

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 full recertification and state licensure survey completed on 10/22/14. This visit included the PCR to the investigation of complaint #IN00156855.</p> <p>Complaint #IN00156855: Not corrected.</p> <p>This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN00151850 completed on 10/22/14.</p> <p>This visit was in conjunction with the PCR to the investigation of complaint #IN00159056 completed on 11/24/14.</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>These deficiencies also reflect 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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W000104	<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 4 of 4 clients living in the group home (B, C, D and E), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the couch in the living room was in good repair and 2) the common area floors not covered by carpet were free of dirt and debris.</p> <p>Findings include:</p> <p>On 1/12/15 from 3:02 PM to 5:37 PM, an observation was conducted at the group home and indicated the following:</p> <p>1) On 1/12/15 during the observation at the group home, the living room couch located near the dining room had a piece of the frame sticking out from underneath the couch. The couch's frame was broken and the springs were exposed on the right hand side of the couch. The right front leg was missing causing the couch to sit crooked. There was no new furniture at</p>	W000104	<p>W104</p> <p>1. Plan of correction: Couch was replaced with a new one (attachment a). Plan of prevention: Facility house manager will complete maintenance request when an item is in need of replacement (attachment b). Quality monitoring: Facility coordinator – QDIP will complete weekly supervisions and monitor condition of the home and furnishings (attachment b)</p> <p>2. Plan of correction: Floors were stripped and waxed 2/4/15 by Laurie Best Cleaning (attachment c). Plan of prevention: Facility house manager will complete maintenance request when an item is in need of replacement (attachment b). Quality monitoring: Facility coordinator – QDIP will complete weekly supervisions and monitor condition of the home and furnishings (attachment b).</p> <p>3) Plan of correction: Facility staff have been trained on enter funds removed from account on ledger (attachment f).</p>	02/04/2015

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	<p>the group home in the living room since the last survey completed on 10/22/14. This affected clients B, C, D and E.</p> <p>On 1/12/15 at 1:29 PM, a receipt indicated two couches were purchased for the group home. The receipt indicated, in part, "Est. (estimated) Ship Date: 6-8 weeks."</p> <p>On 1/12/15 at 11:27 AM, the Group Home Director (GHD) indicated two new couches were ordered but have not been received yet.</p> <p>2) On 1/12/15 during the observation at the group home, the common area floors not covered by carpet (kitchen, dining room, entrance and hallways) were discolored, marked, scuffed and dull. This affected clients B, C, D and E.</p> <p>On 1/12/15 at 4:46 PM, the GHD indicated the issue with the floors not covered by carpet was the staff were using too much cleaner on the floors. The GHD indicated the group home ran out of cleaner due to the staff using too much. The GHD indicated the cleaner needed to be used sparingly however the staff were using too much. The GHD stated the home was scheduled to be "deep-cleaned" soon including a waxing of the floors.</p>		<p>Plans of prevention: Facility house manager has been trained on monitoring and auditing finances daily (attachment b). Quality monitoring: Facility coordinator – QDIP will complete weekly supervisions and monitor condition of the home and furnishings (attachment b)</p>		

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W000140	<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 #IN00156855.</p> <p>9-3-1(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 2 clients in the sample (B), the facility failed to keep a full and accurate accounting of the client's funds.</p> <p>Findings include:</p> <p>On 1/12/15 at 3:11 PM, a review of client B's finances was conducted. Client B's January 2015 Petty Cash Ledger indicated client B should have \$27.26. When the Home Manager (HM) counted client B's money, client B had \$20.35 (off by \$6.91).</p> <p>On 1/12/15 at 3:11 PM, the HM indicated</p>	W000140	<p>Plan of correction: Client B spent fund that were withdrawn and presented a receipt</p> <p>Plan of prevention: Client B's team met and determined that it was appropriate for him to sign out pocket money (attachment f)</p> <p>Plan of monitoring: Facility staff were trained on finances and House manager / coordinator on auditing finances daily / weekly (attachment b)</p>	02/04/2015

