

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2025
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP COD 1118 22ND ST BEDFORD, IN 47421
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00453121.</p> <p>Complaint #IN00453121: A Federal/state deficiency related to the allegation is cited at W385.</p> <p>Dates: March 10, 11, 12 and 13, 2025</p> <p>Facility Number: 001094 Provider Number: 15G653 AIMS Number: 100235630</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #39778 on 3/21/25.</p>	W 0000		
W 0126 Bldg. 00	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS</p> <p>Based on record review and interview for 2 of 3 clients in the sample (B and C) and 3 additional clients (D, E and F), the facility failed to ensure the clients accessed their funds on a regular basis.</p> <p>Findings include:</p> <p>On 3/10/25 at 2:18 PM, a review of the clients' finances was conducted and indicated the following:</p> <p>-Client B accessed his funds on 2/22/25.</p>	W 0126	<p>126 Corrective action for resident(s) found to have been affected: The facility failed to ensure clients assessed their funds on a regular basis.</p> <p>How the facility will identify other residents potentially affected & what measures taken: All resident records were checked and no other clients were affected. The</p>	04/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Smith	Executive Residential Director	04/07/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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W 0149 Bldg. 00	<p>-Client C accessed his funds on 2/22/25.</p> <p>-Client D accessed her funds on 12/21/24.</p> <p>-Client E accessed her funds on 12/21/24.</p> <p>-Client F accessed his funds on 11/20/24.</p> <p>On 3/10/25 at 2:21 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated the clients should access their funds "at least 3 times a week or more."</p> <p>On 3/11/25 at 12:16 PM, the Associate Director stated the clients should access their funds "at least once a month."</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>Based on observation, record review and interview for 2 of 3 clients in the sample (B and C) and 3 additional clients (D, E and F), the facility failed to implement their policies and procedures to prevent client to client aggression.</p> <p>Findings include:</p> <p>On 3/10/25 from 4:14 PM to 6:14 PM, an observation was conducted at the group home.</p>	W 0149	<p>Coordinator was trained on taking clients out in the community to spend funds on desired item. Coordinators will complete a monthly audit to check clients funds</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: Coordinator will make a monthly shopping/activity schedule to help ensure clients are actively engaged in spending their funds.</p> <p>How corrective actions will be monitored to ensure no recurrence: During our monthly leadership meeting, coordinators will turn in completed monthly schedules including client purchases. Audits will be turned in monthly to the AD and ERD</p> <p>149 Corrective action for resident(s) found to have been affected: The facility failed to implement their policy to prevent client to client aggression</p> <p>How the facility will identify other residents potentially affected &</p>	04/08/2025

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	<p>At 5:02 PM as client B walked past client C, who was seated at the dining room table, he pushed the back of client C's head with an open hand causing his head to move forward. At 5:19 PM as client B walked past client C, who was seated at the dining room table, he elbowed the right side of client C's head as he walked past. Staff #3, #4 and #7 did not observe either incident.</p> <p>On 3/10/25 at 12:47 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) A 2/7/25 Bureau of Disabilities Services incident report indicated, "Earlier in the day, [client C] was pushed to the ground by a peer at Day Program. He was seen at the [name of emergency room], where he had x-rays of his chest, and a CT (Computed tomography) scan that showed no injuries. [Client C] appeared to be in pain and had trouble walking. When staff asked [client C] what was hurting him, he pointed to his hip. Staff contacted the nurse pager, the nurse recommended to take [client C] back to the hospital and have his hip examined. [Client C] was taken back to the [name of hospital] and had an x-ray performed on his hip. No injury was found. [Client C] stayed home from the next Day Program to rest. Tylenol will be given for pain as needed. Staff will continue to monitor for further injury. Staff will continue to implement policies to ensure the safety of all clients...."</p> <p>2) On 10/22/24 at 4:06 PM, client D scratched client F's face while on the van. Client F had 3 scratches on his forehead one to two inches in length.</p> <p>3) On 11/3/24 at 5:30 PM, client E slapped client F and then scratched client D while walking to the</p>		<p>what measures taken: The coordinator and staff were trained to notice the first sign of aggression and to place themselves in between clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: The team discussed and implemented a client's room change with clients approval to try and eliminate some of the noise which added to the aggression.</p> <p>How corrective actions will be monitored to ensure no recurrence: The team will have an IDT meeting after three client to client aggressions have occurred or an event of serious nature to discuss further ways to stay proactive to prevent any reoccurrences.</p>	

