

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  08/13/2021
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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 the investigation of complaint #IN00355829.</p> <p>Complaint #IN00355829: Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149, W154 and W331.</p> <p>This visit was in conjunction to the predetermined full recertification and state licensure survey and a Covid-19 focused infection control survey.</p> <p>Survey Dates: August 9, 10, 11, 12 and 13, 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 8/24/21.</p>	W 0000		
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 41 of 60 incident/investigative reports reviewed affecting clients A, B, C, D, E and F, the facility failed to implement its policies and procedures to prevent abuse of the clients, conduct thorough investigations of client A's fractured hand and toe, and implement appropriate corrective actions to prevent client to client abuse.</p>	W 0149	<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</p>	09/12/2021

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>Findings include:</p> <p>On 8/9/21 at 2:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) A 12/8/20 Investigation Report indicated the Group Home Director (GHD) "...read an email on 12/3/20 containing an anonymous report that suggested [group home name][staff #4] had been doing and saying things to antagonize clients into becoming aggressive and make other staff feel uncomfortable. The information given in the anonymous report suggested that [staff #4's] actions had met criteria for the agency definition of verbal/emotional abuse, so an investigation began on the morning of 12/3/20."</p> <p>The investigation indicated in the Direct Evidence section, "The collection of staff statements presents evidence that [staff #4] has displayed behavior that suggests unhealthy boundaries with the clients he supports at [name of group home]. The statement given by [staff #5], who worked with [staff #4] on 12/2/20, includes a description of [staff #4] engaging in behavior that meets the agency criteria for emotional/verbal abuse: [staff #4] encouraging a client to hit him. In his own statement, [staff #4] acknowledges that this interaction with [client F] did occur. The agency's Human Rights Policy provides a definition of verbal/emotional abuse that includes 'any action or words with the intent to cause the individual to react in a negative manner.'"</p> <p>The investigation indicated, "The staff statements support that, on 12/2/2020, [staff #4] encouraged client [client F] to hit him. The behavior</p>		<p>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 days. The QIDP is responsible for completing investigations into episodes of client to client abuse. The QIDP will receive retraining on agency policy regarding investigations into client to client abuse, as well as 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</b></p>				

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	<p>described meets the definition of verbal/emotional abuse that is provided in Stone Belt's Human Rights Policy."</p> <p>The Corrective Action section indicated, "[Staff #4] was suspended on 12/3/2020. This suspension may be lifted, pending the completion of the following items: [Staff #4] will complete retraining on the Prevention of Abuse, Neglect, and Exploitation. [Staff #4] will receive supplemental training on [client F's] BSP. Because there were reports of [staff #4] not following client BSPs, it was also recommended that [staff #4] receive supplemental training on the BSPs of [client B] and [client D], two other Simpson house residents. [Staff #4] will receive a Performance Review for not following BSPs and violating Human Rights Policy."</p> <p>On 8/10/21 at 12:58 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse.</p> <p>On 8/10/21 at 12:58 PM, the Coordinator indicated the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse.</p> <p>On 8/10/21 at 12:58 PM, the Assistant Group Home Director (AGHD) indicated the facility should prevent abuse of the clients. The AGHD indicated the facility had a policy and procedure prohibiting abuse.</p> <p>2) On 7/6/21 at 3:35 PM, client A had been kicking and had bruising on his toe. The 7/7/21 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "...He was</p>		<p><b>facility put in place to ensure no recurrence:</b> Moving forward, the facility will conduct investigations into significant injuries 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. 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.</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.</p> <p><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</p>				

