STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/16/2014
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1835 MAXWELL ST BLOOMINGTON, IN 47401	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for the recertification and state licensure survey. Survey Dates: October 14, 15 and 16, 2014. Facility Number: 000888 Provider Number: 15G374 AIM Number: 100239700 Surveyor: Dotty Walton, QIDP. These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/27/14 by Ruth Shackelford, QIDP.	W000000		
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to implement its policy prohibiting	W000149	W149 483.420 (d) (1) Staff Treatment of Clients	11/01/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	neglect of clients. Findings include: Facility incident reports and BDDS (Bureau of Developmental Disabilities Services) reports and medication error reports were reviewed on 10/14/14 at 1:00 PM, on 10/15/14 at 1:30 PM and on 10/16/14 at 12:15 PM. The review indicated the following A BDDS report of 8/06/14 indicated on 8/05/14 at 3:45 AM, client #1 was discovered to have engaged in self injurious behavior. "Around 3 AM one of [client #1's] roommates woke up, and came into the living room to watch TV. This roommate requires one on one staffing, and so required the attention of the night aide on duty. While attending to [client #1's] roommate, staff heard a noise coming from the hallway. Staff then saw [client #1] performing SIB (self injurious behavior) by hitting his (sic.) forehead, causing it to become red. After coming closer to [client #1], staff discovered that [client #1's] face and ears were bleeding. Staff applied first aid, and put [client #1's] safety helmet, and safety gloves on. Staff also assisted [client #1] with a change of clothes, as [client #1] had urinated, changed his bedding, and assisted [client #1] to getting back to		Plan of correction: Stone Belt has a policy that prohibits mistreatment,neglect, or abuse of a client. Plan ofPrevention: Facility day program staff and Stone Belt SGL staff will be trainedon prevention of mistreatment, neglect, and abuse each month **(Attachment A).** This training will be occurring monthly asthe SGL monthly Shiloh Meeting. Quality Monitoring: Facility manager / associate manager will providedaily monitoring. Plan of Monitoring: Facility coordinator / QDIP will conductrandom monthly observations during overnight shifts to ensure staff arefollowing plans.	

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	sleep, which he did." The BDDS report contained a plan to resolve the matter: "An injury of Unknown Origin was completed, and found that the injuries sustained by [client #1] were due to SIB. [Client #1] has a history of SIB. A [name of agency] Nurse evaluated [client #1], and concluded that the four areas showing injury (both cheekbones and ears) are areas that [client #1] has historically focused on while performing SIB. Staff will undergo additional training focusing on how to handle future situations in the future." The incident (8/5/14 3:45 AM) report which accompanied the BDDS report by staff #8 indicated because of the peer being awake who required one on one staff attention (client #4), staff #8 was not able to perform the routine bed check for all clients at 3:00 AM. The review of BDDS and incident reports indicated no agency investigation into the incident to determine if client #1, who had a history of SIB, was sufficiently monitored (neglected) by staff #8 to prevent the SIB. On 10/16/14 at 1:15 PM the agency's "Human Rights Policy" (Origination Date 10/85 with Annual Review 9/14) was			

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	reviewed and indicated the agency prohibited neglect of clients. The policy contained the following definition of neglect: "g. Neglect: Any action or behavioral intervention 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: ...2. Failure to provide appropriate supervision, care, or training." Interview with Qualified Intellectual Disabilities Professional/QIDP #1 on 10/16/14 at 1:00 PM indicated the facility did not conduct an investigation into the 8/5/14 incident to determine if client #1 had been neglected by staff #8. The interview indicated client #4 has a protocol in place for staff to implement if they are the only staff with the five clients who reside in the facility. If client #4 is awake (not just using the restroom in the night) and requires staff attention, the staff on duty was to call the agency's pager for assistance (staff to come to the facility). QIDP indicated staff #8 forgot to call the pager for assistance. Staff #8 received training by QIDP in regards to calling the agency pager if assistance was needed with client #4, who required a one			