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	<p>dining room table. Clients D and F were not injured.</p> <p>4) On 11/4/24 at 7:30 AM, clients B, D, E and F hit each other while on the van during transport to the day program. Client D hit client F with an open hand. There was no additional information on the 11/5/24 incident report.</p> <p>5) On 11/20/24 at 5:00 PM, client B smacked client F in the face. Client F did not have an injury.</p> <p>6) On 11/26/24 at 7:00 AM, client D scratched the left side of client C's face. Client C had a scratch on his face 2.5 inches long.</p> <p>7) On 12/17/24 at 7:45 AM, client D grabbed client E's ear and then hit her on the top of the head. Client E was not injured.</p> <p>8) On 12/28/24 at 12:45 PM, client E slapped client C on the side of his face. Client C did not have an injury.</p> <p>9) On 1/27/25 at 5:45 PM, client B hit client D on the top of her head with an open hand. Client D was not injured.</p> <p>10) On 1/31/25 at 5:00 PM, client B hit client F on the top of the head. Client F was not injured.</p> <p>11) On 1/31/25 at 5:30 PM, client B smacked client C on the back with an open hand.</p> <p>12) On 2/12/25 at 4:30 PM, client B hit client C on the upper back. Client B threw a package of disposable wipes and it hit client F on the shoulder. Client B hit client E on the top of her head on the way to his room. None of the clients were injured.</p>			

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	<p>On 3/11/25 at 10:06 AM, a review of client B's record was conducted. Client B's 9/26/24 Behavior Support Plan (BSP) indicated he had a targeted behavior of aggression. The BSP indicated, "...When staff notice [client B] might start to become agitated, staff should be mindful of peers' proximity to [client B]. If they are too close, staff should redirect [client B] or the peer to another area... When [client B] is upset, staff should provide [client B] with one-on-one attention at the earliest signs of agitation. This means only one person (ideally a preferred staff member) should be speaking to [client B] and giving him their full attention. This staff member may hold [client B's] hands and maintain eye contact to focus [client B's] attention. Other staff members should monitor the situation and discretely place themselves in a position to block any attempts of peer-to-peer aggression...."</p> <p>On 3/11/25 at 12:24 PM, the Associate Director (AD) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AD indicated there was a policy and procedure preventing abuse of the clients.</p> <p>On 3/13/25 at 11:12 AM, a review of the facility's 11/20/23 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 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.</p>			

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W 0159 Bldg. 00	<p>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:</p> <ol style="list-style-type: none"> 1. Failure to provide a safe, clean and sanitary environment. 2. Failure to provide appropriate supervision, care, or training. 3. Failure to provide food and medical services as needed. 4. Failure to provide medical supplies or safety equipment as indicated in the individualized support plan... <p>Physical abuse: Consists of any intentional and/or punitive physical action or motion by which physical harm or emotional trauma may occur. This includes, but is not limited to the following:</p> <ol style="list-style-type: none"> 1. Corporal/Physical punishment: hitting, slapping, punching, kicking, pinching and/or striking a client. 2. Willful infliction of injury. 3. Intentionally touching another person in a rude, insolent or angry manner with the potential to result in significant harm or injury." <p>9-3-2(a) 483.430(a) QIDP</p> <p>Based on observation, record review and interview for 3 of 3 clients in the sample (A, B and C), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate</p>	W 0159	159 Corrective action for resident(s) found to have been affected: The Qualified Intellectual Disabilities	04/20/2025

