

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/26/2012
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 214 E SOUTHERN DR BLOOMINGTON, IN 47401
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W0000	<p>This visit was for the investigation of complaint #IN00119804.</p> <p>Complaint #IN00119804 - Substantiated, Federal/state deficiencies related to the allegation are cited at W149 and W154.</p> <p>Survey Dates: November 20 and 26, 2012.</p> <p>Facility Number: 001210 Provider Number: 15G637 AIM Number: 100240200</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on November 30, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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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W0149	<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 19 incident/investigative reports reviewed for 5 of 6 clients living in the group home affecting clients A, C, D, E and F, the facility neglected to implement its policies and procedures to prevent client to client abuse, investigate a fall resulting in fractures, investigate client to client abuse and staff failed to report a red area to the nurse timely resulting in a stage 1 pressure ulcer to client A.</p> <p>Findings include: A review of the facility's incident/investigative reports was conducted on 11/20/12 at 11:53 AM. 1) On 11/13/12 at 6:00 AM, the facility's Bureau of Developmental Disabilities Services (BDDS) report, dated 11/14/12, indicated, "[Client C] had begun her morning routine and was in the living room pacing back and forth. [Client C] had on her helmet, gait belt and braces on her feet per her fall risk plan. While [client C] was walking she had a drop seizure and fell down on top of her right leg and then fell forward hitting her upper lip area on the carpet. [Client C's] seizure ceased and she was coherent shortly after. Staff witnessed the fall and immediately went to assist [client C] in getting up.</p>	W0149	<p>W 149</p> <p>GOVERNING BODY & MANAGEMENT</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that specific governing body and management requirements are met. Specifically, Stone Belt will ensure that policies and procedures that prohibit mistreatment, abuse and neglect are followed.</p> <p>Responsible Person:</p> <p>Southern House Coordinator & SGL Director</p> <p>Date of Completion:</p>	12/26/2012			

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	[Client C] complained of pain in her right ankle/lower leg. Staff assisted [client C] to the couch where she elevated her leg and staff assessed the area. [Client C] said it hurt when she attempted to put weight on the foot. Staff administered basic first aid to the rug burn area on [client C's] upper lip/nose area as well as applied ice to her lower leg. Staff then called the emergency pager and were instructed to take [client C] to the walk in clinic to be seen by a physician. [Client C] was taken to [name of local walk-in clinic] where she had x-rays of her right lower leg. It was determined that [client C] had broken both bones in her lower right leg. The walk-in clinic instructed staff to take [client C] to the [name of hospital] for further treatment. [Client C] was assessed in the emergency department and it was determined that she would need surgery to correct the fractures in her leg. [Client C] was admitted to [name of hospital]. [Client C's] surgery will be performed by Orthopedic Surgeon [name of physician] on Wednesday (November 14, 2012) in the afternoon. While in the emergency department [client C] was also seen by a neurologist, [name of physician] who ordered an EEG (Electroencephalography) as well as a MRI (Magnetic resonance imaging) to check on the status of the benign tumor in		December 26, 2012 Plan of Prevention: House Staff were retrained on Stone Belt's policy of prevention of abuse and neglect, including the definition of both.(Attachment # 1 and # 1A). All SGL staff will be retrained on the policy prohibiting Abuse and Neglect at the monthly inservice on January 4, 2013. Client specific issues included the training of house staff on the post operation/fracture risk plan on client. (Attachment # 2). Quality Assurance Monitoring: Training staff on Stone Belt's policy of prevention of abuse and neglect will continue as needed with current staff and covered during initial staff orientation of new hires. Administrative staff will make unannounced visits at Maxwell House to ensure that the		

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	<p>her frontal lobe which is the cause of her seizures. The Hospital Neurologist will keep in contact with [client C's] primary neurologists to determine further treatment for the seizures. [Client C's] team is having an emergency meeting on Friday, after learning of the conditions of her release from the hospital. [Client C's] team will put a post-op fall risk plan in place and add appropriate safety measures to ensure that [client C] is kept healthy and safe at all times. [Client C's] team will ensure that she follows up with all physician's orders and appointments as instructed." The facility did not provide documentation the incident was investigated.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 11/20/12 at 12:41 PM. AS #1 indicated the facility did not conduct an investigation of client C's fall resulting in fractures. AS #1 indicated there was no investigation since staff was present and the facility knew what occurred. AS #1 indicated the physician indicated there was no concern with the fractures so an investigation was not conducted.</p> <p>2) On 11/12/12 at 1:00 PM, client A was found to have a pressure wound on her right ankle from braces connected to her shoes. The wound was approximately 2.5 centimeters (cm) by 2.5 cm. The wound was on the bony prominence of her ankle.</p>		<p>health and safety of the clients is being monitored.</p> <p>Nursing Manager will update and review Nursing Protocol on an on-going basis.</p>				

