

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2013
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408
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W000000	<p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00137851 completed on 10/30/13.</p> <p>Complaint #IN00137851: Not Corrected.</p> <p>This visit was in conjunction with the full recertification and state licensure survey.</p> <p>Survey Dates: December 9, 10, 11 and 12, 2013.</p> <p>Facility Number: 000744 Provider Number: 15G220 AIM Number: 100234860</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/16/13 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 3 of 19 incident/investigative reports reviewed affecting clients D, E, F and G, the facility neglected to implement its policies and procedures to prevent and investigate incidents of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/9/13 at 1:14 PM.</p> <p>1) On 11/7/13 at 6:30 AM, client E called client D a name. Client D hit client E on the arm near his elbow. The facility did not provide documentation an investigation was conducted.</p> <p>2) On 11/18/13 at 7:30 AM, clients E and F both wanted to sit in the front seat. Client F kicked client E two times on the leg. The facility did not provide documentation an investigation was conducted.</p> <p>3) On 11/21/13 at 7:30 AM, client F kicked client G. The facility did not provide documentation an investigation</p>	W000149	W149 Plan of Prevention: Facility staff will be retrained on Prevention of Abuse, Neglect, Exploitation and Incident Reporting. Clients will receive retraining on agency's Client Responsibilities and Rules in Residential Living which include but are not limited to; No hitting, kicking or trying to hurt other people. Plan of Prevention: The agency has implemented a new internal incident reporting system designed to address various failures in implementing the agency's procedures on reporting and investigation allegation A/N/E. The process included the following steps: The written incident report is submitted within 24 hours (or immediately if it contains an allegation A/N/E) to a designated administrative staff. The staff enters the incident into the electronic system, attaches required follow up/investigative forms, completes a BDDS report if indicated, notifies a supervisor if indicated and sends an electronic copy of the report to the facility support team. Each member of the support team reads, reviews, documents actions taken and signs the report. The report requires the review and signature of the director before the report is electronically files. Quality	01/12/2014	

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	<p>was conducted.</p> <p>On 12/10/13 at 12:33 PM, the Coordinator indicated he completed an inquiry into the incident dated 11/7/13 but did not know where the investigation was located. The Coordinator indicated the inquiry of Client to Client Aggression should be in the facility's electronic record system. The Coordinator indicated he was on vacation during the incidents on 11/18/13 and 11/21/13. The Coordinator was unsure if an inquiry was completed. The Coordinator indicated inquiries should have been completed for the incidents of client to client aggression.</p> <p>On 12/11/13 at 2:16 PM, the Director of Supported Group Living (DSGL) indicated client to client inquiries (investigations) should be completed for client to client aggression. The DSGL indicated the staff should prevent client to client aggression.</p> <p>A review of the facility's abuse and neglect policy, dated September 2013, was conducted on 12/9/13 at 1:49 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain,</p>		<p>Assurance Monitoring: The group home internal audit will be revised to reflect all of the required elements of an incident report. The QA team process will be revised to include a review of all ISDH surveys; a review and report of all SGL A/N/E investigations by third party QA team member and the QA team will recommend and monitor corrective actions.</p>				

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	<p>injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a client, parent/guardian, advocate, staff member, or other involved party."</p> <p>This deficiency was cited on 10/30/13. The facility failed to implement a systemic plan of correction to prevent</p>			

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W000154	<p>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 3 of 19 incident/investigative reports reviewed affecting clients D, E, F and G, the facility failed to investigate incidents of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/9/13 at 1:14 PM.</p> <p>1) On 11/7/13 at 6:30 AM, client E called client D a name. Client D hit client E on the arm near his elbow. The facility did not provide documentation an investigation was conducted.</p> <p>2) On 11/18/13 at 7:30 AM, clients E and F both wanted to sit in the front seat. Client F kicked client E two times on the leg. The facility did not provide documentation an investigation was conducted.</p>	W000154	<p>W154 Plan of Correction: Coordinator will be retrained on following agency policy of investigating client to client aggression regardless of vacation or absences by designating staff to cover incident follow ups when gone. The agency's new electronic incident reporting system has been updated to include a start date for any incident requiring follow up and an alert which is sent on the fifth day that the follow up needs to be completed (if it has not been closed). Plan of Prevention: The new electronic Incident Reporting System attaches Inquiries to incidents of client to client aggression and injuries of unknown origin. Coordinator will complete the inquiries within five days. The Director of SGL will review all client to client aggression and injury of unknown origin to ensure completion. The Director will receive an alert of all inquiries that are not complete at the fifth day mark. Quality Assurance Monitoring: The</p>	01/12/2014

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	<p>3) On 11/21/13 at 7:30 AM, client F kicked client G. The facility did not provide documentation an investigation was conducted.</p> <p>On 12/10/13 at 12:33 PM, the Coordinator indicated he completed an inquiry into the incident dated 11/7/13 but did not know where the investigation was located. The Coordinator indicated the inquiry of Client to Client Aggression should be in the facility's electronic record system. The Coordinator indicated he was on vacation during the incidents on 11/18/13 and 11/21/13. The Coordinator was unsure if an inquiry was completed. The Coordinator indicated inquiries should have been completed for the incidents of client to client aggression.</p> <p>On 12/11/13 at 2:16 PM, the Director of Supported Group Living (DSGL) indicated client to client inquiries (investigations) should be completed for client to client aggression.</p> <p>This deficiency was cited on 10/30/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		agency's new electronic incident reporting system has been revised to alert the facility director after 5 days that the follow up report needs to be completed.		

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