STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G655	A. BUILDING 00 B. WING	05/23/2024

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

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W 0000 Bldg. 00	This visit was for a Post Certification Revisit (PCR) to the predetermined full recertification and state licensure survey completed on 2/19/24. Dates of Survey: May 22 and 23, 2024 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 5/30/24.	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 5 clients living in the group home (A, B, C, D and E), the facility failed to implement their policy to prevent client to client aggression and staff neglect of the clients. Findings include: On 5/22/24 at 11:58 AM, a review of the incident reports was conducted and indicated the following: 1) On 2/21/24 at 5:30 PM, client B hit client E. Client E was not injured. 2) On 2/29/24 at 7:45 AM, client A accidentally ran into client B with his wheelchair. Client B hit	W 0149	**W149: Staff Treatment of Clients** **Corrective action for resident(s) found to have been affected:** The facility failed to implement their policy to prevent client to client aggression and staff neglect of the clients. **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:**	06/23/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaitlynn Rodriguez	Associate Director	06/17/2024

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	client A twice (location not indicated). Client A was not injured. 3) On 3/10/24 at 5:30 AM, client E pushed and then hit client D. Client D was not injured. Staff #2 was asleep at the time of the incident. A staff in training reported staff #2 was asleep at the time of the incident. The 3/11/24 Investigation Report indicated, "...While covering the overnight shift, [staff #2] fell asleep. [Staff #8], a new staff, was there to train on overnight duties. [Staff #8] states that during the overnight [staff #2] was asleep off and on during the night. [Staff #2] states she was tired after working a lot of hours and spending time with her ten year old daughter. [Staff #2] apologized for falling asleep. [Staff #8] reports that [client E] and [client B] had a possible client to client as she overheard [client B] tell [client E] he was sorry. While talking to [client E] and [client B], both clients denied hitting each other although [client B] did admit he told [client E] he was sorry... During this investigation it is my findings: [Staff #2] did neglect the clients by falling asleep. There was another staff present however [staff #8] isn't fully trained at the site with all of the clients...." The facility substantiated neglect affecting clients A, B, C, D and E. On 5/22/24 at 12:31 PM, the Associate Director (AD) indicated the facility substantiated staff #2 was negligent due to falling asleep during her shift. On 5/22/24 at 12:56 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility substantiated neglect.		Due to the staff sleeping, we have changed her schedule. She switched positions to 2pm-10pm, and does not work over 16 hours a day. Due to the client on client aggression, staff have been retrained on active treatment to prevent this from occurring. Staff have also been retrained on client Behavior Support Plan. When the aggressive client is showing trigger signs, they are to stand next to him so they can block him from hurting others. **How corrective actions will be monitored to ensure no recurrence:** Coordinator completes weekly visits. During these visits she will observe if active treatment is occurring. The Associate Director will also review shift notes each day to ensure no client on client aggression is occurring. The Associate Director will review trends to determine why this is occurring and will work closely with the Behavior Support Specialist.	

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	4) On 3/11/24 at 4:05 PM, client E hit client B on the back while in the group home van after an ambulance drove by. Client B was not injured. 5) On 4/1/24 at 7:45 AM, client E hit client B. Client B was not injured. 6) On 4/12/24 at 7:42 AM, client E pushed client B onto the floor after client B yelled at staff. Client B was not injured. 7) On 4/16/24 at 4:45 PM, client E pushed client D out of his chair while he was sitting at the dining room table. Client E put himself on the floor. While he was on the floor, client C hit him twice on the head and face. As client C left the area, he hit client A twice on the head. Client E had a 3 inch scratch on the right side of his face. None of the other clients were injured. 8) On 5/2/24 at 7:45 AM, client E bit client B on the right elbow. Client B's skin was not broken however there were teeth marks present. Client E was not injured. On 5/22/24 at 12:31 PM, the Associate Director (AD) indicated client to client aggression was abuse and the facility should prevent abuse. The AD indicated the facility had a policy and procedure prohibiting abuse. On 5/22/24 at 12:56 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse. The QIDP indicated the facility had a policy and procedure prohibiting abuse. On 5/22/24 at 2:44 PM, a review of the facility's 11/20/23 Human Rights Policy was conducted.			

