| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G653 | A. BUILDING 00<br>B. WING | 01/29/2024 |

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| W 0000<br><br>Bldg. 00 | This visit was for a pre-determined full recertification and state licensure survey.<br><br>Survey Dates: January 24, 25, 26 and 29, 2024<br><br>Facility Number: 001094<br>Provider Number: 15G653<br>AIMS Number: 100235630<br><br>These deficiencies also reflect state findings in accordance with 460 IAC 9.<br>Quality Review of this report completed by #15068 on 2/6/24. | W 0000 | | |
| W 0104<br><br>Bldg. 00 | 483.410(a)(1)<br>GOVERNING BODY<br>The governing body must exercise general policy, budget, and operating direction over the facility.<br>Based on observation and interview for 6 of 6 clients who attended the facility operated day program (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure empty and full portable oxygen tanks were not stored unsecured on the floor behind a rocking chair.<br><br>Findings include:<br><br>On 1/24/24 from 12:47 PM to 1:50 PM, an observation was conducted at the facility operated day program. Throughout the observation, there were 3 full and 3 empty portable oxygen containers located in a day program area behind a rocking chair. The containers were not in a storage container or an | W 0104 | **Corrective action for resident(s) found to have been affected:**<br>The governing body failed to ensure empty and full portable oxygen tanks were stored properly. The agency purchased an oxygen tank holder to be kept at LARC, (the day program) to ensure proper storage of both full and empty tanks. This device has been received and is in place at this time.<br><br>**How facility will identify other residents potentially affected & what measures taken:**<br>All residents potentially are affected, and corrective measures | 02/29/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Genna Lynn | Executive Residential Director | 02/16/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | apparatus to ensure they did not tip over. At 1:01 PM when the surveyor asked staff #5 about the containers, staff #5 went over to move one of the containers. Staff #5 accidentally knocked one of the oxygen containers over while attempting to pick it up. Staff #5 indicated the area where the oxygen containers were located was where they stored them. This affected clients #1, #2, #3, #4, #5 and #6.<br><br>On 1/25/24 at 12:21 PM, the nurse indicated the oxygen containers needed to be stored secured so they could not tip over. On 1/24/24 at 3:18 PM, the nurse indicated the oxygen tanks needed to be secured on a concrete floor so they could not tip over and explode. The nurse indicated the oxygen tanks needed to be moved from behind the rocking chair in the day program area.<br><br>On 1/25/24 at 11:29 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the oxygen containers should be stored securely.<br><br>On 1/25/24 at 11:29 AM, the Group Home Director (GHD) indicated the portable oxygen containers should be stored securely. The GHD indicated the containers should be in a roller or cage so they could not tip over.<br><br>On 1/24/24 at 3:25 PM, the day program Coordinator indicated the oxygen tanks needed to be secured and moved from behind the rocking chair. The Coordinator indicated the tanks should not be stored in the program area.<br><br>9-3-1(a) | | address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence:**<br>The day program coordinator and building maintenance will be re-trained to ensure that oxygen tanks are stored appropriately in an appropriate manner and away from clients or areas where they can be mishandled.<br><br>**How corrective actions will be monitored to ensure no recurrence:**<br>Maintenance staff will conduct a weekly walk through of the day program facility to look for any safety issues and to look specifically at the way that oxygen tanks are being stored to ensure the safety of all. | |
| W 0149<br><br>Bldg. 00 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement | | | |