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W000149	<p>earlier in the day on 1/12/15, the HM withdrew \$6.91 to give to client B for the day. The HM indicated he gave client B a piece of paper indicating client B had withdrawn \$6.91 from his account. The HM indicated he did not document the withdrawal on the ledger.</p> <p>On 1/13/15 at 12:40 PM, the Group Home Director (GHD) indicated the facility should account for the client's funds to the penny, including when withdrawals were made from his account.</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>9-3-2(a)</p> <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</p>	W000149	<p>1. Plan of correction: Client B is scheduled to transition to ResCare SLP setting closer to guardian on 3/1/15. Historically conflicts between these clients are frequent and numerous plans have been attempted (attachment d). Plan of prevention: Staff</p>	02/04/2015

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	<p>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] 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</p>		<p>completed comprehensive Crisis Prevention Intervention 2/6/15.</p> <p>Quality monitoring: Facility coordinator – QDIP or Facility director will provide daily supervisions and support staff in providing safe environment for clients (attachment b).</p> <p>2. Plan of correction: Staff #7 received written warning for medication error.</p> <p>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 pill packs (attachment b).</p> <p>Plan of monitoring: Facility coordinator – QDIP will provide weekly medication observations (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).</p> <p>Plan of prevention: Client was also moved to a different program away from client b (attachment f).</p> <p>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 3/1/15. Historically conflicts between these clients are frequent and numerous plans</p>				

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	<p>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 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>have been attempted (attachment d). Planof prevention: Staff completed comprehensive Crisis Prevention Intervention2/6/15. Qualitymonitoring: Facility coordinator – QDIP or Facility director will provide dailysupervisions and support staff in providing safe environment for clients(attachment b).</p>				

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	<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 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</p>			

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	<p>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 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)</p>			

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	<p>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. [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</p>			

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	<p>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 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>			

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W000157	<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 #IN00156855.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 29 incident/investigative reports reviewed affecting client B, the facility failed to 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: 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</p>	W000157	<p>1. 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 pill packs (attachment b). Plan of monitoring: Facility coordinator – QDIP will provide weekly medication observations (attachment b).</p>	01/23/2015

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	<p>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 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>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 #IN00156855.</p> <p>9-3-2(a)</p>				

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 2 clients in the sample (B and C) and two additional clients (D and E), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor each client's program plan by failing to ensure:</p> <p>1) client B and D's individual program plans (IPP) were revised at least annually and 2) regular reviews of client B, C, D and E's progress of their training objectives was conducted.</p> <p>Findings include:</p> <p>1) On 1/13/15 at 11:35 AM, a review of client B's record was conducted. Client B's electronic record indicated his most recent IPP was dated 8/7/13. There was no documentation in client B's record the facility revised client B's IPP since 8/7/13.</p> <p>On 1/13/15 at 11:23 AM, a review of client D's record was conducted. Client D's electronic record indicated his most recent IPP was dated 7/26/13. There was no documentation in client D's record the facility revised client D's IPP since</p>	W000159	<p>1)Plan of correction: ClientB IPP's were updated August 2014 theywere not entered in to fortis. They areentered at the time and the goals have been ran appropriately the since theywere introduced. Plan of prevention:Coodinator – QDIP received training on electronic record management 2/2/15(attachment f). Plan of monitoring:Electronic alerts are sent out each week notifying coordinators when plans areoutdated.</p> <p>2)Plan of correction: ClientD's IPP's were updated August 2014 theywere not entered in to fortis. They areentered at the time and the goals have been ran appropriately the since theywere introduced. Plan of prevention: Coordinator– QDIP received training on electronic record management 2/2/15 (attachment f). Plan of monitoring:Electronic alerts are sent out each week notifying coordinators when plans areoutdated.</p>	02/02/2015

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	
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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	<p>7/26/13.</p> <p>On 1/13/15 at 12:49 PM, the Group Home Director (GHD) indicated the clients' current IPPs were not in their electronic records due to the facility not having written informed consent for the clients' IPPs. The GHD indicated the IPPs were revised in 2014 however the plans were not in the clients' records due to not having the required documentation for the Records Department to scan the files into the system. On 1/13/15 at 1:07 PM, the GHD indicated the previous Coordinator did not obtain written informed consent for the clients' plans. The GHD indicated the guardians were involved in the meetings regarding the development of the plans by phone. The GHD indicated the clients' IPPs were implemented without the guardians' written informed consent.</p> <p>2) On 1/13/15 at 12:20 PM, a review of client B's record was conducted. Client B's electronic record indicated his most recent monthly review of his progress on his training objectives was conducted on 6/1/14. The most recent quarterly review was conducted on 6/8/14.</p> <p>On 1/13/15 at 12:20 PM, a review of client C's record was conducted. Client C's electronic record indicated his most</p>						

