

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/30/2012	
NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND ST BEDFORD, IN 47421			
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>This visit was done in conjunction with the post certification revisit (PCR) for the investigation of complaint #IN00096692.</p> <p>Dates of survey: March 26, 27, 28, 29 and 30, 2012.</p> <p>Facility Number: 001094 Provider Number: 15G653 AIM Number: 200235630</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/9/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000					

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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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 observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), and 3 additional clients ( #4, #5 and #6), the Governing Body failed to exercise general operating direction over the facility by failing to include/implement policies and procedures which included/addressed the Elder Justice Act; which requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility; (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act.)</p> <p>Findings include:</p> <p>According to review of the agency's Policy regarding reporting Abuse/Neglect of clients with revision date of 9/27/10 on 3/28/2012 at 12:15 PM, the Governing Body failed to exercise general policy and operating direction over the facility in that the governing body failed to include the Elder Justice Act (as defined above) in their agency's written policies and procedures.</p>	W0104	<p><b>W 104</b> <b>GOVERNING BODY</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt Arc, Inc. operates and implements general policy, budget and operating direction over all residential facilities. In particular, the Elder Justice Act for all group homes, including Elliott House.</p> <p><b>Responsible Person:</b></p> <p>Elliott House Coordinator/Stone Belt HR Department</p> <p><b>Date of Completion:</b></p> <p>April 20, 2012</p> <p><b>Plan of Prevention:</b></p> <p>The Elder Justice Act has been posted in all group homes including Elliott House. In addition, all SGL staff have been trained on the Act during the monthly SGL Inservice on April 6, 2012. (Attachment # 1 and # 1A) HR Director reviewing how the Elder Justice Act will be implemented into Stone Belt policy and procedures.</p>	04/20/2012			

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	<p>During observations at the facility's owned day program on 3/26/2012 from 1:45 PM until 3:00 PM and the residential facility on 3/26/2012 from 4:30 PM until 6:15 PM and on 3/27/2012 from 5:55 AM until 8:00 AM clients #1, #2, #3, #4, #5 and #6 were observed going about activities. Environmental tours of the facility during the observation times failed to indicate posted documentation regarding the Elder Justice Act and the rights/responsibilities thereof.</p> <p>The Human Resources Director was interviewed on 3/28/2012 at 2:55 PM regarding the required implementation of the Elder Justice Act.</p> <p>The interview indicated the agency was aware of the Elder Justice Act, had commenced procedural changes for training and policy changes; but had not yet implemented such training or amended their policies and procedures at the time of survey.</p> <p>9-3-1(a)</p>		<p><b>Quality Assurance Monitoring:</b></p> <p>The Coordinator will ensure that the Elder Justice Act is posted in all Stone Belt locations and that staff are trained on an annual basis on the Act.</p>		

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W0189	<p>483.430(e)(1) <b>STAFF TRAINING PROGRAM</b> The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), and 3 additional clients (#4, #5 and #6), the facility failed to provide each current employee with initial training regarding the Elder Justice Act which requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility; (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act) and failed to ensure each employee understood their rights and responsibilities pertaining to the Act.</p> <p>Findings include:</p> <p>During observations at the facility's owned day program on 3/26/2012 from 1:45 PM until 3:00 PM and the residential facility on 3/26/2012 from 4:30 PM until 6:15 PM and on 3/27/2012 from 5:55 AM until 8:00 AM clients #1, #2, #3, #4, #5 and #6 were observed going about activities. Environmental tours of the facility during the observation times</p>	W0189	<p><b>W 189 STAFF TRAINING PROGRAM Plan of Correction:</b> Stone Belt Arc, Inc. operates and implements general policy, budget and operating direction over all residential facilities. In particular, the Elder Justice Act for all group homes, including Elliott House. <b>Responsible Person:</b> Elliott House Coordinator/Stone Belt HR Department <b>Date of Completion:</b> April 20, 2012 <b>Plan of Prevention:</b> The Elder Justice Act has been posted in all group homes including Elliott House. In addition, all SGL staff have been trained on the Act during the monthly SGL Inservice on April 6, 2012. (Attachment # 1 and # 1A) HR Director reviewing how the Elder Justice Act and how it will be implemented into Stone Belt policy and procedures. <b>Quality Assurance Monitoring:</b> The Coordinator will ensure that the Elder Justice Act is posted in all Stone Belt locations and that staff are trained on an annual basis on the Act.</p>	04/20/2012			