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| | written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on observation, record review and interview for 1 of 3 clients in the sample (#3) and one additional client (#5), the facility failed to implement its policies and procedures to prevent client #5 from falling out of the back of the wheelchair lift van, conduct an investigation of client #3's injuries of unknown origin and prevent further potential abuse and neglect while an investigation was in progress.<br><br>Findings include:<br><br>On 1/24/24 at 1:51 PM, a review of the facility's incident reports was conducted and indicated the following:<br><br>1) On 1/23/24 at 4:00 PM, client #5 fell out of the back of the group home van while the lift was on the ground. The 1/24/24 Bureau of Disabilities Services incident report indicated, "Staff (Coordinator) were (sic) unloading clients from the van to go into the group home. [Client #5] unbuckled his seatbelt and didn't wait for the lift to get to the van before rolling himself to the back of the van and falling down onto the lift, hitting his head. Staff took [client #5] to the ER (emergency room) and was examined for injuries. Client was found to have a two inch scratch on his head. Client was prescribed Tylenol every 6 hours for 2 days. Staff were instructed to observe client for irregular sleepiness, nausea, vomiting, confusion, or any irregular symptoms. Staff will continue to implement polices to ensure the safety of all clients."<br><br>There was no documentation the facility implemented actions to prevent further potential abuse and neglect while an investigation was in | W 0149 | **Corrective action for resident(s) found to have been affected:**<br>The facility failed to implement its policies and procedures to prevent client #5 from falling out of the back of the wheelchair lift van, conduct an investigation of client #3's injuries of unknown origin and prevent further potential abuse and neglect while an investigation was in progress. The QIDP responsible for the investigation for the injury of unknown origin is no longer employed by the agency. The lead QIDP will ensure that the new QIDP – when hired- is fully trained and understands the need to investigate unknown injuries. The lead QIDP will assume QIDP duties until someone is hired. The coordinator responsible for the client who fell out of the van has been retrained on individual specific client safety on the van and is in the process of being demoted. All SGL leadership will be re-trained on suspending employees involved in potential neglect immediately.<br><br>**How facility will identify other residents potentially affected & what measures taken:**<br>All residents potentially are affected, and corrective measures address the needs of all clients.<br>**Measures or systemic changes facility put in place to ensure** | 02/29/2024 |

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| | progress.<br><br>The 1/29/24 Investigation Report indicated, "... [Coordinator] exhibited unintentional neglect in this incident. Before taking [client #4] under the awning, [Coordinator] should have made sure that the lift was in the 'up' position... [Coordinator] was not immediately suspended pending investigation. She was suspended on 1/24/24 at 6:10 PM. She returned to work as soon as interviews were completed and a conclusion was made... [Coordinator] was suspended on 1/24/24 and retrained to ensure that [client #5's] wheel chair is strapped to the floor of the van so that if he gets in it, it will not move until staff release it. All [name of group home] staff will be re-trained on how to transport [name of group home] clients using 2 vans versus one. [Client #5's] wheel chair will be positioned beside his jumper seat and strapped to the floor of the van. All staff will be cautioned to place the lift back in the 'up' position if they must walk away from the van to assist a client while other clients are still on board. [Coordinator] will be given a Performance review. This investigator will ensure that in cases of potential neglect, involved staff will be suspended immediately pending investigation. In addition, Associate Directors will be trained to ensure the same."<br><br>On 1/24/24 from 4:19 PM to 6:15 PM, an observation was conducted at the group home. Throughout the observation, the Coordinator worked with clients #1, #2, #3, #4, #5 and #6 at the group home.<br><br>On 1/24/24 at 4:54 PM, the Coordinator indicated prior to this date, the group home was using two vans to do transport so she was at the home with clients #2, #4 and #5. The Coordinator indicated | | **no recurrence:**<br>All serious events are to be reported to the SGL emergency pager and then reported to director of the program. The director is responsible to ensure that staff are suspended pending investigation. The Lead QIDP will be informed of the incident with a client's broken tooth and the need to see that as an unknown injury to ensure it is investigated. When conducting training for new QIDP's, the lead Q will use scenarios to assist with competency. A plan has been put into place to ensure the safety of all clients at this facility when riding in and getting off of the van.<br>**How corrective actions will be monitored to ensure no recurrence:**<br><br>All serious events are to be reported to the SGL emergency pager and then reported to director of the program. The director is responsible to ensure that staff are suspended pending investigation. The Lead QIDP will be informed of the incident with a client's broken tooth and the need to see that as an unknown injury to ensure it is investigated. When conducting training for new QIDP's, the lead Q will use scenarios to assist with competency. A plan has been put into place to ensure the safety of all clients at this facility when riding in and getting off of the van. | |

