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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G653	A. BUILDING 00 B. WING	03/26/2024

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

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W 0000 Bldg. 00	This visit was for a Post Certification Revisit (PCR) to the pre-determined full recertification and state licensure survey completed on 1/29/24. This visit was in conjunction to the investigation of complaint #IN00427781. Survey Dates: March 25 and 26, 2024 Facility Number: 001094 Provider Number: 15G653 AIMS Number: 100235630 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/4/24.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. 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's governing body failed to exercise operating direction over the facility by failing to ensure the 2/29/24 Plan of Correction (POC) was implemented as written regarding training the day program Coordinator and maintenance staff on the storage of portable oxygen tanks, competency based training on client #3's oxygen concentrator, conducting medication administration observations, and failed to develop and implement a plan addressing evacuating the clients from the group home in an emergency.	W 0104	**-W104 Governing Bodies** **Corrective action for resident(s) found to have been affected:** The governing body failed to ensure staff was appropriately trained on client’s oxygen concentrator, conducting medication administration observations, and failed to develop and implement a plan addressing evacuating the clients from the group home in an emergency. As well we failed to train the coordinator and maintenance staff	04/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaitlynn Rodriguez	Associate Director	04/17/2024

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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	Findings include: 1) On 3/25/24 at 12:18 PM, a review of the 2/29/24 POC indicated at W104, "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." There was no documentation the Day Program Coordinator and building maintenance were retrained. On 3/26/24 at 11:06 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the coordinator and the maintenance staff should have been trained. On 3/26/24 at 11:06 AM, Associate Director #2 indicated the coordinator and the maintenance staff should have been trained. 2) On 3/25/24 at 12:18 PM, a review of the 2/29/24 POC indicated at W192, "...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...." On 3/25/24 from 4:19 PM to 5:45 PM, an observation was conducted at the group home. Staff #4 and staff #17 were working with client #3. Throughout the observations, client #3 received oxygen through a nasal cannula. Her oxygen concentrator was set on 2.3 liters per minute (LPM) from 4:19 PM to 5:24 PM. From 5:24 PM to		on appropriate storage of portable oxygen tanks. **How facility will identify other residents potentially affected & what measures taken:** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence:** The day program coordinator and group home coordinator 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. Group home nurse will retrain staff over client's oxygen concentrator to make sure they are competent. SGL Coordinator will conduct 1 med observation a week, and will document this in her site visits through our empower system. Nursing will continue to also conduct one med observation a week, as three is not realistic. Associate Director will also conduct one med observation a week. Bedford Group Homes have now started multidose packs for medications to help medication administration be simpler. Associate Director has created an overnight evacuation drill plan, and will have all staff trained by the	

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	5:45 PM, client #3's oxygen concentrator was set at 2.0 LPM. Staff did not test client #3's spo2 (shows the percentage of oxygen in someone's blood) at any time. On 3/26/24 at 9:36 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 above 90%...." On 3/25/24 at 4:32 PM, staff #17 indicated she was not trained to adjust client #3's oxygen concentrator. Staff #17 indicated she did not know what it was supposed to be set on. On 3/26/24 at 9:59 AM, a review of staff training on client #3's oxygen concentrator was conducted. Staff #17 was present for a training conducted on 2/23/24. The training indicated, "Trained on how to use an oxygen concentrator...." There was no documentation staff #4 received training. On 3/26/24 at 10:25 AM, Associate Director #2 indicated the staff should know what the oxygen concentrator should be set on and how to adjust it. She indicated the staff should be competently trained. On 3/26/24 at 10:36 AM, the Qualified Intellectual Disabilities Professional indicated the staff should know what the oxygen concentrator should be set on and how to adjust it. 3) On 3/25/24 at 12:18 PM, a review of the 2/29/24 POC indicated at W368, "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		4/19/2024. **How corrective actions will be monitored to ensure no recurrence:** Associate Directors will review site visits weekly to ensure group home coordinator is documenting her med observation weekly. Nursing will be retrained on ensuring direct support staff are knowledgeable about client risk plans, and are competent.	

