

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/22/2021
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2606 H ST BEDFORD, IN 47421
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W 0000  Bldg. 00	<p>This visit was for a Post Certification Revisit (PCR) to the predetermined full recertification and state licensure survey completed on 8/13/21.</p> <p>Survey Dates: October 21 and 22, 2021</p> <p>Facility Number: 001166 Provider Number: 15G655 AIM Number: 100445440</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/5/21.</p>	W 0000		
W 0140  Bldg. 00	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 3 clients in the sample (C and E) and two additional clients (B and D), the facility failed to account for the clients' funds entrusted to the facility to the penny.</p> <p>Findings include:</p> <p>On 10/21/21 at 7:12 AM, a review of the clients' finances was conducted and indicated the following:</p> <p>1) Client B's October 2021 debit card ledger indicated he had \$103.24. When the Associate Manager (AM) called the bank to confirm the balance of the account, the balance was \$94.90.</p>	W 0140	<p>W 140 CLIENT FINANCES CFR(s): 483.420(b)(1)(i)</p> <p><b>Corrective action for resident(s) found to have been affected:</b> The agency has updated its protocol for accessing and tracking client finances. The house manager of the facility is responsible for ensuring that client financial accounts are balanced to the cent at all times. The house manager will receive training on the updated protocol for accessing client financial</p>	11/21/2021

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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	<p>2) Client C's October 2021 debit card ledger indicated he had \$114.47. When the Associate Manager (AM) called the bank to confirm the balance of the account, the balance was \$107.75.</p> <p>3) Client D's October 2021 debit card ledger indicated he had \$102.05. When the Associate Manager (AM) called the bank to confirm the balance of the account, the balance was \$100.81.</p> <p>4) Client E's October 2021 debit card ledger indicated he had \$86.26. When the Associate Manager (AM) called the bank to confirm the balance of the account, the balance was \$64.86.</p> <p>On 10/21/21 at 7:28 AM, the AM indicated the facility should account for the clients' funds to the penny. The AM stated the "receipts are not getting put in" the electronic system after the clients spend their money.</p> <p>This deficiency was cited on 8/13/21. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		<p>accounts and logging any credits/debits, so that the ledger and actual account balance match.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken:</b> All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b> The agency currently uses a Client-specific Audit form, a checklist of items to review at each facility on at least a quarterly basis, which includes a financial review to be completed by the Client Support Coordinator. There is a newly-hired Coordinator for the home who will receive training on how to monitor the client finances through this review process.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b> The agency currently uses a Client-specific Audit form, which is a checklist of items to review at each facility on at least a quarterly basis. As stated above, the Director of SGL and Associate Director of SGL will review and revise the facility audit form to add electronic review of individual client finances as an item to be reviewed by the Coordinator on at</p>		

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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 13 of 18 incident/investigative reports reviewed affecting clients A, B, C, D, E and F, the facility failed to implement its policies and procedures to prevent client to client abuse and ensure 4 incidents of client to client abuse were investigated.</p> <p>Findings include:</p> <p>On 10/21/21 at 11:53 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 8/22/21 at 12:30 PM, client A came out of his room, ran down the hallway and hit client C on the head. Client C hit client A on the chest and grabbed his wrists. Client C was not injured. Client A had red marks on his wrists.</p> <p>2) On 8/22/21 at 3:30 PM, client A went into the bathroom and smacked client D. Staff heard client D say "don't hit" to client A. Client D was not injured.</p> <p>There was no investigation into the incident.</p>	W 0149	<p>least a quarterly basis. When Coordinators complete a form, the Facility Audit form will be turned into the Director and Associate Director of SGL, so that they will be made aware of any deficiencies and corrective actions taken.</p> <p>W 149 STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) <b>Corrective action for resident(s) found to have been affected:</b> The Director or Associate Director of SGL currently investigate any allegations of abuse, neglect, or exploitation. This process will be amended to include investigations into significant injuries, such as fractures, so that there is documentation that the facility investigated the cause of the injury, ruled out abuse or neglect, and ensured there was a plan to prevent recurrence of the injury. The agency has a policy that indicates all incidents of abuse, including client to client abuse, will be investigated and the results of the investigation will be reviewed by the administrator or designated representative within five working</p>	11/21/2021