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| | the second van was not at the group home at the time. She indicated the van was backed in, it was raining and she got client #4 off of the lift. She indicated she was trying to get client #4 under the awning by the front door when client #5 fell out of the van in his wheelchair. She indicated prior to client #5 falling out of the van, he was in a van seat and transferred himself into his wheelchair and started backing up. She indicated she heard the van's alarm for proximity to the lift go off and she verbally prompted client #5 to stop. He did not and fell backward out of the van and onto the lift on the ground. The Coordinator stated "It was my fault for not putting the lift up." She stated client #5 "normally waits." She indicated she did not think she was negligent. She indicated she did not think she was neglecting him at the time of the incident. She indicated she could have done things differently. She indicated she received training on the van and using the wheelchair lift. She indicated client #5 had a mark on the top of his head in the shape of the metal grate on the lift.<br><br>On 1/24/24 at 4:15 PM, the Group Home Director (GHD) indicated she should have suspended the Coordinator during the investigation. The GHD indicated she knew about the incident but had not read the incident report regarding the situation. On 1/25/24 at 11:29 AM, the GHD indicated she did not suspend the Coordinator. The GHD indicated the Coordinator told her she had transported the clients 50 times and client #5 never fell out of the van. The Coordinator indicated she usually could verbally prompt client #5 to wait and he would wait. This time he did not wait and rolled out of the back of the van. The GHD stated, regarding not suspending the Coordinator, "I did it wrong." The GHD indicated the Coordinator should have been suspended during the investigation. | | The facility coordinator will observe van usage and departures at least once per week to ensure staff are conducting van exits appropriately. | |

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| | On 1/24/24 at 3:43 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was in the middle of conducting the investigation. The QIDP indicated the nurse called her to let her know client #5 fell out of the van. Client #5 was sent to the ER. The QIDP indicated the Coordinator was with client #5 when he fell. The Coordinator parked the van to unload the clients. The Coordinator got client #4 off the van, left the lift down and moved client #4 to the side. Meanwhile, client #5 rolled himself backward out of the van. The QIDP indicated client #5 had an indentation on his head from what appeared to be the metal grates on the lift. There was no blood or bruising at the time. The QIDP stated the Coordinator was "pretty broken up" about the incident. The QIDP indicated she was recommending changing from transporting the clients in two vans to just using one van so there would be two staff present. On 1/25/24 at 12:07 PM, the QIDP indicated the Coordinator made a mistake. The QIDP indicated the Coordinator told her she had done the same thing 50 times before and client #5 did not fall out of the van. The QIDP indicated even though it happened 50 times before, it doesn't make it right. The QIDP indicated the Coordinator needed to be retrained. The QIDP stated it "could have been so bad." The QIDP indicated it was neglect.<br><br>2) On 11/4/23 at 7:45 PM, client #3 was in her recliner. The 11/5/23 BDS report indicated, "[Client #3] was sitting in her recliner most of the day. Staff were sitting talking with [client #3], she smiled at staff and staff noticed a new broken tooth in her mouth. Her bottom left side has a tooth that seems to have broken almost completely today. Her top broken tooth has broken off more as well. [Client #3] has | | | |

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| | osteoporosis and that causes weakness in her bones and teeth. She was using a metal straw and she loves to eat popcorn; both could have caused the damage to her teeth. The nurse pager was called and notified, it will be written in shift notes. Staff will take [client #3] to her dentist as soon as appointment allows. Nurse [Stone Belt nurse]/Hospice will follow up. [Client #3] will eat popcorn with no kernels and drink without use of a metal straw; staff will change straw type. Staff will continue to implement policies to ensure the safety of all clients."<br><br>There was no documentation of an investigation.<br><br>On 1/24/24 at 3:35 PM, the QIDP indicated client #3's missing teeth should have been investigated. On 1/25/24 at 11:49 AM, the QIDP indicated she convened the interdisciplinary team to discuss the incident. The QIDP indicated they discussed client #3 not using a metal straw and ensuring there were no popcorn kernels in her popcorn. The QIDP indicated although an appointment with the dentist was made, when client #3 arrived to the dentist she was told her insurance was no longer accepted and she would need to find a new dentist. The QIDP indicated client #3 had an appointment scheduled with a new dentist but there was a wait to get in.<br><br>On 1/25/24 at 11:51 AM, the Group Home Director indicated it was an injury of unknown origin and should have been investigated.<br><br>On 1/26/24 at 11:51 AM, a review of the facility's 10/15/10 Human Rights Policy was conducted. The policy indicated, "To be safeguarded by staff from any individuals anywhere, including family or community members, who are inflicting physical and/or emotional pain on the client or | | | |

