

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 12/01/2022
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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 predetermined full recertification and state licensure survey. This visit included the investigation of complaint #IN00383419.</p> <p>Complaint #IN00383419: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Dates of Survey: November 28, 29, 30 and December 1, 2022.</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.</p> <p>Quality Review of this report completed by #27547 on 12/6/22.</p>	W 0000		
W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C) and 2 additional clients (D and E), the facility failed to ensure clients A, B, C, D and E's rights to due process in regard to the door chime on the front door and to ensure client A's goals to reduce or eliminate restrictions were attainable.</p>	W 0125	<p>Corrective action for resident(s) found to have been affected:</p> <p>The facility failed to ensure that due process was given to all clients in regards to a door chime on the front door of the home. Upon further review, there was no</p>	01/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Genna Lynn

Executive Residential Director

02/13/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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>Findings include:</p> <p>1. Observations were conducted at the group home on 11/28/22 from 4:00 PM to 6:15 PM and on 11/29/22 from 5:55 AM to 7:35 AM. Each time someone opened the front door there was a chime which could be heard throughout the group home. Clients A, B, C, D and E were present throughout the observations.</p> <p>On 11/29/22 at 4:00 PM, client A's record was reviewed. Client A's 3/23/22 BSP (Behavior Support Plan) did not address a door chime on the front door.</p> <p>On 11/29/22 at 3:35 PM, client B's record was reviewed. Client B's 3/8/22 BSP did not address a door chime on the front door.</p> <p>On 11/29/22 at 4:25 PM, client C's record was reviewed. Client C's 4/25/22 BSP did not address a door chime on the front door.</p> <p>On 11/29/22 at 5:05 PM, a focused review of client D's record was conducted. The review indicated client D did not have a BSP.</p> <p>On 11/29/22 at 5:00 PM, a focused review of client E's record was conducted. Client E's 3/23/22 3/8/22 BSP did not address a door chime on the front door.</p> <p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) and DSGL (Director of Supervised Group Living) were interviewed. The QIDP stated, "I found out that a maintenance guy came and when they left they turned it on. We forgot to turn it back off". The DSGL stated, "Why is it even on there if it isn't</p>		<p>reason for a door chime to be placed on the door. The chime appears to have been left on the door from previous issues that occurred some time ago. A work order has been written to remove the chime from the door to the facility as soon as possible.</p> <p>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.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: The QIDP will now be responsible to work with the behavior clinician to ensure that there are no restrictions in place where clients have not had due process. The QIDP will complete a sweep of the facility at least monthly to ensure that there are no unapproved restrictive measures in place.</p> <p>How corrective actions will be monitored to ensure no recurrence: The QIDP/designee will complete a monthly sweep of the facility to ensure no restrictive measures or devices are in use without appropriate processes in place and report their findings to the SGL Associate Director or SGL Director by the 30th of each</p>		

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W 0149 Bldg. 00	<p>needed? I will put in an order to have it removed". The QIDP and the DSGI indicated the door chime was an unnecessary restriction.</p> <p>2. On 11/29/22 at 4:00 PM, client A's record was reviewed. Client A's 3/23/22 BSP included a restriction of assigned seating on the van. The BSP indicated, "RESTRICTIVENESS REDUCTION PLAN: The use of assigned seating in a vehicle will be reassessed when there are zero incidents of agitation/aggression/hitting behavior per month for four consecutive quarters".</p> <p>On 11/30/22 at 12:25 PM, the QIDP was interviewed. The QIDP indicated zero incidents of agitation/aggression/hitting behavior over a 12 month timeframe was not attainable for client A.</p> <p>9-3-2(a)</p> <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 26 of 38 incident reports reviewed affecting clients A, B, C, D and E, the facility failed to implement its policies and procedures to prevent abuse of the clients; conduct a thorough investigation for client E's thumb fracture and to ensure the results of investigations were reported to the administrator within 5 business days.</p> <p>Findings include:</p> <p>On 11/29/22 at 9:30 AM and 1:15 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p>	W 0149	<p>month.</p> <p>Corrective action for resident(s) found to have been affected: The agency has a policy for preventing client abuse, including the requirement for investigating unknown injuries and episodes of client-to-client abuse and investigating such within a 5 business day period. The QIDP who was responsible for conducting the investigation regarding the client's possible fractured thumb as well as the additional client to client abuse investigations submitted initial</p>	01/01/2023	