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individual bubble packs to multi-dose packs. This will be an easier way for DSP's (sic) 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 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...."

-The medication system was not changed in March 2024.

-On 3/25/24 at 12:47 PM, a review of the nurse's medication administration observations was conducted. The nurse conducted weekly observations of medication administration in the home on 2/27/24, 3/6/24, 3/14/24 and 3/22/24. There were no observations conducted by the group home administrative staff.

On 3/25/24 at 12:31 PM, the nurse indicated she was instructed to conduct weekly observations of the clients' medication administration. The nurse indicated she was informed the other two observations would be completed by the group home administrative staff. The nurse stated, "I did one observation per week."

On 3/25/24 at 12:40 PM, the Nurse Manager (NM) indicated he instructed the nurse to conduct one medication pass observation a week. The NM indicated he informed the former Group Home Director the nurse would conduct one observation per week. The NM stated he "told her it should not just be assigned to the nurse."

On 3/25/24 at 2:35 PM, Associate Director #2

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	indicated in an email, when asked about medication administration observations, "...I am not able to find these." On 3/26/24 at 10:25 AM, Associate Director #2 indicated the observations should have been conducted as indicated. On 3/26/24 at 10:36 AM, the Qualified Intellectual Disabilities Professional indicated the observations should have been conducted as indicated. 4) On 3/25/24 at 12:18 PM, a review of the 2/29/24 POC indicated at W446, "...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...." There was no documentation the QIDP scheduled a meeting to discuss the evacuation process. There was no plan developed. There was no documentation the staff was trained. This affected clients #1, #2, #3, #4, #5 and #6. On 3/26/24 at 10:25 AM, Associate Director #2 indicated they were going to meet today to discuss evacuation drills and develop a plan. On 3/26/24 at 10:36 AM, the QIDP indicated no plan was developed. The QIDP indicated a plan needed to be developed. This deficiency was cited on 1/29/24. The facility			

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	failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. 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. Findings include: On 3/25/24 from 4:19 PM to 5:45 PM, an observation was conducted at the group home. Throughout the observations, client #3 received oxygen through a nasal cannula. Her oxygen concentrator was set on 2.3 liters per minute (LPM) from 4:19 PM to 5:24 PM. From 5:24 PM to 5:45 PM, client #3's oxygen concentrator was set at 2.0 LPM. Staff did not test client #3's spo2 (shows the percentage of oxygen in someone's blood) at any time. On 3/26/24 at 9:36 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 above 90%...." On 3/25/24 at 4:32 PM, staff #17 indicated she was not trained to adjust client #3's oxygen concentrator. Staff #17 indicated she did not know what it was supposed to be set on.	W 0192	**-W192 Staff Training Program** **Corrective action for resident(s) found to have been affected:** The facility failed to ensure staff received competency based training on clients oxygen needs including how to use and change the settings on her oxygen concentrator. **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:** Group home nurse will retrain staff over client's oxygen concentrator to make sure they are competent. Nurse when conducting med observations weekly, will randomly quiz staff over the oxygen concentrator to make sure staff are competent. Nursing will also	04/26/2024

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	On 3/26/24 at 9:59 AM, a review of staff training on client #3's oxygen concentrator was conducted. Staff #17 was present for a training conducted on 2/23/24. The training indicated, "Trained on how to use an oxygen concentrator...." On 3/26/24 at 10:25 AM, Associate Director #2 indicated the staff should know what the oxygen concentrator should be set on and how to adjust it. She indicated the staff should be competently trained. On 3/26/24 at 10:36 AM, the Qualified Intellectual Disabilities Professional indicated the staff should know what the oxygen concentrator should be set on and how to adjust it. This deficiency was cited on 1/29/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)		train coordinator and Associate Directors as trainers, so when we conduct our weekly observations we can quiz staff as well. When we complete this we will document this in our site visits on our online empower system. As well, we will document this training through our training system in empower. **How corrective actions will be monitored to ensure no recurrence:** Associate Directors will review site visits weekly to ensure group home coordinator is documenting her training over the oxygen concentrator. Nursing will be retrained on ensuring direct support staff are knowledgeable about client risk plans, and are competent.	
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 3 clients in the sample (#3 and #4), the facility failed to ensure staff administered the clients' medications as ordered. Findings include: On 3/25/24 at 12:59 PM, a review of the facility's incident reports was conducted and indicated the following medication errors:	W 0368	-**W 368 Drug Administration** **Corrective action for resident(s) found to have been affected:** The facility failed to ensure staff administered to clients' medications as ordered. **How facility will identify other residents potentially affected &**	04/26/2024