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| | violating his/her rights. Abuse and neglect are never acceptable... Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma. Consideration of cognitive competence of the accused must be made in situations involving client violations... Neglect: Any action or behavioral interventions that risks the physical or emotional safety and wellbeing of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to:<br>1. Failure to provide a safe, clean and sanitary environment.<br>2. Failure to provide appropriate supervision, care, or training.<br>3. Failure to provide food and medical services as needed.<br>4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan...."<br><br>9-3-2(a) | | | |
| W 0154<br><br>Bldg. 00 | 483.420(d)(3)<br>STAFF TREATMENT OF CLIENTS<br>The facility must have evidence that all alleged violations are thoroughly investigated.<br>Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to conduct an investigation of client #3's injury of unknown origin.<br><br>Findings include:<br><br>On 1/24/24 at 1:51 PM, a review of the facility's | W 0154 | **Corrective action for resident(s) found to have been affected:**<br>The facility failed to conduct an investigation of client #3's injury of unknown origin (broken tooth). The QIDP responsible for the investigation for the injury of unknown origin is no longer | 02/29/2024 |

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| | incident reports was conducted and indicated the following: On 11/4/23 at 7:45 PM, client #3 was in her recliner. The 11/5/23 BDS report indicated, "[Client #3] was sitting in her recliner most of the day. Staff were sitting talking with [client #3], she smiled at staff and staff noticed a new broken tooth in her mouth. Her bottom left side has a tooth that seems to have broken almost completely today. Her top broken tooth has broken off more as well. [Client #3] has osteoporosis and that causes weakness in her bones and teeth. She was using a metal straw and she loves to eat popcorn; both could have caused the damage to her teeth. The nurse pager was called and notified, it will be written in shift notes. Staff will take [client #3] to her dentist as soon as appointment allows. Nurse [Stone Belt nurse]/Hospice will follow up. [Client #3] will eat popcorn with no kernels and drink without use of a metal straw; staff will change straw type. Staff will continue to implement policies to ensure the safety of all clients."<br><br>There was no documentation of an investigation.<br><br>On 1/24/24 at 3:35 PM, the QIDP indicated client #3's missing teeth should have been investigated. On 1/25/24 at 11:49 AM, the QIDP indicated she convened the interdisciplinary team to discuss the incident. The QIDP indicated they discussed client #3 not using a metal straw and ensuring there were no popcorn kernels in her popcorn. The QIDP indicated although an appointment with the dentist was made, when client #3 arrived to the dentist she was told her insurance was no longer accepted and she would need to find a new dentist. The QIDP indicated client #3 had an appointment scheduled with a new dentist but there was a wait to get in. | | employed by the agency. The lead QIDP will ensure that the new QIDP – when hired- is fully trained and understands the need to investigate unknown injuries. The lead QIDP will assume QIDP duties until someone is hired. The Lead QIDP will be informed of the incident with a client's broken tooth and the need to see that as an unknown injury to ensure it is investigated. When conducting training for new QIDP's, the lead Q will use scenarios to assist with competency.<br><br>**How facility will identify other residents potentially affected & what measures taken:**<br>All residents potentially are affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence:**<br>The lead QIDP will ensure that the new QIDP – when hired- is fully trained and understands the need to investigate unknown injuries. The lead QIDP will assume QIDP duties until someone is hired. The Lead QIDP will be informed of the incident with a client's broken tooth and the need to see that as an unknown injury to ensure it is investigated. When conducting training for new QIDP's, the lead Q | |

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| | On 1/25/24 at 11:51 AM, the Group Home Director indicated it was an injury of unknown origin and should have been investigated.<br><br>9-3-2(a) | | will use scenarios to assist with competency.<br><br>**How corrective actions will be monitored to ensure no recurrence:**<br><br>The associate Director responsible for this facility will track all IR's relating to an unknown injury to ensure investigations are completed as required. | |
| W 0155<br><br>Bldg. 00 | 483.420(d)(3)<br>STAFF TREATMENT OF CLIENTS<br>The facility must prevent further potential abuse while the investigation is in progress.<br>Based on observation, record review and interview for 1 of 3 non-sampled clients (#5), the facility failed to prevent further potential abuse and neglect while an investigation was in progress.<br><br>Findings include:<br><br>On 1/24/24 at 1:51 PM, a review of the facility's incident reports was conducted and indicated the following: On 1/23/24 at 4:00 PM, client #5 fell out of the back of the group home van while the lift was on the ground. The 1/24/24 Bureau of Disabilities Services incident report indicated, "Staff (Coordinator) were (sic) unloading clients from the van to go into the group home. [Client #5] unbuckled his seatbelt and didn't wait for the lift to get to the van before rolling himself to the back of the van and falling down onto the lift, hitting his head. Staff took [client #5] to the ER | W 0155 | **Corrective action for resident(s) found to have been affected:**<br>The facility failed to prevent further potential abuse and neglect while an investigation was in progress. The staff responsible for the client falling out of the back of the van was not suspended in a timely manner.<br><br>**How facility will identify other residents potentially affected & what measures taken:**<br>All residents potentially are affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure** | 02/29/2024 |

