STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G655		09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	2606 H ST BEDFORD, IN 47421

(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
W 0000 Bldg. 00	This visit was for a fundamental recertification and state licensure survey. Survey Dates: September 9, 10, 11, 12, 16 and 17, 2015 Facility Number: 001166 Provider Number: 15G655 AIM Number: 100445440 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/22/15.	W 0000		
W 0149 Bldg. 00	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 23 incident/investigative reports reviewed affecting clients #2, #3, #5 and #6, the facility neglected to implement its policies and procedures to prevent abuse of the clients. Findings include: On 9/10/15 at 1:24 PM, a review of the	W 0149	W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS Plan of Correction: Day program and facility staff trained onimplement written policies and procedures that prohibitmistreatment, neglect or abuse of the client. Including incidents of client onclient abuse (attachment a). Plan of Prevention: Day program	10/02/2015

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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	facility's incident/investigative reports was conducted and indicated the following: 1) On 8/24/15 at 2:30 PM at the facility-operated day program, client #6 shoved a peer on her left arm. Client #6 told the peer he was going to kill her. After the incident was over, another peer indicated client #6 hit her right knee cap when he jumped up to shove a peer. On 9/16/15 at 12:17 PM, the Program Coordinator (PC) indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the clients. 2) On 8/18/15 at the facility-operated day program, client #6 was sitting at a table looking at a binder. A peer attempted to look at the binder. Client #6 yelled at the peer and pushed him. On 9/16/15 at 12:17 PM, the PC indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the clients. 3) On 8/5/15 at 8:00 AM, client #5		and facility coordinators trainedon implement written policies and procedures that prohibitmistreatment, neglect or abuse of the client. Including incidents of client onclient abuse (attachment b). Plan of Monitoring: QIDP will provide weekly monitoring of dayprogram and facility to ensure staff are preventing abuse and neglect. Manager will provide daily monitoring to ensurestaff are preventing abuse and neglect (attachment c).	

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	slapped client #3 on the right upper arm as he was getting into the van. Client #3's arm had a small red mark from the slap. On 9/16/15 at 12:17 PM, the PC indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the clients. 4) On 6/30/15 at 8:00 AM (former staff #10 self-reported the incident to the facility on 7/9/15), client #5 did not go on transport to the day program due to having a doctor's appointment. Client #5 stayed at the home with former staff #10. Client #5 stated, "Buck roo" and "hit [first name of staff #10]." Staff #10 ignored client #5's statements for a few minutes. Client #5 stood up off the couch and said "hit [first name of staff #10]." Client #5 tripped on the foot stool. Staff #10 caught client #5 by the left arm and lowered him to the floor. Staff #10 lifted client #5 off the floor and held client #5's arm behind his back to escort him to the mat and client #5 fought against staff #10. Staff #10 was suspended. The investigation, dated 7/13/15, indicated in staff #10's statement,			

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	"According to [staff #10] the incident occurred when [staff #10] had stayed at the house with [client #5]. At which time [client #5] started to say 'Hit [Staff #10]' and 'Buck Roo,' which are indicators of a possible behavior. [Client #5] got up from the couch he was sitting on to come after [staff #10] on another couch. As [client #5] came toward [staff #10] he tripped over the foot stool and started to fall. [Staff #10] jumped up and grab (sic) [client #5's] arm; during which time [staff #10] brought [client #5's] arm up behind his back. During this time [staff #10] stated that 'He held the arm behind [client #5] and moved him toward the matt (sic) to calm down.' As I spoke with [staff #10] about the incident he had confirmed that he understood the hold was not appropriate. He also stated he had recently been under stress at home over personal things. During the interview [staff #10] stated 'I know I messed up and what I did was wrong.' I, [Program Coordinator], suspended [staff #10] and filed an incident report. It was determined that [staff #10] had used an inappropriate hold and needed to go through training for CPI (Crisis Prevention Institute) and be retrained on [client #5's] BSP (behavior support plan). It was also determined that [staff #10] could use EAP (employee assistance program) for stress. After four days off I			