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	<p>1) A 10/3/22 BDDS (Bureau of Developmental Disabilities Services) report indicated on 10/1/22, client E woke up with a bruised and swollen left hand. Client E was taken to urgent care and was diagnosed with a fracture to his left thumb.</p> <p>On 11/29/22 at 5:00 PM, a focused review of client E's record was conducted.</p> <p>An OSR (Outside Services Report) dated 10/1/22 indicated client E was diagnosed with a left thumb fracture. The report indicated, "Age indeterminate fracture of the distal tuft (end of last bone in finger) of left thumb suspected".</p> <p>An OSR dated 10/4/22 indicated client E was seen for a follow-up with an orthopedic doctor. Client E was diagnosed with a thumb injury and a thumb spica cast was applied.</p> <p>There was no documentation the facility conducted an investigation for the unknown thumb injury/fracture.</p> <p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) and DSGL (Director of Supervised Group Living) were interviewed. The QIDP stated, "When he went to the ortho (orthopedic) appointment they didn't see a fracture. The cast was put on as a precautionary measure. He went back for a follow-up appointment and they did another x-ray. Everything was fine so he didn't have to go back". The QIDP and DSGL indicated unknown fractures/injuries should be investigated.</p> <p>2) On 6/1/22 at 7:30 AM, client C got upset and ran from the dining room to the living room to hit client B in the arm. Client B was not injured.</p>		<p>reports that were thought to be fabricated and therefore, not submitted to the surveyor for review. That QIDP has since been terminated. The SGL Director will ensure that an investigation, albeit late, will be conducted concerning this injury.</p> <p>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.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: All investigations are reviewed and signed off on by the SGL Associate Director or SGL Director. A new position has been created to assist with the monitoring/tracking of investigations to ensure they are completed timely. This position will begin in January 2023. The Empower database system will be utilized to track and monitor all investigations.</p> <p>How corrective actions will be monitored to ensure no recurrence: All investigations are reviewed and signed off on by the SGL Associate Director or SGL Director. A new position has been created to assist with the monitoring/tracking of investigations to ensure they are</p>	

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	<p>3) On 6/2/22 at 6:00 PM, client C was eating dinner and got up and hit client B. Client B was not injured.</p> <p>4) On 6/4/22 at 5:15 PM, client C got up from the table and hit client B on the back twice. Client C sat back down then got up and hit client B again. Client C was placed in a 1 person hold. Client B was not injured.</p> <p>5) On 6/12/22 at 5:00 PM, client C charged down the hallway to the dining room and hit client B with open hands on top of the head. Client B was not injured.</p> <p>6) On 6/23/22 at 5:00 PM, client E started yelling and slamming doors. Client E calmed down and headed to his room. Client C stepped out of his room and hit client E four times on his crossed arms. Client E was not injured.</p> <p>7) On 6/25/22 at 6:00 PM, client A was eating dinner at the table and got up and smacked client E on the head with both hands. Client E was not injured.</p> <p>8) On 6/26/22 at 3:45 PM, client A was eating and ran out of the kitchen and hit client D on top of the head. Client D was not injured.</p> <p>9) On 6/30/22 at 4:45 AM, client C hit client B four times. Client B was not injured.</p> <p>10) On 7/4/22 at 2:15 PM, clients A and E were sitting on the couch waiting for client E to pick out a movie. Client A hit client E on the head. Client E was not injured.</p> <p>11) On 7/4/22 at 3:00 PM, client B blocked the hallway to make client C mad. Client B turned to</p>		completed timely. This position will begin in January 2023. The Empower database system will be utilized to track and monitor all investigations.	

