

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  06/17/2014
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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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W000000	<p>This visit was for the post certification revisit (PCR) to the PCR (dated 5/8/14) to the PCR (dated 3/14/14) to the fundamental recertification and state licensure survey completed on 11/15/13.</p> <p>Survey Dates: June 16 and 17, 2014</p> <p>Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/23/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<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. Based on record review and interview for 1 of 6 incident reports reviewed affecting client #2, the facility neglected to implement its policies and procedures to investigate a seizure-related fall with injuries as possible neglect.</p>	W000149	<p>Plan of Correction: The facility coordinator interviewed staff #3 who assisted client #2 in the shower on the evening of 5/31/2014 when client #2 had a seizure resulting in an injury. Staff #3 reported that he had supervised client #2 numerous</p>	06/28/2014

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/16/14 at 12:10 PM and indicated the following: On 5/31/14 at 6:30 PM, client #2 entered the shower with staff #3's assistance. Staff #3 left the bathroom area to place soiled clothes in the laundry room. While staff #3 was out of the bathroom, he heard what sounded like client #2 falling in the shower. The Bureau of Developmental Disabilities Services (BDDS) report, dated 6/1/14, indicated, in part, "When staff member entered the bathroom, [client #2] was on the floor having a seizure. Staff member turned the water off and knelt beside him. This seizure lasted no longer than 15 seconds. Shortly after, [client #2] wanted to stand. Staff assisted him in standing. When he was back up, [client #2] had another seizure, began to fall, and staff supported him to the ground. This seizure lasted no longer than 10 seconds. Staff laid him down on the floor, put a towel under his head and called the pager. Staff member reviewed client's risk plan with pager's assistance and was instructed to monitor client noting that if he were to have any more consecutive seizures to call 911. Shortly after talking with the pager, [client #2] was strong enough to stand. [Client #2]</p>		<p>times in his 3 year tenure at the facility and believed he could momentarily leave client #2 in the bathroom to put client #2's feces soiled clothing in the laundry room. The coordinator helped the staff problem solve what to do in the future with soiled clothing and reviewed client #2's need for supervision in the shower. the facility coordinator did not consider this neglect. Completed 6/28/2014. See attachment #1. The facility coordinator has received a written performance review for failure to meet facility standards and implement systemic plans of prevention during multiple surveys. Plan of Prevention: Client #2's Personal Care Assessment, IHP and Seizure Risk Plan have been updated to direct the staff in providing appropriate supports for client#2. Facility staff have been trained in client #2 revised plans. See attachment #2. Completed 6/26/2014 Quality Monitoring: facility coordinator will complete home observations of staff implementation of client #2's revised seizure risk plan and IHPs during twice weekly visits to the facility</p>		

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	<p>continued through the remainder of the day without issue. [Client #2] sustained bruising on his arms, back, shoulders, and buttock as the result of his initial fall. He also has a few scrapes on his back which was treated with an antibiotic cream." The facility did not conduct an investigation into the incident.</p> <p>On 6/16/14 at 4:25 PM, the Coordinator indicated the facility did not investigate client #2's fall in the shower. The Coordinator indicated the Director reviewed the incident report and requested additional information. The Coordinator indicated client #2 did not have unsupervised showers. The Coordinator indicated he wrote a plan and trained staff after the incident indicating client #2 was to be supervised at all times while in the shower.</p> <p>On 6/16/14 at 1:34 PM, the Director of Supervised Group Living (DSGL) indicated she sent an email to the Coordinator asking for additional information after reading the incident report. The DSGL indicated the Coordinator informed her client #2 was supposed to receive supervised showers. The DSGL indicated she asked the Coordinator if there were written instructions to staff regarding the supervision level of client #2 while in the</p>			

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	<p>shower. The DSGL indicated the Coordinator responded there were no written instructions to staff regarding client #2's supervision levels but would amend the program plans to include this information. The DSGL indicated the incident should have been investigated.</p> <p>On 6/16/14 at 12:13 PM, 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. 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</p>				

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	<p>and whenever serious incidents occur, will pursue all measures allowed by Indiana Law. <u>Events Requiring</u>. 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 involving clients in SLP residences are to be completed within 10 days. Investigations must be started within 24 hours.</p> <p>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</p>			

