

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 MAXWELL ST BLOOMINGTON, IN 47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000000	<p>This visit was for a post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on July 12, 2013.</p> <p>This visit was in conjunction with the investigation of complaint #IN00135576.</p> <p>Survey Dates: September 5, 6 and 9, 2013.</p> <p>Facility Number: 000888 Provider Number: 15G374 AIM Number: 100239700</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/24/13 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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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 5 of 5 clients (#1, #3, #4, #5 and #6) living at the group home (client #2 was temporarily moved to another group home while mold was being removed from the group home), the governing body failed to exercise operating direction over the facility by failing to ensure the kitchen cabinets were cleaned and/or replaced and patches on the walls were sanded and repainted.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/5/13 from 3:46 PM to 5:19 PM. Throughout the home, there were patches on the walls due to repairs to the walls. The patches were not sanded and painted. In the bathroom next to the kitchen, there was peeling paint around the ceiling in the shower area. The walls in the bathroom were marked and discolored. The bathroom also had unpainted patches from previously repaired holes. The kitchen cabinets were discolored and stained on the lower cabinets near the sink and the oven. There were non-functioning drawers in the kitchen cabinets from clients breaking</p>	W000104	<p>Plan of Correction: Stone Belt exercises general policy, budget, and operating direction over the facility. Specifically, Stone Belt will ensure that holes in the walls are repaired and kitchen cabinets maintained. Date of Completion: It is part of a comprehensive remodel plan that will be completed by December 10, 2013. Person Responsible: Maxwell Program Coordinator</p> <p>Plan of Prevention: Stone Belt will ensure that the cabinets are repaired and clean, and that any holes in the walls are repaired, sanded and painted. Stone Belt will ensure that the drawers in the kitchen are functioning or replaced. The trim in the kitchen will be repaired. Quality Assurance Monitoring: Coordinator will review all environmental aspects on a quarterly basis using the Internal Audit Form. This will be done with the House Manager and then reviewed by the SGL Director. There has been a change in management. There is an Interim Supported Group Living Director in place. A new Director for Supported Group Living will be hired.</p>	12/10/2013			

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	<p>the drawers and the hole being covered up with a piece of wood. The black trim in the kitchen was chipped, stained and discolored. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with the Program Coordinator (PC) was conducted on 9/6/13 at 8:52 AM. The PC indicated the cabinets needed to be replaced. The PC indicated there was repair work being completed due to mold in the home and then the cabinets and painting were going to be done.</p> <p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 3 of 3 clients observed to receive their medications (#1, #3 and #4), the facility failed to ensure the clients had privacy during medication administration.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 9/5/13 from 3:46 PM to 5:19 PM. At 3:47 PM, client #3 received his medications from staff #9. Client #3 received his medications in the living room of the group home. Client #1 was in the living room and close enough to hear the medication training provided to client #3 by staff #9. Client #1 was not prompted to leave the area during the medication administration to client #3. At 4:51 PM, client #4 received his medications from staff #9 in the living room. Client #3 was in the living room and close enough to hear the medication training provided to client #4 by staff #9. Client #3 was not prompted to leave the area during the medication administration to client #4. At 5:08 PM, client #1 received his medications from staff #9 in the living room from staff #9. Client #4</p>	W000130	<p>Plan of Correction: Stone Belt has dedicated a medication administration area that ensures privacy with medication passes. The medication administration area has been moved to a new temporary location pending the completion of the repair work at the home. The permanent location of the medication administration area will be in the staff office. Date of Completion: October 10, 2013 Person Responsible: Maxwell Program Coordinator Plan of Prevention: Stone Belt will ensure that clients will have privacy during medication pass. Stone Belt will ensure all policies surrounding medication administration are followed and that staff are trained on these policies. Quality Assurance Monitoring: Coordinator will review aspects of medication administration on a quarterly basis using the Internal Audit Form. This will be done with the House Manager and then reviewed by the SGL Director. There has been a change in management. There is an Interim Supported Group Living Director in place. A new Director for Supported Group Living will be hired. There has been a change</p>	10/10/2013	

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	<p>was in the living room and close enough to hear the training provided by staff #9 to client #1. Client #4 was not prompted to leave the area during client #1's medication administration.</p> <p>An interview with the Program Coordinator (PC) was conducted on 9/6/13 at 9:01 AM. The PC indicated the living room was not private. The PC indicated the front room of the group home would be the best area to administer medications since the office was not available for the medication pass due to the construction work being completed at the group home. The PC indicated the direct care staff need to try to ensure privacy during the clients' medication administration.</p> <p>9-3-2(a)</p>		in management. There is an Interim Group Home Director in place. A new Director for Supported Group Living will be hired.		