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	<p>failed to indicate posted documentation regarding the Elder Justice Act and the rights/responsibilities thereof.</p> <p>During the various times of the observation periods, RC/Residential Coordinator #1, House Manager/HM #4 and direct contact staff #5, #6, #9, #10, #11 and #14 worked with the clients. Environmental tours of the day program site and the facility during the observation times indicated no posted documentation regarding the Elder Justice Act and the staff's rights/responsibilities thereof.</p> <p>A list of employees, who worked at the facility with clients #1, #2, #3, #4, #5 and #6 was compiled by RC/Residential Coordinator #1 on 3/26/12 at 1:15 PM. The list was reviewed on 3/26/2012 at 1:30 PM and contained the following direct contact and administrative staff: Director of Group Homes #2, RC #1, LPN #15, HM #4 and Direct Contact staff #5, #6, #7, #8, #9, #10, #11, #12, #13 and #14.</p> <p>Employee files for Direct Contact staff #6, #10, #11 and #13 were reviewed on 3/28/2012 at 12:20 PM. The review indicated no training regarding the Elder Justice Act.</p> <p>Residential Coordinator #1 was</p>			

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	<p>interviewed on 3/27/2012 at 10:15 AM and indicated the agency had not yet trained the employees regarding the required implementation of the Elder Justice Act.</p> <p>Interview with the agency's Human Resources Director on 3/28/2012 at 2:55 PM indicated the agency was aware of the Elder Justice Act and they were in the process of adding training about it to their new staff orientation curriculum. The interview indicated the new curriculum had not yet been implemented nor had current staff been trained regarding the Elder Justice Act.</p> <p>9-3-3(a)</p>			

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W0242	<p>483.440(c)(6)(iii) <b>INDIVIDUAL PROGRAM PLAN</b> The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on observation, record review and interview for 2 of 3 sampled clients (clients #1 and #2), the facility failed to ensure clients received skills training in communication.</p> <p>Findings include:</p> <p>During observations at the facility on 3/26/12 from 4:30 PM until 6:15 PM and on 3/27/12 from 5:55 AM until 8:00 AM, clients #1 and #2 were observed to go about their daily routines. Clients #1 and #2 were nonverbal and did not communicate with others during the observations.</p> <p>Review of client #1's record on 3/27/12 at 9:13 AM indicated an Individual Service Plan/ISP dated 9/09/11 which had no communication training objective.</p> <p>Review of client #2's record on 3/27/12 at 9:50 AM indicated a 6/29/11 ISP which contained no communication training</p>	W0242	<p><b>W 242 INDIVIDUAL PROGRAM PLAN</b></p> <p><b>Plan of Correction:</b></p> <p>.The individual program plan will include, for those clients that lack them, training in personal skills essential for privacy and independence, until the client has demonstrated the client is developmentally incapable of acquiring them. Specifically, a communication objective will be completed.</p> <p><b>Responsible Person:</b></p> <p>Elliott House Coordinator</p> <p><b>Date of Completion:</b></p> <p>April 27, 2012</p> <p><b>Plan of Prevention:</b></p> <p>The Coordinator will complete a communication objective for both</p>	04/27/2012			

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	<p>objective.</p> <p>Interview with the Residential Coordinator staff #1 on 3/28/12 at 3:30 PM indicated clients #1 and #2 required assistance and prompting to communicate but had no training objectives in this area.</p> <p>9-3-4(a)</p>		<p>clients that are non-verbal. Staff will be trained on the objectives following completion.</p> <p><b>Quality Assurance Monitoring:</b></p> <p>SGL Director will review objective upon completion as well as reviewing on a monthly basis for future tracking.</p>		

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility's nursing services failed to ensure clients' risk plans were written or revised as needed and failed to ensure monitoring of clients was done in regards to medication errors.</p> <p>Findings include:</p> <p>Review of the facility's reportable incidents on 3/26/12 at 3:00 PM and on 3/28/12 at 12:55 PM indicated the following:</p> <p>1. On 8/8/11, 9/01/11 and 12/13/11, client #1 sustained falls which required first aid. Residential Coordinator staff #1 recommended the LPN write and implement a fall risk plan for client #1. Review of client #1's record on 3/27/12 at 9:13 AM indicated an Individual Service Plan/ISP dated 9/09/11 and risk plans by LPN #15 dated 10/27/11. The review indicated no falls risk plan.</p> <p>2. On 2/06/12, client #2 required 5 mg. Valium (for anxiety) for a dental cleaning and fell when leaving the dentist's office. the incident report indicated staff #5 and</p>	W0331	<p><b>W 331 NURSING SERVICES</b></p> <p><b>Plan of Correction:</b></p> <p>Stone Belt Arc, Inc. will provide nursing services in accordance with the clients needs to ensure proper health and safety.</p> <p><b>Responsible Person:</b></p> <p>Elliott Coordinator and Nursing Manager</p> <p><b>Date of Completion:</b></p> <p>April 27, 2012</p> <p><b>Plan of Prevention:</b></p> <p>1) A fall risk plan will be completed by Nursing Manager and training will be completed with house staff. 2) Nursing Manager will update the current fall risk plan to ensure necessary precautions are being taken. 3) Nursing Manager including the monitoring of Blood Pressure to Medication Information Sheet and Medication Administration Report when Lasix is given.</p> <p><b>Quality Assurance Monitoring:</b></p> <p>Nursing Manager and Support Team will monitor risk plans on a</p>	04/27/2012			