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W000154	<p>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."</p> <p>This deficiency was cited on 5/8/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 6 incident reports reviewed affecting client #2, the facility failed to investigate a seizure-related fall with injuries as possible neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 6/16/14 at 12:10 PM and indicated the following: On 5/31/14</p>	W000154	The facility coordinator followed up with staff interviews including staff #3 and the supervisor of staff #3 who was in the home at the time of the incident involving Client#3. The facility coordinator reported that the supervisor interviewed staff#3 who assisted client #2 in the shower on the evening of 5/31/2014 when client#2 had a seizure resulting in an injury. Staff #3 reported that he had supervised client #2 numerous times in his 3 year	06/28/2014

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	<p>at 6:30 PM, client #2 entered the shower with staff #3's assistance. Staff #3 left the bathroom area to place soiled clothes in the laundry room. While staff #3 was out of the bathroom, he heard what sounded like client #2 falling in the shower. The Bureau of Developmental Disabilities Services (BDDS) report, dated 6/1/14, indicated, in part, "When staff member entered the bathroom, [client #2] was on the floor having a seizure. Staff member turned the water off and knelt beside him. This seizure lasted no longer than 15 seconds. Shortly after, [client #2] wanted to stand. Staff assisted him in standing. When he was back up, [client #2] had another seizure, began to fall, and staff supported him to the ground. This seizure lasted no longer than 10 seconds. Staff laid him down on the floor, put a towel under his head and called the pager. Staff member reviewed client's risk plan with pager's assistance and was instructed to monitor client noting that if he were to have any more consecutive seizures to call 911. Shortly after talking with the pager, [client #2] was strong enough to stand. [Client #2] continued through the remainder of the day without issue. [Client #2] sustained bruising on his arms, back, shoulders, and buttock as the result of his initial fall. He also has a few scrapes on his back which was treated with an antibiotic</p>		<p>tenure at the facility and believed he could momentarily leave client #2 in the bathroom to put client #2's feces soiled clothing in the laundryroom. The coordinator discussed client#2's recent increased seizure activity and the need for supervision during showering. The coordinator discussed staff #3's motives,intentions and ability to support client #2 safely with members of the facility team. The coordinator reported "the team is confident in the staff's motives and actions". The coordinator did not find staff #3 neglectful. Completed 6/11/2014. See attachment #1. Plan of Prevention: Client #2's Seizure Risk Plan, Behavior Plan and IHP have been revised to provide written guidelines and direction for client #2's personal care needs including showering. The facility staff have been trained inclient # 2's revised plans and to follow up on all incidents involving client injuries even if the cause is known. See attachment #2. Plan of Completion 6/20/2014. Quality Monitoring: facility coordinator will monitor through home observation of staff implementation of client #2's revised seizure risk plan and IHPs twice weekly during facility visits.</p>	

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	<p>cream." The facility did not conduct an investigation into the incident.</p> <p>On 6/16/14 at 4:25 PM, the Coordinator indicated the facility did not investigate client #2's fall in the shower. The Coordinator indicated the Director reviewed the incident report and requested additional information. The Coordinator indicated client #2 did not have unsupervised showers. The Coordinator indicated he wrote a plan and trained staff after the incident indicating client #2 was to be supervised at all times while in the shower.</p> <p>On 6/16/14 at 1:34 PM, the Director of Supervised Group Living (DSGL) indicated she sent an email to the Coordinator asking for additional information after reading the incident report. The DSGL indicated the Coordinator informed her client #2 was supposed to receive supervised showers. The DSGL indicated she asked the Coordinator if there were written instructions to staff regarding the supervision level of client #2 while in the shower. The DSGL indicated the Coordinator responded there were no written instructions to staff regarding client #2's supervision levels but would amend the program plans to include this information. The DSGL indicated the</p>			

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W000449	<p>incident should have been investigated.</p> <p>This deficiency was cited on 5/8/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to take appropriate corrective action to address issues noted during evacuation drills.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 6/16/14 at 3:48 PM. On 12/4/13 at 10:30 PM an overnight shift (10:00 PM to 6:00 AM) fire drill was conducted with three staff (the Qualified Intellectual Disabilities Professional, Home Manager and one direct care staff). The drill took 23 minutes to complete. The drill indicated, in part, "All clients asleep. [Client #4]</p>	W000449	<p>Deficiency ID: W449 Plan of Correction: facility director reviewed evacuation plans, practice drills, how to add teaching and training program goals to IHPs if needed and drill schedule with facility coordinator. Facility staff rehearsed drills and successfully completed four sleep time fire drills dated 6/20;6/21;6/27;6/28/2014. See Attachment #3. The facility coordinator has received a written performance review for failure to successfully meet the standards for evacuation drills during repeated surveys. Completed by 6/28/2014. Plan of Prevention: facility staff have been trained on all aspects of group home fire safety regulations including F-1 forms, monitoring fire safety devices, alarms, sprinklers, extinguishers, strobes,</p>	06/28/2014