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	to one staff due to behaviors. 9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to investigate a possible instance of staff to client neglect. Findings include: Facility incident reports and BDDS (Bureau of Developmental Disabilities Services) reports and medication error reports were reviewed on 10/14/14 at 1:00 PM, on 10/15/14 at 1:30 PM and on 10/16/14 at 12:15 PM. The review indicated the following: A BDDS report of 8/06/14 indicated on 8/05/14 at 3:45 AM, client #1 was discovered to have engaged in self injurious behavior. "Around 3 AM one of [client #1's] roommates woke up, and came into the living room to watch TV. This roommate requires one on one staffing, and so required the attention of the night aide on duty. While attending to	W000154	W154 483.420 (d) (3) Staff Treatment of Clients Plan ofcorrection: Unknown injury inquiry was completed and the team determined thatinjuries were the result of SIB. Overnight staff was trained in following client #1's BSP to contactpager if and when he is awake. No further issues have resulted. Team hascontinued to follow client #1's BSP and monitoring him when he is awake. Plan of Prevention: Facility house manager /associate manager will conduct random weekly observations during overnightshifts to ensure staff are following plans. Staff were trained on prevention and reporting abuse and neglect (**Attachment A).** Plan of Monitoring: Facility coordinator / QDIP will conduct randommonthly observations during overnight shifts to ensure staff are followingplans.	11/07/2014

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	[client #1's] roommate, staff heard a noise coming from the hallway. Staff then saw [client #1] performing SIB (self injurious behavior) by hitting his (sic.) forehead, causing it to become red. After coming closer to [client #1], staff discovered that [client #1's] face and ears were bleeding. Staff applied first aid, and put [client #1's] safety helmet, and safety gloves on. Staff also assisted [client #1] with a change of clothes, as [client #1] had urinated, changed his bedding, and assisted [client #1] to getting back to sleep, which he did." The BDDS report contained a plan to resolve the matter: "An injury of Unknown Origin was completed, and found that the injuries sustained by [client #1] were due to SIB. [Client #1] has a history of SIB. A [name of agency] Nurse evaluated [client #1], and concluded that the four areas showing injury (both cheekbones and ears) are areas that [client #1] has historically focused on while performing SIB. Staff will undergo additional training focusing on how to handle future situations in the future." The incident (8/5/14 3:45 AM) report which accompanied the BDDS report by staff #8 indicated because of the peer being awake who required one on one staff attention (client #4), staff #8 was not			

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	able to perform the routine bed check for all clients at 3:00 AM. The review of BDDS and incident reports indicated no agency investigation into the incident to determine if client #1, who had a history of SIB, was sufficiently monitored (neglected) by staff #8 to prevent the SIB. Interview with Qualified Intellectual Disabilities Professional/QIDP #1 on 10/16/14 at 1:00 PM indicated the facility did not conduct an investigation into the 8/5/14 incident to determine if client #1 had been neglected by staff #8. The interview indicated client #4 has a protocol in place for staff to implement if they are the only staff with the five clients who reside in the facility. If client #4 is awake (not just using the restroom in the night) and requires staff attention, the staff on duty was to call the agency's pager for assistance (staff to come to the facility). QIDP indicated staff #8 forgot to call the pager for assistance. Staff #8 received training by QIDP in regards to calling the agency pager if assistance was needed with client #4, who required a one to one staff due to behaviors. 9-3-2(a)			

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W000189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview for 2 of 3 sampled clients (#1 and #3), the facility failed to ensure staff properly monitored clients who were at risk for aspiration and received nebulizer treatments. Findings include: During observations at the facility on 10/14/14 from 4:10 PM until 6:30 PM, the meal preparation and its consumption were observed. Clients #1 and #3's meals were pureed by staff #11. The food was set upon the dining room table and clients #1 and #3 started to eat without staff supervision. Client #1 was observed to eat in a rapid manner taking bites before swallowing the previous one. During observations at the facility on the morning of 10/16/14 from 5:45 AM until 8:00 AM, client #3 was observed to be in bed with a nebulizer face mask on receiving medicated breathing treatment.	W000189	W189 483.430 (e) (1) StaffTraining Program 1.Plan ofcorrection: Client #3 ‘s high risk plan pertaining to his risk of aspirationwas trained with DSP and house managers **(Attachment C).** Plan of Prevention:Facility house manager / associate manager will conduct random weeklyobservations during overnight shifts to ensure staff are following plans. Plan of Monitoring: Facility coordinator / QDIPwill conduct random monthly observations during overnight shifts to ensurestaff are following plans. 2.Plan ofcorrection: Client #3 ‘s dining plan pertaining to his risk of aspirationwas trained with DSP and house managers **(Attachment C).** Plan of Prevention: Facility house manager /associate manager or day aid/fmps will be present for all meals to ensureclient 3 is monitored at each mealtime. Plan of Monitoring:Facility coordinator / QDIP will conduct	11/07/2014

