**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:**

15G220

**MULTIPLE CONSTRUCTION**

A. BUILDING

00

B. WING

**DATE SURVEY COMPLETED:**

04/07/2017

**NAME OF PROVIDER OR SUPPLIER**

STONE BELT ARC INC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

4700 HITE DR

BLOOMINGTON, IN 47408

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**PREFIX**

**TAG**

**ID**

**PROVIDER’S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

**COMPLETION DATE**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>W 0000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W 0000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W 0102</td>
<td></td>
<td></td>
<td>05/05/2017</td>
</tr>
</tbody>
</table>

**GOVERNING BODY AND MANAGEMENT**

The facility must ensure that specific governing body and management requirements are met.

Based on record review and interview for 3 of 3 clients in the sample (#1, #4 and #6) and two additional clients (#2 and #5), the facility failed to meet the Condition of Participation: Governing Body. The facility’s governing body failed to exercise operating direction over the facility by failing to ensure staff prevented client to client abuse, investigated falls and recurring medication errors while client #4 was on home visits, and took appropriate corrective action for resident(s) found to have been affected.

Staff, including QIDP and Coordinator will be trained on how to prevent, report and follow up on client to client abuse, medication errors and falls.

QIDP will be trained to review and...
corrective actions to address client #1’s falls and client #4’s recurring medication errors while on home visits. The governing body failed to oversee the Qualified Intellectual Disabilities Professional (QIDP) to ensure the QIDP integrated, coordinated and monitored the clients’ individualized program plans. The governing body failed to ensure the QIDP addressed recurring issues with client #4 going on home visits and returning with medications that were not administered as ordered by the physician. The governing body failed to ensure the QIDP adequately addressed client #1’s six falls in the past 3 months. The governing body failed to ensure the QIDP reviewed and updated client #6’s ISP and comprehensive functional assessment annually. The governing body failed to ensure the QIDP reviewed client #1’s and #6’s July and August 2016 program plans to ensure the clients were making progress on their training objectives.

Findings include:

1) Please refer to W104. For 3 of 3 clients in the sample (#1, #4 and #6) and two additional clients (#2 and #5), the facility’s governing body failed to exercise operating direction over the facility by failing to ensure staff prevented client to client abuse, investigate all falls, client to client abuse and med errors and take corrective action. QIDP will be trained to integrate, coordinate and monitor all client’s IPP for relevance.

Monitoring will occur. QIDP will be trained on reviewing ISP, program plans and CFA annually.

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
New form to aid in information gathering for the purpose on investigating falls has been created and staff (QIDP and Coordinator) will be trained on importance of investigating all falls. Client that had several falls has been scheduled for physical therapy on 4/26 9am.

When a client that has a history of med errors at home, has plans to visit family, staff will prevent med errors by using a pill minder to aid in client and family’s organization of med
investigated falls and recurring medication errors while client #4 was on home visits, and took appropriate corrective actions to address client #1’s falls and client #4’s recurring medication errors while on home visits. The governing body failed to oversee the Qualified Intellectual Disabilities Professional (QIDP) to ensure the QIDP integrated, coordinated and monitored the clients’ individualized program plans.

2) Please refer to W122. For 21 of 28 incident/investigative reports reviewed affecting 2 of 3 clients in the sample (#1 and #6) and three additional clients (#2, #4 and #5), the governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to implement its policies and procedures to prevent client to client abuse, investigate falls and recurring medication errors while client #4 was on home visits, and take appropriate corrective actions to address falls and client #4’s recurring medication errors while on home visits.

9-3-1(a)

administration at home. Client’s mother has agreed to this resource. If more med errors occur, client and family will be asked to attend IDT meeting to discuss issue.

Director and associate director will review all client to client abuse investigations and ensure proper corrective action is taking place by QIDP and coordinator. Corrective action will be documented in the investigation and followed up in support team.

Director and associate director will audit client’s charts monthly for compliance.

How corrective actions will be monitored to ensure no recurrence

The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction (POC). The meeting will be chaired by SGL Director (or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training.
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING

**Date Survey Completed:** 04/07/2017

**Name of Provider or Supplier:** STONE BELT ARC INC

**Street Address, City, State, Zip Code:** 4700 HITE DR BLOOMINGTON, IN 47408

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Regulatory or LSC Identifying Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>W 0104</td>
<td>Bldg. 00</td>
<td>483.410(a)(1) GOVERNING BODY</td>
<td>The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 2 of 3 clients in the sample (#1 and #6) and three additional clients (#2, #4 and #5), the facility's governing body failed to exercise operating direction over the facility by failing to ensure staff prevented client to client abuse, investigated falls and recurring medication errors while client #4 was on home visits, and took appropriate corrective actions to address client #1's falls and client #4's recurring medication errors while on home visits. The governing body failed to oversee the Qualified Intellectual Disabilities Professional (QIDP) to ensure the QIDP integrated, coordinated and monitored the clients' individualized program plans. Findings include: 1) Please refer to W149. For 21 of 28 incident/investigative reports reviewed affecting clients #1, #2, #4, #5 and #6,</td>
</tr>
</tbody>
</table>

**Provider's Plan of Correction**

- The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.
- **W 104 Governing Body**
  - Corrective action for resident(s) found to have been affected
  - Staff, including QIDP and Coordinator will be trained on how to prevent, report and follow up on client to client abuse, medication errors and falls.
  - QIDP will be trained to review and investigate all falls, client to client abuse and med errors and take corrective action. QIDP will be trained to integrate, coordinate and monitor all client's IPP for relevance.
  - Monitoring will occur. QIDP will be trained on reviewing ISP, program plans and CFA annually

**How facility will identify other residents potentially affected & what measures taken**

All residents potentially are affected, and corrective
the governing body neglected to implement its policies and procedures to prevent client to client abuse, investigate falls and recurring medication errors while client #4 was on home visits, take appropriate corrective actions to address falls and client #4's recurring medication errors while on home visits.

2) Please refer to W154. For 16 of 28 incident reports reviewed affecting clients #1, #2, #4, #5 and #6, the governing body failed to conduct thorough investigations of falls and recurring issues with medications errors while client #4 was on home visits with his mom.

3) Please refer to W157. For 14 of 28 incident reports reviewed affecting clients #1 and #4, the governing body failed to implement appropriate corrective actions to address client #4's recurrent issues with medication errors while on home visits and client #1's falls.

4) Please refer to W159. For 2 of 3 clients in the sample (#1 and #6) and one additional client (#4), the governing body failed to ensure the QIDP integrated, coordinated and monitored the clients' individualized support plans (ISP). The governing body failed to ensure the QIDP addressed recurring issues with client #4 measures address the needs of all clients.

**Measures or systemic changes**

**facility put in place to ensure**

**no recurrence**

New form to aid in information gathering for the purpose on investigating falls has been created and staff (QIDP and Coordinator) will be trained on importance of investigating all falls.

When a client that has a history of med errors at home, has plans to visit family, staff will prevent med errors by using a pill minder to aid in client and family's organization of med administration at home. Client's mother has agreed to this resource. If more med errors occur, client and family will be asked to attend IDT meeting to discuss issue.

Director and associate director will review all client to client abuse investigations and ensure proper corrective action is taking place by QIDP and coordinator. Corrective action will be documented in the investigation and followed up in support team.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 15G220

**MULTIPLE CONSTRUCTION**

**A. BUILDING**

**B. WING**

**DATE SURVEY COMPLETED:** 04/07/2017

**NAME OF PROVIDER OR SUPPLIER:** STONE BELT ARC INC

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 4700 HITE DR, BLOOMINGTON, IN 47408

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>W 0122</td>
<td>going on home visits and returning with medications that were not administered as ordered by the physician. The governing body failed to ensure the QIDP adequately addressed client #1's six falls in the past 3 months. The governing body failed to ensure the QIDP reviewed and updated client #6's ISP and comprehensive functional assessment annually. The governing body failed to ensure the QIDP reviewed client #1's and #6's July and August 2016 program plans to ensure the clients were making progress on their training objectives.</td>
<td>483.420</td>
<td>[9-3-1(a)]</td>
<td>Director and associate director will audit client’s charts monthly for compliance.</td>
</tr>
</tbody>
</table>

**W 0122 Client Protections**

**Event ID:** 0POC11  **Facility ID:** 000744  **If continuation sheet:** Page 6 of 70
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
<tr>
<td>PREFIX</td>
<td>TAG</td>
<td>ID</td>
<td>PREFIX</td>
</tr>
<tr>
<td></td>
<td>1) Implement its policies and procedures to prevent client to client abuse, investigate falls and recurring medication errors while client #4 was on home visits, and take appropriate corrective actions to address falls and client #4's recurring medication errors while on home visits.</td>
<td>Exploitation Policy including how to prevent, report and follow up on client to client abuse. Staff will be trained to report, investigate and follow up on medication errors and falls.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Findings include:</td>
<td>QIDP will be trained to review and investigate all falls, client to client abuse and med errors and take corrective action.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1) Please refer to W149. For 21 of 28 incident/investigative reports reviewed affecting clients #1, #2, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, investigate falls and recurring medication errors while client #4 was on home visits, take appropriate corrective actions to address falls and client #4's recurring medication errors while on home visits.</td>
<td>How facility will identify other residents potentially affected &amp; what measures taken</td>
<td>All residents potentially are affected, and corrective measures address the needs of all clients.</td>
</tr>
<tr>
<td></td>
<td>2) Please refer to W154. For 16 of 28 incident reports reviewed affecting clients #1, #2, #4, #5 and #6, the facility failed to conduct thorough investigations of falls and recurring issues with medications errors while client #4 was on home visits with his mom.</td>
<td>Measures or systemic changes facility put in place to ensure no recurrence</td>
<td>New form to aid in information gathering for the purpose of investigating falls has been created and staff (QIDP and Coordinator) will be trained on importance of investigating all falls.</td>
</tr>
<tr>
<td></td>
<td>3) Please refer to W157. For 14 of 28 incident reports reviewed affecting clients #1 and #4, the facility failed to implement appropriate corrective actions</td>
<td></td>
<td>When a client that has a history of med errors at home, has plans to visit family, staff will prevent med errors by using a pill minder to aid in client and family's organization of med administration at home. Client's</td>
</tr>
</tbody>
</table>
to address client #4's recurrent issues with medication errors while on home visits and client #1's falls.