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	and [client #6] couldn't hear the alarm, were confused and combative while trying to convince them what we were doing. [Client #5] went into a tantrum, with SIBs (self injurious behavior); very groggy due to his high HS (hour of sleep) dose of Seroquel. [Client #1] refused to get out of bed and was yelling at staff, took the longest to engage in the drill. [Clients #1 and #6] both required multiple prompts." The plan of correction for the drill indicated, "The team will discuss. A plan will be put in place to ensure efficient evacuation of all clients. The team will execute more drills to address the time issue." On 3/18/14, a fire drill was conducted taking 2 minutes with three staff present. On 3/20/14 at 5:54 AM, a fire drill was conducted taking 1 minute and 33 seconds to complete with three staff present. On 3/22/14 at 5:50 AM, a fire drill was conducted taking 2 minutes to complete with two staff. On 4/4/14 at 6:00 AM, a fire drill was conducted taking 1 minute and 45 seconds to complete with four staff. On 4/6/14 at 5:50 AM, a fire drill was conducted taking 3 minutes to complete with two staff. On 4/26/14 at 5:50 AM, a fire drill was conducted taking 4 minutes to complete with two staff. The facility did not conduct additional evacuation drills since 4/26/14 during the overnight shift.		emergency lighting, evacuation drills, how to address problems with drills, the frequency and times of drills. Quality Monitoring: The facility coordinator has received a written performance review addressing his failure to use the facility's quality monitoring tools effectively and to correct deficiencies which are within his responsibilities. He has been retrained in the use of the quality monitoring tools including the monthly/quarterly checklist which contains probes about the time and frequency of evacuation drills. The facility director will review the facility coordinator's completed quality monitoring reports for compliance.				

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	<p>A review of the facility's Emergency Fire Drill Evacuation Plan, not dated, was conducted on 6/16/14 at 3:48 PM. The plan indicated, "In the event of an emergency, especially one that occurs during the hours of 10P and 6A, when one staff is present, staff should do the following: 1) Alert all clients by knocking on their doors. 2) Awake [client #5] and take him out to his [name] van and ensure that he is safe. 3) Ensure that [client #3] is awake and have him exit the house, if he has done so independently. 4) Ensure that [client #6] is awake and assist him in preparing to leave the house. 5) Ensure that [client #1] is awake and assist him in preparing to leave the house. 6) If [client #4] is not already up, prompt him with physical and verbal cues to get him moving. 7) Assist [client #2] with getting out of the house into the van."</p> <p>On 6/16/14 at 3:48 PM, the House Manager (HM) indicated he was unable to locate documentation indicating the group home conducted evacuation drills since the last survey exited on 5/8/14. The HM indicated the group home was supposed to conduct a drill on the weekend of 6/13/14 to 6/15/14 but it was not conducted since the weekend manager was not working.</p>			

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	<p>On 6/16/14 at 4:14 PM, the Coordinator indicated the facility conducted evacuation drills since the last survey exited on 5/8/14. The Coordinator indicated the group home was supposed to conduct an overnight drill during the weekend on 6/13/14 to 6/15/14. The Coordinator indicated he was not aware the evacuation drill was postponed since the weekend manager was not working this weekend. The Coordinator indicated the tornado drill conducted on 5/25/14 at 5:53 AM was actually a fire drill that was mislabeled. The Coordinator indicated the former Director of Supervised Group Living instructed him to increase the number of overnight drills from one every 3 months to one per month for the next 6 months.</p> <p>A review of the tornado drill conducted on 5/25/14 at 5:53 AM indicated, in part, "Type of Drill: Tornado (in staff's handwriting)." The drill form indicated the drill was a non-evacuation taking 5 minutes to complete.</p> <p>This deficiency was cited on 5/8/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>			

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

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