

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G643	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/16/2012
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404
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W0000	<p>This visit was for the investigation of Complaint #IN00105820.</p> <p>Complaint #IN00105820: Substantiated, Federal and state deficiency related to the allegation(s) are cited at W102, W104, W149, W156, W249, W318 and W331.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: April 12, 13, and 16, 2012</p> <p>Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220</p> <p>Survey Team: Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 4/23/12 by Dotty Walton, Medical Surveyor III.</p>	W0000		
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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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W0102	<p><b>483.410 GOVERNING BODY AND MANAGEMENT</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview, The Condition of Participation: Governing Body was not met. The governing body failed to ensure the facility implemented its policy and procedures for monitoring a client's health status and for preventing client to client abuse of client F by client B. The governing body failed to ensure the facility implemented its policy and procedures in regard to training staff to manage a client's health conditions and failed to ensure the facility's health care/nursing services met the client's health needs for client A.</p> <p>Based on record review and interview, the governing body failed to exercise general policy and operating direction over the facility to ensure staff were trained to manage clients' behavioral supervision/management needs, health conditions and failed to ensure the facility's health care/nursing services met health needs for 2 of 3 sampled clients (clients A and B) and one additional client (F).</p> <p>Findings include:</p>	W0102	<p><b>W102 GOVERNING BODY &amp; MANAGEMENT</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt ensures that specific governing body and management requirements are met. Stone Belt implements its policy and procedures for 1) monitoring of a clients health care and 2) preventing client to client abuse and 3) training of staff to ensure that the health care/nursing services meet the client's health care needs. Conducting multiple training annually and as necessary will continue to ensure staff are trained accordingly.</p> <p><b>Responsible Person:</b></p> <p>SGL Director/Nursing Services Manager</p> <p><b>Date of Completion:</b></p> <p>May 16, 2012</p> <p><b>Plan of Prevention:</b></p> <p>1) Director of Milestones Services conducting training with all nursing staff that provide health care services to Stone Belt clients. The training, ICF/MF</p>	05/16/2012	

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	<p>The governing body failed to meet the Condition of Participation: Health Care Services for 1 of 3 sampled clients (client A). The governing body failed to ensure the facility's nursing services monitored the health conditions and referred client A for medical evaluation when indicated by changes in vital signs and level of alertness/activity. The governing body failed to ensure nursing services clarified and followed up on physician recommendations for client A. The governing body failed to ensure the facility's nursing services provided staff training in regard to monitoring BP (blood pressure) and signs and symptoms of health conditions to monitor and report to the nurse/physician for client A. Please see W318.</p> <p>Based on record review and interview, the governing body failed for 2 of 3 sampled clients (A and B) and one additional client (F), to exercise general policy and operating direction over the facility to ensure staff were trained to manage client's health conditions and failed to ensure the facility's health care/nursing services met health needs for client A and the facility failed to implement its policies and procedures to prevent neglect and/or abuse of client F by failing to ensure client B received 1:1 staff supervision as indicated in his Behavior Intervention</p>		<p>Condition of Participation Health Care Services (Attachment # 1) including both general and specific training centered around "Monitoring of Health Status." 2) Stone Belt staff reviewed the policy of Prevention of Abuse and Neglect and Client Rights (Attachment # 2). This not only included the specific home but all SGL staff attending monthly inservice. (Attachment # 3). This subject is also trained during new staff orientation. 3) Director of Milestones Services conducting training with all nursing staff that provide health care services to Stone Belt clients. The training, ICF/MF Condition of Participation Health Care Services (Attachment # 1). The Stone Belt nursing staff receive the training on May 2, 2012. (Attachment # 4)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>The SGL Director and the Nursing Services Manager will monitor nursing services to assure that proper health care is provided to all clients. Stone Belt will continue to provide annual training and orientation training on the Prevention of Abuse, Neglect and Client Rights. Stone Belt Quality Assurance Team reviews Incident Reports on a quarterly basis as well as policies and procedures.</p>				

