

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2015
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 DECKARD DR BLOOMINGTON, IN 47408
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W000000	<p>This visit was for a Post Certification Revisit (PCR) to the PCR, completed on 10/22/14, to the investigation of complaint #IN00151850 completed on 7/17/14.</p> <p>Complaint #IN00151850: Not corrected.</p> <p>This visit was in conjunction to the PCR to the investigation of complaint #IN00159056 completed on 11/24/14.</p> <p>This visit was in conjunction to the PCR to the full recertification and state licensure survey completed on 10/22/14. This visit included the PCR to the investigation of complaint #IN00156855.</p> <p>Survey Dates: January 12, 13, 14 and 15, 2015</p> <p>Facility Number: 001209 Provider Number: 15G634 AIM Number: 100240160</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 1/21/15 by Ruth Shackelford, QIDP.</p>	W000000		

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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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 4 of 29 incident/investigative reports reviewed affecting clients B, C and E, the facility neglected to implement its policies and procedures to prevent client to client abuse and take appropriate corrective action to address a medication error.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/12/15 at 12:10 PM and indicated the following:</p> <p>1) On 1/4/15 at 4:30 PM clients B and E were watching television in the living room. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 1/5/15, indicated, "[Client B] began harassing [client E] by following him around the house, entering [client E's] room without permission, and shouting 'no' at [client E]. [Client E] pushed [client B] into a wall. [Client B]</p>	W000149	<p>1. Plan of correction: Client B is scheduled to transition to ResCare SLP setting closer to guardian. Historically conflicts between client B and E are frequent and numerous plans have been attempted (attachment d). Plan of prevention: Staff completed comprehensive Crisis Prevention Intervention 2/6/15. Quality monitoring: Facility coordinator – QDIP or Facility director will provide daily supervisions and support staff in providing safe environment for clients (attachment b). 2. Plan of correction: Staff #7 received written warning for medication error. Plan of prevention: Facility house manager and day aide will continue to provide daily observations during medication administration. A new medication storage box was introduced in the home to allow staff the ability to better see pillpacks (attachment b). Plan of monitoring: Facility coordinator – QDIP will provide weekly medication observations</p>	02/06/2015

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	<p>stayed on his feet, and staff ensured he had no injuries. Five minutes later while [client B] continued to pester [client E], [client E] smacked [client B] on top of the head three times...."</p> <p>On 1/12/15 at 11:55 AM, the Group Home Director (GHD) indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure in place prohibiting abuse of the clients.</p> <p>2) On 12/21/14 at 8:00 AM, staff #7 administered client B a medication prescribed for client E. The Medication Error Report, dated 12/21/14, indicated, "Accidentally gave [client E's] Lorazepam 2 mg (milligram) in place of [client B's] Alprazolam 2 mg." The Supervisor: Document action taken section was not marked (verbal discussion/training, performance review given, written warning, retake med (medication) admin (administration) course plus 3 passes, or written warning with termination of employment). The report was not signed by staff #7's supervisor. The facility did not provide documentation staff #7 received a verbal warning for the medication error.</p> <p>On 1/13/15 at 12:32 PM, the Group</p>		<p>(attachment b).</p> <p>3. Plan of correction: Staff were training on LL program client that 'poked client twice with a plastic fork (attachment e). Plan of prevention: Investigation was completed. Client was also moved to a different program away from client b (attachment f). Plan of monitoring: LL program coordinator will continue to offer training, monitoring, and support to LL direct care staff.</p> <p>4. Plan of correction: Client B is scheduled to transition to ResCare SLP setting closer to guardian. Historically conflicts between these clients are frequent and numerous plans have been attempted (attachment d). Plan of prevention: Staff completed comprehensive Crisis Prevention Intervention 2/6/15. Quality monitoring: Facility coordinator – QDIP or Facility director will provide daily supervisions and support staff in providing safe environment for clients (attachment b).</p>	