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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	<p>recent monthly review of his progress on his training objectives was conducted on 6/30/14. The most recent quarterly review was completed on 4/18/14.</p> <p>On 1/13/15 at 12:20 PM, a review of client D's record was conducted. Client D's electronic record indicated his most recent monthly review of his progress on his training objectives was conducted on 6/30/14. The most recent quarterly review was completed on 4/18/14.</p> <p>On 1/13/15 at 12:20 PM, a review of client E's record was conducted. Client E's electronic record indicated his most recent monthly review of his progress on his training objectives was conducted on 6/30/14. The most recent quarterly review was completed on 4/18/14.</p> <p>On 1/13/15 at 1:07 PM, the Group Home Director (GHD) indicated the clients' monthly and quarterly reviews had not been completed. The GHD indicated she was focused on client safety and not the documentation.</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</p>						

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W000260	<p>#IN00156855.</p> <p>9-3-3(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (B) and one additional client (D), the facility failed to revise, at least annually, the clients' individual program plans (IPP).</p> <p>Findings include:</p> <p>On 1/13/15 at 11:35 AM, a review of client B's record was conducted. Client B's electronic record indicated his most recent IPP was dated 8/7/13. There was no documentation in client B's record the facility revised client B's IPP since 8/7/13.</p> <p>On 1/13/15 at 11:23 AM, a review of client D's record was conducted. Client D's electronic record indicated his most recent IPP was dated 7/26/13. There was no documentation in client D's record the facility revised client D's IPP since 7/26/13.</p>	W000260	<p>1)Plan of correction: ClientB IPP's were updated August 2014 theywere not entered in to fortis. They areentered at the time and the goals have been ran appropriately the since theywere introduced. Plan of prevention:Coodinator – QDIP received training on electronic record management 2/2/15(attachment f). Plan of monitoring:Electronic alerts are sent out each week notifying coordinators when plans areoutdated.</p> <p>2)Plan of correction: ClientD's IPP's were updated August 2014 theywere not entered in to fortis. They areentered at the time and the goals have been ran appropriately the since theywere introduced. Plan of prevention:Coordinator – QDIP received training on electronic record management 2/2/15(attachment f). Plan of monitoring:Electronic alerts are sent out each week notifying coordinators when plans</p>	02/02/2015	

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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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W000407	<p>On 1/13/15 at 12:49 PM, the Group Home Director (GHD) indicated the clients' current IPPs were not in their electronic records due to the facility not having written informed consent for the clients' IPPs. The GHD indicated the IPPs were revised in 2014 however the plans were not in the clients' records due to not having the required documentation for the Records Department to scan the files into the system. On 1/13/15 at 1:07 PM, the GHD indicated the previous Coordinator did not obtain written informed consent for the clients' plans. The GHD indicated the guardians were involved in the meetings regarding the development of the plans by phone. The GHD indicated the clients' IPPs were implemented without the guardians' written informed consent.</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>9-3-4(a)</p> <p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social</p>		are outdated.				

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	<p>proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on observation, record review and interview for 1 of 2 clients in the sample (B), the facility failed to ensure client B was properly placed in regard to his social, behavioral and psychiatric needs.</p> <p>Findings include:</p> <p>On 1/12/15 from 3:02 PM to 5:37 PM an observation was conducted at the group home. At 4:16 PM, client B arrived home. Client B attempted to bring in plastic totes (to store empty soda cans) to his bedroom. Client B was redirected by the Home Manager (HM) to leave the totes outside. Client B complied with the HM's request. Client B approached the Group Home Director (GHD) and shook his fist at her. Client B was speaking loudly and appeared upset with the GHD. At 5:21 PM, client B was in his bedroom banging on the wall between client B and client E's bedrooms. Client B exited his bedroom, opened the side door just outside his bedroom door and brought the plastic totes into his bedroom. Client B refused the HM's requests to take the cans outside. Client B also refused to take his 5:00 PM medications.</p> <p>A review of the facility's</p>	W000407	<p>Plan of correction: Client Bis 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).</p> <p>Plan of prevention: Staff completed comprehensive Crisis Prevention Intervention 2/6/15.</p> <p>Quality monitoring: Facility coordinator – QDIP or Facility director will provide daily supervisions and support staff in providing safe environment for clients (attachment b).</p>	02/28/2015