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	<p>diagnosed with a small fracture in right toe... He will follow up with podiatrist in three to five days...."</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 8/10/21 at 9:04 AM, a review of client A's record was conducted and indicated the following:</p> <p>On 7/6/21 at 3:50 PM, client A had bruising on his right great toe. The 7/6/21 Outside Services Report indicated, "Small (right) great toe fracture... Follow-up for this problem: [name of podiatrist]."</p> <p>A 7/7/21 Outside Services Report indicated, "Reason for visit: follow up fracture in toe." At the bottom of the form, the QIDP documented, "Wait was too long &amp; (and) hit [name of Coordinator] in face with shoe. Decided to try again another day." There was no documentation the facility took client A for a follow up appointment with his podiatrist as indicated.</p> <p>On 8/12/21 at 10:10 AM, the Group Home Director (GHD) indicated there was no investigation of the incident. The GHD stated "it was clear" the broken toe was "related to behavior." The GHD indicated he was not sure what client A was kicking to break his toe. The GHD stated "happened right after behavioral incidents." The GHD indicated client A should have had his follow up appointments.</p> <p>3) On 6/11/21 at 1:30 PM, client A's left hand was swollen and bruised. The 6/11/21 BDDS report indicated, "...He has a boxer fracture (a break in a metacarpal bone that connects the ring</p>		<p>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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	<p>finger or the little finger to the wrist). He was put in a splint. It was a significant injury that required outside medical services.... He was put in a splint and will be seen at orthopedic on Monday (6/14/21)...."</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 8/10/21 at 9:04 AM, a review of client A's record was conducted and indicated the following: There was no documentation of an appointment with the orthopedic from 6/14/21. There was no documentation client A had a follow up appointment with the orthopedic until 8/9/21.</p> <p>A 6/14/21 note in the Activity Report section in client A's record indicated, "Staff notes on today's ortho appt are as follows; [Client A] went to [name] Orthopedic in [name of city] (E.R. (emergency room) on 6-11). He was seen by [name of doctor]. [Client A] has a fracture/broken bone by his left pinky finger. A hand brace was put on. Be sure that if it is taken off for showers (only if staff is comfortable with putting it back on) make sure his pinky finger goes in the hole for the finger and put the strap over three fingers. I didn't know if [client A] would mess with the velcro, so they went ahead and put an ace bandage over it, but not a must. He is to return to see [name of doctor] on Friday June 25th. @ 10:20."</p> <p>There was no documentation client A had a follow up appointment on 6/25/21.</p> <p>On 8/12/21 at 10:24 AM, the nurse indicated based on the appointment calendar, client A had a follow up appointment on 6/14/21 however she</p>			

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	<p>was unable to locate the documentation. The nurse indicated she found a note dated 6/14/21 from her and staff. The nurse indicated although the note indicated a follow up appointment was scheduled on 6/25/21, she found another note indicating the appointment was on 6/28/21 however she was unable to locate the documentation. The nurse indicated client A's record should contain documentation of the follow up appointments.</p> <p>On 8/12/21 at 10:10 AM, the GHD indicated there was no investigation of the fracture. The GHD stated "it was clear" the fracture was "related to behavior." The GHD indicated the fracture was caused from hitting hard surfaces and in the van during transport. The GHD indicated client A should have had a follow up appointment.</p> <p>4) On 8/13/20 at 4:30 PM, client D swatted and hit client E as they passed each other in the hallway.</p> <p>5) On 9/22/20 at 3:00 PM, client A smacked client B with both of his hands. Client B was not injured.</p> <p>6) On 9/26/20 at 2:30 PM, client A struck client B on the top of his head. Client B was not injured.</p> <p>7) On 11/7/20 at 12:15 PM, client A struck client B on the left shoulder with an open hand. Client B was not injured.</p> <p>8) On 1/24/21 at 8:30 AM, client A struck client F on the top of his head with an open hand. Client F was not injured.</p>			