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| | (emergency room) and was examined for injuries. Client was found to have a two inch scratch on his head. Client was prescribed Tylenol every 6 hours for 2 days. Staff were instructed to observe client for irregular sleepiness, nausea, vomiting, confusion, or any irregular symptoms. Staff will continue to implement polices to ensure the safety of all clients."<br><br>There was no documentation the facility implemented actions to prevent further potential abuse and neglect while an investigation was in progress.<br><br>On 1/24/24 from 4:19 PM to 6:15 PM, an observation was conducted at the group home. Throughout the observation, the Coordinator worked with clients #1, #2, #3, #4, #5 and #6 at the group home.<br><br>On 1/24/24 at 4:15 PM, the Group Home Director (GHD) indicated she should have suspended the Coordinator during the investigation. The GHD indicated she knew about the incident but had not read the incident report regarding the situation. On 1/25/24 at 11:29 AM, the GHD indicated she did not suspend the Coordinator. The GHD indicated the Coordinator told her she had transported the clients 50 times and client #5 never fell out of the van. The Coordinator indicated she usually could verbally prompt client #5 to wait and he would wait. This time he did not wait and rolled out of the back of the van. The GHD stated, regarding not suspending the Coordinator, "I did it wrong." The GHD indicated the Coordinator should have been suspended during the investigation.<br><br>On 1/24/24 at 3:43 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was | | **no recurrence:**<br>All serious events are to be reported to the SGL emergency pager and then reported to director of the program. The director is responsible to ensure that staff are suspended pending investigation. Once an IR is completed, the Director must sign off on the IR and take further actions if needed.<br>**How corrective actions will be monitored to ensure no recurrence:**<br><br>All serious events are to be reported to the SGL emergency pager and then reported to director of the program. The director is responsible to ensure that staff are suspended pending investigation. Once an IR is completed, the Director must sign off on the IR and take further actions if needed. | |

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| | in the middle of conducting the investigation. The QIDP indicated the nurse called her to let her know client #5 fell out of the van. Client #5 was sent to the ER. The QIDP indicated the Coordinator was with client #5 when he fell. The Coordinator parked the van to unload the clients. The Coordinator got client #4 off the van, left the lift down and moved client #4 to the side. Meanwhile, client #5 rolled himself backward out of the van. The QIDP indicated client #5 had an indentation on his head from what appeared to be the metal grates on the lift. There was no blood or bruising at the time. The QIDP stated the Coordinator was "pretty broken up" about the incident. The QIDP indicated she was recommending changing from transporting the clients in two vans to just using one van so there would be two staff present.<br><br>9-3-2(a) | | | |
| W 0192<br><br>Bldg. 00 | 483.430(e)(2)<br>STAFF TRAINING PROGRAM<br>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.<br>Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure staff received competency based training on client #3's oxygen needs including how to use and change settings on her oxygen concentrator.<br><br>Findings include:<br><br>On 1/24/24 from 4:19 PM to 6:15 PM and 1/25/24 from 5:57 AM to 7:47 AM, observations were conducted at the group home. Throughout the observations, client #3 received oxygen through a nasal cannula. Her oxygen concentrator was set | W 0192 | **Corrective action for resident(s) found to have been affected:**<br>The facility failed to ensure staff received competency training on client #3's oxygen needs including how to change the settings on her oxygen concentrator. All staff have been trained by the facility nurse on using the oxygen concentrator and the client's specific oxygen needs.<br><br>**How facility will identify other residents potentially affected &** | 02/29/2024 |