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	<p>and monitor the clients' program plans. The QIDP failed to ensure client A had a comprehensive functional assessment (CFA) completed within 30 days of admission and client A's dietary needs were assessed within 30 days of admission, client B had a plan to address spitting out his medication, client C had written instructions to staff on how he was to wear his back brace, client A had a plan to address headbanging, client A's plan included accurate information about the kitchen door lock and clients B's and C's plan included the restriction of the kitchen door being locked at night.</p> <p>Findings include:</p> <p>1) Please refer to W210. For 1 of 3 clients in the sample (A), the QIDP failed to ensure client A had a comprehensive functional assessment (CFA) completed within 30 days of admission and client A's dietary needs were assessed within 30 days of admission.</p> <p>2) Please refer to W227. For 3 of 3 clients in the sample (A, B and C), the QIDP failed to ensure: 1) client B had a plan to address spitting out his medication, 2) client C had written instructions to staff on how he was to wear his back brace, and 3) client A had a plan to address headbanging.</p> <p>3) Please refer to W240. For 3 of 3 clients in the sample (A, B and C), the QIDP failed to ensure client A's plan included accurate information about the kitchen door lock and clients B's and C's plan included the restriction of the kitchen door being locked at night.</p> <p>9-3-3(a)</p>		<p>Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. The QIDP failed to ensure client A had a comprehensive functional assessment (CFA) completed within 30 days of admission and client A's dietary needs were assessed within 30 days of admission, client B had a plan to address spitting out his medication, client C had written instructions to staff on how he was to wear his back brace, client A had a plan to address headbanging, client A's plan included accurate information about the kitchen door lock and clients B's and C's plan included the restriction of the kitchen door being locked at night.</p> <p>How the facility will identify other residents potentially affected & what measures taken: The QIDP will have a monthly audit with CFA'S and a follow-up check list of what's needed after any new admissions. AD will reach out to our maintenance department to install a keypad lock. The Functional Assessment was completed by the QIDP and the BSP's were updated.</p> <p>The Measures or systemic changes facility put in place to ensure no recurrence: The AD will edit the QIDP audit form to reflect</p>		

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W 0210 Bldg. 00	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure client A had a comprehensive functional assessment (CFA) completed within 30 days of admission and client A's dietary needs were assessed within 30 days of admission.</p> <p>Findings include:</p> <p>On 3/11/25 at 9:31 AM, a review of client A's record was conducted. Client A was admitted to the group home on 11/25/24. There was no documentation of a CFA in client A's record. There was no documentation client A's dietary needs were assessed since his admission to the group home.</p> <p>On 3/12/25 at 10:05 AM, the nurse stated client A's dietary needs should have been assessed "right away." The nurse stated it was "not done."</p>	W 0210	<p>Cfa's, appointments, dietary needs to be completed before 30 days of admissions. Plans were updated and staff were trained on the back brace including written instructions.</p> <p>How corrective actions will be monitored to ensure no recurrence: The QIDP will turn in audit forms to the AD or ERD monthly. Behaviorist and staff will train clients on how to properly use keypad</p> <p>210 Corrective action for resident(s) found to have been affected: The facility failed to ensure client A had a comprehensive functional assessment (CFA) completed within 30 days of admission and client A's dietary needs were assessed within 30 days of admission.</p> <p>How the facility will identify other residents potentially affected & what measures taken: The QIDP will have a monthly audit with CFA'S and a follow-up check list of what's needed after any new admissions.</p> <p>Measures or systemic changes</p>	04/08/2025