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	<p>walk away and client C hit client B on the back. Client B was not injured.</p> <p>The results of the investigation were reported to the administrator on 7/11/22, but the administrator did not sign the investigation indicating it was reviewed.</p> <p>12) On 7/4/22 at 4:45 PM, client C walked into the kitchen to get more dinner. Client A got up and hit client C. Client C was not injured.</p> <p>13) On 7/6/22 at 5:30 PM, client A was eating in the kitchen and client C smacked him. Client A was not injured.</p> <p>The results of the investigation were reported to the administrator on 7/19/22.</p> <p>14) On 7/9/22 at 4:00 PM, client B was in the kitchen getting something to drink. Client C ran into the kitchen and shoved client B against the kitchen sink causing him to spill his drink all over the counter and his clothes. Client B was not injured.</p> <p>The results of the investigation were reported to the administrator on 7/19/22.</p> <p>15) On 7/13/22 at 5:30 PM, client A was walking down the hallway to his room and hit client D on the head. Client D was not injured.</p> <p>16) On 7/21/22 at 4:45 PM, client E walked by client A and client A hit client E. Client E was not injured.</p> <p>The results of the investigation were reported to the administrator on 8/3/22, but the administrator did not sign the investigation indicating it was</p>			

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	<p>reviewed.</p> <p>17) On 7/25/22 at 8:30 PM, client C ran out of the kitchen and pushed client B into the table. Client B was not injured.</p> <p>18) On 7/26/22 at 8:20 AM, client A ran from his room into client E's room and hit him twice. Client E was not injured.</p> <p>19) On 7/26/22 at 5:00 PM, client A was sitting in the kitchen waiting for dinner. Client E entered the kitchen to throw something away. Client A hit client E on the head. Client E was not injured.</p> <p>20) On 8/22/22 at 10:00 PM, client E hit client B on the back with both hands. Client B had slight redness which disappeared after a few minutes.</p> <p>The results of the investigation were reported to the administrator on 9/8/22.</p> <p>21) On 9/1/22 at 6:45 AM, client B cleared his throat and client C ran out of his room and client client B on the back. Client B was not injured.</p> <p>22) On 9/8/22 at 4:20 PM, client A stood up to go eat dinner and smacked client E. Client C pushed client E onto the mat. Client C tried to flip over the dining room table. While staff were assisting with clients C and E, client A smacked client B. Clients B and E were not injured.</p> <p>23) On 9/12/22 at 2:15 PM, client D went into the classroom (day program) and an unknown client smacked his arm. Client D was not injured.</p> <p>24) On 9/27/22 at 4:30 PM, client E was yelling which set client C off. Client C flipped a table over which agitated client A. Client A came out of the</p>			

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	<p>kitchen and hit client E. Client E was not injured.</p> <p>25) On 10/29/22 at 4:45 PM, the clients were getting ready to eat dinner. Client C hit client E on top of the head. Client E then hit client C on top of the head. Clients C and E were not injured.</p> <p>26) On 11/23/22 at 3:47 PM, client E was obsessing about going to visit his mom. Client C got mad at client E and shoved a table. The table hit client D in the stomach. Client D was not injured.</p> <p>On 11/28/22 at 5:31 PM, the Coordinator was interviewed. The Coordinator stated, "I moved staff around in [city] to get the right fit in the home. We finally have the right fit. Staff are great". The Coordinator indicated client to client aggression had decreased significantly over the last three months. The Coordinator indicated they had meetings, medication changes, changes to the BSPs (Behavior Support Plans) and reinforcement plans to decrease the client to client aggression. The Coordinator indicated some of the changes were successful and some were not. The Coordinator indicated client to client aggression was abuse and client to client aggression should be prevented.</p> <p>On 11/29/22 at 6:22 AM, staff #1 was interviewed. Staff #1 indicated everyone worked hard to put things in place to decrease the client to client aggression and they finally found a combination of things which have worked. Staff #1 indicated there were no injuries as a result of the client to client aggression. Staff #1 indicated they (clients) all set each other off at times.</p> <p>On 11/29/22 at 12:40 PM, client C was interviewed. Client C indicated he gets along with his housemates for the most part. Client C stated,</p>			