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| | on 1.5 liters per minute (LPM).<br><br>On 1/25/24 at 10:03 AM, a review of client #3's record was conducted. Client #3's January 2024 Physician's Orders indicated, "Oxygen at 1.5L (liters)/NC (nasal cannula) while up. May titrate to keep spo2 (shows the percentage of oxygen in someone's blood) above 90%...."<br><br>On 1/25/24 at 6:38 AM, staff #7 indicated client #3's oxygen should be set between 1-2 LPM. She indicated she was not trained and did not know how to adjust the settings on client #3's oxygen concentrator.<br><br>On 1/25/24 at 6:40 AM, staff #6 indicated client oxygen should be set between 1-2 LPM. He indicated he was not trained and did not know how to adjust the settings on client #3's oxygen concentrator. He indicated he was not trained on the concentrator.<br><br>On 1/25/24 at 12:21 PM, the nurse indicated the staff needed to be trained on client #3's oxygen levels and the concentrator. The nurse indicated the lowest client #3's oxygen should be set on was 1.5 LPM.<br><br>On 1/25/24 at 11:23 AM, the Group Home Director indicated the staff needed to be trained on client #3's oxygen use.<br><br>On 1/25/24 at 11:23 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not sure how to adjust client #3's oxygen concentrator and was not sure what it was supposed to be set on. The QIDP indicated the staff, including her, needed to receive training on client #3's oxygen use. | | **what measures taken:**<br>All residents potentially are affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence:**<br>Thefacility coordinator will ensure that all house staff understand how to use the oxygen and concentrator by asking questions during site visits to ensure competency.<br>**How corrective actions will be monitored to ensure no recurrence:**<br><br>Thefacility coordinator will ensure that all house staff understand how to use the oxygen and concentrator by asking questions during site visits to ensure competency. | |

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| W 0259<br>Bldg. 00 | 9-3-3(a)<br><br>483.440(f)(2)<br>PROGRAM MONITORING & CHANGE<br>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.<br>Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2's comprehensive functional assessment (CFA) was reviewed and updated annually.<br><br>Findings include:<br><br>On 1/25/24 at 9:47 AM, a review of client #2's record was conducted. Client #2's most recent CFA was dated 9/14/22. There was no documentation client #2's CFA was reviewed and updated since 9/14/22.<br><br>On 1/25/24 at 11:14 AM, the Group Home Director indicated client #2's CFA should be reviewed and updated annually.<br><br>On 1/25/24 at 11:17 AM, the Qualified Intellectual Disabilities Professional indicated client #2's CFA should be reviewed and updated annually.<br><br>9-3-4(a) | W 0259 | **Corrective action for resident(s) found to have been affected:**<br>The facility failed to ensure client #2's comprehensive functional assessment was reviewed and update annually. The QIDP responsible for client #2's CFA is no longer employed by the agency but did indicate she was under the impression that the form was going to change so she did not complete it. Client #2's CFA has now been completed.<br><br>**How facility will identify other residents potentially affected & what measures taken:**<br>All residents potentially are affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence:**<br>The Lead QIDP will ensure that all QIDP's are trained to competency on completing CFA's as required.<br><br>**How corrective actions will be monitored to ensure no recurrence:** | 02/29/2024 |

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| | | | The Lead QIDP is responsible to train all new QIDP's. The Associate Director responsible for this facility will spot check CFA's monthly to ensure they are completed. | |
| W 0352<br><br>Bldg. 00 | 483.460(f)(2)<br>COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE<br>Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.<br>Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2 had an annual dental examination.<br><br>Findings include:<br><br>On 1/25/24 at 9:47 AM, a review of client #2's record was conducted. Client #2's most recent dental examination was conducted on 10/18/22. The 10/18/22 Stone Belt Outside Services Report (Dental) indicated, "...Please list future treatments (if needed): 6 month cleaning...." There was no documentation client #2 had an annual dental exam since 10/18/22.<br><br>On 1/25/24 at 11:15 AM, the Group Home Director indicated client #2 should have had an annual dental exam.<br><br>On 1/25/24 at 11:23 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #2 may have missed his appointment. The QIDP indicated client #2 should have returned for a follow up in the recommended timeframe.<br><br>On 1/25/24 at 12:21 PM, the nurse indicated client #2 should have returned for a follow up in the | W 0352 | **Corrective action for resident(s) found to have been affected:**<br>The facility failed to ensure client #2 had an annual dental examination. Client #2 is being scheduled for his dental appointment.<br><br>**How facility will identify other residents potentially affected & what measures taken:**<br>All residents potentially are affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence:**<br>The QIDP is no longer employed by the agency and the site coordinator is being demoted. We are currently short one medical support specialist and are actively recruiting for that position. The medical support specialist is | 02/29/2024 |

