the facility needed to have written instructions to staff about what is expected to be documented and how the testing would be completed. The Coordinator indicated the plan needed to be implemented as written with documentation of the results of the weekly check of her urine. The Coordinator indicated client D made a comment to the Home Manager recently indicating she needed to wipe before or after the catheterization, not both. The Coordinator indicated the plan was revised to specifically indicate client D was to wipe before and after catheterization. On 1/28/15 at 1:48 PM, the Nurse Manager (NM) indicated client D's plan for UTIs should be implemented weekly as indicated. The NM indicated the staff should document the outcome of the weekly test. 9-3-6(a)			
W 436	483.470(g)(2) SPACE AND EQUIPMENT			

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Bldg. 00	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. Based on observation, record review and interview for 1 of 3 clients in the sample (C), the facility failed to furnish, maintain in good repair and teach client C to use and make an informed choice about the use of her glasses. Findings include: Observations were conducted at the group home on 1/22/15 from 4:07 PM to 6:16 PM and 1/26/15 from 5:58 AM to 7:48 AM. During the observations, client C was not wearing glasses and was not prompted to wear her glasses. An observation was conducted at the facility-operated day program on 1/23/15 from 10:48 AM to 11:48 AM. During the observation, client C was not wearing glasses. On 1/27/15 at 11:51 AM, a review of client C's record was conducted. Client C's 1/13/15 Nurse Quarterly Physical indicated, in part, "Adaptive Equipment: Glasses - does not always choose to wear...." Client C's 7/14/14 Individual	W 436	**Plan ofCorrection: Client C team determined to introduce a goal to her plan to trainher to wear her glasses as ordered by physician (attachment m).** **Plan ofPrevention: Facility staff trained on importance of training client C on neweye glass goal (attachment n).** **Plan ofMonitoring: Facility day aid and coordinator / QIDP-D was trained on ensuringthat adaptive equipment including glasses; are furnished, maintained, and ingood repair along with teachingclient(s) to use and make an informedchoice about the use of her glasses (attachment o).**	02/01/2015

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	15G170		01/30/2015

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	Support Plan did not include a training objective to teach and train client C to wear her glasses. Client C's most recent vision appointment, dated 10/16/14, indicated, in part, "...367.21 (astigmatism - natural and commonly occurring cause of blurred or distorted vision that is usually associated with an imperfectly shaped cornea). 1 yr (year) f/u (follow up)." On 1/27/15 at 1:46 PM, the Coordinator indicated client C did not have a program plan to wear glasses. The Coordinator indicated he had not observed client C wear glasses in 3 years. The Coordinator indicated he spoke to client C about her glasses and she indicated she did not have glasses and did not know where they were. On 1/28/15 at 2:00 PM, the Nurse Manager (NM) indicated client C did have glasses. The NM indicated he had observed client C wearing her glasses in the past year. The NM indicated client C should have a program plan to teach her to wear her glasses. 9-3-7(a)			
W 440	483.470(i)(1) EVACUATION DRILLS			

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Bldg. 00	The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 5 clients living in the group home (A, B, C, D and E), the facility failed to ensure quarterly evacuation drills were conducted for each shift. Findings include: On 1/22/15 at 4:42 PM, a review of the facility's evacuation drills was conducted. During the day shift (6:00 AM to 2:00 PM), there were no evacuation drills conducted from 6/20/14 to 1/22/15. During the evening shift (2:00 PM to 10:00 PM), there were no evacuation drills conducted from 5/18/14 to 1/22/15. During the night shift (10:00 PM to 6:00 AM), there were no evacuation drills conducted from 6/22/14 to 1/22/15. This affected clients A, B, C, D and E. On 1/23/15 at 1:37 PM, the Coordinator indicated the facility should conduct one drill per shift per quarter. The Coordinator stated, "The staff failed to do the evacuation drills." 9-3-7(a)	W 440	**Facilitycreated drill schedule to ensure quarterly evacuation drills are conducted foreach shift (attachment p).** **Plan ofPrevention: Facility staff trained to follow schedule to ensure quarterlyevacuation drills are conducted for each shift (attachment q).** **Plan ofMonitoring: Facility house managers trained to follow schedule to ensure quarterlyevacuation drills are conducted for each shift (attachment r).**	02/01/2015
W 999 Bldg. 00				

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	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met: 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician. This state rule was not met as evidenced by: Based on record review and interview for 2 of 3 employee (staff #1 and #2) files reviewed, the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis	W 999	**Plan ofCorrection: Facility human resources coordinator will ensure that eachresidential staff person shall submitwritten evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chestx-ray wascompleted. The result of the Mantoux shall be recorded in millimeter ofinduration with the date given,date read, and by whom administered.** **Plan ofPrevention: Facility human resource director will provide oversight to ensurerecords contain each residential staff personshall submit written evidence thata Mantoux (5TU, PPD) tuberculosis skin test or chest x-raywas completed. Theresult of the Mantoux shall be recorded in millimeter of induration withthedate given, date read, and by whom administered.** **Plan ofMonitoring: Facility coordinator / QIDP-D trained**	02/01/2015

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	(TB) screening was conducted. Findings include: On 1/22/15 at 3:21 PM, a review of the facility's employee files was conducted. Staff #1's most recent Mantoux was completed on 10/9/13. There was no documentation in staff #1's employee file indicating staff #1 had an annual Mantoux since 10/9/13. Staff #2's most recent Mantoux was completed on 11/20/13. There was no documentation in staff #2's employee file indicating staff #2 had an annual Mantoux since 11/20/13. On 1/22/15 at 3:23 PM, the Coordinator indicated he was aware staff #2's TB screening was late. The Coordinator indicated she was contacted however she did not respond to coming into the facility to get her TB test. On 1/22/15 at 3:27 PM, the Group Home Director indicated the staff should have an annual Mantoux. On 1/28/15 at 2:00 PM, the Nurse Manager indicated the staff should have an annual Mantoux. 9-3-3(e)		**on moniotoring staff files to ensure that their home's staffhuman resource record contains evidence that Mantoux test was completed andread (attachment b).**	

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