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	<p>"[Client B], [client A] and [client E] get on my nerves. They're loud and it bothers me". Client C indicated he hits them (clients A, B and E) when they get on his nerves. Client C indicated he's not trying to hurt them, he just wants them to stop whatever they're doing to annoy him. Client C stated, "Things are getting better".</p> <p>On 11/29/22 at 12:54 PM, client D was interviewed. Client D indicated client E smacked him a couple months ago and last week client C pushed the dining room table and it hit him in the stomach. Client D indicated he was not injured, but he had a red mark on his stomach. Client D stated, "One client gets upset and the others follow. I just sit back and watch the show. Get me some popcorn". Client D indicated staff intervenes as fast as they can but they (clients) are fast. Client D stated the last few months have been "much better". Client D indicated the group home had some new staff and they are better than the old staff.</p> <p>On 11/30/22 at 12:25 PM, the QIDP, DSGL and LPN were interviewed. The QIDP, DSGL and LPN indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. The QIDP indicated the results of investigations were due to the administrator within 5 business days. The QIDP and DSGL indicated the administrator should sign the investigation indicating the investigation was reviewed. The QIDP indicated corrective measures were implemented after the incidents, but the corrective measures were not effective. The QIDP indicated incidents of client to client aggression had significantly decreased over the last three months.</p>			

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	<p>On 12/1/22 at 8:30 AM, a review of the facility's 2/26/21 Incident Reporting Procedure indicated, "A staff member who witnesses an incident, discovers the results of an incident, or receives the initial report of an incident from a person not on staff, immediately does the following: Interrupts the inappropriate behavior. Takes measures to protect, comfort and ensure treatment of the individuals involved in the incident, obtaining emergency care as needed. Requests assistance as needed from immediate supervisor and/or pager. In cases of suspected abuse/neglect or exploitation, the director of the program is to be notified immediately. In the event that the allegation involves a client who receives services from another provider, Stone Belt will notify a manager with the responsible provider of alleged, suspected, or actual abuse or neglect. If no action is taken in response to the report, continue to report to the supervisor or next level of management. Completes a Stone Belt Incident Report according to agency instructions. Coordinators will ensure that legal guardian is notified of alleged, suspected, or actual abuse and/or neglect... Incidents which involve allegations or situations of abuse, neglect, exploitation, mistreatment and violations of client rights are to be reported immediately to the program director, APS (adult protective services)/CPS (child protective services), BDDS, the individual's legal representative, providers of case management, and anyone designated by the individual...."</p> <p>On 12/1/22 at 8:45 AM, a review of the facility's 6/8/21 Investigations Procedure indicated, "...It is the policy of Stone Belt to conduct thorough investigations whenever needed to ensure the health, welfare, and rights of individuals for whom services are provided. All investigations will be</p>			

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W 0154 Bldg. 00	<p>conducted in a timely manner and, when applicable, will include follow-up requirements designed to prevent recurring problematic incidents... All investigations must be completed within Five (5) business days of knowledge of the incident and results distributed to appropriate team members as necessary...."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 38 incident/investigative reports reviewed affecting client E, the facility failed to conduct an investigation of client E's thumb injury.</p> <p>Findings include:</p> <p>On 11/29/22 at 9:30 AM and 1:15 PM, a review of the facility's incident/investigative reports was conducted.</p> <p>A 10/3/22 BDDS (Bureau of Developmental Disabilities Services) report indicated on 10/1/22, client E woke up with a bruised and swollen left hand. Client E was taken to urgent care and was diagnosed with a fracture on his left thumb.</p> <p>On 11/29/22 at 5:00 PM, a focused review of client E's record was conducted.</p> <p>An OSR (Outside Services Report) dated 10/1/22 indicated client E was diagnosed with a left thumb fracture. The report indicated, "Age indeterminate fracture of the distal tuft (end of last bone in finger) of left thumb suspected".</p>	W 0154	<p>Corrective action for resident(s) found to have been affected: The agency has a policy for preventing client abuse, including the requirement for investigating unknown injuries and investigating such within a 5 business day period. The QIDP who was responsible for conducting the investigation regarding the client's possible fractured thumb submitted initial reports that were thought to be fabricated and therefore, not submitted to the surveyor for review. That QIDP has since been terminated. The SGL Director will ensure that an investigation, albeit late, will be conducted concerning this injury. 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.</p>	01/01/2023