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	The client was lying down on his left side. Nightshift staff #8 had started the treatment and morning shift staff #7 continued to periodically monitor client #3. Staff did not stay with the client to assure he was in a functional position to receive the full benefit of the nebulizer treatment. Client #3 was observed to eat his pureed breakfast at the dining table alone on 10/16/14 at 6:58 AM in a rapid manner. He was physically prompted by staff #10 to slow his eating rate by staff holding his hand. The client slowed only when staff physically prompted him. Staff #10 did not stay with the client, but walked by periodically to prompt him to slow his eating rate. Review of client #3's record on 10/15/14 at 1:30 PM indicated his diagnoses included, but were not limited to, asthma, dysphagia, and hypoxia. The review indicated he had a risk plan dated 3/11/14 for aspiration and he had the potential of "choking due to the way and rate at which he eats." The review indicated he received a pureed diet and nectar thickened liquids to address his diagnosis of dysphagia. He received oxygen at night for hypoxia and breathing treatments of Pulmicort, Atrovent, and Xopenex via nebulizer twice daily for asthma and to help increase his oxygen levels.		random monthly observations duringovernight shifts to ensure staff are following plans. 3.Plan ofcorrection: Client #1 ‘s dining plan pertaining to his risk of aspirationwas trained with DSP and house managers **(Attachment C).** Plan of Prevention: Facility house manager /associate manager or day aid/fmps will be present for all meals to ensureclient 3 is monitored at each mealtime. Plan ofMonitoring: Facility coordinator / QDIP will conduct random monthlyobservations during overnight shifts to ensure staff are following plans.	

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	Review of client #1's record on 10/15/14 at 1:45 PM indicated his diagnosis included, but was not limited to, seizures. He received a pureed diet. Interview with LPN #1 on 10/16/14 at 10:10 AM indicated staff should monitor client #3 while in bed getting his nebulizer treatment so he could be in a functional position. The interview indicated clients #1 and #3 should be monitored by staff during their meals to ensure they ate in a slow, safe manner. 9-3-3(a)			
W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility failed to address client #2's refusing to eat with his peers and his refusals to eat certain foods by accessing acceptable food substitutes. Findings include:	W000227	W227 483.430 (e) (1) Staff Training Program 1.Plan ofcorrection: Client #2's ISP was revised to include two IPPs; eat meals familystyle and another one to select alternative meal choices and assist in preparation. **(AttachmentB).**	11/07/2014

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	During observations at the facility on 10/14/14 from 4:10 PM until 6:30 PM, the meal preparation and its consumption was observed. Client #2 was prompted to come to the dining area by the Qualified Intellectual Disabilities Professional/QIDP #1. The meal of baked fish, green peas and macaroni and cheese with beverage choice was offered to client #2. Client #2 stated he did "not like" fish and macaroni and cheese. QIDP #2 added fish and macaroni and cheese to client #2's dinner plate. Client #2 went outside to the deck area to eat accompanied by QIDP #1. Review of client #2's record on 10/15/14 at 8:40 PM indicated an Individual Support Plan/ISP dated 10/01/2013. The ISP did not contain training for client #2 to learn to read the menu and select/prepare food items in place of disliked items nor did it include training for eating meals family style with his peers. Interview with QIDP #1 on 10/16/14 at 10:30 AM indicated client #2's program plan did not include training in selecting a substitute menu item or learning to eat with his peers. 9-3-4(a)		Plan of Prevention: Facility house manager /associate manager or day aid/fmps will be present for all meals to ensureclient 2 is receiving trainingobjectives. Plan ofMonitoring: Facility coordinator / QDIP will conduct random monthlyobservations during overnight shifts to ensure staff are following plans.	