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	<p>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] 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>2) On 12/29/14 from 11:45 PM to 3:30 AM, the BDDS report, dated 12/30/14, indicated, in part, "...[client B] started to pester the staff repeatedly, keeping them from getting their work done. Staff realized they could not complete work with [client B] hovering and focused their attention on trying to get him to go back to bed. Client became very angry and proceeded to start banging on windows and walls and slamming doors. Around 12:00 AM, client became physically aggressive with staff, including spitting, hitting, kicking, and throwing binders,</p>			

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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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	<p>sandals and plastic wear at them. Client spit in the face of both staff #1 and staff #2 several times. After failing to hit staff #2 with a sandal, client tried to grab the collar of staff's shirt and left a 2-3 inch scratch on staff's neck, causing bleeding. In order to get client off staff #2, staff #1 put client in a bear hug for 40-50 seconds. At 12:30 the staff talked client back to his room where he continued to spit and slam his head and body against his wall. At about 12:45 PM (should be AM), he seemed to calm down enough to begin apologizing to staff for the aggression. At about 1:00 AM staff left his room. Client stayed in his room for about 5-10 minutes before coming out and trying to slam doors again. Since the physical aggression had stopped, staff stood by as client displayed more aggression without getting in the middle of it. Around 2:00 AM when client realized that he was not getting a reaction from staff, he again began attempting to hit and kick and throw things at the staff, who successfully avoided the attempts and there were no more injuries to staff. Around 2:30 AM the physical aggression had stopped again, and client was only slamming doors. While keeping a close eye on him, staff let him be. At about 3:00 AM client finally gave up, apologized to both staff for trying to hurt them, and just hung out after that. Client</p>			

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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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	<p>went to bed around 3:30 AM and stayed in bed thereafter...."</p> <p>3) On 12/23/14 at 12:30 AM, client B was awake and behaving "manic and obsessing over staff" per the BDDS report dated 12/23/14. The report indicated, "[Client B] was attempting to tell staff something, but staff could not understand immediately. [Client B] was banging his head on the wall, beating on windows, and attempted to elope by running out the front door and back in another door; [client B] was never out of eye-sight. [Client B] broke a trash can, breadbox, window alarm, and threw many items across the house; [client B] hit and kicked one staff. Staff attempted a 2 person transport: once unsuccessfully, which lasted 30 seconds, and once successfully, which lasted 45 seconds. Staff contacted Central pager and psych (psychiatric) pager. [Name of city] police were called around 3:30 AM, and showed up around 4:00 AM. Two officers talked to [client B] and told him he had one more chance. Police escorted [client B] to his room and left. At 4:00 AM, the SGL (Supervised Group Living) Director arrived after [client B] had cleaned his mess; [client B] fixed communication log. [Client B] told director and staff what he had to say concerning a prior incident. Per BSP</p>			

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	<p>(behavior support plan), the window alarm must be replaced. [Client B] has been served notice, and will find alternative placement due to aggressive behavior and a number of aggressive incidents in history...."</p> <p>4) On 12/22/14 at 4:15 PM, client B began "corralling" staff in an attempt to keep staff out of the office. The BDDS report, dated 12/24/14, indicated, "...staff at [name of group home] had to stay in the office to take care of some important paperwork, so a different staff had to be in charge of cooking dinner. [Client B] didn't like this change up in who was to cook, and so began behaviors... Staff once again explained the situation to [client B], and he became even more agitated and started spitting at staff, which then led to actual kicking and slapping of staff. [Client B] started slamming doors, and when staff moved to help guide him down the hall to his room to calm, [client B] began laying on the floor and refusing to move. After a bit of effort, [client B] finally made it to his room. [Client B] was still spitting and trying to hit staff, so an exclusionary timeout was instituted for 15 minutes as per his behavior plan. During this time, [client B] was still motioning to bite staff and throwing things. After promising to be calm, the timeout was ended and staff</p>			