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W 0227 Bldg. 00	<p>On 3/11/25 at 9:52 AM, the Qualified Intellectual Disabilities Professional (QIDP) stated he "forgot about it. Doesn't have one right now."</p> <p>On 3/11/25 at 9:53 AM, the Associate Director indicated client A's CFA should have been completed within 30 days of admission.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>Based on observation, record review and interview for 3 of 3 clients in the sample (A, B and C), the facility failed to ensure: 1) client B had a plan to address spitting out his medication, 2) client C had written instructions to staff on how he was to wear his back brace, and 3) client A had a plan to address headbanging.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 3/11/25 from 6:00 AM to 7:41 AM. At 6:10 AM, client B received his medications from staff #2. Client B received his medications one at a time. Client B coughed and spit his Clonidine (treatment of agitation and anxiety associated with Attention Deficit Hyperactivity Disorder) on the floor. At 6:16 AM, staff #2 indicated client B spitting out his medication was behavior related and not related to a swallowing issue.</p> <p>On 3/12/25 at 10:07 AM, the nurse indicated client</p>	W 0227	<p>facility put in place to ensure no recurrence: The AD will edit the QIDP audit form to reflect CFA's, appointments, dietary needs to be completed within 30 days of admissions. The QIDP's were trained on the form.</p> <p>How corrective actions will be monitored to ensure no recurrence: The QIDP will turn in audit forms to the AD or ERD monthly.</p> <p>227 Corrective action for resident(s) found to have been affected: The facility failed to ensure: 1) client B had a plan to address spitting out his medication, 2) client C had written instructions to staff on how he was to wear his back brace, and 3) client A had a plan to address headbanging.</p> <p>How facility will identify other residents potentially affected & what measures taken: Client plans were checked for updates.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: Staff were trained by the Nurse on how to properly put on client C's back brace and</p>	04/08/2025

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	<p>B used to spit out his Calcium pill (supplement) due to its large size so the nurse asked to get it discontinued. The nurse stated client B "does it (spit out medications) on a regular basis." The nurse indicated it was a behavior. The nurse stated, "I have not let the BC (Behavior Clinician) know."</p> <p>On 3/12/25 at 1:20 PM, the BC stated, "he's been doing that for months." The BC indicated spitting out his medications was not part of his plan. The BC stated it "should be addressed in his plan. Didn't think about adding that one."</p> <p>2) An observation was conducted at the group home on 3/10/25 from 4:14 PM to 6:14 PM. From 4:14 PM to 5:30 PM, client C's back brace was loose around his waist and falling down over his buttocks. At 5:30 PM, staff #4 indicated client C's back brace should be higher and tighter. Staff #4 stated the brace "keeps falling down." Staff #4 stated, "He (client C) usually doesn't let us adjust it." The brace continued to be loose and falling down over his buttocks until 6:00 PM when the brace was snug and secured tight around his torso.</p> <p>On 3/10/25 at 12:47 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: A 2/7/25 Bureau of Disabilities Services incident report indicated, "Earlier in the day, [client C] was pushed to the ground by a peer at Day Program. He was seen at the [name of emergency room], where he had x-rays of his chest, and a CT (Computed tomography) scan that showed no injuries. [Client C] appeared to be in pain and had trouble walking. When staff asked [client C] what was hurting him, he pointed to his hip. Staff contacted the nurse pager, the nurse recommended to take [client C]</p>		<p>written instructions were provided to the home. Client B's BSP was updated to include spitting out of medications. Client A's plan was updated to include headbanging in his plan.</p> <p>How corrective actions will be monitored to ensure no recurrence: Wearing of the backbrace was put into the Medication Administration Record and will be monitored. The BSP updates will be monitored in client behavior tracking.</p>	