9-3-2(a)

mother has agreed to this resource. If more med errors occur, client and family will be asked to attend IDT meeting to discuss issue.

Director and associate director will review all client to client abuse investigations and ensure proper corrective action is taking place by QIDP and coordinator. Corrective action will be documented in the investigation and followed up in support team.

How corrective actions will be monitored to ensure no recurrence

The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction (POC). The meeting will be chaired by SGL Director (or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>W 0149</td>
<td></td>
<td></td>
<td>resurvey</td>
<td>W 0149</td>
<td></td>
<td></td>
<td>W 149 Staff Treatment of Clients</td>
<td>05/05/2017</td>
</tr>
</tbody>
</table>

**W 149 Staff Treatment of Clients**

Corrective action for resident(s) found to have been affected

Staff, including QIDP and Coordinator will be trained on Prevention of Abuse Neglect and Exploitation Policy including how to prevent, report and follow up on client to client abuse. Staff will be trained to report, investigate and follow up on medication errors and falls.

QIDP will be trained to review and investigate all falls, client to client abuse and med errors and take corrective action.

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

On 4/3/17 at 12:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:

A) Client #4 returned to the group home with medications that were not administered during visits to his mom's house on the following dates:

   1) On 7/4/16 at 5:00 PM when client #4 returned to the group home from a visit with his mom, a medication he took with
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>ID</th>
<th>PREFIX TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**MULTIPLE CONSTRUCTION**

**DATE SURVEY COMPLETED:** 04/07/2017

**NAME OF PROVIDER OR SUPPLIER:** STONE BELT ARC INC

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 4700 HITE DR
BLOOMINGTON, IN 47408

**ID**

**PREFIX**

**TAG**

**NEW FORM TO AID IN INFORMATION GATHERING FOR THE PURPOSE OF INVESTIGATING FALLS HAS BEEN CREATED AND STAFF (QIDP AND COORDINATOR) WILL BE TRAINED ON IMPORTANCE OF INVESTIGATING ALL FALLS.**

**WHEN A CLIENT THAT HAS A HISTORY OF MED ERRORS AT HOME, HAS PLANS TO VISIT FAMILY, STAFF WILL PREVENT MED ERRORS BY USING A PILL MINDER TO AUXILIATE IN CLIENT AND FAMILY’S ORGANIZATION OF MEDICATION ADMINISTRATION AT HOME. CLIENT’S MOTHER HAS AGREED TO THIS RESOURCE. IF MORE MED ERRORS OCCUR, CLIENT AND FAMILY WILL BE ASKED TO ATTEND IDT MEETING TO DISCUSS ISSUE.**

**DIRECTOR AND ASSOCIATE DIRECTOR WILL REVIEW ALL CLIENT TO CLIENT ABUSE INVESTIGATIONS AND ENSURE PROPER CORRECTIVE ACTION IS TAKING PLACE BY QIDP AND COORDINATOR. CORRECTIVE ACTION WILL BE DOCUMENTED IN THE INVESTIGATION AND FOLLOWED UP IN SUPPORT TEAM.**

**HOW CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE NO RECURRENTENCE**

**Him (Colcrys for gout) was not administered by client #4 or his mom on 7/4/16. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.**

**2) On 7/23/16 during the morning medication pass to client #4 it was discovered client #4 did not receive Androgel (low testosterone) every third day in the morning during his home visit from 7/20/16 to 7/24/16. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.**

**3) On 9/5/16 when client #4 returned from a home visit (9/2/16 to 9/5/16), it was discovered he missed one dose of the following: Tamsulosin (urination), Losartan (hypertension), Ropinirole (restless leg syndrome), Atorvastatin (high cholesterol), Allopurinol (gout), Aspirin (blood clot prevention) and Androgel. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.**

**4) On 10/22/16 at 5:30 PM when client #4 returned to the group home from visiting his mom, it was discovered he did not receive Androgel. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.**
5) On 11/13/16 when client #4 returned to the group home from visiting his mom, he was not administered one dose of the following medications: Ropinirole, Atorvastatin, Tamsulosin, Allopurinol, Aspirin, Loratadine (allergies), Losartan and Colcrys. No adverse reactions were noted. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

6) On 12/26/16 at 8:03 PM when client #4 returned to the group home from visiting his mom, he did not receive Androgel. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

7) On 3/12/17 when client #4 returned to the group home from visiting his mom, it was found he did not take one dose of the following medications: Loratadine, Allopurinol, Aspirin, Atorvastatin, Colcrys and Losartan. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.
8) On 3/25/17 when client #4 returned to the group home from visiting his mom, it was found he was not administered one dose of the following medications: Losartan, Tamsulosin, Ropinirole and Atorvastatin. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

On 4/4/17 at 1:34 PM, a focused review of client #4's record was conducted. Client #4's record did not contain documentation indicating the facility addressed the medication errors while client #4 was visiting his parents. There was no documentation indicating how the facility was going to prevent a medication error from happening again while visiting his mom. A 7/15/16 Support Team Review Form indicated, in part, "Had 1 IR (incident report) for not taking all medication with mom over a weekend." There was no additional information about the medication error. Client #4's 5/13/16 Individualized Support Plan included the following medication administration goal, "...He has never prepared his own medications in the past as he was not consistently able (sic) state the name, dose, and reason for all of his medication...."

On 4/4/17 at 2:37 PM, the nurse provided
a copy of a 11/15/16 letter she sent to client #4's mom. The letter indicated, "I am writing you today because it has come to my attention that [client #4] has not been taking his medications as ordered by the physician while on home visits with you. I am sure you realize how important it is that [client #4] take his medication per his physicians (sic) orders. Currently, [client #4] takes medication to lower his cholesterol and prevent clot formation, both of which, reduces his risk of having a stroke. [Client #4] also receives a topical application of Androgel, which is important for keeping his testosterone at an acceptable level so that he does not have adverse side effects of low testosterone. When he misses these medications, it is directly affecting his health. [Client #4] does not currently administer his medications independently. Staff at [name of group home] administer [client #4's] medication. When [client #4] is away with family and friends, it is expected that the person signing the medication permission slip will administer his medication per physician's orders. If there is anything we can do to help make this a smoother process for you, please don't hesitate to contact me...."

On 4/4/17 at 1:37 PM, the nurse stated client #4's mom "will not give them..."
(medications).” The nurse indicated client #4's mom made a comment to the direct care staff indicating it was not her responsibility to give client #4 his medications. The nurse indicated she sent a letter to client #4's mom a couple of months ago indicating when she signed client #4 out of the group home for a visit she was signing she understood it was her responsibility to ensure client #4 received his medications as ordered. The nurse indicated she received no response or acknowledgement of receipt of the letter she sent to client #4's mom. The nurse stated "she got nothing" in response from client #4's mom in regard to the letter. The nurse stated this was an on-going issue that "keeps happening." The nurse stated, "He (client #4) needs his meds." The nurse indicated unless the client missed three doses of the same medication in a row, she did not contact the physician to notify them of the medication error.

On 4/5/17 at 2:25 PM, the Assistant Group Home Director (AGHD) indicated she asked the nurse to send a letter to client #4's mom after a November 2016 home visit with medications not administered. The AGHD indicated when client #4's mom signs client #4 out of the group home for the home visit, the permission slip indicated she was
assuming responsibility for administering his medications. The AGHD indicated she spoke to client #4's mom in person about assisting client #4 with his medications. The AGHD indicated her talk with client #4's mom helped for a short period of time. The AGHD indicated there was no documentation client #4's IDT (interdisciplinary team) met to discuss the issue. The AGHD indicated she did not have documentation of her discussion with client #4's mom. The AGHD indicated there had been no discussion of supervised visits or of the group home staff going to client #4's mom's house to administer his medications. The AGHD indicated after client #4's mom received the letter from the nurse, client #4's mom called the Home Manager (HM) due to being upset about the letter. The AGHD indicated the facility did not have documentation of the HM's phone call or of client #4's mom receiving the letter.

On 4/5/17 at 2:25 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility should have documentation of the steps taken to address client #4's recurring issues with medication errors during home visits with his mom. The QIDP indicated there was no documentation the facility contacted/ notified the doctor of the
medication errors. The QIDP stated when asked if the doctor was notified, "I don't believe so."

On 4/5/17 at 2:39 PM, the Group Home Director (GHD) stated when asked if client #4's physician was notified of client #4's medication errors, "I don't think so." The GHD stated when asked if investigations were conducted for client #4's recurring medication errors during home visits, "Nothing in writing."