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	<p>3) On 8/22/21 at 10:45 PM, client A hit client F on the top of the head. Client F was not injured.</p> <p>4) On 8/24/21 at 5:15 PM, client A slapped client B on the back two times. Client B was not injured.</p> <p>5) On 9/3/21 at 5:10 PM, client A hit client F on the top of the head. Client F was not injured.</p> <p>6) On 9/6/21 at 5:45 PM, client B pushed client E as he ran past him. Client E was not injured.</p> <p>7) On 9/7/21 at 4:20 PM, client A hit client C. Client C was not injured.</p> <p>8) On 9/10/21 at 7:50 AM, client D hit client F 5 or 6 times on the top of his head while in the van. Client F was not injured.</p> <p>9) On 9/14/21 at 12:45 PM, client A slapped client F on the side of the head with an open hand. Client F was not injured.</p> <p>10) On 9/30/21 at 4:30 PM, client A slapped client D on the top of the head with both hands. Client D hit client B on the shoulder. There were no injuries noted.</p> <p>There was no investigation into the incident.</p> <p>11) On 10/3/21 at 12:40 PM, client A slapped client F on the head twice. Client F was not injured.</p> <p>There was no investigation into the incident.</p> <p>12) On 10/14/21 at 4:20 PM, client A slapped client F on the head with an open hand. Client F</p>		<p>days. The QIDP is responsible for completing investigations into episodes of client to client abuse and injuries of unknown origin. The QIDP has received retraining on agency policy regarding investigations into client to client abuse, and will receive subsequent disciplinary action for failing to follow procedure. The retraining will include a comprehensive overview of agency policy, the steps for completing a thorough investigation, and appropriate corrective actions to take.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken:</b> All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence:</b> The program directors will assign investigations into client to client abuse and injuries of unknown origin to the QIDP with a due date of five working days from the date of the report. These investigations will be completed within five working days and the results will be reviewed by the administrator (program director) within the same time frame. The program directors will review the completed investigations and monitor for timeliness and thoroughness.</p>				

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	<p>was not injured.</p> <p>There was no investigation into the incident.</p> <p>13) On 10/19/21 at 5:30 PM, client B pushed client E out of his chair while client E was eating dinner. The report did not indicate if client E was injured or not.</p> <p>On 10/21/21 at 11:58 AM, the Associate Group Home Director (AGHD) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse of the clients. The AGHD indicated incidents of client to client aggression should be investigated.</p> <p>On 10/22/21 at 10:15 AM, a review of the facility's 9/14 abuse and neglect policy was conducted. The facility's policy titled, Incident Investigation/Review Protocol, dated 5/14/13, 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 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</p>		<p>Once the QIDP has completed retraining on investigation procedure, any deficiencies will result in further corrective action, including disciplinary action for the QIDP.</p> <p><b>How corrective actions will be monitored to ensure no recurrence:</b></p> <p>The program directors will assign investigations into client to client abuse and injuries of unknown origin to the QIDP with a due date of five working days from the date of the report. The program directors will review the completed investigations and monitor for timeliness and thoroughness. Once the QIDP has completed retraining on investigation procedure, any deficiencies will result in further corrective action, including disciplinary action for the QIDP. Incidents will be reviewed monthly at Support Team meetings, including a review of the corrective actions recommended to ensure completion.</p>		

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W 0154 Bldg. 00	<p>abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law...."</p> <p>This deficiency was cited on 8/13/21. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 4 of 18 incident/investigative reports reviewed affecting clients A, B, D and F, the facility failed to investigate four incidents of client to client abuse.</p> <p>Findings include:</p> <p>On 10/21/21 at 11:53 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 8/22/21 at 3:30 PM, client A went into the bathroom and smacked client D. Staff heard client D say "don't hit" to client A. Client D was not injured.</p> <p>There was no investigation into the incident.</p> <p>2) On 9/30/21 at 4:30 PM, client A slapped client D on the top of the head with both hands. Client D hit client B on the shoulder. There were no injuries noted.</p> <p>There was no investigation into the incident.</p>	W 0154	<p>W 154 STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)</p> <p><b>Corrective action for resident(s) found to have been affected:</b></p> <p>The Director or Associate Director of SGL currently investigate any allegations of abuse, neglect, or exploitation. This process will be amended to include investigations into significant injuries, such as fractures, so that there is documentation that the facility investigated the cause of the injury, ruled out abuse or neglect, and ensured there was a plan to prevent recurrence of the injury. The agency has a policy that indicates all incidents of abuse, including client to client abuse, will be investigated and the results of the investigation will be reviewed by the administrator or designated</p>	11/21/2021

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	<p>3) On 10/3/21 at 12:40 PM, client A slapped client F on the head twice. Client F was not injured.</p> <p>There was no investigation into the incident.</p> <p>4) On 10/14/21 at 4:20 PM, client A slapped client F on the head with an open hand. Client F was not injured.</p> <p>There was no investigation into the incident.</p> <p>On 10/21/21 at 11:58 AM, the Associate Group Home Director (AGHD) indicated incidents of client to client aggression should be investigated.</p> <p>This deficiency was cited on 8/13/21. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		<p>representative within five working days. The QIDP is responsible for completing investigations into episodes of client to client abuse and injuries of unknown origin. The QIDP has received retraining on agency policy regarding investigations into client to client abuse, and will receive subsequent disciplinary action for failing to follow procedure. The retraining will include a comprehensive overview of agency policy, the steps for completing a thorough investigation, and appropriate corrective actions to take.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken:</b></p> <p>All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence:</b></p> <p>The program directors will assign investigations into client to client abuse and injuries of unknown origin to the QIDP with a due date of five working days from the date of the report. These investigations will be completed within five working days and the results will be reviewed by the administrator (program director) within the same time frame. The program directors will review the completed investigations and monitor for</p>		