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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 5 of 12 incident/investigative reports reviewed affecting clients #2, #5 and #6, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients and report an incident to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/5/13 at 1:59 PM.</p> <p>1) On 9/1/13 at 3:40 PM, client #6 was in his room engaging in property destruction (VCR tapes thrown around his room, TV lying screen down on the floor and VCR thrown to the floor) when client #5 went to see what was going on. When client #5 stood in the doorway, client #6 walked toward client #5. Client #5 backed away into the hallway. Client #6 followed client #5 and hit him (report did not indicate location).</p> <p>2) On 9/1/13 at 8:00 AM, client #5 woke up soiled with feces. Staff prompted</p>	W000149	<p>Plan of Correction: Stone Belt has policies and procedures that address mistreatment, neglect and abuse of clients. Responsible Person: Maxwell Program Coordinator Date of Completion: October 10, 2013 Plan of Prevention: On 9-6-2013 and 10-6-2013 Maxwell House staff were retrained on the Stone Belt policy of the prevention of abuse, mistreatment and neglect. The training reviewed the definitions of abuse neglect and mistreatment and gave examples of situations that are required to be reported. Staff were encouraged to bring up scenarios and receive guidance from program and professional staff about what, when and how to report. The training included the Stone Belt policy on incident reporting within 24 hours. Quality Assurance Monitoring: The Stone Belt Staff receive training during new hire orientation and annually on The Stone Belt Abuse, Mistreatment, Neglect and Incident Report Policies. The Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents. The QIPD is required</p>	10/10/2013	

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	<p>client #5 to take a shower. Client #5 yelled "no" when staff offered assistance. Client #5 attempted to punch staff, tore down the shelving unit and attempted to stab the staff with the piece of metal he broke off the shelf. A second staff intervened and removed the metal shelving piece from client #5's hands. Client #5 continued aggressive actions toward staff and attempted to break another piece of metal off the shelving. Client #5 was placed in a two person baskethold. After 5 minutes, client #5 calmed and asked to go into the front room to calm. Client #5 calmed and apologized to staff. In the process of removing the metal from his hands, client #5 sustained superficial cuts to his pinky and ring fingers. The Social Worker was going to the house to assess the situation.</p> <p>3) On 8/30/13 at 3:00 PM (reported to BDDS on 9/4/13), client #5 was taking food to his room. Staff prompted client #5 to stay in the dining room. Client #5 threw his food and started to throw everything he could get his hands on in the kitchen onto the floor. He climbed on top of the washer and dryer and lay flat. Staff held him there so he could calm down. After 5 minutes, staff asked if he wanted to go to his room. He got off the washer and dryer and started to remove all the knobs and throw them. He ran into</p>		<p>to visit the home weekly and more frequently as needed. The nurse, social worker and behaviorist visit the group home a minimum of twice monthly. Maxwell team members have been directed to consider these visits opportunities to observe and monitor staff/client interactions and conversations and to coach/model/teach/train DSPs how to implement individualized programs and how to effectively and consistently implement agency policies and procedures in every day situations. The incident reports will be reviewed by the Maxwell Program Coordinator and ancillary professional staff. There has been a change in management. There is an Interim Supported Group Living Director in place. A new Director for Supported Group Living will be hired. Additional Information 10/21/2013W149/W153-What kind of training was done that is different than what staff initially received that has proven ineffective? Incident report training was done on 9-6-2013 at a departmental meeting for all DSP staff. A list of reportable incidents and examples of situations included under each item was reviewed and openly discussed with group home staff. On 10-4-2013 at the October departmental meeting incident reporting was again reviewed as staff were reminded that all</p>				