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	<p>#11 were assisting her and she was wearing knee pads and a gait belt was being used.</p> <p>On 8/1/11, client #2 received 10 mg of Valium for a dental visit and fell on the carpeted office floor.</p> <p>During observations at the facility on 3/26/2012 from 4:30 PM until 6:15 PM and on 3/27/2012 from 5:55 AM until 8:00 AM client #2 was wearing knee pads and staff held onto a gait belt she wore while she ambulated. A merry walker (assistive seating/rolling device which encompasses one's body) was observed to be in client #2's bedroom during the above observations.</p> <p>Review of client #2's record on 3/27/12 at 9:50 AM indicated a falls risk plan by LPN #15 dated 11/15/11 indicated "When not using her Merry Walker, staff will have knee pads on [client #2] as well as a gait belt for protection from falling."</p> <p>Interview with RC #1 on 3/27/12 at 10:30 AM indicated the Falls Risk plan was confusing in that the Merry Walker was supposed to be used only in the event client #2 refused the use of the gait belt for safety from falls. The gait belt with staff assistance and the knee pads were the customary care client #2 was to receive daily. The record review</p>		annual basis and will ensure training of plans.				

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	<p>indicated a Behavior Support Plan/BSP dated 7/10 which indicated client #2 required an antianxiety medication for medical procedures. The BSP indicated client #2 received 20 mg. of Valium 60 minutes before appointments and 10 mg. more of the Valium 30 minutes prior to procedures for a total dosage of 30 mg. The incident reports indicated a range of 5 to 10 mg. of Valium used for the dental procedures. Interview with RC #1 on 3/28/12 at 3:30 PM indicated the antianxiety medication procedure was in need of revision as was the client's falls risk plan.</p> <p>3. 8/16/11, staff #4 gave client #3 40 mg. of Lasix (diuretic which affects blood pressure) in error at the bedtime medication pass. Client #3 had received 40 mg. of Lasix that day at 7:00 AM and 2:00 PM which was the prescribed dosage. The incident report indicated the on call nurse had been notified but did not instruct staff to take client #3's vital signs/blood pressure. Interview with staff #4 on 3/28/12 at 5:00 PM indicated client #3 had received 120 mg. of the Lasix instead of the prescribed amount of 80 mg. The interview indicated the on call nurse had not instructed the staff to check client #3's blood pressure after the medication error.</p>			

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview for 2 of 3 sampled clients (#2 and #3), and 2 additional clients (#5 and #6), the facility failed to ensure the clients' medications were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>Review of the facility's reportable incidents on 3/26/12 at 3:00 PM and on 3/28/12 at 12:55 PM indicated the following medications had not been given according to the physician's orders:</p> <p>8/05/11, staff #12 reversed client #2's evening and morning dosages of the anticonvulsant Dilantin by giving client #2 200 mg. of Dilantin instead of 100 mg. at 7:00 AM.</p> <p>8/12/11, staff #16 reversed client #3's evening and morning dosages of the anticonvulsant depakote (given for mood) by giving client #3 1000 mg. of depakote instead of 500 mg. at 7:00 AM.</p> <p>8/16/11, staff #4 gave client #3 40 mg. of Lasix (diuretic) in error at the bedtime medication pass. Client #3 had received 40 mg. of Lasix that day at 7:00 AM and 2:00 PM which was the prescribed</p>	W0368	<p><b>W 368 DRUG ADMINISTRATION</b></p> <p><b>Plan of Correction:</b> The Stone Belt Inc., system for drug administration assures that all drugs are administered in compliance with physician's orders. <b>Responsible Person:</b> Elliott Coordinator <b>Date of Completion:</b> April 20, 2012 <b>Plan of Prevention:</b> Retraining on Medication Administration was completed by Coordinator. (Attachment # 2) <b>Quality Assurance Monitoring:</b> Coordinator and SGL Director review all medication administration errors to ensure that the Stone Belt, Inc., medication protocol is being followed.</p>	04/27/2012			

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	<p>dosage.</p> <p>11/09/11 at 7:00 AM, staff failed to give client #5 his ear drops.</p> <p>1/04/12, client #6's morning medications were not administered by staff #11; 200 mg./milligrams of Colace (stool softener), 10 mg. of Metoclopramide (for digestive tract motility), 20 mg. of Lexapro (antidepressant), and 10 mg. of Singulair (for allergies).</p> <p>3/05/12, client #5 did not receive his bedtime Ambien (for sleep) by staff #10</p> <p>Interview with RC #1 on 3/28/12 at 3:00 PM indicated facility staff were expected to administer clients' medications according to the physician's orders.</p> <p>9-3-6(a)</p>				