STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G643	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	1006 W 11TH ST BLOOMINGTON, IN 47404

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W 0000 Bldg. 00	This visit was for a Post Certification Revisit (PCR) to the full recertification and state licensure survey and the investigation of complaint #IN00182639 completed on 2/19/16. Complaint #IN00182639: Not Corrected. Survey Dates: April 21 and 22, 2016 Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/27/16.	W 0000		
W 0157 Bldg. 00	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 3 of 26 incident reports reviewed affecting clients #3, #4 and #6, the facility failed to ensure appropriate	W 0157	**W 157** Staff Treatment of Clients **Corrective action for resident(s) found to have been affected** QIDP will be re-trained	05/22/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	corrective actions were implemented to address medication errors. Findings include: On 4/21/16 at 1:58 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 3/16/16 at 7:00 AM, client #3 received two doses of Abilify 10 mg (milligrams). The 3/17/16 Bureau of Developmental Disabilities Services (BDDS) report indicated, "Physician's order is for [client #3] to be administered Abilify (aripiprazole) 10mg tab; however, staff administered two tabs instead of one... This med error was found during med check. There were no noticeable effects to [client #3] due to this med error." The 3/16/16 Medication Error Report (MER) indicated staff #1 was responsible for the medication error. There was no documentation corrective or disciplinary action was taken with staff #1. The Document Action Taken section was blank. 2) On 3/16/16 at 7:00 AM, client #4 did not receive Risperidone 1 mg as ordered from staff #1. The MER indicated, "No		in corrective action policy and procedure Moreover, QIDP will be monitored by Director, weekly to ensure corrective actions are being completed **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Director will meet with QIDP and house staff weekly to ensure all incidents including medication errors are reviewed and corrective action is completed **How corrective actions will be monitored to ensure no recurrence** Director(or designee) will meet with QIDP weekly to review all incident reports including all medication errors and corrective actions.	

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	discernible effects are noted." The 3/16/16 MER's Document Action Taken section was blank. There was no documentation corrective or disciplinary action was taken with staff #1. 3) On 2/26/16 at 9:00 PM, staff #11 failed to administer client #6's Levothyroxine 125 microgram as ordered for low thyroid. The 2/27/16 MER indicated in the Document Action Taken section, "Verbal discussion/Training." There was no signature on the form indicating who the supervisor was providing the verbal discussion/training. The signature section was blank. On 4/21/16 at 3:48 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated there was no documentation corrective actions were implemented for the medication errors. On 4/22/16 at 1:36 PM, the Nurse Manager (NM) indicated monitoring was a piece of the process to eliminate medication errors. The NM indicated the facility needed to ensure corrective/disciplinary actions were implemented with the staff following medication errors.			

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	This deficiency was cited on 2/19/16. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint #IN00182639. 9-3-2(a)			
W 0260 Bldg. 00	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. Based on record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5's individualized program plan was reviewed and revised at least annually. Findings include: On 4/21/16 at 3:27 PM, a review of client #5's record was conducted. Client #5's most recent individual program plan (IPP) was dated 12/15/14. There was no documentation in client #5's record indicating his program plan was revised	W 0260	W 260 Program Monitoring and Change **Corrective action for resident(s) found to have been affected** QIDP will be re-trained in Individual Program Planning. Moreover, QIDP will be monitored by Director, weekly to ensure IPP schedule for all clients is being followed **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no**	05/22/2016