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	<p>The skin was red and not broken. The nurse assessed the wound and confirmed a stage 1 pressure ulcer. The report indicated client A's foot pedals were broken on her wheelchair which prevented her from moving her feet around. The facility did not provide documentation an investigation was conducted.</p> <p>A review of the facility's emails related to client A's pressure ulcer were reviewed on 11/20/12 at 2:28 PM. On 11/20/12 at 4:58 PM, the Director of Nursing sent an email to staff #1, Program Coordinator, AS #1, the group home nurse, and staff #6. The email indicated, in part, "[Client A] stated she told her house staff last week. [Name of social worker] told [name of group home nurse] about it this morning. I just happened to be going over before anyone else, so I checked her out. The person she told last week is the person that was responsible for reporting it. [Name of group home nurse] should have been made aware of it then. Get with [name of Program Coordinator] and [name of AS #1] to find out what they want you to do at this point. We are already late in reporting this to the State. Ask them how best to handle the situation. Thanks for your help, and please, going forward, keep the nurses posted when thing (sic) like this happens." The Program Coordinator</p>						

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	<p>replied on 11/12/12 at 5:05 PM and indicated, in part, "From what [name of staff #1] said it just seemed to be a slight red mark on Thursday when she saw it. [Client A] had not said anything to staff since then about the area or it causing her discomfort, to my knowledge." The group home nurse responded, on 11/20/12 at 5:24 PM, in part, "Its (sic) not so much assessing every red mark, its (sic) more of the nurses teaching staff what are pressure sores and when one is suspected what to do to keep if from getting worse. Pressure sore is any redness or break in the skin caused by too much pressure on your skin for too long a period of time." An interview with staff #1 was conducted on 11/26/12 at 2:46 PM. Staff #1 indicated client A informed her of the injury while staff #1 was assisting client A in the shower. Staff #1 indicated client A's ankle was slightly pink in color and she put a Band-aid on it. Staff #1 indicated she did not inform the nursing staff. An interview with the nurse was conducted on 11/20/12 at 1:51 PM. The nurse indicated staff #1 did not notify nursing about the wound when it was first discovered a week before it was assessed by the Director of Nursing. Staff #1 who initially discovered the wound put a Band-Aid on the sore but did not do anything to relieve the pressure. The</p>						

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	<p>nurse indicated nursing staff found out about the wound after client A informed the social worker who then notified nursing staff. The nurse indicated when she was informed she contacted the Director of Nursing who then assessed the area on 11/12/12. The nurse indicated the group home staff were retrained on what to report to nursing. The nurse indicated staff #1 should have reported the red area to nursing staff when she first discovered the red area.</p> <p>An interview with the Director of Nursing (DON) was conducted on 11/26/12 at 1:42 PM. The DON indicated while assessing client A's wound, client A told the DON that client A informed staff #1 of the wound "last week." The DON indicated it was either Wednesday or Thursday when client A informed staff #1. Client A indicated to the DON that staff #1 put a Band-aid on the wound. The DON indicated staff #1 should not have put a Band-aid on the wound and should have contacted the nursing staff. The DON indicated staff #1 should have removed the pressure and padded the area.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 11/20/12 at 12:41 PM. AS #1 indicated the facility did not conduct an investigation of the pressure ulcer. AS #1 indicated the nurse assessed the area and determined the</p>				

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	<p>cause. On 11/26/12 at 1:23 PM, AS #1 indicated he was not aware there was an issue with staff failing to report the pressure wound to nursing.</p> <p>3) On 11/10/12 at 3:45 PM, clients D and F were in the living room watching television. Client F told client D to "turn around, shut up." Client D walked over to client F and hit her on the left thigh with an open palm.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 11/20/12 at 12:41 PM. AS #1 indicated client to client abuse should be prevented. AS #1 indicated the staff should follow the policy and prevent client to client abuse from occurring.</p> <p>4) On 9/28/12 at 7:25 AM, client D entered the kitchen and told client F to shut up. Client F reacted by "rushing" after client D and slapping her on the back. Client D was able to reach around staff and scratched client F on the right forearm. Client F's scratches required first aid. The facility did not provide documentation the incident was investigated.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 11/20/12 at 12:41 PM. AS #1 indicated client to client abuse should be prevented. AS #1 indicated the staff should follow the policy and prevent client to client abuse from occurring. AS #1 indicated the</p>						