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	<p>9) On 2/23/21 at 7:35 AM, client A ran down the hallway and started to hit client C on the head two times before staff intervened. Client C's forehead was red.</p> <p>10) On 3/19/21 at 5:00 PM, client A tapped client C on the top of his head 3-4 times.</p> <p>11) On 3/20/21 at 9:30 AM, client A struck client E on the shoulder.</p> <p>12) On 3/23/21 at 7:15 PM, client C reported to staff client A entered the kitchen and hit him on top of the head.</p> <p>13) On 4/4/21 at 9:00 AM, client A went into client D's room and staff heard client D cry out. Client D reported client A hit him. Client D was not injured.</p> <p>14) On 4/4/21 at 5:00 PM, client A slapped client B (location was not indicated). Client B was not injured.</p> <p>15) On 4/25/21 at 5:10 PM, client D returned to the group home from a visit with his mom. Staff heard two loud smacks followed by yelling and screaming. Client B went to the staff crying and indicated client D hit him. Client B was not injured.</p> <p>16) On 5/1/21 at 5:30 PM, client A hit client F on the head two times before staff intervened. Client F was not injured.</p> <p>17) On 5/21/21 at 6:40 PM, client A ran into the living room and smacked client D on the top of the head. Client D was not injured.</p> <p>18) On 5/22/21 at 10:40 AM, client A ran out of</p>			

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	<p>the kitchen to hit client E twice on the arm. Client E was not injured.</p> <p>19) On 5/22/21 at 6:40 PM, client A ran over to client F and hit him on the top of his head with both hands. Client F was not injured.</p> <p>20) On 5/28/21 at 6:30 AM, client A ran up to client D and hit him on the head with both hands. Client D was not injured.</p> <p>21) On 5/29/21 at 8:30 AM, client A smacked client C on the head two times before staff intervened. Client C was not injured.</p> <p>22) On 6/5/21 at 3:50 PM, client A struck client D on the head.</p> <p>23) On 6/13/21 at 3:00 PM, client A ran into client E's room and hit him on the head and arm. Client E shoved client A.</p> <p>24) On 6/16/21 at 4:30 PM, client A ran up to client B and slapped him. Client A then ran at client D and slapped him.</p> <p>25) On 6/18/21 at 6:25 AM, client A hit client E several times on the back and grabbed his arm as client E tried to walk away. Client E was not injured.</p> <p>26) On 6/18/21 at 8:30 PM, client A went into client D's room and slapped him.</p> <p>27) On 6/21/21 at 4:25 PM, client B slapped client E on the back as client E walked down the hallway. Client E had a red mark on his back.</p> <p>28) On 6/21/21 at 5:00 PM, client A ran into the hallway and slapped client B. Client B hit client</p>			

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	<p>A. Client B continued to attempt to go after client A and had to be restrained by two staff.</p> <p>29) On 6/24/21 at 6:25 AM, client C exited his room to go to the bathroom. Client A exited his room. Client A hit client C two times before staff intervened. Client C had a red spot on his head.</p> <p>30) On 6/26/21 at 8:15 AM, client A ran out of his room and slapped client E twice before staff intervened. Client E was not injured.</p> <p>31) On 6/26/21 at 10:10 AM, client A chased client B through the dining room hitting him on the back of the head and shoulders. Client B was not injured.</p> <p>32) On 6/27/21 at 7:00 PM, client A slapped client E on the back of his shoulders and neck area. Client E was not injured.</p> <p>33) On 6/30/21 at 7:30 PM, client A ran into client B's room and slapped him (location of slap was not indicated).</p> <p>There was no documentation the facility conducted an investigation.</p> <p>34) On 7/4/21 at 1:15 PM, client A ran into client E's room. Staff stopped client A before client A hit client E. Client E reached over staff and pushed client A by the head. Client A was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>35) On 7/10/21 at 5:00 PM, client A tapped client D on the top of his head with both hands.</p>			

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	<p>Client D was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>36) On 7/11/21 at 5:15 PM, client A jumped up off the couch and slapped client D on the back of the head. Client D was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>37) On 7/21/21 at 4:40 PM, client A hit client D on the back as client D was trying to find something to watch on the television.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>38) On 7/24/21 at 7:45 PM, client D hit client F on the shoulders after staff reminded him to drink water instead of coffee. Client F had red marks on his shoulders.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>39) On 7/31/21 at 6:25 PM, client B was on the floor having a behavior. Client A ran up to client B and kicked him. Client A attempted to hit client B when client B kicked him in the head. Client A ran away. Neither client was injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>40) On 8/8/21 at 10:45 AM, client B struck client E on the arm as he was walking into the kitchen.</p>			