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	<p>the bathroom and threw items onto the floor. He broke the shelving. Staff intervened and put him in a 2 person transport. He broke out of the hold and punched the wall. Staff used a 2 person baskethold for 5 minutes. After being released, he ran to his room and shut the door. The report indicated, "This incident has been turned over to the Stone Belt Social Work department for investigation." The facility had not completed the investigation on 9/5/13 when the incident reports were reviewed.</p> <p>A review of an email submitted by the Social Worker was conducted on 9/6/13 at 9:02 AM. On 9/6/13 at 9:02 AM, the Social Worker emailed the surveyor the following information: "We have not completed the investigation concerning the incident at [name of group home] concerning restraints and the question of client rights violation. At this point we still need to interview one employee who has not had a phone. We expect to have that completed following the needed interview. The investigator has no indication or evidence at this time that there is any event of abuse or neglect involved with this situation. All the information is identifying the need for staff retraining on timely and accurate reporting, and use of restraints. We are addressing those issues with retraining at</p>		<p>policies including incident reporting including a list of reportable situations are found on the agency's Knowledge Base. How will visiting the homes effectively ensure that incidents are reported? Discussions with staff reveal information about behaviors and situations that raise questions or are not clear. The QIPD and ancillary staff have been instructed on the opportunities that home visits provide to observe client/staff interactions and conversations for the correct implementation of active teaching and positive and effective behavioral interventions and situations that require incident reporting procedures are to be followed. Will daily notes be reviewed for incidents that should have been reported? Forum posts (agency communication system) will be reviewed each day by management staff and professional staff. Will modeling, teaching, training be provided by those management staff that visit the homes. The QIPD and ancillary staff have been instructed on the opportunities that home visits provide to provide ongoing teaching, training, coaching and modeling will be provided by the QIDP and other professional staff who visit the home. How often will the visits occur? QIDP is in the home at least weekly and more frequently as needed.</p>				

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	<p>our Shiloh meeting today with [name of group home] staff."</p> <p>4) On 8/25/13 at 6:15 PM, client #6 sat down to eat dinner next to client #5. Client #6 rubbed his pinky on client #5's arm. Client #6 was redirected and client #6 stared at client #5. Client #6 smacked client #5 on the left ear.</p> <p>5) On 8/20/13 at 6:00 PM, client #6 struck client #2 on his right shoulder blade while waiting to get into the van while it was raining.</p> <p>A review of the facility's abuse and neglect policy, dated 10/17/11, was conducted on 9/5/13 at 1:11 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, 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</p>		Professional staff including the Maxwell nurse, social worker and behaviorist visit the home at minimum of two times per month.				

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	<p>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>An interview with the Program Coordinator (PC) was conducted on 9/6/13 at 9:33 AM. The PC indicated client to client aggression was considered abuse. The PC indicated the staff should prevent abuse. The PC indicated the group home staff were receiving training on client #5's Behavior Support Plan on 9/6/13. The PC indicated client #6's client to client incidents have increased recently. The PC indicated BDDS reports should be submitted within 24 hours.</p> <p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 12 incident/investigative reports reviewed affecting client #5, the facility failed to report an incident to the Bureau of Developmental Disabilities 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 9/5/13 at 1:59 PM.</p> <p>On 8/30/13 at 3:00 PM (reported to BDDS on 9/4/13), client #5 was taking food to his room. Staff prompted client #5 to stay in the dining room. Client #5 threw his food and started to throw everything he could get his hands on in the kitchen onto the floor. He climbed on top of the washer and dryer and lay flat. Staff held him there so he could calm down. After 5 minutes, staff asked if he wanted to go to his room. He got off the washer and dryer and started to remove all the knobs and throw them. He ran into</p>	W000153	<p>Plan of Correction: Stone Belt Arc, Inc. will ensure any incidents of Abuse, Neglect, and/or mistreatment of the clients will be reported immediately. The investigation for the incident reported from 8/30/2013 was completed and found to be unsubstantiated. Person Responsible: Maxwell Program Coordinator Date of Completion: October 10, 2013 Plan of Prevention: Staff have been retrained to report immediately to the Coordinator and/or Director of Group Homes for any suspected incident of Abuse, Neglect, and or mistreatment of clients. Quality Assurance Monitoring: The Stone Belt Staff receive training during new hire orientation and annually on The Stone Belt Abuse, Mistreatment, Neglect and Incident Report Policies. The Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents. The incident reports will be reviewed by the Maxwell Program Coordinator and ancillary professional staff. There has been a change in</p>	10/10/2013			