B) Client #1 had falls with no investigation or corrective action taken on the following dates:

9) On 1/21/17 at 5:50 PM, client #1 was walking from the kitchen to the living room. He lost his footing and fell onto his knees and rolled onto his side. He was not injured. There was no documentation if the fall was witnessed by staff or not. There was no documentation the facility conducted an investigation.

10) On 1/24/17 at 7:05 AM, client #1 was in the upstairs hallway near the office when staff heard a loud noise in the hallway. Client #1 was on his knees outside of the upstairs bathroom. There was no documentation indicating whether or not client #1 was injured during the
11) On 2/12/17 at 8:30 AM, client #1 fell at the entrance to the office. He was not injured. The 2/12/17 Incident Report indicated, "...[staff #3] was following behind [client #1]... [Client #1] tripped over his own feet and fell at the entrance of the office, landing on his knees and hands...." There was no documentation the facility conducted an investigation.

12) On 2/19/17 at 1:23 PM, client #1 stepped out of the van and fell to the ground. Client #1 was not injured. There was no documentation the facility conducted an investigation.

13) On 2/21/17 at 7:45 PM, client #1 was walking down the upstairs hallway when staff heard a thud. Staff observed client #1 sitting on the floor in the hallway. Client #1 was not injured. There was no documentation the facility conducted an investigation.

14) On 3/11/17 at 2:40 PM, client #1 walked out of the living room and fell to his knees. Client #1 was not injured. There was no documentation the facility conducted an investigation.
On 4/5/17 at 11:41 AM, a review of client #1’s record was conducted. Client #1’s most recent Nursing Quarterly Physical, dated 3/20/17, did not address his increase in falls during the quarter. The most recent Support Team documentation, dated 2/7/17, did not address client #1’s falls. There was no documentation client #1’s 12/6/16 Fall Risk Plan was reviewed and deemed current. On 4/5/17 at 3:28 PM, the AGHD forwarded an email from the nurse to the surveyor for review. The 1/25/17 email from the nurse to the GHD, AGHD and QIDP indicated, "I don't wish to make any changes to [client #1's] fall risk plan, but we will need to document a conversation at the next support team meeting about his current plan and recent falls." There was no documentation of a conversation on the support team note. There was no documentation in client #1’s record the facility took action regarding client #1’s falls.

On 4/4/17 at 2:28 PM, the nurse indicated the facility should have conducted investigations for the falls. The nurse indicated client #1 had not been assessed by a Physical Therapist. The nurse indicated the facility was looking into the possibility of an assistive device such as a walker or a cane. The
## Summary Statement of Deficiencies

A nurse indicated a lot of times prior to a fall, client #1 was anxious about something. The nurse indicated client #1 liked to hold onto something while ambulating. The nurse indicated client #1 had a recent increase in falls. The nurse indicated until 3/31/17 at the house meeting, there was no recent discussion pertaining to client #1's falls.

On 4/3/17 at 1:36 PM, the QIDP indicated there was no documentation the facility conducted an investigation. The QIDP indicated he asked questions of the staff and the clients about the falls however there was no documentation of investigations being conducted. The QIDP indicated the facility should have conducted investigations of the falls. The QIDP indicated he did not have documentation client #1's falls were being addressed by the facility.

On 4/3/17 at 1:49 PM, the GHD indicated there was no documentation of an investigation of the fall. The GHD indicated the facility should investigate the cause of falls.

C) Additional clients with falls with no investigations:

15) On 2/13/17 at 5:00 PM, client #2 was at a local gym when he slipped and
fell while changing his clothes in order to get into the hot tub. Client #2 had a small cut on his left knee and a mark on his right knee. There was no documentation the facility conducted an investigation.

16) On 3/10/17 at 11:00 AM, client #6 fell while volunteering delivering food to a home. Client #6 tripped and fell on his left knee causing a scrape. There was no documentation the facility conducted an investigation.

On 4/4/17 at 2:28 PM, the nurse indicated the facility should have conducted investigations for the falls.

On 4/3/17 at 1:36 PM, the QIDP indicated falls were not investigated. The QIDP indicated he asked questions of the staff and clients about the falls however there was no documentation of investigations being conducted. The QIDP indicated there should have been investigations conducted of the falls.

On 4/3/17 at 1:49 PM, the GHD indicated there was no documentation of an investigation of the fall. The GHD indicated the facility should investigate the cause of falls.

D) Client to client aggression incidents:
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION 15G220

**Date Survey Completed:** 04/07/2017

**Name of Provider or Supplier:** STONE BELT ARC INC

**Street Address, City, State, Zip Code:**

4700 HITE DR

BLOOMINGTON, IN 47408

#### Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>#</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>9/27/16</td>
<td>On 9/27/16 at 4:15 PM, client #6 hit client #4 on the top of the head. Both clients were yelling at each other.</td>
</tr>
<tr>
<td>18</td>
<td>12/13/16</td>
<td>On 12/13/16 at 9:15 PM, client #6 hit client #5's right hand after client #5 yelled out client #6's name.</td>
</tr>
<tr>
<td>19</td>
<td>1/3/17</td>
<td>On 1/3/17 at 12:00 at the facility-operated workshop, client #5 stated, &quot;I hit [name of peer] because he would not leave me alone.&quot; Client #5 hit his peer on the back of his leg.</td>
</tr>
<tr>
<td>20</td>
<td>3/3/17</td>
<td>On 3/3/17 at 6:20 PM, clients #5 and #6 hit each other on the arm.</td>
</tr>
<tr>
<td>21</td>
<td>3/9/17</td>
<td>On 3/9/17 at 6:20 PM, client #5 slapped client #6 on the chest and client #6 punched client #5's chest.</td>
</tr>
</tbody>
</table>

On 4/3/17 at 1:36 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 of the clients.

On 4/3/17 at 1:49 PM, the GHD 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...
On 4/3/17 at 2:43 PM, a review of the facility's 5/14/13 policy titled Incident Investigation/Review Protocol indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being proactive and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law...."  The 9/14 Human Rights Policy defined neglect as, "Any action or behavioral interventions that risks the physical or emotional safety and prohibited abuse of the clients.
wellbeing of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party... Failure to provide appropriate supervision, care, or training...."

9-3-2(a)

W 0154 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 16 of 28 incident reports reviewed affecting clients #1, #2, #4, #5 and #6, the facility failed to conduct thorough investigations of falls and recurring issues with medication errors while client #4 was on home visits with his mom.

Findings include:

W 154 Staff Treatment of Clients

Corrective action for resident(s) found to have been affected

Staff will be trained to report, investigate and follow up on medication errors and falls.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 15G220

MULTIPLE CONSTRUCTION

A. BUILDING 00
B. WING

DATE SURVEY COMPLETED 04/07/2017

STATEMENT OF DEFICIENCIES

IDENTIFICATION NUMBER:

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STREET ADDRESS, CITY, STATE, ZIP CODE

4700 HITE DR
BLOOMINGTON, IN 47408

NAME OF PROVIDER OR SUPPLIER

STONE BELT ARC INC

On 4/3/17 at 12:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following incidents were not investigated by the facility:

1) On 7/4/16 at 5:00 PM when client #4 returned to the group home from a visit with his mom, a medication he took with him (Colcrys for gout) was not administered by client #4 or his parents.

2) On 7/23/16 during the morning medication pass to client #4 it was discovered client #4 did not receive Androgel (low testosterone) every third day in the morning during his home visit from 7/20/16 to 7/24/16.

3) On 9/5/16 when client #4 returned from a home visit (9/2/16 to 9/5/16), it was discovered he missed one dose of the following: Tamsulosin (urination), Losartan (hypertension), Ropinirole (restless leg syndrome), Atorvastatin (high cholesterol), Allopurinol (gout), Aspirin (blood clot prevention) and Androgel.

4) On 10/22/16 at 5:30 PM when client #4 returned to the group home from visiting his parents, it was discovered he did not receive Androgel.

QIDP will be trained to review and investigate all falls, med errors and take corrective action.

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

New form to aid in information gathering for the purpose on investigating falls has been created and staff (QIDP and Coordinator) will be trained on importance of investigating all falls and implementing corrective actions.

When a client that has a history of med errors at home, has plans to visit family, staff will prevent med errors by using a pill minder to aid in client and family's organization of med administration at home. Client's mother has agreed to this resource. If more med errors occur, client and family will be asked to attend IDT meeting to discuss issue. Corrective action will be documented in the investigation and followed up in
<table>
<thead>
<tr>
<th>X4 ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>15G220</td>
<td></td>
<td></td>
<td>5) On 11/13/16 when client #4 returned to the group home from visiting his mom, he was not administered one dose of the following medications: Ropinirole, Atorvastatin, Tamsulosin, Allopurinol, Aspirin, Loratadine (allergies), Losartan and Colcrys. No adverse reactions were noted.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td>On 11/13/16 when client #4 returned to the group home from visiting his mom, he was not administered one dose of the following medications: Ropinirole, Atorvastatin, Tamsulosin, Allopurinol, Aspirin, Loratadine (allergies), Losartan and Colcrys. No adverse reactions were noted.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6)</td>
<td>On 12/26/16 at 8:03 PM when client #4 returned to the group home from visiting his mom, he did not receive Androgel.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7)</td>
<td>On 3/12/17 when client #4 returned to the group home from visiting his mom, it was found he did not take one dose of the following medications: Loratadine, Allopurinol, Aspirin, Atorvastatin, Colcrys and Losartan.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8)</td>
<td>On 3/25/17 when client #4 returned to the group home from visiting his mom, it was found he was not administered one dose of the following medications: Losartan, Tamsulosin, Ropinirole and Atorvastatin.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On 4/4/17 at 1:34 PM, a focused review of client #4's record was conducted. Client #4's record did not contain documentation indicating the facility conducted investigations of the medication errors while client #4's was</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How corrective actions will be monitored to ensure no recurrence**

The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction (POC). The meeting will be chaired by SGL Director (or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### IDENTIFICATION NUMBER:
15G220

#### MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

#### DATE SURVEY COMPLETED
04/07/2017

---

**NAME OF PROVIDER OR SUPPLIER**

**STONE BELT ARC INC**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

4700 HITE DR
BLOOMINGTON, IN 47408

---

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
<tr>
<td>TAG</td>
<td></td>
<td>TAG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

visiting his mom.