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W 0156 Bldg. 00	<p>An OSR dated 10/4/22 indicated client E was seen for a follow-up with an orthopedic doctor. Client E was diagnosed with a thumb injury and a thumb spica cast was applied.</p> <p>There was no documentation the facility conducted an investigation for the unknown thumb fracture.</p> <p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) and DSGL (Director of Supervised Group Living) were interviewed. The QIDP stated, "When he went to the ortho (orthopedic) appointment they didn't see a fracture. The cast was put on as a precautionary measure. He went back for a follow-up appointment and they did another x-ray. Everything was still fine so he didn't have to go back". The QIDP and DSGL indicated unknown fractures should be investigated.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 5 of 38 incident/investigative reports reviewed affecting</p>	W 0156	<p>Measures or systemic changes facility put in place to ensure no recurrence: All investigations are reviewed and signed off on by the SGL Associate Director or SGL Director. A new position has been created to assist with the monitoring/tracking of investigations to ensure they are completed timely. This position will begin in January 2023. The Empower database system will be utilized to track and monitor all investigations.</p> <p>How corrective actions will be monitored to ensure no recurrence: All investigations are reviewed and signed off on by the SGL Associate Director or SGL Director. A new position has been created to assist with the monitoring/tracking of investigations to ensure they are completed timely. This position will begin in January 2023. The Empower database system will be utilized to track and monitor all investigations.</p> <p>Corrective action for resident(s) found to have been affected:</p>	01/01/2023			

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	<p>clients A, B, C and E, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days.</p> <p>Findings include:</p> <p>On 11/29/22 at 9:30 AM and 1:15 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 7/4/22 at 3:00 PM, client B blocked the hallway to make client C mad. Client B turned to walk away and client C hit client B on the back. Client B was not injured.</p> <p>The results of the investigation were reported to the administrator on 7/11/22, but the administrator did not sign the investigation indicating it was reviewed.</p> <p>2) On 7/6/22 at 5:30 PM, client A was eating in the kitchen and client C smacked him. Client A was not injured.</p> <p>The results of the investigation were reported to the administrator on 7/19/22.</p> <p>3) On 7/9/22 at 4:00 PM, client B was in the kitchen getting something to drink. Client C ran into the kitchen and shoved client B against the kitchen sink causing him to spill his drink all over the counter and his clothes. Client B was not injured.</p> <p>The results of the investigation were reported to the administrator on 7/19/22.</p> <p>4) On 7/21/22 at 4:45 PM, client E walked by client A and client A hit client E. Client E was not injured.</p>		<p>The agency has a policy for preventing client abuse, including the requirement for investigating unknown injuries and episodes of client-to-client abuse and investigating such within a 5 business day period including submission to the associate Director or Director for review and signature. The QIDP who was responsible for conducting the investigations of client to client abuse submitted reports that were never submitted to the directors for review but were submitted to the surveyor for review. That QIDP has since been terminated.</p> <p>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.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: All investigations are reviewed and signed off on by the SGL Associate Director or SGL Director. A new position has been created to assist with the monitoring/tracking of investigations to ensure they are completed timely. This position will begin in January 2023. The Empower database system will be utilized to track and monitor all investigations.</p>	

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W 0186 Bldg. 00	<p>The results of the investigation were reported to the administrator on 8/3/22, but the administrator did not sign the investigation indicating it was reviewed.</p> <p>5) On 8/22/22 at 10:00 PM, client E hit client B on the back with both hands. Client B had slight redness which disappeared after a few minutes.</p> <p>The results of the investigation were reported to the administrator on 9/8/22.</p> <p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) and DSGL (Director of Supervised Group Living) were interviewed. The QIDP indicated the results of investigations were due to the administrator within 5 business days. The QIDP and DSGL indicated the administrator should sign the investigation indicating the investigation was reviewed.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure there were sufficient staff scheduled at the group home to allow client B to attend weekly church services.</p>	W 0186	<p>How corrective actions will be monitored to ensure no recurrence:</p> <p>All investigations are reviewed and signed off on by the SGL Associate Director or SGL Director. A new position has been created to assist with the monitoring/tracking of investigations to ensure they are completed timely. This position will begin in January 2023. The Empower database system will be utilized to track and monitor all investigations.</p> <p>Corrective action for resident(s) found to have been affected:</p> <p>The facility failed to ensure there were sufficient staff scheduled at the group home to allow client B</p>	01/01/2023