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	<p>the bathroom and threw items onto the floor. He broke the shelving. Staff intervened and put him in a 2 person transport. He broke out of the hold and punched the wall. Staff used a 2 person baskethold for 5 minutes. After being released, he ran to his room and shut the door. The report indicated, "This incident has been turned over to the Stone Belt Social Work department for investigation." The facility had not completed the investigation on 9/5/13 when the incident reports were reviewed.</p> <p>An interview with the Program Coordinator (PC) was conducted on 9/9/13 at 11:35 AM. The PC indicated BDDS reports should be submitted within 24 hours.</p> <p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		<p>management. There is an Interim Supported Group Living Director in place. A new Director for Supported Group Living will be hired. Additional Information 10/21/2013W149/W153-What kind of training was done that is different than what staff initially received that has proven ineffective? Incident report training was done on 9-6-2013 at a departmental meeting for all DSP staff. A list of reportable incidents and examples of situations included under each item was reviewed and openly discussed with group home staff. On 10-4-2013 at the October departmental meeting incident reporting was again reviewed as staff were reminded that all policies including incident reporting including a list of reportable situations are found on the agency's Knowledge Base. How will visiting the homes effectively ensure that incidents are reported? Discussions with staff reveal information about behaviors and situations that raise questions or are not clear. The QIPD and ancillary staff have been instructed on the opportunities that home visits provide to observe client/staff interactions and conversations for the correct implementation of active teaching and positive and effective behavioral interventions and situations that require incident reporting procedures are to be followed. Will daily notes</p>		

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			<p>be reviewed for incidents that should have been reported? Forum posts (agency communication system) will be reviewed each day by management staff and professional staff. Will modeling, teaching, training be provided by those management staff that visit the homes. The QIPD and ancillary staff have been instructed on the opportunities that home visits provide to provide ongoing teaching, training, coaching and modeling will be provided by the QIDP and other professional staff who visit the home. How often will the visits occur? QIDP is in the home at least weekly and more frequently as needed. Professional staff including the Maxwell nurse, social worker and behaviorist visit the home at minimum of two times per month.</p>	

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W000226	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure the client's Individual Support Plan (ISP) was completed within 30 days after admission to the group home.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 9/6/13 at 8:57 AM. Client #5's record did not contain an ISP. Client #5's admission date to the group home was 4/17/13.</p> <p>An interview with the Program Coordinator (PC) was conducted on 9/6/13 at 8:57 AM. The PC indicated client #5's ISP meeting and documentation had not been done. The PC indicated client #5 did not have training objectives in place.</p> <p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>	W000226	<p>Plan of Correction: Stone Belt will ensure that within 30 days of admission, the interdisciplinary team will complete an individual program plan and functional assessment for each client. Individual Support Plans have been completed for clients #5 and the Comprehensive Functional Assessments have been completed for client #5. Date of Completion: October 10, 2013 Person Responsible: Maxwell Program Coordinator Plan of Prevention: The Program Coordinators have been retrained on the ISP process/annual/admissions process and the regulations surrounding active teaching and training. Quality Assurance Monitoring: The House Program Coordinator will complete the admissions checklist to ensure all steps of the process have been completed within the initial 30 days. There has been a change in management. There is an Interim Group Home Director in place. A new Director for Supported Group Living will be hired. Additional Information 10/21/2013W226/W260-Where did the system fail in that the ISP was not done? Adequate training on the ICF/IDD regulations in general and on the Active</p>	10/10/2013	

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			Teaching component in particular was not provided to the QIDP initially upon hire. Training took place on 9-20-2013 with the Maxwell QIDP which reviewed the standards and elements addressing admissions, 30 day assessments, the development of ISP, and on the monitoring and revising of the ISP. What monitoring procedure is in place to ensure that the deficient practice is not likely to reoccur? The IT department has implemented a system for monitoring and tracking ISP's for each client for each group home. A notice is sent out to the QIDP and the supervisor when ISP's are due. Subsequent notices are sent out when the ISP is not completed. The director will be responsible for ensuring that any follow up is completed. Each week ISP's are not completed a new notice is sent to the director requiring action.		