On 4/5/17 at 2:39 PM, the Group Home Director (GHD) stated when asked if investigations were conducted for client #4's recurring medication errors during home visits, "Nothing in writing."

9) On 1/21/17 at 5:50 PM, client #1 was walking from the kitchen to the living room. He lost his footing and fell onto his knees and rolled onto his side. He was not injured. There was no documentation if the fall was witnessed by staff or not. There was no documentation the facility conducted an investigation.

10) On 1/24/17 at 7:05 AM, client #1 was in the upstairs hallway near the office when staff heard a loud noise in the hallway. Client #1 was on his knees outside of the upstairs bathroom. There was no documentation indicating whether or not client #1 was injured during the fall. The fall was not witnessed by staff. There was no documentation the facility conducted an investigation.

11) On 2/12/17 at 8:30 AM, client #1 fell at the entrance to the office. He was not injured. The 2/12/17 Incident Report indicated, "...[staff #3] was following behind [client #1]... [Client #1] tripped
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>TAG</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>TAG</td>
</tr>
<tr>
<td>over his own feet and fell at the entrance of the office, landing on his knees and hands....&quot; There was no documentation the facility conducted an investigation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12) On 2/19/17 at 1:23 PM, client #1 stepped out of the van and fell to the ground. Client #1 was not injured. There was no documentation the facility conducted an investigation.

13) On 2/21/17 at 7:45 PM, client #1 was walking down the upstairs hallway when staff heard a thud. Staff observed client #1 sitting on the floor in the hallway. Client #1 was not injured. There was no documentation the facility conducted an investigation.

14) On 3/11/17 at 2:40 PM, client #1 walked out of the living room and fell to his knees. Client #1 was not injured. There was no documentation the facility conducted an investigation.

On 4/5/17 at 11:41 AM, a review of client #1’s record was conducted. There was no documentation the facility conducted an investigation for client #1’s falls.

On 4/4/17 at 2:28 PM, the nurse indicated the facility should have conducted investigations for the falls.
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
<tr>
<td>TAG</td>
<td></td>
<td>TAG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On 4/3/17 at 1:36 PM, the QIDP indicated there was no documentation the facility conducted investigations. The QIDP indicated he asked questions of the staff and the clients about the falls however there was no documentation of investigations being conducted. The QIDP indicated the facility should have conducted investigations of the falls.

On 4/3/17 at 1:49 PM, the GHD indicated there was no documentation the facility conducted investigations of client #1's falls. The GHD indicated the facility should investigate the cause of falls.

15) On 2/13/17 at 5:00 PM, client #2 was at a local gym when he slipped and fell while changing his clothes in order to get into the hot tub. Client #2 had a small cut on his left knee and a mark on his right knee.

16) On 3/10/17 at 11:00 AM, client #6 fell while volunteering delivering food to a home. Client #6 tripped and fell on his left knee causing a scrape.

On 4/4/17 at 2:28 PM, the nurse indicated the facility should have conducted investigations for the falls.

On 4/3/17 at 1:36 PM, the QIDP
| ID | PREFIX | TAG | SUMMARY STATEMENT OF DEFICIENCIES | ID | PREFIX | TAG | PROVIDER'S PLAN OF CORRECTION | (X5) COMPLETION DATE |
|---|---|---|---|---|---|---|---|---|---|
| W 0157 | Bldg. 00 | W 0157 | STAFF TREATMENT OF CLIENTS | W 157 Staff Treatment of Clients | 05/05/2017 |
| 483.420(d)(4) |  |  | If the alleged violation is verified, appropriate corrective action must be taken. | Corrective action for resident(s) found to have been affected |
|  |  |  | Based on record review and interview for 14 of 28 incident reports reviewed affecting clients #1 and #4, the facility failed to implement appropriate corrective actions to address client #4's recurrent issues with medication errors while on home visits and client #1's falls. | Staff will be trained to report, investigate and follow up on medication errors and falls. |
|  |  |  | Findings include: | QIDP will be trained to review and investigate all falls, med errors |

indicated the falls were not investigated. The QIDP indicated he asked questions of the staff and clients about the falls however there was no documentation of investigations being conducted. The QIDP indicated there should have been investigations conducted of the falls.

On 4/3/17 at 1:49 PM, the GHD indicated there was no documentation the facility conducted investigations of the falls. The GHD indicated the facility should investigate the cause of falls.

9-3-2(a)
On 4/3/17 at 12:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following incidents without appropriate corrective actions by the facility:

A) Client #4 returned to the group home with medications that were not administered during visits to his mom's house on the following dates:

1) On 7/4/16 at 5:00 PM when client #4 returned to the group home from a visit with his mom, a medication he took with him (Colcrys for gout) was not administered by client #4 or his mom on 7/4/16. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

2) On 7/23/16 during the morning medication pass to client #4 it was discovered client #4 did not receive Androgel (low testosterone) every third day in the morning during his home visit from 7/20/16 to 7/24/16. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

3) On 9/5/16 when client #4 returned from a home visit (9/2/16 to 9/5/16), it was discovered he missed one dose of the medications.

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

New form to aid in information gathering for the purpose of investigating falls has been created and staff (QIDP and Coordinator) will be trained on importance of investigating all falls and implementing corrective actions.

When a client that has a history of med errors at home, has plans to visit family, staff will prevent med errors by using a pill minder to aid in client and family's organization of med administration at home. Client's mother has agreed to this resource. If more med errors occur, client and family will be asked to attend IDT meeting to discuss issue. Corrective action will be documented in the investigation and followed up in support team.
<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>10/22/16</td>
<td>On 10/22/16 at 5:30 PM when client #4 returned to the group home from visiting his mom, it was discovered he did not receive Androgel. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.</td>
</tr>
<tr>
<td>5</td>
<td>11/13/16</td>
<td>On 11/13/16 when client #4 returned to the group home from visiting his mom, he was not administered one dose of the following medications: Ropinirole, Atorvastatin, Tamsulosin, Allopurinol, Aspirin, Loratadine (allergies), Losartan and Colcrys. No adverse reactions were noted. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.</td>
</tr>
<tr>
<td>6</td>
<td>12/26/16</td>
<td>On 12/26/16 at 8:03 PM when client #4 returned to the group home from visiting his mom, he did not receive Androgel. There was no documentation</td>
</tr>
</tbody>
</table>

How corrective actions will be monitored to ensure no recurrence

The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction (POC). The meeting will be chaired by SGL Director or designee. The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.
7) On 3/12/17 when client #4 returned to the group home from visiting his mom, it was found he did not take one dose of the following medications: Loratadine, Allopurinol, Aspirin, Atorvastatin, Colcrys and Losartan. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

8) On 3/25/17 when client #4 returned to the group home from visiting his mom, it was found he was not administered one dose of the following medications: Losartan, Tamsulosin, Ropinirole and Atorvastatin. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

On 4/4/17 at 1:34 PM, a focused review of client #4's record was conducted. Client #4's record did not contain documentation indicating the facility addressed the medication error while client #4 was visiting his parents. There was no documentation indicating how the facility was going to prevent a medication error from happening again while visiting his mom. A 7/15/16
Support Team Review Form indicated, in part, "Had 1 IR (incident report) for not taking all medication with mom over a weekend." There was no additional information about the medication error. Client #4's 5/3/16 Individualized Support Plan included the following medication administration goal, "...He has never prepared his own medications in the past as he was not consistently able (sic) state the name, dose, and reason for all of his medication...."

On 4/4/17 at 2:37 PM, the nurse provided a copy of a 11/15/16 letter she sent to client #4's mom. The letter indicated, "I am writing you today because it has come to my attention that [client #4] has not been taking his medications as ordered by the physician while on home visits with you. I am sure you realize how important it is that [client #4] take his medication per his physicians (sic) orders. Currently, [client #4] takes medication to lower his cholesterol and prevent clot formation, both of which, reduces his risk of having a stroke. [Client #4] also receives a topical application of Androgel, which is important for keeping his testosterone at an acceptable level so that he does not have adverse side effects of low testosterone. When he misses these medications, it is directly affecting his health. [Client #4] does not currently..."
administer his medications independently. Staff at [name of group home] administer [client #4's] medication. When [client #4] is away with family and friends, it is expected that the person signing the medication permission slip will administer his medication per physician's orders. If there is anything we can do to help make this a smoother process for you, please don't hesitate to contact me...."