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W 0488  Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.  Based on observation and interview for 2 of 3 clients in the sample (C and E) and two additional clients (D and F), the facility failed to ensure the clients served themselves during breakfast.	W 0488	timeliness and thoroughness. Once the QIDP has completed retraining on investigation procedure, any deficiencies will result in further corrective action, including disciplinary action for the QIDP. <b>How corrective actions will be monitored to ensure no recurrence:</b> The program directors will assign investigations into client to client abuse and injuries of unknown origin to the QIDP with a due date of five working days from the date of the report. The program directors will review the completed investigations and monitor for timeliness and thoroughness. Once the QIDP has completed retraining on investigation procedure, any deficiencies will result in further corrective action, including disciplinary action for the QIDP. Incidents will be reviewed monthly at Support Team meetings, including a review of the corrective actions recommended to ensure completion.	11/21/2021
			W 488 DINING AREAS AND SERVICE CFR(s): 483.480(d)(4)	

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	<p>Findings include:</p> <p>On 10/21/21 from 6:03 AM to 7:41 AM, an observation was conducted at the group home. At 6:25 AM, staff #2 gave client F his high sided plate with sausage on it. Staff #2 put client D's plate with sausage and a biscuit on it on the table. At 6:27 AM, staff #2 poured client E's milk. At 6:28 AM, staff #2 poured client D's milk. Staff #2 stated to client D, "Your breakfast is ready." Staff #2 cut up client C's biscuit and sausage. At 6:35 AM, staff #2 asked client C if he wanted more sausage. Client C asked if he could take it to work. Staff #2 packed up the sausage and placed it into client C's lunchbox. At 6:44 AM, staff #6 took client F's dishes to the kitchen sink and then cleaned off the table.</p> <p>On 10/21/21 at 12:59 PM, the Associate Group Home Director (AGHD) indicated the clients should be serving themselves, pouring their own drinks and cleaning up. The AGHD stated the clients should be "actively participating in the process."</p> <p>This deficiency was cited on 8/13/21. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>		<p><b>Corrective action for resident(s) found to have been affected:</b> Facility staff will receive retraining on strategies to engage each client with grocery shopping, meal preparation, and dining in a manner that is consistent with each individual client's developmental level. <b>How facility will identify other residents potentially affected &amp; what measures taken:</b> All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence:</b> Interdisciplinary team members will conduct visits to the facility during meal times to ensure that client individual support plans are being followed with respect to meal preparation and participation. <b>How corrective actions will be monitored to ensure no recurrence:</b> Interdisciplinary team members will conduct visits to the facility during meal times to ensure that individual support plans are being followed with respect to meal preparation and participation. IDT members will document these visits and provide corrective action if deficiencies are observed.</p>		

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W 9999  Bldg. 00		W 9999	<p>W9999 FINAL OBSERVATIONS</p> <p><b>Corrective action for resident(s) found to have been affected:</b></p> <p>1) Facility staff will receive retraining on the agency Incident Reporting Procedure, which will include an emphasis on reporting incidents within 24 hours.</p> <p>2) The Director of SGL will consult with the agency's Human Resources department to ensure that the two identified staff members receive annual TB tests.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken:</b></p> <p>All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence:</b></p> <p>1) Facility staff will be expected to complete ongoing training on incident reporting on at least an annual basis.</p> <p>2) The agency has begun using a new employee self-service software program. Human Resources will use this program to monitor employee records, including compliance items like TB tests.</p> <p><b>How corrective actions will be</b></p>	11/21/2021	

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			<p><b>monitored to ensure no recurrence:</b></p> <p>1) As many of the incidents that were reported late involve medication errors that were discovered late, the coordinator will be tasked with ensuring that the facility staff are following the medication administration procedure by having a second staff member check the administration of each medication pass to ensure there are no errors. Per policy, this "buddy check" should occur within the allotted timeframe to administer the medications, to avoid errors. With respect to late reporting, the agency has a policy for notifying the emergency pager or coordinator of any incident that occurs on shift, including medication errors discovered. The team member receiving the notification will instruct the reporting staff member to complete an incident report immediately and then follow up to ensure that the report has been submitted.</p> <p>2) Human Resources will notify staff who are soon to be due for TB skin tests and assist them with scheduling these tests with facility nursing staff. If any employee is overdue for a TB test, Human Resources will notify the Director of SGL and/or the employees immediate supervisor.</p>	