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	<p>returned to the kitchen. Upon arriving there, [client B] began to do anything possible to stop staff from cooking including turning off oven, sitting on the freezer, and taking the bag of food from staff. The door of the kitchen was shut so staff could cook without any further disruptive behavior, but [client B] made multiple attempted to climb through the window. [Client B] found a stack of pens/markers and threw them at staff, stole a baking sheet, reached through the window to knock things off of the counter, and hit stuff out of staff's hands...."</p> <p>5) On 12/18/14 at 8:00 AM, client B refused to take his medications.</p> <p>6) On 12/2/14 at 7:20 AM, client B refused to return a 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 let go. Staff #9 yelled for assistance and the 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</p>			

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	<p>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 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</p>			

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	#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. [Client B] stopped trying to strike staff and proceeded to sit in the hallway, refusing to move or talk to staff..."			

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	<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 11:27 AM, the Group Home Director (GHD) indicated the facility had served notice to client B to terminate his services at the group home. The GHD indicated client B's guardian had selected a waiver provider and the group home was waiting for the new provider to start services with client B. The GHD indicated client B needed another placement to meet his needs.</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 #IN00156855.</p>			

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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W000436	<p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 2 of 4 clients living in the group home with adaptive equipment (D and E), the facility failed to ensure the clients' glasses were in good repair.</p> <p>Findings include:</p> <p>On 1/12/15 from 3:02 PM to 5:37 PM an observation was conducted at the group home. During the observation, clients D and E were not observed to wear glasses.</p> <p>On 1/12/15 at 3:38 PM, the Home Manager (HM) indicated there was a box in the office at the group home with glasses in it. The HM located the box and opened it. There were 5 pairs of glasses in the box. Four of the five pairs of glasses were broken (frames broken or missing lenses). The HM indicated he was not sure if the good pair of glasses</p>	W000436	<p>1)Plan of correction: ClientD first available appointment was 2/18/15 for new eye glasses (attachment g). Plan of prevention: Facilityday Aide and house manager have been trained on medical appointment schedulesand ensuring these are appointments occur on time. Facility staff have beentrained on maintain and training clients in wearing / using adaptive equipmentper physician's orders. Plan of monitoring: Facilitycoordinator QDIP has been trained on monitoring that client's adaptiveequipment (attachment b).</p>	02/18/2015

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	<p>was client D or client E's glasses. The HM indicated clients D and E did not have glasses to wear.</p> <p>A review on 1/13/15 at 11:55 AM indicated an email, dated 12/16/14 at 1:48 PM, sent from the Group Home Director (GHD) to the group home staff indicated, in part, "It is the responsibility of the day aid to ensure that adaptive equipment is located in the home and is (sic) good condition. Please let them know if there is an item listed in a BSP (behavior support plan), ISP (individual support plan), or HRP (health risk plan) that is no longer applicable or has been lost. This includes items such as: helmets, padded gloves, eye glasses, retainers, mouth guards, communication devices, et cetera. This is very important! Not providing this equipment to our SGL (Supervised Group Living) clients is consider (sic) a state and federal violation...."</p> <p>A review on 1/13/15 at 1:25 PM indicated an email, dated 1/13/15 at 1:25 PM, sent from staff #4 to the group home staff indicated, in part, "I'm very happy to tell you all about [client E's] day. He got up and took a shower, brushed his teeth and got dressed with very little prompting. We went to [name] eye center and got his glasses repaired."</p>						

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W009999	<p>On 1/13/15 at 12:53 PM, the Group Home Director indicated the clients' adaptive equipment (glasses) should be in good repair and available to the clients.</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 #IN00156855.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met:</p> <p>1) 460 IAC 9-3-2 Resident Protections</p> <p>c) The residential provider shall demonstrate that its employment</p>	W009999	<p>Plan of correction: Staff #2has submitted a criminal history background it is located in his HR file (attachment I). Plan of prevention: HRcoordinator will ensure that items are in HR files and located in appropriateplaces. Plan of monitoring: HRdirector will provide monitoring of HR files quarterly to ensure items arefiled correctly. Plan of correction: Staff#3's core a and core b scores are documented in HR file (attachment j) Plan of prevention:</p>	02/02/2015