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| | recommended timeframe.<br><br>9-3-6(a) | | responsible to ensure that appointments are made in a timely manner. The QIDP has oversight of appointments as well. The associate director will ensure that a new medical support specialist is trained to competency once hired and that a new QIDP is trained to competence with regard to medical appointments as well.<br>**How corrective actions will be monitored to ensure no recurrence:**<br>The Associate director will complete spot checks at this facility to ensure that appointments are scheduled for all medical needs and follow ups. | |
| W 0368<br><br>Bldg. 00 | 483.460(k)(1)<br>DRUG ADMINISTRATION<br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br>Based on record review and interview for 2 of 3 clients in the sample (#1 and #3) and one additional client (#6), the facility failed to ensure the clients' medications were administered as ordered.<br><br>Findings include:<br><br>On 1/24/24 at 1:51 PM, a review of the facility's incident reports was conducted and indicated the following medication errors:<br><br>1) On 10/27/23 at 8:00 PM, client #6 did not receive Docusate (constipation) as ordered. Client #6 did not have an adverse reaction to the error. | W 0368 | **Corrective action for resident(s) found to have been affected:**<br>The facility failed to ensure that clients 1 and 3's medications were administered as ordered by their physicians. The facility is changing our medication system from individual bubble packs to multi-dose packs. This will be an easier way for DSP's to administer medications. This will start with the cycle fill in March. In addition, the governing body has met several times to review our medication management procedures. This facility's nurse | 02/29/2024 |

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| | 2) On 11/26/23 at 11:00 AM, client #6 did not receive Metoclopramide (gastroesophageal reflux disease (GERD)) as ordered. Client #6 did not have an adverse reaction to the error.<br><br>3) On 11/26/23 at 8:00 PM, client #3 did not receive Trihexyphen (antispasmodic drug used to treat stiffness, tremors, spasms, and poor muscle control) as ordered. Client #3 did not have an adverse reaction to the error.<br><br>4) On 12/12/23 at 5:00 PM, client #6 did not receive Metoclopramide as ordered. Client #6 did not have an adverse reaction to the error.<br><br>5) On 1/2/24 at 7:00 PM, client #6 did not receive Loratadine (allergies). Client #6 did not have an adverse reaction to the error.<br><br>6) On 1/17/24 at 10:00 PM, client #1 did not receive Diazepam (muscle spasms). Client #1 did not have an adverse reaction to the error.<br><br>7) On 1/21/24 at 7:00 AM, client #3 did not receive Seroquel (mood disorder) as ordered. Client #3 did not have an adverse reaction to the error.<br><br>On 1/24/24 at 3:16 PM, the nurse indicated the clients should receive their medications as ordered. The nurse stated the medication errors were due to a "variety of issues."<br><br>9-3-6(a) | | will begin onsite re-training at least 3 times per week. During this retraining, the nurse will model medication passes, re-train, coach and observe direct care staff passing medications in this facility.<br><br>**How facility will identify other residents potentially affected & what measures taken:**<br>All residents potentially are affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence:**<br>The facility is changing our medication system from individual bubble packs to multi-dose packs. This will be an easier way for DSP's to administer medications. This will start with the cycle fill on March 4, 2024. In addition, the governing body has met several times to review our medication management procedures. This facility's nurse will begin onsite re-training at least 3 times per week. During this retraining, the nurse will model medication passes, re-train, coach and observe direct care staff passing medications in this facility. | |

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| | | | **How corrective actions will be monitored to ensure no recurrence:**<br>The governing body has met several times to review our medication management procedures. This facility's nurse will begin onsite re-training at least 3 times per week. During this retraining, the nurse will model medication passes, re-train, coach and observe direct care staff passing medications in this facility. | |
| W 0446<br><br>Bldg. 00 | 483.470(i)(2)(ii)<br>EVACUATION DRILLS<br>The facility must make special provisions for the evacuation of clients with physical disabilities.<br>Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to develop and implement a plan addressing evacuating the clients from the group home in an emergency.<br><br>Findings include:<br><br>On 1/24/24 at 2:35 PM, a review of the facility's evacuation drills was conducted and indicated the following affecting clients #1, #2, #3, #4, #5 and #6:<br><br>-On 3/25/23 at 3:40 AM, a fire drill was conducted. The drill took 5 minutes and 30 seconds to complete. | W 0446 | **Corrective action for resident(s) found to have been affected:**<br>The facility failed to develop and implement a plan addressing evacuating the clients from the group home in an emergency. The lead QIDP will schedule a meeting to discuss the evacuation process at this facility paying particular attention to the amount of time the evacuation should take as well as the order in which clients should be assisted to assure a safe evacuation. A plan will be developed and staff will be trained on the plan. | 02/29/2024 |