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	and updated annually. On 4/21/16 at 3:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #5's IPP had not been reviewed/revised since 12/15/14. The QIDP indicated the IPP meeting had not been held and his plan had not been reviewed since 12/15/14. This deficiency was cited on 2/19/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		**recurrence** Director will meet with QIDP weekly to ensure all ensure IPP schedule for all clients is being followed **How corrective actions will be monitored to ensure no recurrence** Director(or designee) will meet with QIDP weekly to ensure all ensure IPP schedule for all clients is being followed	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 5 of 6 clients living in the group home (#2, #3, #4, #5 and #6), the facility's nursing services failed to ensure staff administered the clients' medications according to the physician's orders. Findings include: On 4/21/16 at 1:58 PM, a review of the facility's incident/investigative reports was conducted and indicated the	W 0331	W 331 Nursing Services **Corrective action for resident(s) found to have been affected** Nursing staff and QIDP will monitor medication administration weekly at least 4(2 supervised medication passes each)times a week, until 2 weeks of zero medication errors, then QIDP will continue monitoring medication passes 2 times a week until 2 weeks of zero medication errors. Moreover, QIDP will be monitored by Director, weekly to ensure	05/22/2016

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	following: 1) On 4/8/16 at 2:00 PM, staff #8 failed to administer client #2's medications as prescribed. Staff #8 failed to administer client #2's Divalproex Sprinkles (8) 125 milligrams (mg) for seizures and Levocartin 300 mg (nutritional supplement). The error was discovered on 4/9/16 during the morning shift. The 4/9/16 Medication Error Report (MER) indicated, in part, "[Staff #8] failed to check with [client #2's] dedicated staff upon relieving him... Monitor [client #2] and report and unusual medical condition, especially seizures... What effect did the error have on the client ? Apparently none. No seizure activity overnight." 2) On 3/16/16 at 7:00 AM, client #3 received two doses of Abilify 10 mg (bipolar). The 3/17/16 Bureau of Developmental Disabilities Services (BDDS) report indicated, "Physician's order is for [client #3] to be administered Abilify (aripiprazole) 10mg tab; however, staff administered two tabs instead of one... This med error was found during med check. There were no noticeable effects to [client #3] due to this med error." 3) On 3/16/16 at 7:00 AM, client #4 did		corrective actions are being completed and visits are being made **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Director will meet with QIDP and nursing staff to ensure all supervised medication monitoring is taking place **How corrective actions will be monitored to ensure no recurrence** Director(or designee) will meet with QIDP weekly to review all incident reports including all medication errors and corrective actions and supervised medication administration	

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	not receive Risperidone 1 mg (agitation) as ordered from staff #1. The MER indicated, "No discernible effects are noted." 4) On 3/3/16, 3/4/16, 3/5/16, 3/6/16, 3/7/16 and 3/8/16 at 8:00 AM, client #5 received Seroquel 200 mg (anxiety/agitation) instead of 300 mg. The MER indicated, "No adverse effects noted." Staff #2 committed the medication errors on 3/5/16 and 3/6/16. Staff #9 committed the medication errors on 3/3/16, 3/4/16 and 3/8/16. Staff #10 committed the medication error on 3/7/16. 5) On 2/26/16 at 9:00 PM, staff #11 failed to administer client #6's Levothyroxine 125 microgram (hypothyroid) as ordered. On 4/22/16 at 1:36 PM, the Nurse Manager (NM) indicated the staff should administer the clients' medications as ordered by their physicians. The NM indicated during his monitoring and observations of medication passes, there have been no errors by the staff. The NM indicated the errors occur at times when the staff were not being monitored. The NM indicated he instructed the staff to administer medications as if they were being monitored by the nurse or			

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	administrative staff. The NM indicated he created a sheet for the staff to review during the medication pass. The NM indicated he was currently monitoring the clients' medication administration two times a week. The NM indicated monitoring was a piece of the process to eliminate medication errors. The NM indicated the facility needed to ensure corrective actions were implemented with the staff following medication errors. On 4/22/16 at 2:28 PM, the NM indicated the medication errors involving client #5's Seroquel were due to the staff not sending in client #5's previously ordered 200 mg bubble package of the Seroquel. The NM indicated client #5's Seroquel was increased from 200 mg to 300 mg by his psychiatrist recently. The NM indicated the staff should have ensured the 200 mg bubble packs were removed from the group home when the medication dosage changed. The NM indicated this was not completed. When the 300 mg package was empty, the staff found the 200 mg package and started passing 200 mg instead of 300 mg of Seroquel. The NM indicated if the staff compared the packaging label with the Medication Administration Record, the medication errors would have been avoided. The NM indicated the staff should also be conducted buddy checks			