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	<p>back to the hospital and have his hip examined. [Client C] was taken back to the [name of hospital] and had an x-ray performed on his hip. No injury was found. [Client C] stayed home from the next Day Program to rest. Tylenol will be given for pain as needed. Staff will continue to monitor for further injury. Staff will continue to implement policies to ensure the safety of all clients...."</p> <p>On 3/11/25 at 11:13 AM, a review of client C's record was conducted. Client C did not have a plan addressing the use of his back brace. Client C's 7/18/24 Outside Services Report indicated he had lower back pain and was diagnosed with "lumbar burst fracture." The treatment indicated, "N/A (not applicable)."</p> <p>On 3/10/25 at 5:30 PM, staff #4 stated client C's back brace "should be tighter. It keeps falling down. He usually won't let us (direct care staff) adjust it." Staff #4 indicated there was no plan instructing staff on how client C's back brace should fit.</p> <p>On 3/12/25 at 9:22 AM, the Associate Director indicated in an email, "...I spoke with [nurse] today. The company that brought the brace trained staff on how to use it. We do not have training information on that...."</p> <p>On 3/12/25 at 10:07 AM, the nurse indicated client C was supposed to wear his back brace daily due to a previous fracture of his vertebrae. The nurse indicated the company who made the brace trained the staff after the fracture in 2024. The nurse indicated the brace was discontinued until recently when client C was pushed to the ground by a peer at the facility-operated day program. The nurse indicated the brace was reinstated however the staff were not retrained. The nurse</p>			

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP COD 1118 22ND ST BEDFORD, IN 47421
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	<p>indicated there were two new staff working in the home that were not trained by the company (Coordinator and staff #4). The nurse indicated she asked the staff in the home if they knew how to use the brace and everyone indicated they did. The nurse indicated there were no written instructions to staff on how to use the brace. The nurse indicated the brace should be snug. The nurse stated, "Should have written instructions to staff." On 3/12/25 at 11:12 AM, the nurse indicated she found the brace on-line and sent the instructions on its use to the staff working in client C's home with pictures on how it was to be used.</p> <p>3) On 3/10/25 at 12:47 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 1/25/25 at 1:00 PM, client A asked for his shower chair however, it was in another occupied bathroom. Client A started crying and asked to call his mom. He turned on the toilet and repeatedly hit his head on the grab bar adjacent to the toilet. Client A was taken to the emergency room due to head trauma and making statements that he wanted to kill himself.</p> <p>On 3/12/25 at 3:56 PM, a review of client A's behavior tracking for headbanging was conducted. The review indicated the following incidents of headbanging:</p> <p>-12/23/24: 2 -12/28/24: 1 -1/22/25: 1 -1/27/25: 1 -2/2/25: 1 -2/3/25: 2 -2/6/25: 1</p>			

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W 0240 Bldg. 00	<p>Total: 9</p> <p>On 3/11/25 at 8:44 AM, the Coordinator indicated when she started three months ago, client A was engaging in self-injurious behavior numerous times each shift. The Coordinator indicated client A's maladaptive behavior had improved since she started working at the group home.</p> <p>On 3/11/25 at 11:24 AM, the BC indicated client A needed a plan to address headbanging.</p> <p>On 3/11/25 at 12:11 PM, the Associate Director indicated client A's Behavior Support Plan should address self-injurious behavior.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN</p> <p>Based on observation, record review and interview for 3 of 3 clients in the sample (A, B and C), the facility failed to ensure client A's plan included accurate information about the kitchen door lock and clients B's and C's plan included the restriction of the kitchen door being locked at night.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/10/25 from 4:14 PM to 6:14 PM and 3/11/25 from 6:00 AM to 7:41 AM. Throughout the observations, there was no keypad lock on the kitchen door. This affected clients A, B and C.</p> <p>1) On 3/11/25 at 9:31 AM, a review of client A's record was conducted. Client A's 12/16/24 Behavior Support Plan (BSP) indicated in the</p>	W 0240	<p>240</p> <p>Corrective action for resident(s) found to have been affected: The facility failed to ensure client A's plan included accurate information about the kitchen door lock and clients B's and C's plan included the restriction of the kitchen door being locked at night.</p> <p>How facility will identify other residents potentially affected & what measures taken: The restriction effects all clients and plans were reviewed and updated to reflect this.</p> <p>Measures or systemic changes</p>	04/08/2025