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	<p>Plan (BIP). Please see W104.</p> <p>This federal tag relates to complaint # IN00105820.</p> <p>9-3-1(a)</p>			

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview, the governing body failed for 2 of 3 sampled clients (A and B) and one additional client (F), to exercise general policy and operating direction over the facility to ensure staff were trained to manage client's health conditions and failed to ensure the facility's health care/nursing services met health needs for client A and the facility failed to implement its policies and procedures to prevent neglect and/or abuse of client F by failing to ensure client B received 1:1 staff supervision as indicated in his Behavior Intervention Plan (BIP).</p> <p>Findings include:</p> <p>Please see W149 for the facility's failure to implement its policies and procedures to prevent neglect and/or abuse of 1 additional client (client F) by failing to ensure client B received 1:1 staff supervision as indicated in his Behavior Intervention Plan (BIP). The facility also neglected to meet the health needs of client A and failed to clarify and implement physician orders in a timely manner.</p>	W0104	<p><b>W 104 GOVERNING BODY</b></p> <p><b>PROTECTION OF CLIENT RIGHTS</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt exercises general policy, budget and operating direction over the various group homes.</p> <p><b>Responsible Person:</b></p> <p>SGL Director, Nursing Manager, Coordinator</p> <p><b>Date of Completion:</b></p> <p>May 4, 2012</p> <p><b>Plan of Prevention:</b></p> <p>1) Director of Milestones Services conducting training with all nursing staff that provide health care services to Stone Belt clients. The training, ICF/MF Condition of Participation Health Care Services (Attachment # 1) including both general and specific training centered around "Monitoring of Health Status." The training included the review of physicians orders.</p> <p>2) Stone Belt staff reviewed the</p>	05/04/2012			

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	<p>Please see W331 for the failure of the agency's nursing services to prevent medical neglect of 1 of 3 sampled clients (clients A). The facility neglected to meet the health needs of client A and failed to clarify and implement physician orders in a timely manner.</p> <p>This federal tag relates to complaint # IN00105820.</p> <p>9-3-1(a)</p>		<p>policy of Prevention of Abuse and Neglect and Client Rights (Attachment # 2). This not only included the specific home but all SGL staff attending monthly inservice. (Attachment # 3). This subject is also trained during new staff orientation.</p> <p>3) House staff were retrained on client's Behavior Support Plan which includes the 1:1 staffing on March 30, 2012. (Attachment # 5) Staff that were responsible during the specific incident received disciplinary action. (Attachment # 6).</p> <p><b>Quality Assurance Monitoring:</b></p> <p>The SGL Director and the Nursing Services Manager will monitor nursing services to assure that proper health care is provided to all clients. Stone Belt will continue to provide annual training and orientation training on the Prevention of Abuse, Neglect and Client Rights. Stone Belt Quality Assurance Team reviews Incident Reports on a quarterly basis as well as policies and procedures. Coordinator and Behavior Specialist will ensure that all staff receive necessary training on individual behavior plans. All Administrative staff will monitor during house visits.</p>		

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility neglected to implement its policies and procedures to prevent neglect of 2 of 3 sampled clients (clients A) and one a additional client (F). The facility neglected to meet the health needs of client A and failed to clarify and implement physician orders in a timely manner. The facility failed to implement its policies and procedures to prevent neglect and/or abuse of 1 additional client (client F) by failing to ensure client B received 1:1 staff supervision as indicated in his Behavior Intervention Plan (BIP).</p> <p>Findings include:</p> <p>1. An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (BDDS) incident report, dated 01/19/2012 at 3:05 p.m., was reviewed on 04/12/2012 at 11:50 a.m. The report indicated client A was evaluated in an outpatient clinic after falling when he let go of his walker to sit on the toilet. The record indicated the client did not have any fractures and was prescribed Baclofen for muscle spasms and Voltaren gel for inflammation to the right elbow.</p>	W0149	<p><b>W149</b> <b>STAFF TREATMENT OF CLIENTS</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt has developed and implemented written policies and procedures that prohibit mistreatment, neglect or abuse of a client.</p> <p><b>Responsible Person:</b></p> <p>Nursing Services Manager, SGL Director, Coordinator</p> <p><b>Date of Completion:</b></p> <p>May 4, 2012</p> <p><b>Plan of Prevention:</b></p> <p>1) Director of Milestones Services conducting training with all nursing staff that provide health care services to Stone Belt clients. The training, ICF/MF Condition of Participation Health Care Services (Attachment # 1) including both general and specific training centered around "Monitoring of Health Status." The training included the review of physicians orders.</p> <p>2)Stone Belt staff reviewed the</p>	05/04/2012			