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	<p>41) On 8/8/21 at 6:00 PM, client A hit client B on the top of the head twice with both hands. Client B cried after being hit.</p> <p>On 8/9/21 at 1:30 PM, staff #3 indicated client A had a recent increase in physical aggression after an increase in Invega. Staff #3 stated, "Non-stop going after others." Staff #3 indicated client A fractured his hand from hitting. Staff #3 indicated client A was kicking the office door trying to get in and it caused him to have a broken toe. Staff #3 indicated client A's peers spend more time in their rooms and lock their doors to keep him out. On 8/9/21 at 1:50 PM, staff #3 indicated clients B, C and D show fear of client A. Client D watched behind him when the door alarm sounds indicating client A left his bedroom.</p> <p>On 8/9/21 at 1:55 PM, client C indicated when he was in his bedroom at the group home, he called the group home phone to ask staff if client A was in the common area. Client C stated he called the house phone "so I can leave my room." Client C stated there were times when he "needs to use the restroom so I call to see if OK to come out." Client C indicated there was one time he forgot to lock his door and client A came into his bedroom and hit him. Client C indicated he was not afraid of client A however he did not like to be hit.</p> <p>On 8/9/21 at 2:14 PM, staff #5 indicated client B did not like client A. Staff #5 indicated client B reported he was afraid of being hit by client A. Staff #5 stated, "No one else (is) scared but none like to be hit."</p> <p>On 8/9/21 at 3:45 PM, the QIDP stated client A's aggression had "decreased majorly." The QIDP</p>			

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	<p>indicated when client A was in the middle of his increased aggression, client C was afraid of getting hit by him. The QIDP indicated client C was no longer afraid of being hit by client A.</p> <p>On 8/9/21 at 4:42 PM, the Home Manager (HM) indicated client C was afraid of client A. The HM indicated client C was glad when client A stopped attending the facility-operated day program. The HM indicated client A and his peers' quality of life was low due to client A's aggression. The HM indicated client F, at times, screamed when client A went toward him. Clients C and E stayed in their rooms due to client A.</p> <p>On 8/9/21 at 4:59 PM, client C indicated he was afraid of getting hit by client A. Client C stated, "I am afraid. All I want is to be his friend. He's hit me. Played bongo on my head." Client C indicated he spent more time in his room due to avoiding client A. On 8/9/21 at 5:04 PM, client C stated, "If I wasn't cooking with [QIDP], I'd be in my room."</p> <p>On 8/9/21 at 5:14 PM, staff #6 stated "not sure anyone afraid or scared" of client A. Staff #6 stated client A's peers were "definitely anxious. They hear the alarm (client A's door alarm) and you can hear their doors close." Staff #6 indicated client A did not hit hard and he was doing better. Staff #6 stated client A's behavior "has improved."</p> <p>On 8/10/21 at 7:17 AM, staff #7 indicated clients B and C were afraid of client A due to his hitting. Staff #7 stated client A was "doing better. Not hitting as hard. Not caused any injuries. He's doing a lot better."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G655	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/13/2021
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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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	<p>On 8/10/21 at 12:58 PM, the QIDP 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. The QIDP indicated the timeframe for reporting incidents to BDDS was 24 hours. The QIDP indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. The QIDP indicated all incidents of client to client aggression needed to be investigated.</p> <p>On 8/10/21 at 12:58 PM, the Coordinator indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The Coordinator indicated the facility had a policy and procedure prohibiting abuse. The Coordinator indicated the timeframe for reporting incidents to BDDS was 24 hours. The Coordinator indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. The Coordinator indicated all incidents of client to client aggression needed to be investigated.</p> <p>On 8/10/21 at 12:58 PM, the Assistant Group Home Director 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. The AGHD indicated the timeframe for reporting incidents to BDDS was 24 hours. The AGHD indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. The AGHD indicated all incidents of client to client aggression needed to be investigated.</p> <p>On 8/12/21 at 1:51 PM, a review of the facility's 2/26/21 Incident Reporting Procedure indicated,</p>			