On 4/4/17 at 1:37 PM, the nurse stated client #4's mom "will not give them (medications)." The nurse indicated client #4's mom made a comment to the direct care staff indicating it was not her responsibility to give client #4 his medications. The nurse indicated she sent a letter to client #4's mom a couple of months ago indicating when she signed client #4 out of the group home for a visit she was signing she understood it was her responsibility to ensure client #4 received his medications as ordered. The nurse indicated she received no response or acknowledgement of receipt of the letter she sent to client #4's mom. The nurse stated "I got nothing" from client #4's mom regarding the letter she sent. The nurse stated this was an on-going issue that "keeps happening." The nurse stated, "He (client #4) needs his meds."
On 4/5/17 at 2:25 PM, the Assistant Group Home Director (AGHD) indicated she asked the nurse to send a letter to client #4's mom after a November 2016 home visit with medications not administered. The AGHD indicated when client #4's mom signs client #4 out of the group home for the home visit, the permission slip indicated she was assuming responsibility for administering his medications. The AGHD indicated she spoke to client #4's mom in person about assisting client #4 with his medications. The AGHD indicated her talk with client #4's mom helped for a short period of time. The AGHD indicated there was no documentation client #4's IDT (interdisciplinary team) met to discuss the issue. The AGHD indicated she did not have documentation of her discussion with client #4's mom. The AGHD indicated there had been no discussion of supervised visits or of the group home staff going to client #4's mom's house to administer his medications. The AGHD indicated after client #4's mom received the letter from the nurse, client #4's mom called the Home Manager (HM) due to being upset about the letter. The AGHD indicated the facility did not have documentation of the HM's phone call or of client #4's mom receiving the letter.
### Summary of Deficiencies

**Identification Number:** 15G220

**Date Survey Completed:** 04/07/2017

**Provider or Supplier Name:** STONE BELT ARC INC

**Address:** 4700 HITE DR, BLOOMINGTON, IN 47408

---

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Date of Deficiency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td></td>
<td></td>
<td>04/07/2017</td>
<td>On 4/5/17 at 2:25 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility should have documentation of the steps taken to address client #4’s recurring issues with medication errors during home visits with his mom. The QIDP indicated there was no documentation the facility contacted/notified the doctor of the medication errors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>04/07/2017</td>
<td>B) Client #1 had falls with no corrective action taken on the following dates:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9) On 1/21/17 at 5:50 PM, client #1 was walking from the kitchen to the living room. He lost his footing and fell onto his knees and rolled onto his side. He was not injured. There was no documentation if the fall was witnessed by staff or not. There was no documentation the facility conducted an investigation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10) On 1/24/17 at 7:05 AM, client #1 was in the upstairs hallway near the office when staff heard a loud noise in the hallway. Client #1 was on his knees outside of the upstairs bathroom. There was no documentation indicating whether or not client #1 was injured during the fall. The fall was not witnessed by staff. There was no documentation the facility conducted an investigation.</td>
</tr>
</tbody>
</table>
11) On 2/12/17 at 8:30 AM, client #1 fell at the entrance to the office. He was not injured. The 2/12/17 Incident Report indicated, "...[staff #3] was following behind [client #1]... [Client #1] tripped over his own feet and fell at the entrance of the office, landing on his knees and hands...." There was no documentation the facility conducted an investigation.

12) On 2/19/17 at 1:23 PM, client #1 stepped out of the van and fell to the ground. Client #1 was not injured. There was no documentation the facility conducted an investigation.

13) On 2/21/17 at 7:45 PM, client #1 was walking down the upstairs hallway when staff heard a thud. Staff observed client #1 sitting on the floor in the hallway. Client #1 was not injured. There was no documentation the facility conducted an investigation.

14) On 3/11/17 at 2:40 PM, client #1 walked out of the living room and fell to his knees. Client #1 was not injured. There was no documentation the facility conducted an investigation.

On 4/5/17 at 11:41 AM, a review of client #1's record was conducted.
#1's most recent Nursing Quarterly Physical, dated 3/20/17, did not address his increase in falls during the quarter. The most recent Support Team documentation, dated 2/7/17, did not address client #1's falls. There was no documentation client #1's 12/6/16 Fall Risk Plan was reviewed and deemed current. On 4/5/17 at 3:28 PM, the AGHD forwarded an email from the nurse to the surveyor for review. The 1/25/17 email from the nurse to the GHD, AGHD and QIDP indicated, "I don't wish to make any changes to [client #1’s] fall risk plan, but we will need to document a conversation at the next support team meeting about his current plan and recent falls." There was no documentation of a conversation on the support team note. There was no documentation in client #1's record the facility took action regarding client #1's falls.

On 4/4/17 at 2:28 PM, the nurse indicated client #1 had not been assessed by a Physical Therapist. The nurse indicated the facility was looking into the possibility of an assistive device such as a walker or a cane. The nurse indicated a lot of times prior to a fall, client #1 was anxious about something. The nurse indicated client #1 liked to hold onto something while ambulating. The nurse
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>W 0159</td>
<td>indicated client #1 had a recent increase in falls. The nurse indicated until 3/31/17 at the house meeting, there was no recent discussion pertaining to client #1's falls. On 4/3/17 at 1:36 PM, the QIDP indicated he did not have documentation client #1's falls were being addressed by the facility 9-3-2(a)</td>
<td>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 3 clients in the sample (#1 and #6) and one additional client (#4), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' individualized support plans (ISP). The QIDP failed to address recurring issues with client #4 going on home visits and returning with medications that were not administered as ordered by the physician. W 0159</td>
<td>W 159 QIDP Corrective action for resident(s) found to have been affected Staff, including QIDP and Coordinator will be trained on how to prevent, report and follow up on client to client abuse, medication errors and falls. QIDP will be trained to review and</td>
<td>05/05/2017</td>
</tr>
</tbody>
</table>
The QIDP failed to adequately address client #1's six falls in the past 3 months. The QIDP failed to ensure client #6's ISP and comprehensive functional assessment were reviewed and updated annually. The QIDP failed to review client #1 and #6's July and August 2016 program plans to ensure the clients were making progress of their training objectives.

Findings include:

1) On 4/3/17 at 12:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:

   a) On 1/21/17 at 5:50 PM, client #1 was walking from the kitchen to the living room. He lost his footing and fell onto his knees and rolled onto his side. He was not injured.

   b) On 1/24/17 at 7:05 AM, client #1 was in the upstairs hallway when staff heard a loud noise in the hallway. Client #1 was on his knees outside of the upstairs bathroom. There was no documentation on the 1/24/17 Incident Report indicating whether or not client #1 was injured.

   c) On 2/12/17 at 8:30 AM, client #1 fell at the entrance to the office. He was not injured.

   d) On 2/12/17 at 8:30 AM, client #1 fell at the entrance to the office. He was not injured.

To investigate all falls, client to client abuse and med errors and take corrective action.

QIDP will be trained to integrate, coordinate and monitor all client's IPP for relevance.

Monitoring will occur. QIDP will be trained on reviewing ISP, program plans and CFA annually. QIDP will be trained and monitored for producing ands reviewing program plans, based on client's goals and subsequent progress.

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
New form to aid in information gathering for the purpose on investigating falls has been created and staff (QIDP and Coordinator) will be trained on importance of investigating all falls. Client that had several falls has been scheduled for physical therapy on 4/26 9am.
d) On 2/19/17 at 1:23 PM, client #1 stepped out of the van and fell to the ground. Client #1 was not injured.

e) On 2/21/17 at 7:45 PM, client #1 was walking down the upstairs hallway when staff heard a thud. Staff observed client #1 sitting on the floor in the hallway. Client #1 was not injured.

f) On 3/11/17 at 2:40 PM, client #1 walked out of the living room and fell to his knees. Client #1 was not injured.

On 4/5/17 at 11:41 AM, a review of client #1’s record was conducted. Client #1’s most recent Nursing Quarterly Physical, dated 3/20/17, did not address his increase in falls during the quarter. The most recent Support Team documentation, dated 2/7/17, did not address client #1’s falls. There was no documentation client #1’s 12/6/16 Fall Risk Plan was reviewed and deemed current. On 4/5/17 at 3:28 PM, the AGHD forwarded an email from the nurse to the surveyor for review. The 1/25/17 email from the nurse to the GHD, AGHD and QIDP indicated, "I don't wish to make any changes to [client #1’s] fall risk plan, but we will need to document a conversation at the next support team meeting about his current

When a client that has a history of med errors at home, has plans to visit family, staff will prevent med errors by using a pill minder to aid in client and family’s organization of med administration at home. Client’s mother has agreed to this resource. If more med errors occur, client and family will be asked to attend IDT meeting to discuss issue.

Director and associate director will review all client to client abuse investigations and ensure proper corrective action is taking place by QIDP and coordinator. Corrective action will be documented in the investigation and followed up in support team.

Director and associate director will audit client’s charts monthly for compliance.

How corrective actions will be monitored to ensure no recurrence

The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being
| ID | PREFIX | TAG | SUMMARY STATEMENT OF DEFICIENCIES | ID | PREFIX | TAG | PROVIDER'S PLAN OF CORRECTION | completion date |
|---|---|---|---|---|---|---|---|---|---|
| 15G220 | 00 | | | | | | | | 04/07/2017 |

**NAME OF PROVIDER OR SUPPLIER**

STONE BELT ARC INC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

4700 HITE DR
BLOOMINGTON, IN 47408

---

plan and recent falls." There was no documentation of a conversation on the support team note. There was no documentation in client #1's record the facility took action regarding client #1's falls.