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	following medication administration. The NM indicated if the staff conducting the buddy check compared the packaging label to the MAR, the medication errors would have been discovered sooner or avoided. This deficiency was cited on 2/19/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 5 of 6 clients living in the group home (#2, #3, #4, #5 and #6), the facility failed to ensure staff administered the clients' medications according to the physician's orders. Findings include: On 4/21/16 at 1:58 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:	W 0368	W 368 Drug Administration **Corrective action for resident(s) found to have been affected** Nursing staff and QIDP will monitor medication administration weekly at least 4(2 supervised medication passes each)times a week, until 2 weeks of zero medication errors, then QIDP will continue monitoring medication passes 2 times a week until 2 weeks of zero medication errors. Moreover, QIDP will be monitored by Director, weekly to ensure corrective actions are being	05/22/2016

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	1) On 4/8/16 at 2:00 PM, staff #8 failed to administer client #2's medications as prescribed. Staff #8 failed to administer client #2's Divalproex Sprinkles (8) 125 milligrams (mg) for seizures and Levocartin 300 mg (nutritional supplement). The error was discovered on 4/9/16 during the morning shift. The 4/9/16 Medication Error Report (MER) indicated, in part, "[Staff #8] failed to check with [client #2's] dedicated staff upon relieving him... Monitor [client #2] and report and unusual medical condition, especially seizures... What effect did the error have on the client ? Apparently none. No seizure activity overnight." 2) On 3/16/16 at 7:00 AM, client #3 received two doses of Abilify 10 mg (bipolar). The 3/17/16 Bureau of Developmental Disabilities Services (BDDS) report indicated, "Physician's order is for [client #3] to be administered Abilify (aripiprazole) 10mg tab; however, staff administered two tabs instead of one... This med error was found during med check. There were no noticeable effects to [client #3] due to this med error." 3) On 3/16/16 at 7:00 AM, client #4 did not receive Risperidone 1 mg (agitation)		completed and visits are being made **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Director will meet with QIDP and nursing staff to ensure all supervised medication monitoring is taking place **How corrective actions will be monitored to ensure no recurrence** Director(or designee) will meet with QIDP weekly to review all incident reports including all medication errors and corrective actions and supervised medication administration visits	

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	as ordered from staff #1. The MER indicated, "No discernible effects are noted." 4) On 3/3/16, 3/4/16, 3/5/16, 3/6/16, 3/7/16 and 3/8/16 at 8:00 AM, client #5 received Seroquel 200 mg (anxiety/agitation) instead of 300 mg. The MER indicated, "No adverse effects noted." Staff #2 committed the medication errors on 3/5/16 and 3/6/16. Staff #9 committed the medication errors on 3/3/16, 3/4/16 and 3/8/16. Staff #10 committed the medication error on 3/7/16. 5) On 2/26/16 at 9:00 PM, staff #11 failed to administer client #6's Levothyroxine 125 microgram (hypothyroid) as ordered. On 4/22/16 at 1:36 PM, the Nurse Manager (NM) indicated the staff should administer the clients' medications as ordered by their physicians. The NM indicated during his monitoring and observations of medication passes, there have been no errors by the staff. The NM indicated the errors occur at times when the staff were not being monitored. The NM indicated he instructed the staff to administer medications as if they were being monitored by the nurse or administrative staff. The NM indicated			

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	he created a sheet for the staff to review during the medication pass. The NM indicated he was currently monitoring the clients' medication administration two times a week. The NM indicated monitoring was a piece of the process to eliminate medication errors. The NM indicated the facility needed to ensure corrective actions were implemented with the staff following medication errors. This deficiency was cited on 2/19/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			