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	"...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...." The 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 conducted in a timely manner and, when applicable, will include follow-up requirements designed to prevent recurring problematic incidents... All investigations must be completed			

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W 0154 Bldg. 00	<p>within Five (5) business days of knowledge of the incident and results distributed to appropriate team members as necessary...."</p> <p>This federal tag relates to complaint #IN00355829.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) <b>STAFF TREATMENT OF CLIENTS</b> The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 9 of 60 incident/investigative reports reviewed affecting clients A, B, D, E and F, the facility failed to conduct thorough investigations of client A's fractures (toe and hand) and incidents of client to client aggression.</p> <p>Findings include:</p> <p>On 8/9/21 at 2:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 7/6/21 at 3:35 PM, client A had been kicking and had bruising on his toe. The 7/7/21 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "...He was diagnosed with a small fracture in right toe... He will follow up with podiatrist in three to five days...."</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 8/10/21 at 9:04 AM, a review of client A's record was conducted and indicated the following:</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> The Director or Associate Director of SGL currently investigates 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>	09/12/2021

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  08/13/2021	
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>On 7/6/21 at 3:50 PM, client A had bruising on his right great toe. The 7/6/21 Outside Services Report indicated, "Small (right) great toe fracture... Follow-up for this problem: [name of podiatrist]."</p> <p>A 7/7/21 Outside Services Report indicated, "Reason for visit: follow up fracture in toe." At the bottom of the form, the QIDP documented, "Wait was too long &amp; (and) hit [name of Coordinator] in face with shoe. Decided to try again another day." There was no documentation the facility took client A for a follow up appointment with his podiatrist as indicated.</p> <p>On 8/12/21 at 10:10 AM, the Group Home Director (GHD) indicated there was no investigation of the incident. The GHD stated "it was clear" the broken toe was "related to behavior." The GHD indicated he was not sure what client A was kicking to break his toe. The GHD stated "happened right after behavioral incidents." The GHD indicated client A should have had his follow up appointments.</p> <p>2) On 6/11/21 at 1:30 PM, client A's left hand was swollen and bruised. The 6/11/21 BDDS report indicated, "...He has a boxer fracture (a break in a metacarpal bone that connects the ring finger or the little finger to the wrist). He was put in a splint. It was a significant injury that required outside medical services.... He was put in a splint and will be seen at orthopedic on Monday (6/14/21)...."</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 8/10/21 at 9:04 AM, a review of client A's</p>		<p>days. The QIDP is responsible for completing investigations into episodes of client to client abuse. The QIDP will receive retraining on agency policy regarding investigations into client to client abuse, as well as 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> Moving forward, the facility will conduct investigations into significant injuries 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 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</p>				