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	<p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (BDDS) incident report, dated 01/27/2012 at 7:35 a.m. was reviewed on 04/12/2012 at 11:50 a.m. The report indicated client A was dead when staff went to wake him for medication administration.</p> <p>Client A's record was reviewed on 04/12/2012 at 1:00 p.m. The Nursing Consultation Note, dated 01/23/2012 indicated, "...[Client A] had a fall on 01/19/2012...Dx (diagnosis) strain R (right) lower arm @ (at) elbow (and) R (right) sternocleidomastoid (anterior portion of the neck) due to fall. Baclofen is being given. The HOUSE is unable to obtain the Voltaren from the pharmacy...BP (blood pressure) 180/84...." The record did not indicate an alternative anti-inflammatory medication was prescribed and did not indicate the nurse provided instructions/training for monitoring and reporting symptoms of high blood pressure.</p> <p>The Treatment Record, dated 01/1/2012-01/2012, indicated, "...BP (blood pressure) weekly...." The record indicated BP ranges from 123-164/76-90. The record did not indicate symptoms to monitor and report for high blood</p>		<p>policy of Prevention of Abuse and Neglect and Client Rights (Attachment # 2). This not only included the specific home but all SGL staff attending monthly inservice. (Attachment # 3). This subject is also trained during new staff orientation.</p> <p>3) House staff were retrained on client's Behavior Support Plan which includes the 1:1 staffing on March 30, 2012. (Attachment # 5) Staff that were responsible during the specific incident received disciplinary action. (Attachment # 6).</p> <p><b>Quality Assurance Monitoring:</b></p> <p>The SGL Director and the Nursing Services Manager will monitor nursing services to assure that proper health care is provided to all clients. Stone Belt will continue to provide annual training and orientation training on the Prevention of Abuse, Neglect and Client Rights. Stone Belt Quality Assurance Team reviews Incident Reports on a quarterly basis as well as policies and procedures. Coordinator and Behavior Specialist will ensure that all staff receive necessary training on individual behavior plans. All Administrative staff will monitor during house visits.</p>				

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	<p>pressure and did not include parameters for reporting abnormal vital signs.</p> <p>The record did not indicate client A had an EKG (electrocardiogram) or any laboratory tests during the past year.</p> <p>Client A's Psychotropic Medication Reviews were reviewed on 04/13/2012 at 9:00 a.m. Psychotropic Medication Reviews, dated 02/22/2011, 04/12/2011, 06/14/2011, 08/09/2011, 10/11/2011, and 12/13/2011, indicated, "...CURRENT PSYCHOTROPIC DOSAGE:...Aricept (medication used for dementia) mg (milligrams) q (every) HS(bedtime)..."</p> <p>An Outside Service Report, dated 10/26/2011, indicated, "... Aricept 10 mg po 1.5 mg q hs x (times) 1 month &amp; then 2 mg po q hs thereafter..." The record did not indicate the order was clarified for the desired medication dose. The psychotropic medication review on 12/27/2011 indicated the Aricept dose remained at 10 mg q hs (see below).</p> <p>A psychotropic medication review, dated 12/27/2011, indicated, "...CURRENT PSYCHOTROPIC DOSAGE:...Aricept 10 mg q HS...PHYSICIAN ORDERS...Aricept 23 mg po q HS..."</p> <p>A psychotropic medication review, dated</p>						

