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	04/05/2023

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 pre-determined full recertification and state licensure survey completed on 12/1/22. This visit was in conjunction with the investigation of complaint #IN00400358. Dates of Survey: April 4 and 5, 2023 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 4/11/23.	W 0000		
W 0225 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on record review and interview for 1 of 3 sampled clients (C), the facility failed to assess client C's vocational needs. Findings include: On 4/4/23 at 12:33 PM, a review of client C's record was conducted. Client C's record indicated he participated in a day program. Client C's record did not indicate documentation of a vocational assessment being completed since 4/25/21. On 4/5/23 at 9:35 AM, the Group Home Director (GHD) stated the vocational assessment was "not done." The GHD indicated the former Qualified	W 0225	**Corrective action for resident(s) found to have been affected:** Client C's Comprehensive Functional assessment was not completed as required and was missing the assessment for vocational needs. The Agency has hired a new QIDP who is now fully trained. Unfortunately, this QIDP used and old form to complete client C's assessment. The old form did not contain the vocational section. The QIDP now has the correct form and will complete the correct assessment	05/06/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Genna Lynn	Executive Residential Director	04/27/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	Intellectual Disabilities Professional (QIDP) held the annual on 5/24/22 but only turned in some of the paperwork. This deficiency was cited on 12/1/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		prior to client C's annual which is scheduled for 5-24-23. **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 Executive Residential Director audited the files of every client in this facility to ensure the correct assessment has been completed. All findings have been shared with the QIDP. All deficiencies found will be corrected by 5-6-23. **How corrective actions will be monitored to ensure no recurrence:** The Client services support coordinator will complete quarterly individual audits which include ensuring that an updated assessment is present and uploaded into the client's electronic file. Any deficiencies are reported to the Associate Director who will then ensure corrective action is taken immediately.	
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be			

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	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. Findings include: On 4/4/23 at 12:33 PM, a review of client C's record was conducted. Client C's most recent CFA was completed on 4/25/21. There was no documentation client C's CFA was reviewed for relevancy and updated at least annually since 4/25/21. On 4/5/23 at 9:35 AM, the Group Home Director (GHD) indicated the CFA was not completed. The GHD indicated the facility needed to do a new CFA for client C. This deficiency was cited on 12/1/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)	W 0259	**Corrective action for resident(s) found to have been affected:** Client C's CFA had not been completed since 4/25/21. The QIDP responsible is no longer employed by the facility. A new QIDP has been hired and is now fully trained. The QIDP will complete the assessment before the client's annual which is scheduled for 5-24-23. **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 Executive Residential Director has completed a facility audit of each client served. All findings have been shared with the QIDP. All deficiencies found will be corrected by 5-6-23. **How corrective actions will be monitored to ensure no recurrence:** The Client services support coordinator will complete quarterly individual audits which include ensuring that an updated assessment is present and	05/06/2023

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			uploaded into the client's electronic file. Any deficiencies are reported to the Associate Director who will then ensure corrective action is taken immediately.	
W 0312 Bldg. 00	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 sampled clients (A), the facility failed to ensure client A's psychotropic medication reduction plan targeted a specific medication. Findings include: On 4/4/23 at 12:43 PM, client A's record was reviewed. Client A's 12/28/22 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 six consecutive months, [client A's] team along with a psychiatrist will consider the appropriateness of medication reduction." A review of the Medication Reduction Plan	W 0312	**Corrective action for resident(s) found to have been affected:** Client A's BSP will be modified to indicate specifically which medication will be targeted first for reduction. The BC misunderstood the previous citation and instead corrected the client's goal to make it attainable instead of also identifying the medication for reduction. **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 Executive Residential Director has completed a facility audit of each client served. All findings have been shared with the BC. All	05/06/2023