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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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	<p>record was conducted and indicated the following: There was no documentation of an appointment with the orthopedic from 6/14/21. There was no documentation client A had a follow up appointment with the orthopedic until 8/9/21.</p> <p>A 6/14/21 note in the Activity Report section in client A's record indicated, "Staff notes on today's ortho appt are as follows; [Client A] went to [name] Orthopedic in [name of city] (E.R. (emergency room) on 6-11). He was seen by [name of doctor]. [Client A] has a fracture/broken bone by his left pinky finger. A hand brace was put on. Be sure that if it is taken off for showers (only if staff is comfortable with putting it back on) make sure his pinky finger goes in the hole for the finger and put the strap over three fingers. I didn't know if [client A] would mess with the velcro, so they went ahead and put an ace bandage over it, but not a must. He is to return to see [name of doctor] on Friday June 25th. @ 10:20."</p> <p>There was no documentation client A had a follow up appointment on 6/25/21.</p> <p>On 8/12/21 at 10:24 AM, the nurse indicated based on the appointment calendar, client A had a follow up appointment on 6/14/21 however she was unable to locate the documentation. The nurse indicated she found a note dated 6/14/21 from her and staff. The nurse indicated although the note indicated a follow up appointment was scheduled on 6/25/21, she found another note indicating the appointment was on 6/28/21 however she was unable to locate the documentation. The nurse indicated client A's record should contain documentation of the follow up appointments.</p>		<p>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.</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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	<p>On 8/12/21 at 10:10 AM, the GHD indicated there was no investigation of the fracture. The GHD stated "it was clear" the fracture was "related to behavior." The GHD indicated the fracture was caused from hitting hard surfaces and in the van during transport. The GHD indicated client A should have had a follow up appointment.</p> <p>3) On 6/30/21 at 7:30 PM, client A ran into client B's room and slapped him (location of slap was not indicated).</p> <p>There was no documentation the facility conducted an investigation.</p> <p>4) On 7/4/21 at 1:15 PM, client A ran into client E's room. Staff stopped client A before client A hit client E. Client E reached over staff and pushed client A by the head. Client A was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>5) On 7/10/21 at 5:00 PM, client A tapped client D on the top of his head with both hands. Client D was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>6) On 7/11/21 at 5:15 PM, client A jumped up off the couch and slapped client D on the back of the head. Client D was not injured.</p> <p>There was no documentation the facility conducted an investigation.</p>			

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	<p>7) On 7/21/21 at 4:40 PM, client A hit client D on the back as client D was trying to find something to watch on the television.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>8) On 7/24/21 at 7:45 PM, client D hit client F on the shoulders after staff reminded him to drink water instead of coffee. Client F had red marks on his shoulders.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>9) On 7/31/21 at 6:25 PM, client B was on the floor having a behavior. Client A ran up to client B and kicked him. Client A attempted to hit client B when client B kicked him in the head. Client A ran away. Neither client was injured.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 8/10/21 at 12:58 PM, the Qualified Intellectual Disabilities Professional indicated all incidents of client to client aggression needed to be investigated.</p> <p>On 8/10/21 at 12:58 PM, the Coordinator indicated all incidents of client to client aggression needed to be investigated.</p> <p>On 8/10/21 at 12:58 PM, the Assistant Group Home Director indicated all incidents of client to client aggression needed to be investigated.</p> <p>This federal tag relates to complaint #IN00355829.</p>			

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W 0331  Bldg. 00	<p>9-3-2(a) 483.460(c) <b>NURSING SERVICES</b></p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (A), the facility's nursing services failed to ensure client A had timely follow up appointments for a toe fracture and a hand fracture.</p> <p>Findings include:</p> <p>1) On 8/9/21 at 2:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/6/21 at 3:35 PM, client A had been kicking and had bruising on his toe. The 7/7/21 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "...He was diagnosed with a small fracture in right toe... He will follow up with podiatrist in three to five days...."</p> <p>On 8/10/21 at 9:04 AM, a review of client A's record was conducted and indicated the following:</p> <p>On 7/6/21 at 3:50 PM, client A had bruising on his right great toe. The 7/6/21 Outside Services Report indicated, "Small (right) great toe fracture... Follow-up for this problem: [name of podiatrist]."</p> <p>A 7/7/21 Outside Services Report indicated, "Reason for visit: follow up fracture in toe." At the bottom of the form, the Qualified Intellectual Disabilities Professional (QIDP) documented, "Wait was too long &amp; (and) hit [name of Coordinator] in face with shoe. Decided to try</p>	W 0331	<p>W 331 NURSING SERVICES CFR(s): 483.460(c)</p> <p><b>Corrective action for resident(s) found to have been affected:</b> Client A has now completed the recommend medical follow up for the hand and toe fractures and there is documentation in the client's record that these injuries have resolved with no further follow up recommended.</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 facility nurse is responsible for ensuring that clients receive medical services in accordance with what has been recommended by their physicians, including the completion of recommended follow-up appointments. When a significant injury occurs, the program director or other designated team member will investigate to determine the cause</p>	09/12/2021			