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	<p>01/25/2012, indicated, "...CURRENT PSYCHOTROPIC DOSAGE:...Aricept 23 mg at bedtime...There has also been an increase 2 in the number of falls...possible due to the increased Aricept started on 12/27/2011...Plan D/C (discontinue) Aricept 23 mg dosage. Go back to Aricept 10 mg po (orally) q HS...."</p> <p>The Medication Administration Record (MAR), dated 01/01/2012-01/31/2012 indicated Aricept (medication for dementia) 23 mg (milligrams) was given at bedtime from 01/01/2012-01/26/2012. The record did not indicate the Aricept dose was decreased to 10 mg at bedtime following the 01/25/2012 psychiatric review.</p> <p>The Autopsy Report, dated 01/28/2012, indicated, "...Cause of Death: Cardiac arrhythmia due to Donepezil (generic for Aricept) toxicity...." The report indicated a Donepezil level of 280 mg (therapeutic range is 15-50).</p> <p>During an interview on 04/13/2012 at 9:10 a.m., the Manager of Health Care Services (MHCS) indicated the nurse who was responsible for client A's nursing services no longer worked for the group home. She stated she "had concerns" with the delayed nursing assessment of client A following his fall. The MHCS stated,</p>			

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	<p>"It is up to the physician to order labs and diagnostic tests." She indicated awareness that labs/diagnostic screening were recommended by the manufacturing pharmaceutical companies to monitor for drug related side effects. The MHCS indicated the Aricept order on 10/26/2011 should have been clarified for dose instructions. She stated, "There are always problems getting Voltaren but the doctor's just keep ordering it." She indicated the group home nurse should have consulted the physician to obtain an alternative to the prescribed anti-inflammatory. The MHCS indicated the Aricept dose was not decreased after the Psychotropic Medication Review on 01/25/2012. She indicated she was aware the Aricept decrease was due to a possible link to client A's recent fall. She indicated the facility was in process of obtaining Human Rights Committee (HRC) approval for the reduction. She stated, "The facility practice is to have HRC review all psychotropic medication adjustments."</p> <p>2. An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (BDDS) incident report, dated 03/24/2012 at 10:30 a.m. was reviewed on 04/12/2012 at 1:30 p.m. The report indicated, "...The group home residents</p>				

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	<p>had just completed a fire drill and were waiting outside after the evacuation...Staff...saw [client B] dragging [client F] along the sidewalk by his shirt...and found 3 bite marks and a scrape on his back and shoulder...."</p> <p>Client B's record was reviewed on 04/13/2012 at 11:18 a.m. A Behavioral Intervention Plan, dated 02/2003, revised 01/10/2012, indicated, "...On each shift, [client B] will have specific staff member assigned as his 1:1 staff AT ALL TIMES during waking hours, and in anticipation of [client B] waking in the morning...."</p> <p>An "INQUIRY OF CONSUMER TO CONSUMER AGGRESSION," dated 03/24/2012 indicated, "...The staff were not following [client B's] BSP (Behavior Support Plan) by insuring [client B's] 1:1 staff was with him at all times...."</p> <p>During an interview on 04/12/2012 at 5:00 p.m., the Resident Manager indicated staff did not follow the BSP for 1:1 supervision during the fire drill on 03/24/2012.</p> <p>Interview with the group Home Director on 4/12/12 at 12:20 PM indicated the agency had a policy which prohibited abuse and neglect of clients.</p> <p>Review of the agency's 10/10</p>						

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	<p>abuse/neglect policy was conducted on 4/12/12 at 12:20 PM. The policy defined neglect as: "Failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party."</p> <p>This federal tag relates to complaint #IN00105820.</p> <p>9-3-2(a)</p>				