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	spoke with [staff #10] again on July 13th, 2015 about these options. [Staff #10] resigned from his position after signing a Written warning for the incident." The investigation indicated, "It has been founded (sic) that [staff #10] was under stress and performed a restraint that could have resulted in [client #5] being injured. He failed to report incident to administration within a timely manner and refused to seek EAP or retraining of CPI and BSP. He voluntarily resigned in lieu of seeking assistance with his stress level and training. This is a violation of Stone Belt policy and regulations. IV. Allegation substantiated, not substantiated or inconclusive: Substantiated. [Staff #10] admitted using an unauthorized restraint with [client #5]. V. Recommendation of Corrective Action including date for completion and responsible party by name: [Staff #10] denied training and EAP assistance for his stress and resigned." On 9/10/15 at 2:10 PM, the Program Coordinator (PC) indicated former staff #10 used an unapproved restraint on client #5. The PC indicated staff #10 held client #5's arm behind his back. The PC indicated client #5 was not injured. The PC stated staff #10 "felt bad" and quit. The PC indicated staff #10 resigned at the conclusion of the investigation.			

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	The PC indicated staff #10 failed to immediately report the incident to the administrator. 5) On 6/12/15 at 1:50 PM at the facility-operated day program, client #3 hit client #2 repeatedly in the face. Client #2 was not injured. On 9/16/15 at 12:17 PM, the PC indicated client to client aggression was abuse and the facility should prevent abuse. The PC indicated the facility had a policy and procedure prohibiting abuse of the clients. On 9/10/15 at 1:15 PM, 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			

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	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... ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events." The Human Rights Policy, dated 2/17/14, indicated, in part, "Physical abuse: Consists of any intentional and/or punitive physical action or motion by which physical harm or emotional trauma may occur." 9-3-2(a)			

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W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 2 of 3 clients in the sample (#4 and #6), the facility failed to ensure the clients were assessed within 30 days after admission to the facility. Findings include: On 9/11/15 at 10:00 AM, a review of client #4's record was conducted. Client #4 was admitted to the facility on 8/29/14. There was no documentation in client #4's record indicating the facility conducted a comprehensive functional assessment within 30 days after client #4 was admitted to the group home. On 9/11/15 at 10:40 AM, a review of client #6's record was conducted. Client #6 was admitted to the group home on 8/25/14. There was no documentation in client #6's record indicating the facility conducted a comprehensive functional assessment within 30 days after client #6 was admitted to the group home.	W 0210	W 210 483.440(c)(3) INDIVIDUAL PROGRAMPLAN Within 30 days after admission, the interdisciplinary team must performaccurate assessments or reassessments as neededto supplement the preliminary evaluationconducted prior to admission. Plan of correction: Individual assessment completed and reviewedwith interdisciplinary team located in Fortis database. Plan of prevention: QIDP trained on completing assessments priorand within 30 days of admission (attachment e). Plan of monitoring: Internal audits will be completed on clientrecords quarterly to ensure assessments are completed and appropriatelycompleted (attachment f).	10/02/2015

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	On 9/16/15 at 12:17 PM, the Program Coordinator (PC) indicated she did not conduct a comprehensive functional assessment for clients #4 and #6 within 30 days after the clients were admitted to the group home. The PC stated, "did not find in the admission papers." 9-3-4(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 observation, interview and record review for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1 received his medications in accordance with his physician's orders. Findings include: An observation was conducted at the group home on 9/9/15 from 6:15 AM to 7:54 AM. At 6:41 AM, a cup with three pills was observed to be sitting on top of the refrigerator in the office. Staff #8 indicated the pills may be from the previous evening. At 7:11 AM, staff #8 indicated the three pills were client #1's medications from the previous evening. Staff #8 indicated the pills matched client #1's bedtime medications in color, size	W 0368	Stone Belt received an addendum letter dated 10/7/15 that described how W 368 was not approved and needed to be edited. Below is the edited item. An additional POC cover sheet dated 10/12/15 was uploaded as well. It is signed by Jim Wiltz who is a Director with Stonebelt / Milestones because the facility Director (LH) is on PTO. W 368 483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Plan of correction: Staff who failed to administer medication as prescribed by physician's orders received a medication and performance action per Stone Belt core a and b policy. Plan of prevention: Staff will complete	10/17/2015