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	1) On 2/18/24 at 5:00 PM, client #3 did not receive Donepezil (dementia) as ordered. The staff administered the medication with her bedtime medications after consulting with a nurse. No side effects were noted. 2) On 3/10/24 at 5:00 PM, client #4 received the incorrect doses of Dok (constipation), Depakote (bi-polar disorder), and Phenytoin (seizures). Client #4 received one pill instead of two pills of Dok. Client #4 received one pill instead of three of Depakote. Client #4 received one pill instead of two of Phenytoin. No side effects were noted. On 3/25/24 at 2:40 PM, the nurse indicated the clients' medications should be administered as ordered. On 3/26/24 at 10:25 AM, Associate Director #2 indicated the clients' medications should be administered as ordered. On 3/26/24 at 10:36 AM, the Qualified Intellectual Disabilities Professional indicated the clients' medications should be administered as ordered. This deficiency was cited on 1/29/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)		**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:** Bedford group homes, the month of April, have started multidose packs to help make medication administration more simple for staff. The coordinator will monitor med passes 3 times a week. The Associate Director will monitor med passes once a week. Weekly we will fluctuate the times we go in to watch these medication passes, as most are happening at night time rather than 4pm med passes. Nursing will also be in once a week to observe medications passes as well. **How corrective actions will be monitored to ensure no recurrence:** Associate Directors will review site visits weekly to ensure group home coordinator is documenting her med observation weekly. Associate Director has created a secondary buddy checker form to track when errors are occurring. When we notice an error we will address this immediately. Leadership team will meet once a week all medication errors to determine what is necessary. If we	

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			notice any key med errors, rather than waiting for 3 to send back through med admin, leadership will reach out to nursing to do a med mentoring form with the staff that has completed the error.	
W 0446 Bldg. 00	483.470(i)(2)(ii) EVACUATION DRILLS The facility must make special provisions for the evacuation of clients with physical disabilities. 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. Findings include: On 3/25/24 at 12:18 PM, a review of the 2/29/24 POC indicated, "...The facility failed to develop and implement a plan addressing evacuating the clients from the group home in an emergency. The lead QIDP (Qualified Intellectual Disabilities Professional) 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...." There was no documentation the QIDP scheduled a meeting to discuss the evacuation process. There was no plan developed. There was no documentation the staff was trained. This affected clients #1, #2, #3, #4, #5 and #6. On 3/26/24 at 10:25 AM, Associate Director #2	W 0446	**-W446 Evacuation Drills** **Corrective action for resident(s) found to have been affected:** The facility failed to develop and implement a plan addressing evacuating the clients from the group home in an emergency. **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:** Leadership has met to create evacuation drill plans that are specific to each group home. These are now all uploaded in the system where staff are able to access easily. All staff will be retrained over the plan by 4/19/2024.	04/26/2024

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	indicated they were going to meet today to discuss evacuation drills and develop a plan. On 3/26/24 at 10:36 AM, the QIDP indicated no plan was developed. The QIDP indicated a plan needed to be developed. This deficiency was cited on 1/29/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)		**How corrective actions will be monitored to ensure no recurrence:** Leadership met and created a plan for all 9 group homes. On 5/3/2024 all staff will be trained on these evacuation plans at our monthly Huddle meeting.	