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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404			
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W0156	<p>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.</p> <p>Based on interview and record review of 1 of 1 Reportable Incident Reports for death of client A, the facility failed to report the investigation results to the Administrator (Director of Residential Services) within 5 work days of the incident.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and investigations were reviewed on 04/12/2012 at 11:50 a.m. An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (BDDS) incident report, dated 01/27/2012 at 7:35 a.m. was reviewed on 04/12/2012 at 11:50 a.m. The report indicated client A was dead when staff went to wake him for medication administration.</p> <p>The facility investigation report, dated 02/24/2012, was reviewed on 04/12/2012 at 3:00 p.m. The report indicated, "... [Direct Support Professional (DSP) #5] reported that Friday morning at 7:30 (a.m.) he went in [client A's] room to pass</p>	W0156	<p><b>W 156</b> <b>STAFF TREATMENT OF CLIENTS</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt ensures that all investigations are reported to the administrator or representative in accordance with State law within five working days of the incident.</p> <p><b>Responsible Person:</b></p> <p>Coordinator/Social Work Manager</p> <p><b>Date of Completion:</b></p> <p>May 16, 2012</p> <p><b>Plan of Prevention:</b></p> <p>Stone Belt follows the policies and procedures of the Investigation Protocol. (Attachment # 7), which calls for investigations to be completed in SGL within 5 days. Social Worker completing the investigation based on BQIS Mortality Review and 30 day completion time. Social Workers were retrained on Investigation Reporting</p>	05/16/2012			

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	<p>meds medication). He stated that [client A ] looked awake and was staring up. [DSP #5] reported that he immediately realized that [client A] was "gone." He stated that [client A] looked ashen...[DSP #5] reported that he checked for a pulse and there was not one. He stated that due to his experience as a CNA (Certified Nurse Aide), he knew [client A] was past the point of resuscitation...Conclusions: It appears [DSP #5] did follow [facility] policy as documented on the Knowledge Base. Death of a Client states in part: If the body is cold, and there are no signs of life, note the time and call 911 to request an ambulance...It appears that [facility] training and policy do not match...." The investigation report was not completed within 5 work days following the incident.</p> <p>During an interview on 04/16/2012 at 8:32 a.m., the Group Home Director indicated the investigation should have been completed within 5 working days following the incident.</p> <p>This federal tag relates to complaint #IN00105820.</p> <p>9-3-2(a)</p>		<p>(Attachment # 8)and will attend SDOH Investigation Training.</p> <p><b>Quality Assurance Monitoring:</b></p> <p>SGL Director will review all incidents to assure that, if an investigation if necessary, it will be completed in five days.</p>				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure behavioral and monitoring strategies were implemented as written in the Individual Support Plan (ISP) for 2 of 3 sampled clients (clients A and B).</p> <p>Findings include:</p> <p>1. An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (BDDS) incident report, dated 01/27/2012 at 7:35 a.m. was reviewed on 04/12/2012 at 11:50 a.m. The report indicated client A was dead when staff went to wake him for medication administration.</p> <p>Client A's record was reviewed on 04/12/2012 at 1:00 p.m.</p> <p>The Bed Check record, dated 01/27/2012 indicated, "...2 Hour NIGHT TIME BED CHECK LIST..." with a check mark for bed checks at 10:00 p.m. on 01/26/2012. Bed checks were indicated by a check</p>	W0249	<p><b>W249 PROGRAM IMPLEMENTATION</b></p> <p><b>Plan of Correction:</b></p> <p>The Stone Belt interdisciplinary team formulates a clients individual program plan, and assures that each client receives a continuous active treatment program consisting of needed intervention and services in sufficient number and frequency to support the client.</p> <p><b>Responsible Person:</b></p> <p>Coordinator/Behavior Specialist</p> <p><b>Date of Completion:</b></p> <p>May 16, 2012</p> <p><b>Plan of Prevention:</b></p> <p>1) Bed check protocol and procedures were retrained with house staff on April 26, 2012. (Attachment # 9) Overnight staff complete a check list indicating that clients are checked at 10a,</p>	05/16/2012			