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	indicated the plan did not include what medication would be targeted for reduction first. On 4/4/23 at 5:08 PM, the Behavior Specialist (BS) indicated although she revised the plan since the 12/1/22 survey, she did not indicate which psychotropic medication was targeted for reduction first. The BS indicated she needed to revise the BSP to include which psychotropic medication was targeted for reduction first. This deficiency was cited on 12/1/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-5(a)		deficiencies found will be corrected by 5-6-23. **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.	
W 0352 Bldg. 00	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. 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. Findings include: On 4/4/23 at 12:39 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. On 4/5/23 at 10:30 AM, the Group Home Director (GHD) indicated in an email, "[Client B] is scheduled for 5/25/23 @ (at) 8 AM. He has to do	W 0352	**Corrective action for resident(s) found to have been affected:** Client B did not return for a 6 month dental exam as recommended by a dentist. Client B has been scheduled for the first available appointment which includes sedation. This appointment is scheduled for 5/25/23. **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.	05/06/2023

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	this under sedation which is why it is in May. It was scheduled weeks ago." On 4/5/23 at 10:41 AM, the nurse indicated client B did not have the recommended dental examination in 6 months as recommended. The nurse indicated client B had an appointment scheduled on January 17, 2023 but for some reason it was canceled. She indicated another appointment was currently scheduled in May 2023. The nurse stated "Still needs it done. Has not been completed." On 4/5/23 at 11:02 AM, the nurse indicated the January 2023 appointment was rescheduled due to the former day aide (staff who attended doctor's appointments with client B) did not complete the paperwork for the appointment. This deficiency was cited on 12/1/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)		**Measures or systemic changes facility put in place to ensure no recurrence:** The Executive Residential Director has completed a facility audit of each client served. All findings have been shared with the Nurse and day aids who are responsible for ensuring appointments are made and kept. All deficiencies found will be corrected by 5-6-23. **How corrective actions will be monitored 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. The completed audits will be turned in and reviewed by the client support coordinators who will ensure that action items are followed up.	
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.			

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	Based on observation and interview for 5 of 5 clients living at the group home (A, B, C, D and E), the facility failed to ensure the clients served themselves during dinner. Findings include: On 4/4/23 from 3:50 PM to 5:13 PM, an observation was conducted at the group home. At 4:51 PM, staff #5 placed a serving bowl of chili, packs of crackers and peas/carrots on the table. Staff #5 served client A's chili and peas/carrots into a bowl. Client A was not asked to do it himself. At 4:55 PM, staff #5 served clients B's and E's chili and peas/carrots into their bowls. At 4:56 PM, staff #5 served client C's chili and peas/carrots into their bowls. At 4:59 PM, staff #5 served cheese on top of client A's second bowl of chili. At 5:04 PM when staff #5 started to clean up client B's place at the table, staff #1 told staff #5 client B could do it. Staff #1 prompted client B to get a broom and dustpan to clean up under his chair. At 5:06 PM, staff #5 served client D's chili and peas/carrots into bowls. On 4/5/23 at 11:35 AM, the Group Home Director indicated the clients should be serving themselves during meals. 9-3-8(a)	W 0488	**Corrective action for resident(s) found to have been affected:** The facility failed to ensure that the clients served themselves during dinner. Staff #5 placed a serving bowl of chili on the table and then served each client by dipping out their chili into their bowl rather than allowing each to do it themselves. Staff #5 is a newer DSP who is still learning the role of a DSP. He was re-trained on 4-7-23 with regard to family style dining – how to carry it out and what it looks like. **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 agency conducts monthly huddle meetings for all DSPs that focuses on any issues that need to be corrected and or re-trained. Family style dining will remain a topic of discussion for this meeting. In addition the QIDP and Coordinator are monitoring mealtimes by being present in the home during this time at least twice per week. **How corrective actions will be monitored to ensure no**	05/06/2023

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			recurrence: The QIDP and Coordinator are monitoring family style dining by being present in the home during mealtimes at least twice per week. This will be documented by the completion of a site visit.	