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	<p>Findings include:</p> <p>CI (confidential interview) was conducted. CI indicated at client B's annual meeting in March 2022 CI requested for client B to start attending church again. CI indicated client B attended church weekly prior to Covid and the group home had not taken him to church since then. CI indicated client B enjoys attending church.</p> <p>On 11/29/22 at 3:35 PM, client B's record was reviewed. Client B's 3/9/22 Case Conference Summary indicated, "Social/Cultural/Spiritual Activities: Want him to get back to church".</p> <p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP indicated none of the clients currently attend church. The QIDP stated, "Right now it just depends if staff is available to take them. We try to have staff available but that isn't always the case. [Client B] did attend church weekly before Covid". The QIDP indicated staff should be provided for clients to attend church.</p> <p>9-3-3(a)</p>		<p>to attend weekly church services. The agency has struggled to hire enough direct care staff since the pandemic began and has remained in a "staffing crisis" since. The agency has taken measures to downsize our group home program in order to accommodate the staffing crisis. This process has been slower than anticipated and therefore, we continue to struggle with hiring enough staff. The facility will continue to work to hire adequate numbers of staff to ensure that the client is able to attend weekly church services as desired.</p> <p>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.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: The agency is continuing to work with the BDDS office to downsize our group home program by reducing homes from 11 to 10 in order to accommodate the number of staff we are able to hire. This process has been slower than expected and to date has offered little relief. The facility client services coordinator will work to fill a shift specifically designed to accommodate the client or other</p>		

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W 0225 Bldg. 00	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review and interview for 1 of 3 sampled clients (C), the facility failed to assess client C's vocational needs.</p> <p>Findings include:</p> <p>An observation was conducted at the facility operated day program on 11/29/22 from 12:30 PM to 1:15 PM. Client C was present throughout the observation. Client C interacted with his peers, made paper snowflakes and played Bingo throughout the observation.</p> <p>On 11/29/22 at 4:25 PM, client C's record was reviewed. Client C's record indicated he participated in day program. Client C's record did not indicate documentation of a vocational assessment being completed since 4/8/19.</p>	W 0225	<p>clients who want to attend church services.</p> <p>How corrective actions will be monitored to ensure no recurrence: The Client services support coordinator and the SGL Director will discuss this process weekly on Wednesdays to monitor the success or lack of in getting staff to sign up to work a special shift aimed at taking the client to church. If issues arise, management staff will meet to offer strategies to assist such as offering a bonus.</p> <p>Corrective action for resident(s) found to have been affected: A Client's Comprehensive Functional assessment was not completed as required and was missing the assessment for vocational needs. The QIDP responsible is no longer employed by the facility. The acting QIDP will complete the CFA.</p> <p>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.</p>	01/01/2023

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W 0259 Bldg. 00	<p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP indicated vocational assessments should be reviewed and updated annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure client C's CFA (Comprehensive Functional Assessment) was reviewed for relevancy and updated at least annually.</p> <p>Findings include:</p> <p>On 11/29/22 at 4:25 PM, client C's record was reviewed. Client C's record indicated client C's CFA was completed on 4/25/21. There was no documentation client C's CFA was reviewed for relevancy and updated at least annually.</p>	W 0259	<p>Measures or systemic changes facility put in place to ensure no recurrence: The acting QIDP will review each client's CFA for completeness to ensure that all CFA's are thorough. The SGL Director will spot check CFA's monthly to review for completeness.</p> <p>How corrective actions will be monitored to ensure no recurrence: The acting QIDP will review each client's CFA for completeness to ensure that all CFA's are thorough. The SGL Director will spot check CFA's monthly to review for completeness.</p> <p>Corrective action for resident(s) found to have been affected: A Client's CFA had not been completed since 4/25/21. The QIDP responsible is no longer employed by the facility. The acting QIDP will complete the CFA.</p> <p>How facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures</p>	01/01/2023	

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W 0268 Bldg. 00	<p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP indicated CFAs should be reviewed and updated annually.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT</p> <p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (B), the facility failed to promote client B's dignity in regard to his unkempt facial hair.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/28/22 from 4:00 PM to 6:15 PM and on 11/29/22 from 5:55 AM to 7:35 AM. Throughout the observations, client B's facial hair was scruffy and unkempt.</p>	W 0268	<p>address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence:</p> <p>The acting QIDP will review each client's CFA for completeness to ensure that all CFA's are thorough. The SGL Director will spot check CFA's monthly to review for completeness.</p> <p>How corrective actions will be monitored to ensure no recurrence:</p> <p>The acting QIDP will review each client's CFA for completeness to ensure that all CFA's are thorough. The SGL Director will spot check CFA's monthly to review for completeness.</p> <p>Corrective action for resident(s) found to have been affected:</p> <p>The facility failed to promote a Client's dignity in regard to his unkempt facial hair. All staff will be retrained on promoting the dignity of all clients by ensuring a neat well-kept appearance including the shaving of facial hair on a daily basis.</p> <p>How facility will identify other residents potentially affected &</p>	01/01/2023