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	<p>mark on 01/27/2012 for 12:00 a.m., 2:00 a.m., and 4:00 a.m. The bed check list did not include documentation for 6:00 a.m.</p> <p>The facility investigation report, dated 02/24/2012, was reviewed on 04/12/2012 at 3:00 p.m. The report indicated, "... [Direct Support Professional (DSP) #5] reported that Friday morning at 7:30 (a.m.) he went in [client A's] room to pass meds (medications). He stated that [client A] looked awake and was staring up. [DSP #5] reported that he immediately realized that [client A] was "gone." He stated that [client A] looked ashen...[DSP #5] reported that he checked for a pulse and there was not one...."</p> <p>During an interview on 04/12/2012 at , 5:00 a.m., the Resident Manager (RM) stated "Bed checks require staff go into clients' rooms to see if they are incontinent and make sure they are breathing." He indicated he was uncertain why the bed check was not completed at 6:00 a.m. for client A. The RM indicated one client residing in the home required 1:1 staff supervision and stated, another client required "line of sight supervision" for meals. The bed check record indicated check marks for bed checks for all clients except client A at 6:00 a.m. on 01/27/2012.</p>		<p>Midnight, 2a, 4a, and 6a.</p> <p>2) House staff were retrained on client's Behavior Support Plan which includes the 1:1 staffing on March 30, 2012. (Attachment # 5)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>QMRP Coordinator will review bed check documentation when making visits to the home, both announced and unannounced. Coordinator will also ensure that the 1:1 staffing pattern is being followed during visits.</p>		

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	<p>2. An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (BDDS) incident report, dated 03/24/2012 at 10:30 a.m. was reviewed on 04/12/2012 at 1:30 p.m. The report indicated, "...The group home residents had just completed a fire drill and were waiting outside after the evacuation...Staff...saw [client B] dragging [client F] along the sidewalk by his shirt...and found 3 bite marks and a scrape on his back and shoulder...."</p> <p>Client B's record was reviewed on 04/13/2012 at 11:18 a.m.</p> <p>A Behavioral Intervention Plan, dated 02/2003, revised 01/10/2012, indicated, "...On each shift, [client B] will have specific staff member assigned as his 1:1 staff AT ALL TIMES during waking hours, and in anticipation of [client B] waking in the morning...."</p> <p>An "INQUIRY OF CONSUMER TO CONSUMER AGGRESSION," dated 03/24/2012 indicated, "...The staff were not following [client B's] BSP (Behavior Support Plan) by insuring [client B's] 1:1 staff was with him at all times...."</p> <p>During an interview on 04/12/2012 at</p>			

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	<p>5:00 p.m., the Resident Manager indicated staff did not follow the BSP for 1:1 supervision during the fire drill on 03/24/2012.</p> <p>This federal tag relates to complaint #IN00105820.</p> <p>9-3-4(a)</p>						

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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 3 sampled clients (client A). The facility's health care services failed to ensure nursing services monitored client A's health after he fell. The facility's health care services failed to ensure nursing services monitored client D's health status in regard to obtaining orders for routine laboratory tests and diagnostic evaluations to ensure therapeutic medication levels and stable health. The facility's health services failed to provide staff training in regard to monitoring, recognizing, and reporting symptoms of high blood pressure. The facility's health services failed to ensure physician's orders were followed.</p> <p>Findings include:</p> <p>1. The facility's nursing services failed to monitor the health conditions of client A after he fell and failed to ensure medications were given/discontinued as ordered by the physician. The facility's nursing services failed to obtain/clarify orders for routine laboratory tests and diagnostic evaluations to ensure</p>	W0318	<p><b>W 318 HEALTH CARE SERVICES</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt ensures that specific health care services requirements are met.</p> <p><b>Responsible Person:</b></p> <p>SGL Director and Nursing Services Manager</p> <p><b>Date of Completion:</b></p> <p>May 4, 2012</p> <p><b>Plan of Prevention:</b></p> <p>Director of Milestones Services conducting training with all nursing staff that provide health care services to Stone Belt clients. The training, ICF/MF Condition of Participation Health Care Services (Attachment # 1) including both general and specific training centered around "Monitoring of Health Status." All Stone Belt Nursing Staff participated in the training. (Attachment # 4)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>The Nursing Services Manager</p>	05/04/2012			