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	<p>again another day."</p> <p>There was no documentation of a follow up appointment with client A's podiatrist.</p> <p>On 8/10/21 at 1:08 PM, the QIDP indicated the follow up appointment needed to be rescheduled. The QIDP indicated the Coordinator attempted to take him to the appointment however due to client A's maladaptive behaviors, the appointment could not be completed.</p> <p>On 8/10/21 at 1:08 PM, the Coordinator indicated on 7/7/21, client A was hitting him on the van and they could not make it into the appointment. The Coordinator indicated there was no follow up appointment scheduled at this time.</p> <p>On 8/12/21 at 10:24 AM, the nurse stated client A missed his appointment on 7/7/21 "due to combativeness." The nurse indicated client A should have been seen or another attempt made since 7/7/21 for a follow up appointment. The nurse stated "they should be scheduling one (a follow up appointment)."</p> <p>2) On 8/9/21 at 2:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 6/11/21 at 1:30 PM, client A's left hand was swollen and bruised. The 6/11/21 BDDS report indicated, "...He has a boxer fracture (a break in a metacarpal bone that connects the ring finger or the little finger to the wrist). He was put in a splint. It was a significant injury that required outside medical services.... He was put in a splint and will be seen at orthopedic on Monday (6/14/21)...."</p>		<p>of the injury, whether abuse or neglect occurred, and how to prevent recurrence. One component of this investigative process will be for the director to coordinate with the facility nurse to ensure that the client received all recommended medical, that the client attended any recommended follow up appointments, and that there is documentation of medical recommendations in the client's file.</p> <p><b>How corrective actions will be monitored to ensure no recurrence:</b></p> <p>The facility nurse is responsible for ensuring that clients receive medical services in accordance with what has been recommended by their physicians, including the completion of recommended follow-up appointments. When a significant injury occurs, the program director or other designated team member will investigate to determine the cause of the injury, whether abuse or neglect occurred, and how to prevent recurrence. One component of this investigative process will be for the director to coordinate with the facility nurse to ensure that the client received all recommended medical, that the client attended any recommended follow up appointments, and that there is documentation of medical recommendations in the client's file.</p>				

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	<p>On 8/10/21 at 9:04 AM, a review of client A's record was conducted and indicated the following:</p> <p>There was no documentation of an appointment with the orthopedic from 6/14/21.</p> <p>A 6/14/21 note in the Activity Report section in client A's record indicated, "Staff notes on today's ortho appt are as follows; [Client A] went to [name] Orthopedic in [name of city] (E.R. (emergency room) on 6-11). He was seen by [name of doctor]. [Client A] has a fracture/broken bone by his left pinky finger. A hand brace was put on. Be sure that if it is taken off for showers (only if staff is comfortable with putting it back on) make sure his pinky finger goes in the hole for the finger and put the strap over three fingers. I didn't know if [client A] would mess with the velcro, so they went ahead and put an ace bandage over it, but not a must. He is to return to see [name of doctor] on Friday June 25th. @ 10:20."</p> <p>There was no documentation client A had a follow up appointment on 6/25/21.</p> <p>On 8/12/21 at 10:24 AM, the nurse indicated based on the appointment calendar, client A had a follow up appointment on 6/14/21 however she was unable to located the documentation. The nurse indicated she found a note dated 6/14/21 from her and staff. The nurse indicated although the note indicated a follow up appointment was scheduled on 6/25/21, she found another note indicating the appointment was on 6/28/21 however she was unable to locate the documentation. The nurse indicated client A's record should contain documentation of the follow up appointments.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2021

FORM APPROVED

OMB NO. 0938-0391

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