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W 0351 Bldg. 00	<p>Modification section, "During the night the kitchen will be locked. [Client A] is working on learning the code (door key code) so this will not be a restriction for him for long..."</p> <p>2) On 3/11/25 at 10:06 AM, a review of client B's record was conducted. Client B's 9/26/24 BSP did not include the restriction of the kitchen door being locked at night. Client B's 9/10/24 Individualized Support Plan (ISP) did not include the restriction of the kitchen door being locked at night.</p> <p>3) On 3/11/25 at 11:13 AM, a review of client C's record was conducted. Client C's 10/1/24 BSP did not include the restriction of the kitchen door being locked at night. Client C's 9/10/24 ISP did not include the restriction of the kitchen door being locked at night.</p> <p>On 3/11/25 at 11:22 AM, the Behavior Clinician (BC) indicated the restriction of the kitchen door being locked was in place due to client F's food seeking. The BC indicated she did not put the restriction in client F's peers' plans. The BC indicated there was no keypad on the kitchen door. The BC indicated the clients' plans needed to be updated to include the restriction for the kitchen door.</p> <p>On 3/11/25 at 12:18 PM, the Associate Director indicated the kitchen door being locked should be included in the clients' plans.</p> <p>9-3-4(a) 483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Based on record review and interview for 1 of 1</p>	W 0351	<p>facility put in place to ensure no recurrence: Maintenance installed a keypad to the kitchen door and all client plans were updated to ensure that the restriction of the locked door was included in all plans.</p> <p>How corrective actions will be monitored to ensure no recurrence: All client plans will be reviewed when a restriction is added.</p>	04/08/2025

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W 0385 Bldg. 00	<p>client in the sample who was admitted to the group home since March 2024 (A), the facility failed to ensure he had a dental examination within one month after admission.</p> <p>Findings include:</p> <p>On 3/11/25 at 9:31 AM, a review of client A's record was conducted. Client A was admitted to the group home on 11/25/24. There was no documentation client A had a dental appointment since his admission to the group home.</p> <p>On 3/12/25 at 10:07 AM, the nurse indicated client A's dental appointment was scheduled earlier this month however staff did not confirm the appointment. The nurse indicated when client A was taken to the dentist, the dentist canceled the appointment due to not receiving confirmation of the appointment. She indicated client A's dental appointment was rescheduled. The nurse stated, "[Client A] should have had a dental appointment."</p> <p>On 3/11/25 at 9:53 AM, the Associate Director (AD) indicated client A's dental should have been completed within 30 days. The AD indicated a dental appointment was scheduled on 3/31/25.</p> <p>9-3-6(a) 483.460(l)(3) DRUG STORAGE AND RECORDKEEPING</p> <p>Based on record review and interview for 3 of 3 clients in the sample (A, B and C), the facility failed to ensure staff counted the clients' controlled medications twice daily per Stone Belt policy.</p>	W 0385	<p>Corrective action for resident(s) found to have been affected: The facility failed to ensure he had a dental examination within one month after admission.</p> <p>How facility will identify other residents potentially affected & what measures taken: Day aides were trained to make medical appointments within 30 days of admission.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: The AD and QIDP will assign tasks to our day aide.</p> <p>How corrective actions will be monitored to ensure no recurrence: This will be added to the QIDP audit form. The AD will check this monthly to ensure timely completion and follow up where necessary.</p>	04/08/2025	
			385 Corrective action for resident(s) found to have been affected: The facility failed to ensure staff counted the clients' controlled medications twice daily per Stone		