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	<p>facility should investigate client to client abuse.</p> <p>5) On 9/12/12 at 5:00 PM, client F told client E to shut up and client E ignored client F. Client E walked across the kitchen and was "about 2 steps" from client F. Client F stepped forward and slapped client E on the left arm. Client E tipped over to her right side and hit her upper right side on another client's wheelchair.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 11/20/12 at 12:41 PM. AS #1 indicated client to client abuse should be prevented. AS #1 indicated the staff should follow the policy and prevent client to client abuse from occurring.</p> <p>A review of the facility's abuse and neglect policy, dated 10/17/11, was conducted on 11/20/12 at 12:56 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."</p>				

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	<p>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." This federal tag relates to complaint #IN00119804. 9-3-2(a)</p>				

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W0154	<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 4 of 6 clients living in the group home (A, C, D and F), the facility failed to conduct a thorough investigation of client to client abuse, a fall resulting in fractures and a stage 1 pressure ulcer to client A.</p> <p>Findings include: A review of the facility's incident/investigative reports was conducted on 11/20/12 at 11:53 AM.</p> <p>1) On 11/13/12 at 6:00 AM, the facility's Bureau of Developmental Disabilities Services (BDDS) report, dated 11/14/12, indicated, "[Client C] had begun her morning routine and was in the living room pacing back and forth. [Client C] had on her helmet, gait belt and braces on her feet per her fall risk plan. While [client C] was walking she had a drop seizure and fell down on top of her right leg and then fell forward hitting her upper lip area on the carpet. [Client C's] seizure ceased and she was coherent shortly after. Staff witnessed the fall and immediately went to assist [client C] in getting up. [Client C] complained of pain in her right ankle/lower leg. Staff assisted [client C] to the couch where she elevated her leg</p>			W0154	<p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that all allegations are investigated thoroughly.</p> <p>Date of Completion</p> <p>December 26, 2012</p> <p>Responsible Person</p> <p>Southern Coordinator/SGL Director</p>		12/26/2012

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	and staff assessed the area. [Client C] said it hurt when she attempted to put weight on the foot. Staff administered basic first aid to the rug burn area on [client C's] upper lip/nose area as well as applied ice to her lower leg. Staff then called the emergency pager and were instructed to take [client C] to the walk in clinic to be seen by a physician. [Client C] was taken to [name of local walk-in clinic] where she had x-rays of her right lower leg. It was determined that [client C] had broken both bones in her lower right leg. The walk-in clinic instructed staff to take [client C] to the [name of hospital] for further treatment. [Client C] was assessed in the emergency department and it was determined that she would need surgery to correct the fractures in her leg. [Client C] was admitted to [name of hospital]. [Client C's] surgery will be performed by Orthopedic Surgeon [name of physician] on Wednesday (November 14, 2012) in the afternoon. While in the emergency department [client C] was also seen by a neurologist, [name of physician] who ordered an EEG (Electroencephalography) as well as a MRI (Magnetic resonance imaging) to check on the status of the benign tumor in her frontal lobe which is the cause of her seizures. The Hospital Neurologist will keep in contact with [client C's] primary		<p>Plan of Prevention</p> <p>The Coordinators reviewed and completed training on Stone Belt investigation procedures. (Attachment # 3 and # 3A). This included how to conduct proper investigations and who should be interviewed.</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure, after reviewing the incident, that investigations will be completed thoroughly.</p>		

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	<p>neurologists to determine further treatment for the seizures. [Client C's] team is having an emergency meeting on Friday, after learning of the conditions of her release from the hospital. [Client C's] team will put a post-op fall risk plan in place and add appropriate safety measures to ensure that [client C] is kept healthy and safe at all times. [Client C's] team will ensure that she follows up with all physician's orders and appointments as instructed." The facility did not provide documentation the incident was investigated.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 11/20/12 at 12:41 PM. AS #1 indicated the facility did not conduct an investigation of client C's fall resulting in fractures. AS #1 indicated there was no investigation since staff was present and the facility knew what occurred. AS #1 indicated the physician indicated there was no concern with the fractures so an investigation was not conducted.</p> <p>2) On 11/12/12 at 1:00 PM, client A was found to have a pressure wound on her right ankle from braces connected to her shoes. The wound was approximately 2.5 centimeters (cm) by 2.5 cm. The wound was on the bony prominence of her ankle. The skin was red and not broken. The nurse assessed the wound and confirmed a stage 1 pressure ulcer. The report</p>						