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 clients in the sample (#4 and #6), the facility failed to ensure the clients' comprehensive functional assessments (CFA) were conducted, reviewed annually and updated as needed.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 9/6/13 at 9:01 AM. Client #4's most recent CFA was dated 4/12/12. There was no documentation in client #4's record the CFA was reviewed and updated since 4/12/12.</p> <p>A review of client #6's record was conducted on 9/6/13 at 9:03 AM. Client #6's most recent CFA was dated 6/27/12. There was no documentation in client #6's record the CFA was reviewed and updated since 6/27/12.</p> <p>An interview with the Program Coordinator (PC) was conducted on 9/6/13 at 9:03 AM. The PC indicated client #4 and #6's CFAs had not been updated.</p>	W000259	<p>Plan of Correction: Annually, the interdisciplinary team will complete an individual program plan and functional assessment for each client. A Comprehensive Functional Assessment has been completed for clients #4 and #6 and the Comprehensive Functional Assessments have been completed for client's #4 and #6. Date of Completion: October 10, 2013 Person Responsible: Maxwell Program Coordinator Plan of Prevention: The Program Coordinators have been retrained on the ISP process/annual/admissions process and the regulations surrounding active teaching and training. Quality Assurance Monitoring: There has been a change in management. There is an Interim Supported Group Living Director in place. A new Director for Supported Group Living will be hired. Coordinator will review aspects of the program on a quarterly basis using the Internal Audit Form. Additional Information 10/21/2013W259-What monitoring system is in place? See above notes. The functional assessment is part of the ISP packet and system notifications are sent out when the ISP is not</p>	10/10/2013			

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	<p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>		<p>completed. In addition, the records department notifies the director and the QIDP of missing documentation once packets are turned in. The ISP and assessment packets are turned in upon completion of all documentation.</p>		

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W000260	<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 2 of 3 clients in the sample (#4 and #6), the facility failed to ensure the clients' Individual Support Plans (ISPs) were revised and updated annually.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 9/6/13 at 9:01 AM. Client #4's most recent ISP was dated 4/17/12. There was no documentation in client #4's record indicating his ISP had been revised since 4/17/12.</p> <p>A review of client #6's record was conducted on 9/6/13 at 9:03 AM. Client #6's most recent ISP was dated 6/27/12. There was no documentation in client #6's record the ISP was revised and updated since 6/27/12.</p> <p>An interview with the Program Coordinator (PC) was conducted on 9/6/13 at 9:03 AM. The PC indicated client #4 and #6's ISPs had not been updated.</p> <p>This deficiency was cited on 7/12/13.</p>	W000260	<p>Plan of Correction: Annually, the interdisciplinary team will complete an individual program plan and functional assessment for each client. An Individual Program Plan has been completed for clients #4 and #6. Date of Completion: October 10, 2013 Person Responsible: Maxwell Program Coordinator Plan of Prevention: The Program Coordinators have been retrained on the ISP process/annual/admissions process and the regulations surrounding active teaching and training. Quality Assurance Monitoring: There has been a change in management. There is an Interim Supported Group Living Director in place. A new Director for Supported Group Living will be hired. Coordinator will review aspects of the program on a quarterly basis using the Internal Audit Form. Additional Information 10/21/2013W226/W260-Where did the system fail in that the ISP was not done? Adequate training on the ICF/IDD regulations in general and on the Active Teaching component in particular was not provided to the QIDP initially upon hire. Training took place on 9-20-2013 with the</p>	10/10/2013			

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		Maxwell QIDP which reviewed the standards and elements addressing admissions, 30 day assessments, the development of ISP, and on the monitoring and revising of the ISP. What monitoring procedure is in place to ensure that the deficient practice is not likely to reoccur? The IT department has implemented a system for monitoring and tracking ISP's for each client for each group home. A notice is sent out to the QIDP and the supervisor when ISP's are due. Subsequent notices are sent out when the ISP is not completed. The director will be responsible for ensuring that any follow up is completed. Each week ISP's are not completed a new notice is sent to the director requiring action.		