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| | -On 6/18/23 at 2:00 AM, a fire drill was conducted. The drill took 7 minutes to complete.<br><br>-On 9/24/23 at 5:20 AM, a fire drill was conducted. The drill took 9 minutes to complete.<br><br>-On 12/2/23 at 4:45 AM, a fire drill was conducted. The drill took 3 minutes to complete.<br><br>On 1/24/24 at 2:58 PM, the Qualified Intellectual Disabilities Professional indicated she was not sure what the targeted time of completion was regarding evacuation drills. The QIDP stated, "less than 10 minutes." The QIDP indicated there were four clients (#1, #3, #4 and #5) in the group home requiring assistance exiting the group home.<br><br>On 1/25/24 at 12:01 PM, the Group Home Director indicated she was not sure what the targeted time was to evacuate the clients from the group home. The GHD indicated there needed to be a plan to evacuate the clients from the group home.<br><br>On 1/25/24 at 12:04 PM, the Coordinator indicated she was not sure what the targeted time was to evacuate the clients from the group home. She indicated she was not aware of a plan indicating the order to assist the clients out of the group home.<br><br>9-3-7(a) | | **How facility will identify other residents potentially affected & what measures taken:**<br>All residents potentially are affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence:**<br>The QIDP will address evacuations semi-annually with the support teams. A review of past drills will take place and recommendations will be presented to improve the process if necessary.<br><br>**How corrective actions will be monitored to ensure no recurrence:**<br>The Associate Director will be responsible to ensure that this semi-annual review of evacuations occurs and any recommendations are put into place and staff trained. | |
| W 9999<br><br>Bldg. 00 | State Findings<br><br>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met: | W 9999 | **Corrective action for resident(s) found to have been affected:**<br>The agency failed to ensure that staff #7 and 10 had an annual TB screening. After the survey, the | 02/29/2024 |

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| | 460 IAC 9-3-3 Facility Staffing<br><br>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.<br><br>This state rule was not met as evidenced by:<br><br>Based on record review and interview for 2 of 3 employee files reviewed (#7 and #10), the facility failed to ensure annual Mantoux (5TU, PPD) tuberculosis (TB) screenings were conducted.<br><br>Findings include:<br><br>On 1/25/24 at 8:44 AM, a review of the employee files was conducted and indicated the following:<br><br>-Staff #7's most recent TB test was conducted on 12/19/22. There was no documentation of an annual TB test since 12/19/22.<br><br>-Staff #10's most recent TB test was conducted on 1/11/23. There was no documentation of an annual TB test since 1/11/23.<br><br>On 1/25/24 at 12:21 PM, the nurse indicated staff should have annual TB tests. | | facility nurse was able to locate documentation that one of the staff listed has indeed had their TB test completed. This documentation will be uploaded. The second staff had been off on medical leave and had just returned to work with an expired TB. She has been told she must get a TB test asap In order to continue working.<br><br>**How facility will identify other residents potentially affected & what measures taken:**<br>All residents potentially are affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence:**<br>The Executive Residential Director will work with the Agency's HR department to develop a better system for monitoring and tracking staff TB tests to ensure that no staff works with an expired TB.<br>**How corrective actions will be monitored to ensure no recurrence:**<br>The Associate Director will request a list of all TB tests for this facility's staff from the HR department in order to monitor when they are due next or if they are expired. Any staff with expired tests will not be allowed to work l their TB tests are completed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G653 | A. BUILDING 00<br>B. WING | 01/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| STONE BELT ARC INC | 1118 22ND ST<br>BEDFORD, IN 47421 |

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|---|---|---|---|---|
| | On 1/25/24 at 11:29 AM, the Qualified Intellectual Disabilities Professional indicated staff should have annual TB tests.<br><br>On 1/25/24 at 11:29 AM, the Group Home Director indicated staff should have annual TB tests.<br><br>9-3-3(e) | | | |