On 4/4/17 at 2:28 PM, the nurse indicated client #1 had not been assessed by a Physical Therapist. The nurse indicated the facility was looking into the possibility of an assistive device such as a walker or a cane. The nurse indicated a lot of times prior to a fall, client #1 was anxious about something. The nurse indicated client #1 liked to hold onto something while ambulating. The nurse indicated client #1 had a recent increase in falls. The nurse indicated until 3/31/17 at the house meeting, there was no recent discussion pertaining to client #1's falls.

On 4/3/17 at 1:36 PM, the QIDP indicated he did not have documentation client #1's falls were being addressed by the facility.

2) On 4/3/17 at 12:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:

a) On 7/4/16 at 5:00 PM when client #4
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>B. WING</td>
<td></td>
<td>returned to the group home from a visit with his mom, one dose of a medication he took with him (Colcrys for gout) was not administered by client #4 or his parents.</td>
<td>00</td>
<td>B. WING</td>
<td></td>
<td>CROSSED REFERENCE TO THE APPROPRIATE DEFICIENCY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) On 7/23/16 during the morning medication pass to client #4 it was discovered client #4 did not receive Androgel (low testosterone) every third day in the morning during his home visit from 7/20/16 to 7/24/16.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c) On 9/5/16 when client #4 returned from a home visit (9/2/16 to 9/5/16), it was discovered he missed one dose of the following: Tamsulosin (urination), Losartan (hypertension), Ropinirole (restless leg syndrome), Atorvastatin (high cholesterol), Allopurinol (gout), Aspirin (blood clot prevention) and Androgel.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>d) On 10/22/16 at 5:30 PM when client #4 returned to the group home from visiting his mom, it was discovered he did not receive Androgel.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e) On 11/13/16 when client #4 returned to the group home from visiting his mom, he was not administered one dose of the following medications: Ropinirole, Atorvastatin, Tamsulosin, Allopurinol, Aspirin, Loratadine (allergies), Losartan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
and Colcrys. No adverse reactions were noted.

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
<tr>
<td>TAG</td>
<td></td>
<td>TAG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

f) On 12/26/16 at 8:03 PM when client #4 returned to the group home from visiting his mom, he did not receive Androgel.

g) On 3/12/17 when client #4 returned to the group home from visiting his mom, it was found he did not take one dose of the following medications: Loratadine, Allopurinol, Aspirin, Atorvastatin, Colcrys and Losartan.

h) On 3/25/17 when client #4 returned to the group home from visiting his mom, it was found he was not administered one dose of the following medications: Losartan, Tamsulosin, Ropinirole and Atorvastatin.

On 4/4/17 at 1:34 PM, a focused review of client #4's record was conducted. Client #4's record did not contain documentation indicating the QIDP addressed the medication errors while client #4 was visiting his mom. There was no documentation of interdisciplinary team meetings. There was no documentation the QIDP contacted client #4's mom to discuss the issue. There was no documentation indicating how the QIDP was going to
preven a medication error from happening again while visiting his mom. A 7/15/16 Support Team Review Form indicated, in part, "Had 1 IR (incident report) for not taking all medication with mom over a weekend." There was no additional information about the medication error. Client #4's 5/13/16 Individualized Support Plan included the following medication administration goal, "...He has never prepared his own medications in the past as he was not consistently able (sic) state the name, dose, and reason for all of his medication...."

On 4/4/17 at 2:37 PM, the nurse provided a copy of a 11/15/16 letter she sent to client #4's mom. The letter indicated, "I am writing you today because it has come to my attention that [client #4] has not been taking his medications as ordered by the physician while on home visits with you. I am sure you realize how important it is that [client #4] take his medication per his physicians (sic) orders. Currently, [client #4] takes medication to lower his cholesterol and prevent clot formation, both of which, reduces his risk of having a stroke. [Client #4] also receives a topical application of Androgel, which is important for keeping his testosterone at an acceptable level so that he does not have adverse side effects of low
testosterone. When he misses these medications, it is directly affecting his health. [Client #4] does not currently administer his medications independently. Staff at [name of group home] administer [client #4's] medication. When [client #4] is away with family and friends, it is expected that the person signing the medication permission slip will administer his medication per physician's orders. If there is anything we can do to help make this a smoother process for you, please don't hesitate to contact me...."

On 4/4/17 at 1:37 PM, the nurse stated client #4's mom "will not give them (medications)." The nurse indicated client #4's mom made a comment to the direct care staff indicating it was not her responsibility to give client #4 his medications. The nurse indicated she sent a letter to client #4's mom a couple of months ago indicating when she signed client #4 out of the group home for a visit she was signing she understood it was her responsibility to ensure client #4 received his medications as ordered. The nurse indicated she received no response or acknowledgement of receipt of the letter she sent to client #4's mom. The nurse stated, "I got nothing." The nurse stated this was an on-going issue that "keeps happening." The nurse
stated, "He (client #4) needs his meds." The nurse indicated unless the client missed three doses of the same medication in a row, she did not contact the physician to notify them of the medication error.

On 4/5/17 at 2:25 PM, the Assistant Group Home Director (AGHD) indicated she asked the nurse to send a letter to client #4's mom after a November 2016 home visit with medications not administered. The AGHD indicated when client #4's mom signs client #4 out of the group home for the home visit, the permission slip indicated she was assuming responsibility for administering his medications. The AGHD indicated she spoke to client #4's mom in person about assisting client #4 with his medications. The AGHD indicated her talk with client #4's mom helped for a short period of time. The AGHD indicated there was no documentation client #4's IDT (interdisciplinary team) met to discuss the issue. The AGHD indicated she did not have documentation of her discussion with client #4's mom. The AGHD indicated there had been no discussion of supervised visits or of the group home staff going to client #4's mom's house to administer his medications. The AGHD indicated after client #4's mom received the letter from

---

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>COMPLETION DATE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(X5)</td>
</tr>
</tbody>
</table>

---

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0POC11  Facility ID: 000744  If continuation sheet Required: No  Page 47 of 70
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 04/07/2017

**Name of Provider or Supplier:** STONE BELT ARC INC

**Street Address, City, State, Zip Code:**

4700 HITE DR

BLOOMINGTON, IN 47408

---

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID</td>
<td>PREFIX</td>
<td>TAG</td>
<td>ID</td>
<td>TAG</td>
</tr>
<tr>
<td>PREFIX</td>
<td></td>
<td></td>
<td>PROVIDER'S PLAN OF CORRECTION</td>
<td></td>
</tr>
<tr>
<td>TAG</td>
<td></td>
<td></td>
<td>(EACH CORRECTIVE ACTION SHOULD BE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CROSS-REFERENCED TO THE APPROPRIATE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DEFICIENCY)</td>
<td></td>
</tr>
</tbody>
</table>

1. **The nurse, client #4's mom called the Home Manager (HM) due to being upset about the letter. The AGHD indicated the facility did not have documentation of the HM's phone call or of client #4's mom receiving the letter.**

2. **On 4/5/17 at 2:25 PM, the QIDP indicated the facility should have documentation of the steps taken to address client #4's recurring issues with medication errors during home visits with his mom.**

3. **On 4/5/17 at 11:41 AM, a review of client #1's record was conducted. There was no documentation the QIDP reviewed client #1's program plans in July and August 2016 for progress or lack of progress.**

4. **On 4/5/17 at 1:38 PM, a review of client #6's record was conducted. There was no documentation the QIDP reviewed client #6's program plans in July and August 2016.**

5. **On 4/5/17 at 2:09 PM, the QIDP indicated client #1's and #6's program plans were not reviewed by the QIDP in July and August 2016. The QIDP indicated the clients' program plans should have been reviewed monthly by the former QIDP.**
4) Please refer to W259. For 1 of 3 clients in the sample (#6), the facility failed to ensure client #6's comprehensive functional assessment (CFA) was reviewed and updated at least annually.

5) Please refer to W260. For 1 of 3 clients in the sample (#6), the facility failed to ensure client #6's individual program plan (IPP) was revised at least annually.

9-3-3(a)

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
<tr>
<td>TAG</td>
<td></td>
<td>TAG</td>
<td>COMPLETION DATE</td>
</tr>
</tbody>
</table>

W 0259 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 clients in the sample (#6), the facility failed to ensure client #6's comprehensive functional assessment (CFA) was reviewed and updated at least annually.

Findings include:

On 4/5/17 at 1:38 PM, a review of client #6's record was conducted. Client #6's CFA was dated 1/6/16. There was no

W 259 Program Monitoring and Change
Corrective action for resident(s) found to have been affected
QIDP will be trained and monitored to produce, review and update the client's Comprehensive Functional Assessment with an interdisciplinary team, annually

05/05/2017
documentation the facility reviewed and updated client #6's CFA since 1/6/16.

On 4/5/17 at 2:19 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated client #6's CFA was "overdue." The QIDP indicated the CFA should be reviewed and updated at least annually.

On 4/5/17 at 2:20 PM, the Assistant Group Home Director indicated client #6's CFA should be reviewed and updated annually.

9-3-4(a)
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 15G220

A. BUILDING

MULTIPLE CONSTRUCTION

B. WING 00

DATE SURVEY COMPLETED 04/07/2017

STATEMENT OF DEFICIENCIES

IDENTIFICATION NUMBER: 15G220

A. BUILDING

MULTIPLE CONSTRUCTION

B. WING 00

DATE SURVEY COMPLETED 04/07/2017

NAME OF PROVIDER OR SUPPLIER

STONE BELT ARC INC

STREET ADDRESS, CITY, STATE, ZIP CODE

4700 HITE DR

BLOOMINGTON, IN 47408

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG ID

W 0260

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

PREFIX TAG ID

W260 Program Monitoring and Change

W 0260

(FINDINGS)

W 0260 Program Monitoring and Change

Corrective action for resident(s) found to have been affected
QIDP will be trained and monitored to review client's IPPs with an interdisciplinary team, annually

9-3-4(a)

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
Director and associate director will monitor client's charts for compliance.