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4 had an annual physical exam including an evaluation of his vision and hearing.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 9/5/13 at 3:02 PM. Client #4's most recent hearing evaluation was conducted on 6/20/13. The Outside Services Report, dated 6/20/13, indicated, in part, "R (right) non-occluding wax, L (left) occluding wax. Ear wax needs to be removed L and appt (appointment) needs to be rescheduled." The follow-up appointment was scheduled on 7/29/13. On 7/10/13, client #4 had a hearing test. The form indicated, in part, "R restricted eardrum movement. Refer on both ears poss. (possible) middle ear dysfunction. R may have some HL (hearing loss) in high pitches. See Physician to rule out ME (middle ear) dysfunction. Return in 1 month." There was no documentation client #4 was seen by his physician. There was no documentation client #4 returned in one month. Client #4's most</p>	W000323	<p>Plan of Correction: Stone Belt will provide or obtain annual physical examinations of each client that includes at a minimum an evaluation of vision and hearing. Date of Completion: October 10, 2013 Person Responsible: Facility Nurse Plan of Prevention: Staff training was conducted on Stone Belt Policy and Procedure regarding follow through with appointments and required annual medical examinations. Client #4's Guardian does not want the dilation examination completed. She has submitted written documentation of her request. The Program Coordinator has sent this to the Optometrist for review. Quality Assurance Monitoring: House Program Coordinator will review, on a monthly basis, all required physical exams to ensure that they are completed in a timely manner. The Supported Group Living Checklist for Nurses will be completed on a quarterly basis. There has been a change in management. There is an Interim Supported Group Living Director in place. A new Director for Supported Group Living will be hired.</p>	10/10/2013

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	<p>recent vision evaluation was conducted on 4/12/12. The Outside Services Report, dated 4/12/12, indicated, in part, "Dilation at next visit." The form indicated the next appointment was scheduled on 5/10/12. There was no documentation of the visit on 5/10/12. Client #4's most recent annual physical examination was conducted on 4/22/13. Client #4's vision and hearing were not assessed during the annual exam. The annual physical examination form indicated, in the vision and hearing sections, "Unable."</p> <p>An interview with the Program Coordinator (PC) was conducted on 9/6/13 at 9:01 AM. The PC indicated he could not locate the documentation to confirm client #4's hearing and vision were assessed.</p> <p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 3 clients in the sample (#4 and #6), the facility's Licensed Practical Nurse failed to ensure: 1) client #4 had an annual vision and hearing evaluation, 2) client #4's recommendations from physical therapy and speech assessments were obtained, 3) client #6 returned for a dilated vision exam, and 4) client #6's recommendations from an Occupational Therapy assessment were implemented.</p> <p>Findings include:</p> <p>1) A review of client #4's record was conducted on 9/5/13 at 3:02 PM. Client #4's most recent hearing evaluation was conducted on 6/20/13. The Outside Services Report, dated 6/20/13, indicated, in part, "R (right) non-occluding wax, L (left) occluding wax. Ear wax needs to be removed L and appt (appointment) needs to be rescheduled." On 7/10/13, client #4 had a hearing test. The form indicated, in part, "R restricted eardrum movement. Refer on both ears poss. (possible) middle ear dysfunction. R may have some HL (hearing loss) in high pitches. See Physician to rule out ME (middle ear) dysfunction. Return in 1 month." There was no documentation client #4 was seen</p>	W000331	<p>Plan of Correction: Stone Belt will provide or obtain annual physical examinations of each client that includes at a minimum an evaluation of vision and hearing. OT recommendations were obtained and staff have been trained on how to use them. Date of Completion: October 10, 2013 Person Responsible: Facility Nurse Plan of Prevention: Staff training was conducted on Stone Belt Policy and Procedure regarding follow through with appointments and required annual medical examinations. Client #4's Guardian does not want the dilation examination completed. She has submitted written documentation of her request. The Program Coordinator has sent this to the Optometrist for review. Quality Assurance Monitoring: House Program Coordinator will review, on a monthly basis, all required physical exams to ensure that they are completed in a timely manner. The Supported Group Living Checklist for Nurses will be completed on a quarterly basis. There has been a change in management. There is an Interim Supported Group Living Director in place. A new Director for Supported Group Living will be hired. Additional Information</p>	10/10/2013			