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W 0312 Bldg. 00	<p>On 11/29/22 at 3:35 PM, client B's record was reviewed. Client B's 3/9/22 Program Assessment (comprehensive functional assessment) indicated client B has no knowledge about recognizing the need to shave and he required physical and verbal prompts throughout the shaving process.</p> <p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) and the LPN (Licensed Practical Nurse) were interviewed. The QIDP indicated client B was unable to shave independently and he required total staff assistance with shaving. The LPN stated client B's face should be shaved "Whenever it needs it". The LPN indicated client B was not capable of verbalizing when he needs or wants to be shaved. The QIDP and the LPN indicated client B's facial hair should not be scruffy and unkempt.</p> <p>9-3-5(a)</p> <p>483.450(e)(2) DRUG USAGE be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3</p>	W 0312	<p>what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: The client support coordinator will complete facility site visits at least weekly and will monitor client hygiene and appearance specifically focusing on the shaving of facial hair. Immediate action will be taken if needed. The client support coordinator will ensure that the necessary equipment is present to ensure a well-kept appearance for each client served.</p> <p>How corrective actions will be monitored to ensure no recurrence: The client support coordinator will complete facility site visits at least weekly and will monitor client hygiene and appearance specifically focusing on the shaving of facial hair. Immediate action will be taken if needed.</p> <p>Corrective action for resident(s)</p>	01/01/2023	

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W 0352 Bldg. 00	<p>sampled clients (A), the facility failed to ensure client A's psychotropic medication reduction plan targeted a specific medication.</p> <p>Findings include:</p> <p>On 11/29/22 at 4:00 PM, client A's record was reviewed. Client A's 3/23/22 BSP (Behavior Support Plan) did not include a detailed plan to reduce the use of his psychotropic medications. Client A's BSP indicated he was prescribed the following medications for behavior management: Invega, Prozac, and Cogentin. Client A's Medication Reduction Plan indicated, "Invega, Prozac, and Cogentin are administered as components of [client A's] treatment plan for agitation and anxiety related to his Autism. When symptoms of anxiety, or episodes of agitation and aggression have declined to a rate of less than 2 episodes per month for twelve consecutive months, [client A's] team along with a psychiatrist will consider the appropriateness of medication reduction".</p> <p>A review of the Medication Reduction Plan indicated the plan did not include what medication would be targeted for reduction first.</p> <p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP indicated there should be a medication targeted for reduction.</p> <p>9-3-5(a)</p> <p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis</p>		<p>found to have been affected: The Client's BSP will be modified to indicate specifically which medication will be targeted first for reduction.</p> <p>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.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: The facility behavior clinician will review all BSP's to ensure that, when necessary, a specific medication is targeted for reduction.</p> <p>How corrective actions will be monitored to ensure no recurrence: The IDT will review medication reduction plans at least quarterly during support teams to ensure that a specific medication is listed as the target for reduction in each plan as applicable.</p>				

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	<p>performed at least annually.</p> <p>Based on record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure client B had an annual dental exam.</p> <p>Findings include:</p> <p>On 11/29/22 at 3:35 PM, client B's record was reviewed. An OSR (Outside Services Report) dated 7/9/21 indicated client B had a dental exam on 7/9/21 and the recommendation was for him to return for an appointment in six months. There was no documentation indicating client B has been to the dentist since 7/9/21.</p> <p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) and LPN (Licensed Practical Nurse) were interviewed. The LPN indicated client B has not been to the dentist since 7/9/21. The LPN and the QIDP indicated dental exams should be completed annually or as recommended by the dentist.</p> <p>9-3-6(a)</p>	W 0352	<p>Corrective action for resident(s) found to have been affected: The Client did not return for a 6 month dental exam as recommended by a dentist. The Client will be scheduled for the first available appointment with his dentist.</p> <p>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.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: The Client Support Coordinator will complete a monthly audit of all medical appointments for all clients living in the facility to ensure that all necessary appointments are scheduled. In addition, a new audit form will be developed for use by the day aides who schedule medical appointments. These audits will be completed monthly for the facility. Any needed appointments will be scheduled in a timely manner.</p> <p>How corrective actions will be monitored to ensure no recurrence: The Client Support Coordinator will complete a monthly audit of all</p>	01/01/2023