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	<p>Home Director (GHD) indicated there was no documentation of corrective action taken with staff #7. The GHD indicated it was a verbal warning. The GHD indicated this was staff #7's first medication error and the first error was a verbal warning. The GHD indicated the Home Manager should have documentation of the verbal warning and training.</p> <p>3) On 12/16/14 at 2:25 PM at the facility-operated day program, client B was poked on the arm and stomach with a plastic fork by a peer.</p> <p>On 1/12/15 at 11:55 AM, the Group Home Director (GHD) indicated client to client aggression was abuse and the facility should prevent abuse. The GHD indicated the facility had a policy/procedure in place prohibiting abuse of the clients.</p> <p>4) On 12/2/14 at 7:20 AM, client B refused to return staff #10's cellphone he took from the staff. Staff #10 got the phone back from client B and prepared to leave the group home. Staff #9 and client C were walking around the house. When client C and staff #9 stopped by the office door, client B walked up and pushed client C's head down onto staff #9's arm. Client C bit staff #9's arm and would not</p>			

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	<p>let go. Staff #9 yelled for assistance and staff #10 arrived to assist. The other staff moved client B away and asked client B to go to a quiet area. Staff #9 cleaned the wound on her arm. Staff #10 left the home. The BDDS report, dated 12/2/14, indicated, in part, "Directly after [staff #10's] departure at end of shift (sic), [client B] became angry and threw things at [staff #4]. [Staff #4] asked [client B] to calm down, take deep breaths, and count to 10; [client B] tried to hit, kick, and spit at [staff #4]. [Staff #4] asked [client B] to go to a quiet place to calm, but [client B] refused and continued his aggressive behavior. [Staff #4] and [staff #5] attempted to do a two-person transport to a quiet place, and in response to this, [client B] sat on the living room floor. After a five minute interval, [staff #4] and [staff #5] assisted [client B] back to his feet. [Client B] then sat down again in the hallway, where staff waited another five minutes before assisting [client B] to his feet; each transport lasted 3 seconds. Once standing, [client B] ran to his bedroom, and [staff #4] followed after retrieving the blocking pad. [Staff #4] used the pad to block items [client B] was throwing and aggressive behavior, each time suggesting a calming technique. [Client B's] aggression continued by hitting windows, walls, and slamming door repeatedly. At 8:00 AM</p>			

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	<p>when [staff #11] arrived, he walked in to [name of group home] and to the end of the hall where [client B's] room is located, and attempted to switch places with [staff #4]. [Staff #4] was blocking [client B] from aggressive behavior per [client B's] behavior plan. [Staff #11] attempted to relieve [staff #4] with blocking pads. As the switch was happening [client B] lunged at [staff #11] knocking off his glasses and grabbing his shirt. [Staff #4] assisted [staff #11] by removing [client B] off of [staff #11]. [Staff #4] then used a one-person transport to assist [client B] back in (sic) to his room. [Client B's] aggressive behavior continued and proceeded for approximately five minutes. [Client B] then started showing signs of calming, deep breathing, and counting. [Staff #4 and #11] again attempted to switch positions, and in response, [client B] lunged and grabbed [staff #11's] eyeglasses. [Client B] attempted to bend the glasses before deciding to throw them down the hallway. As a result, [staff #11] sustained a small laceration on the upper right side of his forehead. [Staff #4] again used a one-person transport to assist [client B] to his room; however, [client B] continued to act aggressively for another four to five minutes. [Staff #11] continued to block [client B] in the hallway another eight to ten minutes.</p>			

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	<p>[Client B] stopped trying to strike staff and proceeded to sit in the hallway, refusing to move or talk to staff..."</p> <p>The investigation, dated 12/6/14, indicated client B denied pushing client C's head down causing client C to bite staff #9. The Recommendations section of the investigation indicated, "Allegation stating [client B] 'shoved' [client C's] head is inconclusive. There were 5 staff and 4 clients (2 verbal) none of which (sic) witnessed or heard any proof that [client B] 'forced' [client C] into biting [staff #9]. [Staff #5] utilized CPI (Crisis Prevention Institute) bite release to assist [client C] in letting go of staff's arm. [Staff #9] has been transferred to another setting."</p> <p>On 1/12/15 at 11:23 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</p>			

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	<p>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 and whenever serious incidents occur, will pursue all measures allowed by Indiana Law...."</p> <p>This deficiency was cited on 10/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00151850.</p> <p>9-3-2(a)</p>			