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	<p>by his physician. There was no documentation client #4 returned in one month. Client #4's most recent vision evaluation was conducted on 4/12/12. The Outside Services Report, dated 4/12/12, indicated, in part, "Dilation at next visit." The form indicated the next appointment was scheduled on 5/10/12. There was no documentation of the visit on 5/10/12. Client #4's most recent annual physical examination was conducted on 4/22/13. Client #4's vision and hearing were not assessed during the annual exam. The annual physical examination form indicated, in the vision and hearing sections, "Unable."</p> <p>An interview with the Program Coordinator (PC) was conducted on 9/6/13 at 9:01 AM. The PC indicated he could not locate the documentation to confirm client #4's hearing and vision were assessed.</p> <p>An interview with the nurse was attempted on 9/9/13 at 10:06 AM and 12:16 PM. The nurse was unable to be contacted for an interview.</p> <p>2) A review of client #4's record was conducted on 9/6/13 at 9:01 AM. Client #4 had an Augmentative Communication Evaluation conducted on 1/3/13. The report indicated, "A comprehensive eval</p>		10/21/2013W331-What training was done and with whom on following up on medical appointments and recommendations? Training was provided on 9/6/2013 at the SGL departmental meeting to Maxwell staff to review the Medication Pass procedure and locking procedures by the nurse. Training was completed by the nurse on 10/14/2013 with the management staff and staff responsible for completing medical appointments at the home on Assisting with medical appointments, health chart audits, quality assurance checklist for health care, medication security and storage, medication reordering. The medical appointment checklist was reviewed and the medical storage procedure was reviewed and copies were placed with the Med Administration records as a prompt and reminder for staff to utilize during each shift. What monitoring system is in place to ensure the deficient practice does not reoccur? The QIDP does weekly monitoring and ongoing training with staff. A quarterly internal audit will be completed by the QIDP. The nursing staff are out in the home at a minimum of two times per month to observe medication pass and to coach and train as needed.		

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	<p>(evaluation) report to follow." The recommendations, dated 1/18/13, from the evaluation were not in client #4's record. Client #4 had a physical therapy evaluation on 5/24/13. The recommendations from the appointment were not in client #4's record for review.</p> <p>An interview with the PC was conducted on 9/6/13 at 9:01 AM. The PC indicated client #4's physical therapy and speech recommendations were not obtained.</p> <p>An interview with the nurse was attempted on 9/9/13 at 10:06 AM and 12:16 PM. The nurse was unable to be contacted for an interview.</p> <p>3) A review of client #6's record was conducted on 9/6/13 at 9:07 AM. On 11/29/12, client #6 had a vision examination. The Outside Services Report, dated 11/29/12, indicated, "Hyperopia, external ocular health OK, internal health not fully assessed. RTC (return) 1 wk (week) for dilated portion of exam." On 5/17/13, client #6's mother wrote a letter (the letter was not in client #6's record) indicating, "My child [client #6] dob (date of birth) (omitted) was in your eye care center on 11/29/12 for his yearly exam with (name of group home) house staff. The clinic was unsuccessful at getting [client #6] to take the eye drops</p>			

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	<p>given to do his eye exam for glaucoma. The drops were sent home with house staff to try administering at home and they were also unsuccessful. I would like to give my acknowledgement of this. I would like for his exam to be signed off without the drops." There was no documentation in client #6's record indicating the optometrist received the letter or acknowledged the receipt of the letter.</p> <p>An interview with the PC was conducted on 9/6/13 at 9:07 AM. The PC indicated he did not have documentation of the letter the guardian wrote or documentation the optometrist received the letter.</p> <p>An interview with the nurse was attempted on 9/9/13 at 10:06 AM and 12:16 PM. The nurse was unable to be contacted for an interview.</p> <p>4) A review of client #6's record was conducted on 9/6/13 at 9:07 AM. Client #6 had occupational therapy (OT) assessments conducted on 10/22/12 and 6/21/13. The OT assessment, dated 6/21/13, indicated, in part, "[Client #6] demonstrates significant sensory processing difficulties including auditory, oral sensory, smell, proprioception. According to the the (sic) Sensory Profile</p>						