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	and markings. Staff #8 showed the surveyor the medication packaging for the three medications to confirm the pills were client #1's medications and the pills matched the size, color and markings of the pills found on the top of the refrigerator. Staff #8 indicated the Home Manager (HM) administered the medications on 9/8/15. Staff #8 indicated the HM initialed the Medication Administration Record (MAR) indicating the medications had been administered. Staff #8 stated, "that would be a med error." On 9/9/15 at 7:11 AM, client #1's September 2015 MAR for HS (hour of sleep) was initialed by the HM as administered. On 9/11/15 at 9:17 AM, client #1's Physician's Orders, dated 6/8/15, indicated he was to receive Omeprazole (gastroesophageal reflux disease), Calcium (supplement) and Tamsulosin (enlarged prostate) at bedtime. On 9/10/15 at 2:02 PM, the HM stated, "I got busy and forgot to administer [client #1's] pills to him." The HM indicated he called for client #1 to come to the medication area but client #1 did not come to the medication area. The HM indicated he signed the MAR prior to		medication administration training as scheduled by facility nurses. This includes both the individual staff member who made the error as well as the other staff members in the home. Plan of monitoring: The facility nurse and QIDP will work together to provide coordinated health care at the facility. The nurse will take the lead role on medication administration compliance, including monthly check in of medications where the MAR is compared to physician orders for accuracy. The QIDP will complete weekly medication administration observations. The QIDP will notify the nurse when medication errors occur, and the nurse will retrain staff members, as needed, to address medication errors.	

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	administering client #1's medications. The HM stated, "I never do that." The HM indicated it was a medication error. 9-3-6(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift. Findings include: On 9/10/15 at 3:40 PM, a review of the facility's evacuation drills was conducted and indicated the following: During the day shift (6:00 AM to 2:00 PM), the facility failed to conduct quarterly evacuation drills from 10/12/14 to 7/26/15. During the night shift (10:00 PM to 6:00 AM), the facility failed to conduct quarterly evacuation drills from 9/28/14 to 3/26/15. This affected clients #1, #2, #3, #4, #5 and #6. On 9/11/15 at 9:44 AM, the Group Home Director (GHD) indicated the facility should conduct one evacuation drill per	W 0440	W 440 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuationdrills at least quarterly for each shift of personnel. Plan of correction: Facility Manager trained on facilitatingdrills quarterly for each staff for each shift (attachment g). Plan of prevention: Facility manager will implement fire drillschedule and keep a copy of each drill in the house (attachment h). Plan of monitoring: QIDP will reviewdrills and monitor they are completed and copies kept in the house (attachmenti).	10/02/2015

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	shift per quarter. The GHD indicated the Home Manager received emails from the administrative staff reminding him to conduct the drills. The GHD stated, "[Name of Home Manager] dropped the ball." 9-3-7(a)			
W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1(a) Governing Body (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: 15. A fall resulting in injury, regardless of the severity of the injury. This state rule was not met as evidenced by: Based on record review and interview for	W 9999	460 IAC 9-3-1(a) Governing Body (b) The residential provider shallreport the following circumstances to the divisionby telephone no later than the firstbusiness day. Plan of correction: QIDP and day program coordinator will reportany fall with injury as required by state regulation. Plan of prevention: Facility staff and QIDP trained to report anyfall with injury as required by state regulation (attachment j). Plan of monitoring: Program director will review internal IRs toensure all BDDS reports are filed within 24 hour deadline (attachment k).	10/02/2015

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	1 of 23 incident reports reviewed affecting client #5, the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law, a fall resulting in injury of client #5. Findings include A review of the facility's incident/investigative reports was conducted on 9/10/15 at 1:24 PM and indicated the following: On 8/17/15 at 5:50 PM, client #5 stood up from the couch, fell down and received a rug burn on his left arm. There was no documentation the facility reported the fall with injury to BDDS. On 9/16/15 at 12:17 PM, the Program Coordinator (PC) indicated the fall with injury was not reported to BDDS. The PC indicated a fall with injury was not reportable to BDDS if the injury did not require more than first aid. 9-3-1(b)			