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	The policy indicated, "To be safeguarded by staff from any individuals anywhere, including family or community members, who are inflicting physical and/or emotional pain on the client or violating his/her rights. Abuse and neglect are never acceptable... 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. Consideration of cognitive competence of the accused must be made in situations involving client violations... Neglect: Any action or behavioral interventions that risks the physical or emotional safety and wellbeing of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care, or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan...." This deficiency was cited on 2/19/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a			

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	minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 non-sampled clients (A), the facility failed to ensure client A had a follow-up vision examination in the recommended timeframe. Findings include: On 5/22/24 at 2:31 PM, a focused review of client A's record was conducted. Client A's most recent vision examination was conducted on 4/20/21. The Outside Services Report indicated, "...Follow-up for this problem: 1 yr (year). Date & (and) time: 04-2022...." There was no documentation client A had a vision examination in April 2022 as recommended. On 5/22/24 at 2:33 PM, the Associate Director indicated client A should have had a follow up vision examination in one year as recommended. This deficiency was cited on 2/19/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)	W 0323	**W323- Physician Services** **Corrective action for resident(s) found to have been affected:** The facility failed to ensure client A had a follow-up vision examination in the recommended timeframe. **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:** This appointment did occur, on 11.9.2023 at Precision Eye Care. Associate Director called the vision office after the exit survey. Documentation just had not been uploaded to our online tracking system. **How corrective actions will be monitored to ensure no recurrence:** Coordinator completes monthly audit forms that reviews medical appointments. If they notice any discrepancies they will reach out to the medical day aide to ensure the appointment is scheduled.	06/23/2024
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.			

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	Based on record review and interview for 3 of 3 clients in the sample (C, D and E) and one additional client (B), the facility failed to ensure the clients' medications were administered as ordered. Findings include: On 5/22/24 at 11:58 AM, a review of the incident reports was conducted and indicated the following: 1) On 3/8/24 at 7:00 AM, client D did not receive Guanfacine (attention deficit hyperactivity disorder). No side effects were noted. 2) On 4/9/24 at 7:00 AM, client E did not receive Divalproex (bipolar disorder). No side effects were noted. 3) On 4/9/24 at 7:00 AM, client D did not receive his Oxcarbazepine (seizures). No side effects were noted. 4) On 4/9/24 at 7:00 AM, client B did not receive his Levothyroxine (underactive thyroid gland). No side effects were noted. 5) On 5/21/24 at 8:30 AM, client C did not receive his antibiotic eye drops as ordered for conjunctivitis. No side effects were noted. On 5/22/24 at 11:23 AM, the nurse indicated she had not conducted medication administration observations since the last survey (2/19/24). The nurse indicated the clients' medications should be administered as ordered. On 5/22/24 at 12:31 PM, the Associate Director (AD) indicated the clients' medications should be	W 0368	**W368- Drug Administration** **Corrective action for resident(s) found to have been affected:** The facility failed to ensure the clients' medications were administered as ordered. **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:** The coordinator, nurse, and Associate Director complete at least one site visit a week. During this visit each person will observe one medication pass. This totals to three a week. This will ensure staff are following our medication administration policy. This will be documented in site visits in the comment section of our online tracking system. **How corrective actions will be monitored to ensure no recurrence:** Associate Director reviews site visits weekly. We will ensure medication observations are occurring	06/23/2024

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	administered as ordered. The AD indicated the nurse should be conducting observations of the clients' medication passes on a regular basis. On 5/22/24 at 12:58 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients' medications should be administered as ordered. The QIDP indicated the nurse should be conducting medication pass observations on a regular basis. This deficiency was cited on 2/19/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			
W 9999 Bldg. 00		W 9999	**W9999: Final Observations** **Corrective action for resident(s) found to have been affected:** **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:** **How corrective actions will be monitored to ensure no recurrence:**	06/23/2024