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W 0441 Bldg. 00	<p>483.470(i)(1) EVACUATION DRILLS and under varied conditions to- 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 conduct evacuation drills during various times on the overnight shift.</p> <p>Findings include:</p> <p>On 11/30/22 at 11:05 AM, a review of the facility's evacuation drills was conducted. Evacuation drills were conducted on the overnight shift on 3/3/22 at 10:30 PM, 4/3/22 at 10:25 PM, 9/8/22 at 9:57 PM and on 10/4/22 at 10:00 PM. Clients A, B, C, D and E participated in the drills.</p> <p>A review of the evacuation forms for the overnight shift indicated the drills were conducted between 9:57 PM and 10:30 PM. The drills were not conducted at various times on the overnight shift.</p>	W 0441	<p>medical appointments for all clients living in the facility to ensure that all necessary appointments are scheduled. In addition, a new audit form will be developed for use by the day aides who schedule medical appointments. These audits will be completed monthly for the facility. Any needed appointments will be scheduled in a timely manner. The completed audits will be turned in and reviewed by the client support coordinators who will ensure that action items are followed up.</p> <p>Corrective action for resident(s) found to have been affected: Drills were completed on the overnight shift between 9:57 PM and 10:30 PM instead of at various times. All overnight staff will be re-trained to ensure that the overnight drills occur at various hours throughout the night.</p> <p>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.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence:</p>	01/01/2023

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(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 0460 Bldg. 00	<p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP indicated drills should be conducted once per shift per quarter at varied times on each shift.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview for 1 of 3 sampled clients (B), the facility failed to ensure client B's dining plan was implemented as written.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/28/22 from 4:00 PM to 6:15 PM. At 5:45 PM, client B came to the dining room table to eat. Client B served himself a large piece of meatloaf, mashed potatoes and mixed vegetables. At 6:00 PM, client B asked staff #2 for second servings of each item. Staff #2 stated, "Sure, go ahead". Client B served himself a large piece of meatloaf, mashed potatoes and mixed vegetables. At 6:05 PM, client B served himself another large piece of meatloaf. Staff did not prompt or encourage client B to follow his diet.</p>	W 0460	<p>The Client Support Coordinator will assign drills to the overnight shift and note specific times for the drill to be held ensuring that these times are varied as required.</p> <p>How corrective actions will be monitored to ensure no recurrence: The client support coordinator will review each completed drill to ensure that all drill times are varied. If an issue is noted, the coordinator will request more drills from the overnight staff.</p> <p>Corrective action for resident(s) found to have been affected: Staff did not encourage a Client to follow his diet. The Client should have been encouraged to only have seconds on "free foods." Staff will be re-trained on how to follow the Client's diet.</p> <p>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.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence:</p>	01/01/2023

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 12/01/2022
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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	<p>An observation was conducted at the group home on 11/29/22 from 5:55 AM to 7:35 AM. At 6:36 AM, client B served himself scrambled eggs and an english muffin. At 6:39 AM, client B served himself more scrambled eggs. Staff did not prompt or encourage him to follow his diet.</p> <p>On 11/29/22 at 3:35 PM, client B's record was reviewed. Client B's 10/18/22 Group Home Quarterly Nutrition Assessment indicated client B's diet was, "Regular, seconds on free foods".</p> <p>On 11/30/22 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) and LPN (Licensed Practical Nurse) were interviewed. The QIDP indicated client B's diet was regular with seconds of free foods. The QIDP indicated the free foods are listed on the menu, but they don't include second portions of the meal. The QIDP and LPN indicated staff should prompt and encourage client B to follow his diet.</p> <p>9-3-8(a)</p>		<p>All staff will be re-trained on each client's diet and how to follow them specifically with regard to second servings of food items.</p> <p>How corrective actions will be monitored to ensure no recurrence: The client support coordinator will observe at least one meal per week to provide guidance and on the spot training for all staff should it be needed.</p>		