How corrective actions will be monitored to ensure no recurrence
The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction(POC). The meeting

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
Director and associate director will monitor client's charts for compliance.

How corrective actions will be monitored to ensure no recurrence
The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction(POC). The meeting
## Statement of Deficiencies and Plan of Correction

### Identification Number:

15G220

### Name of Provider or Supplier:

STONE BELT ARC INC

### Street Address, City, State, Zip Code:

4700 HITE DR
BLOOMINGTON, IN 47408

### Date Survey Completed:

04/07/2017

### ID

<table>
<thead>
<tr>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>BLDG.</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>0331</td>
<td>W 0331</td>
<td>00</td>
</tr>
</tbody>
</table>

### Summary Statement of Deficiencies

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**NURSING SERVICES**

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 (#1) and one additional client (#4), the facility's nursing services failed to adequately address client #1's falls and client #4's recurring medication errors while he was on a home visit with his mom.

Findings include:

On 4/3/17 at 12:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:

1. Client #4 returned to the group home with medications that were not administered during visits to his mom's house on the following dates:
   - 7/4/16 at 5:00 PM when client #4

### Provider's Plan of Correction

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

**W 0331 Nursing Services**

Corrective action for resident(s) found to have been affected

The nurses will attend all interdisciplinary team meetings, where all falls and med errors will be reviewed and corrective action will be documented.

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

**will be chaired by SGL Director (or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.**

**COMPLETION DATE:** 05/05/2017
returned to the group home from a visit with his mom, a medication he took with him (Colcrys for gout) was not administered by client #4 or his mom on 7/4/16. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

2) On 7/23/16 during the morning medication pass to client #4 it was discovered client #4 did not receive Androgel (low testosterone) every third day in the morning during his home visit from 7/20/16 to 7/24/16. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

3) On 9/5/16 when client #4 returned from a home visit (9/2/16 to 9/5/16), it was discovered he missed one dose of the following: Tamsulosin (urination), Losartan (hypertension), Ropinirole (restless leg syndrome), Atorvastatin (high cholesterol), Allopurinol (gout), Aspirin (blood clot prevention) and Androgel. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

4) On 10/22/16 at 5:30 PM when client #4 returned to the group home from

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>15G220</td>
<td></td>
<td>00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IDT will meet monthly to review safety of clients and document issues needing follow up/corrective action.

How corrective actions will be monitored to ensure no recurrence

The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction (POC). The meeting will be chaired by SGL Director (or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.
visiting his mom, it was discovered he did not receive Androgel. There was no
documentation indicating the steps the facility took to address the medication
error while at home with his mom.

5) On 11/13/16 when client #4 returned to the group home from visiting his mom,
he was not administered one dose of the following medications: Ropinirole,
Atorvastatin, Tamsulosin, Allopurinol, Aspirin, Loratadine (allergies), Losartan
and Colcrys. No adverse reactions were noted. There was no documentation
indicating the steps the facility took to address the medication error while at
home with his mom.

6) On 12/26/16 at 8:03 PM when client #4 returned to the group home from
visiting his mom, he did not receive Androgel. There was no documentation
indicating the steps the facility took to address the medication error while at
home with his mom.

7) On 3/12/17 when client #4 returned to the group home from visiting his mom, it
was found he did not take one dose of the following medications: Loratadine,
Allopurinol, Aspirin, Atorvastatin, Colcrys and Losartan. There was no
documentation indicating the steps the facility took to address the medication
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>15G220</td>
<td>04/07/2017</td>
<td>B. WING</td>
<td>error while at home with his mom.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A. BUILDING</td>
<td>8) On 3/25/17 when client #4 returned to the group home from visiting his mom, it was found he was not administered one dose of the following medications: Losartan, Tamsulosin, Ropinirole and Atorvastatin. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom. On 4/4/17 at 1:34 PM, a focused review of client #4's record was conducted. Client #4's record did not contain documentation indicating the facility addressed the medication error while client #4 was visiting his parents. There was no documentation indicating how the facility was going to prevent a medication error from happening again while visiting his mom. A 7/15/16 Support Team Review Form indicated, in part, &quot;Had 1 IR (incident report) for not taking all medication with mom over a weekend.&quot; There was no additional information about the medication error. Client #4's 5/13/16 Individualized Support Plan included the following medication administration goal, &quot;...He has never prepared his own medications in the past as he was not consistently able (sic) state the name, dose, and reason for all of his medication....&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
On 4/4/17 at 2:37 PM, the nurse provided a copy of a 11/15/16 letter she sent to client #4's mom. The letter indicated, "I am writing you today because it has come to my attention that [client #4] has not been taking his medications as ordered by the physician while on home visits with you. I am sure you realize how important it is that [client #4] take his medication per his physicians (sic) orders. Currently, [client #4] takes medication to lower his cholesterol and prevent clot formation, both of which, reduces his risk of having a stroke. [Client #4] also receives a topical application of Androgel, which is important for keeping his testosterone at an acceptable level so that he does not have adverse side effects of low testosterone. When he misses these medications, it is directly affecting his health. [Client #4] does not currently administer his medications independently. Staff at [name of group home] administer [client #4's] medication. When [client #4] is away with family and friends, it is expected that the person signing the medication permission slip will administer his medication per physician's orders. If there is anything we can do to help make this a smoother process for you, please don't hesitate to contact me...."
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>On 4/5/17 at 2:25 PM, the Assistant Group Home Director (AGHD) indicated after client #4's mom received the letter from the nurse, client #4's mom called the Home Manager (HM) due to being upset about the letter. The AGHD indicated the facility did not have documentation of the HM's phone call or of client #4's mom receiving the letter.</td>
</tr>
</tbody>
</table>
|    |        |     | On 4/5/17 at 2:25 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility should have documentation of the steps taken to address client #4's recurring issues with medication errors during home visits with his mom. The QIDP indicated there was no documentation the facility contacted/notified the doctor of the medication errors. The QIDP stated when asked if the doctor was notified, "I don't believe so."
|    |        |     | On 4/5/17 at 2:39 PM, the Group Home Director (GHD) stated when asked if client #4's physician was notified of client #4's medication errors, "I don't think so." The GHD stated when asked if investigations were conducted for client #4's recurring medication errors during home visits, "Nothing in writing."
|    |        |     | On 4/4/17 at 1:37 PM, the nurse stated client #4's mom "will not give them..." |
(medications)." The nurse indicated client #4's mom made a comment to the direct care staff indicating it was not her responsibility to give client #4 his medications. The nurse indicated she sent a letter to client #4's mom a couple of months ago indicating when she signed client #4 out of the group home for a visit she was signing she understood it was her responsibility to ensure client #4 received his medications as ordered. The nurse indicated she received no response or acknowledgement of receipt of the letter she sent to client #4's mom. The nurse stated, "She got nothing" in response from client #4's mom. The nurse stated this was an on-going issue that "keeps happening." The nurse stated, "He (client #4) needs his meds." The nurse indicated unless the client missed three doses of the same medication in a row, she did not contact the physician to notify them of the medication error.

B) Client #1 had falls with no documented corrective action by the nurse on the following dates:

9) On 1/21/17 at 5:50 PM, client #1 was walking from the kitchen to the living room. He lost his footing and fell onto his knees and rolled onto his side. He was not injured. There was no
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>0POC11</td>
<td>0</td>
<td>documentation if the fall was witnessed by staff or not. There was no documentation the facility conducted an investigation.</td>
<td>00</td>
<td>0</td>
<td>4700 HITE DR BLOOMINGTON, IN 47408</td>
<td>000744 04/07/2017</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>0POC11</td>
<td>0</td>
<td>10) On 1/24/17 at 7:05 AM, client #1 was in the upstairs hallway near the office when staff heard a loud noise in the hallway. Client #1 was on his knees outside of the upstairs bathroom. There was no documentation indicating whether or not client #1 was injured during the fall. The fall was not witnessed by staff. There was no documentation the facility conducted an investigation.</td>
<td>00</td>
<td>0</td>
<td>4700 HITE DR BLOOMINGTON, IN 47408</td>
<td>000744 04/07/2017</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>0POC11</td>
<td>0</td>
<td>11) On 2/12/17 at 8:30 AM, client #1 fell at the entrance to the office. He was not injured. The 2/12/17 Incident Report indicated, &quot;...[staff #3] was following behind [client #1]... [Client #1] tripped over his own feet and fell at the entrance of the office, landing on his knees and hands....&quot; There was no documentation the facility conducted an investigation.</td>
<td>00</td>
<td>0</td>
<td>4700 HITE DR BLOOMINGTON, IN 47408</td>
<td>000744 04/07/2017</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>0POC11</td>
<td>0</td>
<td>12) On 2/19/17 at 1:23 PM, client #1 stepped out of the van and fell to the ground. Client #1 was not injured. There was no documentation the facility conducted an investigation.</td>
<td>00</td>
<td>0</td>
<td>4700 HITE DR BLOOMINGTON, IN 47408</td>
<td>000744 04/07/2017</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>0POC11</td>
<td>0</td>
<td>13) On 2/21/17 at 7:45 PM, client #1 was walking down the upstairs hallway</td>
<td>00</td>
<td>0</td>
<td>4700 HITE DR BLOOMINGTON, IN 47408</td>
<td>000744 04/07/2017</td>
<td></td>
</tr>
</tbody>
</table>
when staff heard a thud. Staff observed client #1 sitting on the floor in the hallway. Client #1 was not injured. There was no documentation the facility conducted an investigation.