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	<p>therapeutic medication levels and stable health for client A. The facility's nursing services failed to ensure staff were trained in regard to abnormal vital signs and symptoms of high blood pressure to monitor and report. Please see W331.</p> <p>This federal tag relates to complaint # IN00105820.</p> <p>9-3-6(a)</p>		<p>and SGL Director will monitor the health care of all SGL clients to assure Nursing Services is taking a proactive approach to the clients health needs.</p>	

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W0331	<p><b>483.460(c) NURSING SERVICES</b> The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed to ensure nursing services monitored health conditions, followed physician recommendations, and failed to obtain clarification of physician orders for 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 04/12/2012 at 1:00 p.m.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (BDDS) incident report, dated 01/19/2012 at 3:05 p.m., indicated client A was evaluated in an outpatient clinic after falling when he let go of his walker to sit on the toilet. The record indicated the client did not have any fractures and was prescribed Baclofen for muscle spasms and Voltaren gel for inflammation to the right elbow.</p> <p>The Nursing Consultation Note, dated 01/23/2012 indicated, "...[Client A] had a fall on 01/19/2012...Dx (diagnosis) strain R (right) lower arm @ (at) elbow (and) R (right) sternocleidomastoid (anterior</p>			W0331	<p><b>W 331 HEALTH CARE SERVICES</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt ensures that specific health care services requirements are met.</p> <p><b>Responsible Person:</b></p> <p>SGL Director and Nursing Services Manager</p> <p><b>Date of Completion:</b></p> <p>May 4, 2012</p> <p><b>Plan of Prevention:</b></p> <p>Director of Milestones Services conducting training with all nursing staff that provide health care services to Stone Belt clients. The training, ICF/MF Condition of Participation Health Care Services (Attachment # 1) including both general and specific training centered around "Monitoring of Health Status." All Stone Belt Nursing Staff participated in the training. (Attachment # 4)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>The Nursing Services Manager</p>		05/04/2012

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	<p>portion of the neck) due to fall. Baclofen is being given. The HOUSE is unable to obtain the Voltaren from the pharmacy...BP (blood pressure) 180/84...." The record did not indicate an alternative anti-inflammatory medication was prescribed and did not indicate the nurse provided instructions/training for monitoring and reporting symptoms of high blood pressure.</p> <p>The Treatment Record, dated 01/1/2012-01/2012, indicated, "...BP (blood pressure) weekly...." The record indicated BP ranges from 123-164/76-90. The record did not indicate symptoms to monitor and report for high blood pressure and did not include parameters for reporting abnormal vital signs.</p> <p>The record did not indicate client A had an EKG (electrocardiogram) or any laboratory tests during the past year.</p> <p>Client A's Psychotropic Medication Reviews were reviewed on 04/13/2012 at 9:00 a.m.</p> <p>Psychotropic Medication Reviews, dated 02/22/2011, 04/12/2011, 06/14/2011, 08/09/2011, 10/11/2011, and 12/13/2011, indicated, "...CURRENT PSYCHOTROPIC DOSAGE:...Aricept (medication used for dementia) mg</p>		and SGL Director will monitor the health care of all SGL clients to assure Nursing Services is taking a proactive approach to the clients health needs.		