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	<p>Findings include:</p> <p>On 3/10/25 at 12:47 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 2/7/25 at 7:00 AM, staff discovered client E was missing two controlled pills (Lorazepam for anxiety). The 2/7/25 Bureau of Disabilities Services (BDS) report indicated, "[Staff #8] was passing [client E's] morning medications. During medication administration, staff noticed that there were two medications missing from the controlled medication punch card, out of order in the bubble pack. The medication was Lorazepam .5mg (milligrams). After checking through medication count records and around the medication cabinet, one pill was found loose in the medication bin, leaving one pill unaccounted for. The client received her proper dose of medication and no med error occurred. All staff working 24 hours prior to the missing dose of medication were suspended from work and sent for drug testing. Staff are suspended pending drug testing results and an investigation is occurring into the missing medication. Staff will continue to implement policies to ensure the safety of all clients."</p> <p>The 2/14/25 Investigation Report indicated, "...Evidence Summary: In the course of the investigation it appears some staff did not follow medication protocol in performing buddy checks/control count. [Staff #2] didn't do buddy checks when she arrived for her shift and did not count the controlled medications at the start of her shift. Evening staff didn't communicate with each other about the buddy checks. [Staff #8] did buddy checks when she arrived to work Friday morning and noticed the popped slots. [Staff #8] opened the slot more in hopes (sic) of the missing pill</p>		<p>Belt policy.</p> <p>How facility will identify other residents potentially affected & what measures taken: All staff were retrained at our monthly meeting on 4/4/24 on when and how to count controlled medications</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: Coordinator was trained to enter control counts in their site visits daily.</p> <p>How corrective actions will be monitored to ensure no recurrence: Coordinator and Associate house manager will check med log at the beginning of every shift. They will contact the AD or ERD if they notice any deficiencies</p>	

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	<p>would be hidden behind the foil. In doing this it is possible that a pill had fallen out unnoticed. Staff found one of the missing pills in the bottom of the controlled medication box... Analysis of Evidence & Findings:</p> <p>During this investigation, it is my finding that it is unlikely that staff took [client E's] controlled medication. All staff were sent for drug testing and results were negative for the missing medication, with the exception of one staff whose results are still outstanding. It is possible that staff may have accidentally popped the pills while placing them back into the controlled lock box. Although the medication has not been found, it does not appear that exploitation has occurred. If test results for the staff, whose results are not yet known, were to result as positive for the medication, the findings of the investigation will be updated. *The staff whose test we were waiting on results tested negative...</p> <p>Recommended Corrective Action(s) and Recommended Proactive Strategies (Systemic Changes): Staff were retrained on Stone Belt's medication protocol including buddy checks. Staff were trained on how to safely handle meds and to check them before putting them away."</p> <p>On 3/11/25 at 7:14 AM, a review of the Stone Belt Controlled Substance Count Sheets was conducted for clients A, B and C. The review indicated the following:</p> <p>-Client A's Vyvanse (attention deficit hyperactivity disorder) was counted one time on 3/2/25, 3/4/25, 3/5/25, and 3/7/25.</p> <p>-Client B's Diazepam (anxiety) was counted one time on 3/2/25 and 3/4/25.</p> <p>-Client C's Tramadol (pain) was counted one time</p>				

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

PRINTED: 04/22/2025

FORM APPROVED

OMB NO. 0938-039

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	<p>on 3/3/25 and 3/4/25.</p> <p>On 3/13/25 at 9:36 AM, a review of the Medication Inventory procedures was conducted. The procedures indicated, "...All controlled substances (even unopened) must be counted twice daily by staff persons if available. Med counts are to be done on every shift at the site...."</p> <p>On 3/13/25 at 10:33 AM, the nurse indicated the staff should be counting the clients' controlled medications on each shift however, the policy indicates two times daily and once a shift. The nurse stated the controlled medications should be counted "at a minimum twice daily." The nurse indicated the Coordinator was responsible for ensuring the controlled counts were completed.</p> <p>On 3/13/25 at 12:56 PM, the Associate Director (AD) indicated the policy indicated the staff count the controlled medications two times a day however, she trained staff to do it on each shift. The AD stated, "Should be doing it at least twice a day."</p> <p>This federal tag relates to complaints #IN00453121.</p> <p>9-3-6(a)</p>				