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	Caregiver Questionnaire, [client #6] demonstrates a 'definite difference' for the following areas of sensory processing: Sensory seeking, inattention/distractibility, poor registration, fine motor/perceptual, Multisensory processing, oral sensory, modulation, behavioral outcomes, and thresholds for response. He is under responsive or 'seeking' for most of these areas. In addition, he demonstrates many negative, aggressive (sic) behaviors towards colleagues (sic) such as biting, hitting when over/understimulated." The report indicated, "[Client #6] would benefit from a sensory diet in order to decrease negative behaviors that result from sensory needs...". The Sensory Diet indicated, "Brushing Protocol - utilize sensory brush, perform medial/proximal to lateral/distal brushing strokes on upper and lower extremities (shoulder to wrist, hip to foot) and upper back to lower back. Proprioceptive/Pressure needs - weighted vest or pressure vest, weighted backpack for 'walks' or community outings, brushing protocol - see above, tent or semi-enclosed corner for escape from over stimulating situations, yoga ball for deep pressure input. Oral sensory - electric toothbrush and provide gum or 'chewy foods' - gummie bears, dried fruit, twizzlers, etc. Auditory sensory - headphones for personal music input."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2013
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 MAXWELL ST BLOOMINGTON, IN 47401
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	<p>An interview with the Program Coordinator (PC) was conducted on 9/6/13 at 9:07 AM. The PC indicated none of the recommended items from client #6's Sensory Diet was obtained. The PC indicated the Sensory Diet had not been implemented and no plans were developed to implement the recommendations.</p> <p>An interview with the nurse was attempted on 9/9/13 at 10:06 AM and 12:16 PM. The nurse was unable to be contacted for an interview.</p> <p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			

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W000381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation and interview for 5 of 5 clients (#1, #3, #4, #5 and #6) living in the group home (client #2 was temporarily relocated to another group home due to a mold issue at the home), the facility failed to ensure controlled substances were double locked.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 9/5/13 from 3:46 PM to 5:19 PM. During the observations, the clients' medications were not double locked. The facility had medications stored in the locked front hallway closet (not double locked) and in a medication cart (not double locked). This affected clients #1, #3, #4, #5 and #6.</p> <p>On 9/9/13 at 11:54 AM, the Director sent an email indicating clients #1, #2, #5 and #6 were prescribed controlled substances. Client #1 was prescribed Lorazepam. Client #5 was prescribed Vyvanse. Client #6 was prescribed Temarpam.</p> <p>An interview with the Program Coordinator (PC) was conducted on 9/9/13 at 11:35 AM. The PC indicated the clients' controlled medications should</p>	W000381	<p>Plan of Correction: The medications are being double locked as per Stone Belt Policy. Date of Completion: October 10, 2013 Person Responsible: Maxwell Program Coordinator Plan of Prevention: Stone Belt will ensure all policies surrounding medication administration are followed. Staff have been trained on these policies. Quality Assurance Monitoring: Coordinator will review aspects of medication administration on a quarterly basis using the Internal Audit Form. This will be done with the House Manager and then reviewed by the SGL Director. There has been a change in management. There is an Interim Supported Group Living Director in place. A new Director for Supported Group Living will be hired. There has been a change in management. There is an Interim Group Home Director in place. A new Director for Supported Group Living will be hired. Additional Information 10/21/2013W381-What corrective action has been put in place to ensure the medications are double locked? Just to state it is being done is not enough. Observation and training was completed by the nurse to DSP staff passing medications on</p>	10/10/2013			

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W009999	be double locked. 9-3-6(a)	W009999	9/6/2013 and 10/14/2013. QIDP is providing ongoing support and monitoring as well as nursing staff providing ongoing support and monitoring through visits and the Internal Audit Checklist. Plan of Correction: Stone Belt will ensure that each residential staff shall submit written evidence that a Mantoux tuberculosis skin test, screening or chest x-ray is completed. Date of Completion: October 10, 2013 Person Responsible: Facility Nurse Plan of Prevention: The Facility Nurse will review on a monthly basis all staff trainings and testings to ensure that staff working in the home have the proper training and testing. The individual involved specifically with this citation received a TB Screening on May 19, 2013. Quality Assurance Monitoring: The Facility Nurse will review records provided by the Stone Belt Human Resource Department on a quarterly basis to ensure that all staff have necessary training and testing, including Mantoux assessment or test. The Stone Belt Organizational Effectiveness Coordinator monitors training and testing as well.	10/10/2013	