14) On 3/11/17 at 2:40 PM, client #1 walked out of the living room and fell to his knees. Client #1 was not injured. There was no documentation the facility conducted an investigation.

On 4/5/17 at 3:28 PM, the AGHD forwarded an email from the nurse to the surveyor for review. The 1/25/17 email from the nurse to the GHD, AGHD and QIDP indicated, "I don't wish to make any changes to [client #1's] fall risk plan, but we will need to document a conversation at the next support team meeting about his current plan and recent falls." There was no documentation of a conversation on the support team note. There was no
documentation in client #1's record the nurse took action regarding client #1's falls.

On 4/4/17 at 2:28 PM, the nurse indicated client #1 had not been assessed by a Physical Therapist. The nurse indicated the facility was looking into the possibility of an assistive device such as a walker or a cane. The nurse indicated a lot of times prior to a fall, client #1 was anxious about something. The nurse indicated client #1 liked to hold onto something while ambulating. The nurse indicated client #1 had a recent increase in falls. The nurse indicated until 3/31/17 at the house meeting, there was no recent discussion pertaining to client #1's falls.

9-3-6(a)

W 0376

483.460(k)(8)

DRUG ADMINISTRATION

The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician.

Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to have a system to immediately report medication errors to
**Name of Provider or Supplier:** Stone Belt Arc Inc  
**Address:** 4700 Hite Dr, Bloomington, IN 47408

**Summary Statement of Deficiencies:**

Findings include:

On 4/3/17 at 12:26 PM, a review of the facility's incident/investigative reports was conducted and indicated there was no documentation the facility reported the medication error to client #4's physician for the following:

1) On 7/4/16 at 5:00 PM when client #4 returned to the group home from a visit with his mom, a medication he took with him (Colcrys for gout) was not administered by client #4 or his mom on 7/4/16. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

2) On 7/23/16 during the morning medication pass to client #4 it was discovered client #4 did not receive Androgel (low testosterone) every third day in the morning during his home visit from 7/20/16 to 7/24/16. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

3) On 9/5/16 when client #4 returned from a home visit (9/2/16 to 9/5/16), it was discovered he missed one dose of the medication. Nurse will be trained to report all medication errors to client's primary doctor.

**Provider's Plan of Correction:**

- **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**  
  Nurses will report all medication errors to client's primary doctor via fax. Nurses will document this correspondence in their nursing notes and on IR.

- **How corrective actions will be monitored to ensure no recurrence**  
  The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction (POC). The meeting will be chaired by SGL Director (or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at

---

**Event ID:** 0POC11  
**Facility ID:** 000744  
**If continuation sheet:** Page 62 of 70
following: Tamsulosin (urination), Losartan (hypertension), Ropinirole (restless leg syndrome), Atorvastatin (high cholesterol), Allopurinol (gout), Aspirin (blood clot prevention) and Androgel. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

4) On 10/22/16 at 5:30 PM when client #4 returned to the group home from visiting his mom, it was discovered he did not receive Androgel. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

5) On 11/13/16 when client #4 returned to the group home from visiting his mom, he was not administered one dose of the following medications: Ropinirole, Atorvastatin, Tamsulosin, Allopurinol, Aspirin, Loratadine (allergies), Losartan and Colcrys. No adverse reactions were noted. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

6) On 12/26/16 at 8:03 PM when client #4 returned to the group home from visiting his mom, he did not receive Androgel. There was no documentation
indicating the steps the facility took to address the medication error while at home with his mom.

7) On 3/12/17 when client #4 returned to the group home from visiting his mom, it was found he did not take one dose of the following medications: Loratadine, Allopurinol, Aspirin, Atorvastatin, Colcrys and Losartan. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

8) On 3/25/17 when client #4 returned to the group home from visiting his mom, it was found he was not administered one dose of the following medications: Losartan, Tamsulosin, Ropinirole and Atorvastatin. There was no documentation indicating the steps the facility took to address the medication error while at home with his mom.

On 4/4/17 at 1:34 PM, a focused review of client #4's record was conducted. Client #4's record did not contain documentation indicating the facility immediately reported the medication errors to client #4's physician.

On 4/4/17 at 1:37 PM, the nurse indicated unless the client missed three doses of the same medication in a row,
**Summary Statement of Deficiencies**

**(Each deficiency must be preceded by full regulatory or LSC identifying information)**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>W 0440</td>
<td>483.470(i)(1)</td>
<td>Bldg. 00</td>
<td>EVACUATION DRILLS</td>
</tr>
</tbody>
</table>

The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 6 clients living in the group home (#1, #2, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift of personnel.

Findings include:

On 4/3/17 at 1:02 PM, a review of the facility's evacuation drills was conducted. During the evening shift (2:00 PM to 10:00 PM), the facility failed to conduct quarterly evacuation drills from 5/22/16.

**W 0440 Evacuation Drills**

Corrective action for resident(s) found to have been affected

Staff will be trained to conduct drills according to policy. QIDP and Coordinator will monitor drill occurrence.

**How facility will identify other residents potentially affected & what measures taken**

All residents potentially are
to 10/15/16. This affected clients #1, #2, #4, #5 and #6 (client #3 was admitted to the facility on 2/8/17).

On 4/3/17 at 1:36 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility should conduct quarterly evacuation drills.

On 4/3/17 at 1:49 PM, the Group Home Director (GHD) indicated the facility should conduct one drill per shift per quarter.

9-3-7(a)

9-3-7(a)

affected, and corrective measures address the needs of all clients.

Measures or systemic changes facility put in place to ensure no recurrence
Staff will conduct drills. Coordinators will schedule drills with staff and follow up to ensure compliance. Drills are monitored monthly, at least by thorough audit, conducted by coordinator.

How corrective actions will be monitored to ensure no recurrence
The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction (POC). The meeting will be chaired by SGL Director (or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.
The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:

460 IAC 9-3-1 Governing Body

(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:
15. A fall resulting in injury, regardless of the severity of the injury. 16. A medication error or medical treatment error as follows: a. wrong medication given; b. wrong medication dosage given; c. missed medication - not given; d. medication given wrong route; or e. medication error that jeopardizes an individual's health and welfare and requires medical attention.

This state rule was not met as evidenced by:

Based on interview and record review for 9 of 28 incident reports reviewed affecting clients #4 and #6, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDDS) within 24 hours, in accordance with state law, in regard to client #4's medication errors while on resident(s) found to have been affected
Staff will be trained to report all incidents in a timely manner and immediately reported to BDDDS if appropriate.

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
Director and Associate director will monitor all IRs to ensure immediate reporting to BDDDS

How corrective actions will be monitored to ensure no recurrence
The QIDP is supervised by the SGL Director, they will meet at least monthly to ensure all corrective action is being followed for the Plan of Correction(POC). The meeting will be chaired by SGL Director(or designee). The QIDP is responsible for program implementation and monitoring of the facility. The SGL Director will provide all documented training. The SGL Director will ensure that all corrections are in place and
**Findings include:**

On 4/3/17 at 12:26 PM, a review of the facility's incident reports was conducted and indicated the following incidents were not reported to BDDS:

1. On 7/4/16 at 5:00 PM when client #4 returned to the group home from a visit with his mom, one dose of a medication he took with him (Colcrys for gout) was not administered by client #4 or his mom.

2. On 7/23/16 during the morning medication pass to client #4 it was discovered client #4 did not receive Androgel (for low testosterone) every third day in the morning during his home visit from 7/20/16 to 7/24/16.

3. On 9/5/16 when client #4 returned from a home visit (9/2/16 to 9/5/16), it was discovered he missed one dose of the following: Tamsulosin (urination), Losartan (hypertension), Ropinirole (restless leg syndrome), Atorvastatin (high cholesterol), Allopurinol (gout), Aspirin (blood clot prevention) and Androgel.

4. On 10/22/16 at 5:30 PM when client
#4 returned to the group home from visiting his mom's house, it was discovered he did not receive Androgel.

5) On 11/13/16 when client #4 returned to the group home from visiting his mom, he was not administered one dose of the following medications: Ropinirole, Atorvastatin, Tamsulosin, Allopurinol, Aspirin, Loratadine (allergies), Losartan and Colcrys. No adverse reactions were noted.

6) On 12/26/16 at 8:03 PM when client #4 returned to the group home from visiting his mom, he did not receive Androgel.

7) On 3/10/17 at 11:00 AM, client #6 fell while volunteering delivering food to a home. Client #6 tripped and fell on his left knee causing a scrape.

8) On 3/12/17 when client #4 returned to the group home from visiting his mom, it was found he did not take one dose of the following medications: Loratadine, Allopurinol, Aspirin, Atorvastatin, Colcrys and Losartan.

9) On 3/25/17 when client #4 returned to the group home from visiting his mom, it was found he was not administered one dose of the following medications:
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| 00 | Losartan, Tamsulosin, Ropinirole and Atorvastatin.  
On 4/4/17 at 1:17 PM, the Group Home Director (GHD) indicated medication errors and falls with injury should be reported to BDDS within 24 hours. | 9-3-1(b) | |