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	<p>indicated client A's foot pedals were broken on her wheelchair which prevented her from moving her feet around. The facility did not provide documentation an investigation was conducted.</p> <p>A review of the facility's emails related to client A's pressure ulcer were reviewed on 11/20/12 at 2:28 PM. On 11/20/12 at 4:58 PM, the Director of Nursing sent an email to staff #1, Program Coordinator, AS #1, the group home nurse, and staff #6. The email indicated, in part, "[Client A] stated she told her house staff last week. [Name of social worker] told [name of group home nurse] about it this morning. I just happened to be going over before anyone else, so I checked her out. The person she told last week is the person that was responsible for reporting it. [Name of group home nurse] should have been made aware of it then. Get with [name of Program Coordinator] and [name of AS #1] to find out what they want you to do at this point. We are already late in reporting this to the State. Ask them how best to handle the situation. Thanks for your help, and please, going forward, keep the nurses posted when thing (sic) like this happens." The Program Coordinator replied on 11/12/12 at 5:05 PM and indicated, in part, "From what [name of staff #1] said it just seemed to be a slight</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 214 E SOUTHERN DR BLOOMINGTON, IN 47401
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	<p>red mark on Thursday when she saw it. [Client A] had not said anything to staff since then about the area or it causing her discomfort, to my knowledge." The group home nurse responded, on 11/20/12 at 5:24 PM, in part, "Its (sic) not so much assessing every red mark, its (sic) more of the nurses teaching staff what are pressure sores and when one is suspected what to do to keep if from getting worse. Pressure sore is any redness or break in the skin caused by too much pressure on your skin for too long a period of time." An interview with staff #1 was conducted on 11/26/12 at 2:46 PM. Staff #1 indicated client A informed her of the injury while staff #1 was assisting client A in the shower. Staff #1 indicated client A's ankle was slightly pink in color and she put a Band-aid on it. Staff #1 indicated she did not inform the nursing staff.</p> <p>An interview with the nurse was conducted on 11/20/12 at 1:51 PM. The nurse indicated staff #1 did not notify nursing about the wound when it was first discovered a week before it was assessed by the Director of Nursing. Staff #1 who initially discovered the wound put a Band-Aid on the sore but did not do anything to relieve the pressure. The nurse indicated nursing staff found out about the wound after client A informed the social worker who then notified</p>			

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	<p>nursing staff. The nurse indicated when she was informed she contacted the Director of Nursing who then assessed the area on 11/12/12. The nurse indicated the group home staff were retrained on what to report to nursing. The nurse indicated staff #1 should have reported the red area to nursing staff when she first discovered the red area.</p> <p>An interview with the Director of Nursing (DON) was conducted on 11/26/12 at 1:42 PM. The DON indicated while assessing client A's wound, client A told the DON that client A informed staff #1 of the wound "last week." The DON indicated it was either Wednesday or Thursday when client A informed staff #1. Client A indicated to the DON that staff #1 put a Band-aid on the wound. The DON indicated staff #1 should not have put a Band-aid on the wound and should have contacted the nursing staff. The DON indicated staff #1 should have removed the pressure and padded the area.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 11/20/12 at 12:41 PM. AS #1 indicated the facility did not conduct an investigation of the pressure ulcer. AS #1 indicated the nurse assessed the area and determined the cause. On 11/26/12 at 1:23 PM, AS #1 indicated he was not aware there was an issue with staff failing to report the</p>						

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	<p>pressure wound to nursing.</p> <p>3) On 9/28/12 at 7:25 AM, client D entered the kitchen and told client F to shut up. Client F reacted by "rushing" after client D and slapping her on the back. Client D was able to reach around staff and scratched client F on the right forearm. Client F's scratches required first aid. The facility did not provide documentation the incident was investigated.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 11/20/12 at 12:41 PM. AS #1 indicated the facility should investigate client to client abuse. This federal tag relates to complaint #IN00119804.</p> <p>9-3-2(a)</p>			