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	<p>(milligrams) q (every) HS(bedtime)...."</p> <p>An Outside Service Report, dated 10/26/2011, indicated, "... Aricept 10 mg po 1.5 mg q hs x (times) 1 month &amp; then 2 mg po q hs thereafter...." The record did not indicate the order was clarified for the desired medication dose. The psychotropic medication review on 12/27/2011 indicated the Aricept dose remained at 10 mg q hs (see below).</p> <p>A psychotropic medication review, dated 12/27/2011, indicated, "...CURRENT PSYCHOTROPIC DOSAGE:...Aricept 10 mg q HS...PHYSICIAN ORDERS...Aricept 23 mg po q HS...."</p> <p>A psychotropic medication review, dated 01/25/2012, indicated, "...CURRENT PSYCHOTROPIC DOSAGE:...Aricept 23 mg at bedtime...There has also been an increase in the number of falls...possible due to the increased Aricept started on 12/27/2011...Plan D/C (discontinue) Aricept 23 mg dosage. Go back to Aricept 10 mg po (orally) q HS...."</p> <p>The Medication Administration Record (MAR), dated 01/01/2012-01/31/2012 indicated Aricept (medication for dementia) 23 mg (milligrams) was given at bedtime from 01/01/2012-01/26/2012. The record did not indicate the Aricept</p>			

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	<p>dose was decreased to 10 mg at bedtime following the 01/25/2012 psychiatric review.</p> <p>The Autopsy Report, dated 01/28/2012, indicated, "...Cause of Death: Cardiac arrhythmia due to Donepezil (generic for Aricept) toxicity..." The report indicated a Donepezil level of 280 mg (therapeutic range is 15-50).</p> <p>During an interview on 04/13/2012 at 9:10 a.m., the Manager of Health Care Services (MHCS) indicated the nurse who was responsible for client A's nursing services no longer worked for the group home. She stated she "had concerns" with the delayed nursing assessment of client A following his fall. The MHCS stated, "It is up to the physician to order labs and diagnostic tests." She indicated awareness that labs/diagnostic screening were recommended by the manufacturing pharmaceutical companies to monitor for drug related side effects. The MHCS indicated the Aricept order on 10/26/2011 should have been clarified for dose instructions. She stated, "There are always problems getting Voltaren but the doctor's just keep ordering it." She indicated the group home nurse should have consulted the physician to obtain an alternative to the prescribed anti-inflammatory. The MHCS indicated</p>						

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	<p>the Aricept dose was not decreased after the Psychotropic Medication Review on 01/25/2012. She indicated she was aware the Aricept decrease was due to a possible link to client A's recent fall. She indicated the facility was in process of obtaining Human Rights Committee (HRC) approval for the reduction. She stated, "The facility practice is to have HRC review all psychotropic medication adjustments."</p> <p>This federal tag relates to complaint # IN00105820.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G643		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/16/2012	
NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404			
(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			
W9999	<p>STATE FINDINGS:</p> <p>1. The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>Sec. 3(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 (TB) 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.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview, the facility failed to obtain yearly PPDs and/or a chest x-ray and/or annual</p>	W9999	<p><b>W999 FINAL OBSERVATIONS</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt will ensure that all SGL Staff will complete a Mantoux tuberculosis skin test or chest x-ray on an annual basis.</p> <p><b>Responsible Person:</b></p> <p>Coordinator and House Manager</p> <p><b>Date of Completion:</b></p> <p>May 4, 2012</p> <p><b>Plan of Prevention:</b></p> <p>Staff in question had Mantoux test completed on April 27, 2012. House Manager and Coordinator review all TB tests on a monthly basis to assure test are completed. (Attachment # 10)</p> <p><b>Quality Assurance Monitoring:</b></p> <p>Coordinator and House Manager will review Human Resource records to assure all staff have completed annual TB tests.</p>	05/04/2012			

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	<p>tuberculosis screening for 1 of 5 sampled staff (Direct Support Professional #6).</p> <p>Findings include:</p> <p>Employee records were reviewed on 04/12/2012 at 3:15 p.m. The record indicated DSP (Direct Support Professional) #6's PPD was 0 mm (millimeters) (negative) on 01/05/2011. The record did not include documentation to indicate DSP #6 had an annual TB screening.</p> <p>During an interview on 04/12/2012 at 3:30 p.m., the Group Home Director indicated he would provide documentation if DSP #6 was given a PPD during a recent testing session. No documentation was provided.</p> <p>9-3-3(e)</p>				