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	<p>practices assure that no staff person would be employed where there is: 1) evidence of abuse or fraud in any setting; 2) repeated and substantial violation of applicable laws and rules in the operation of any type of residential, health or developmental program in the care of dependant persons; or 3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (#2), the facility failed to conduct a criminal history check.</p> <p>Findings include:</p> <p>On 1/12/15 at 1:39 PM, a review was conducted of staff #2's employee file. Staff #2's employee file did not include documentation the facility conducted a criminal history check.</p> <p>On 1/12/15 at 1:52 PM, the Group Home Director (GHD) reviewed staff #2's employee file and could not locate</p>		HRcoordinator will ensure that items are in HR files and located in appropriate places. Plan of monitoring: HRdirector will provide monitoring of HR files quarterly to ensure items are filed correctly.				

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	<p>documentation verifying a criminal history check was completed. The GHD indicated the facility should have documentation of a criminal history check.</p> <p>2) 460 IAC 9-3-6 Health Care Services</p> <p>b) All personnel who administer medication to residents or observe resident self-administering medication shall have received and successfully completed training using materials approved by the council.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (#3), the facility failed to provide documentation indicating staff #3's test scores for the completion of Core A and B medication administration training.</p> <p>Findings include:</p> <p>On 1/12/15 at 1:39 PM, a review was conducted of staff #3's employee file. Staff #3's employee file did not include the test scores she received for Core A and B medication administration training.</p> <p>On 1/12/15 at 1:48 PM, the Group Home</p>			

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	<p>Director (GHD) reviewed staff #3's employee file and could not locate documentation indicating staff #3's test scores for Core A and B. The GHD indicated the facility should have documentation of staff #3's test scores for Core A and B. The GHD indicated staff #3 administered medications to clients B, C, D and E.</p> <p>3) 460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 17. Use of any aversive technique including but not limited to: a. seclusion (i.e. (that is) placing an individual alone in a room/area from which exit is prevented and 19. Use of any physical or manual restraint regardless of: a. planning; b. human rights committee approval; and c. informed consent.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 29 incident/investigative reports reviewed affecting client B, the facility failed to submit an incident report to the Bureau of Developmental Disabilities</p>						

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	<p>Services (BDDS), within 24 hours, in accordance with state law.</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: On 12/22/14 at 4:15 PM, client B began "corralling" staff in an attempt to keep staff out of the office. The BDDS report, dated 12/24/14, indicated, "...staff at [name of group home] had to stay in the office to take care of some important paperwork, so a different staff had to be in charge of cooking dinner. [Client B] didn't like this change up in who was to cook, and so began behaviors... Staff once again explained the situation to [client B], and he became even more agitated and started spitting at staff, which then led to actual kicking and slapping of staff. [Client B] started slamming doors, and when staff moved to help guide him down the hall to his room to calm, [client B] began laying on the floor and refused to move. After a bit of effort, [client B] finally made it to his room. [Client B] was still spitting and trying to hit staff, so an exclusionary timeout was instituted for 15 minutes as per his behavior plan. During this time, [client B] was still motioning to bite staff and throwing things. After promising to</p>						

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	<p>be calm, the timeout was ended and staff returned to the kitchen. Upon arriving there, [client B] began to do anything possible to stop staff from cooking including turning off oven, sitting on the freezer, and taking the bag of food from staff. The door of the kitchen was shut so staff could cook without any further disruptive behavior, but [client B] made multiple attempted to climb through the window. [Client B] found a stack of pens/markers and threw them at staff, stole a baking sheet, reached through the window to knock things off of the counter, and hit stuff out of staff's hands...."</p> <p>On 1/12/15 at 11:55 AM, the GHD indicated incidents requiring submission to BDDS were to be reported within 24 hours.</p> <p>This state rule was cited on 10/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(c) 9-3-6(b) 9-3-1(b)</p>			