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W000368	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 1 of 3 sampled clients (client #3), and one additional client (client #4), the facility failed to ensure all medications were administered according to the physician' orders without error. Findings include: Facility incident reports and BDDS (Bureau of Developmental Disabilities Services) reports and medication error reports were reviewed on 10/14/14 at 1:00 PM, on 10/15/14 at 1:30 PM and on 10/16/14 at 12:15 PM. The review indicated the following medications not administered according to the physician's orders: A BDDS report of 5/7/14 indicated on 5/6/14 at 7:00 AM it was discovered staff	W000368	Addendum 12/15 Plan ofMonitoring: Facility house manager (weekday) associate house manager (weekends) will conduct DAILY monitoring. Coordinator / QDIP will conduct random weekly observations during medication administration to ensure staff are following physician orders. Addendum 11/21/2014 W368/W369-A morefrequent monitoring system is initially needed until compliance isdemonstrated. Plan of Monitoring: Facilitycoordinator / QDIP will conduct random weekly observations during medicationadministration to ensure staff are following physician orders. Plan of Correction: Overnight staff have beenconducting safety drills at various times with normal ratio. W368 483.4460 (k) (1) Drug Administration 1.Plan ofcorrection: Client #4's administration of Levothyroxine	11/07/2014

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	had administered client #4's levothyroxine 112 mcg./micrograms (hormone) twice. The night shift staff had given it and the day shift staff also gave it. The report indicated there was a lack of communication between the shifts. Review (10/16/14 8:10 AM) of client #4's 10/14 Medication Administration Record/MAR indicated client #4 was to receive levothyroxine 112 mcgs. once daily in the morning. The review of incident reports indicated client #3 had missed his Jevity 1.5 (supplement) at lunch at the facility run day program on 7/17/14 at 1:00 PM and on 10/2/14 at 12:00 PM. Review (10/15/14 8:30 PM) of client #3's physician's orders on the 9/22/14 Medication Information Sheet (MIS) located in his record indicated he was to be given the Jevity 1.5 "drink one can four times a day after meals and at bedtime" for weight loss. Interview with LPN #1 on 10/16/14 at 10:10 AM indicated medications were to be given according to the physician's orders. 9-3-6(a)		was trained with staff. **(AttachmentD).** Plan of Prevention: Facility house manager /associate manager or day aid/fmps will be present for all medicationpasses to ensure client #4 is receiving his Levothyroxine per thephysician order/MAR. Plan ofMonitoring: Facility coordinator / QDIP will conduct random monthlyobservations during overnight shifts to ensure staff are following physicianorders/MAR. 2.Plan ofcorrection: Client #3's administration of Jevity was trained with staff. **(AttachmentD).** If client refuses Jevity then it is to be documented as such on theMAR. Plan of Prevention: Facility house manager /associate manager or day aid/fmps will be present for all medication passes toensure client #3 is receiving his Jevityas ordered and reflected on MAR. Plan ofMonitoring: Facility coordinator / QDIP will conduct random monthlyobservations during medication administration to ensure staff are following physicianorders.	

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W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 40 medications observed (client #3), the facility failed to ensure all medications were administered without error. Findings include: During observations at the facility on the evening of 10/14/14 at 5:45 PM, staff #3 gave client #3 Jevity 1.5 (nutritional supplement) prior to the evening meal which was at 6:00 PM. Review of client #3's Medication Administration Record (MAR) on 10/14/14 at 5:57 PM, indicated client #3 was to receive the Jevity 1.5 after meals and at bedtime. Review (10/15/14 8:30 PM) of client #3's	W000369	W369 483.460 (k) (2) Drug Administration 1.Plan ofcorrection: Client #3's administration of Jevity after meals was trained withstaff. **(Attachment D).** If client refuses Jevity then it is to bedocumented as such on the MAR. Plan of Prevention: Facility house manager /associate manager or day aid/fmps will be present for all medication passes toensure client #3 is receiving his Jevity as ordered and reflected on MAR. Plan ofMonitoring: Facility coordinator / QDIP will conduct random monthlyobservations during medication administration to ensure staff are following physicianorders.	11/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/16/2014
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	physician's orders on the 9/22/14 Medication Information Sheet (MIS) located in his record indicated he was to be given the Jevity 1.5 "drink one can four times a day after meals and at bedtime" for weight loss. Interview with LPN #1 on 10/16/14 at 10:10 AM stated the physician had specified the Jevity supplement be given to client #3 after meals and the best practice would be to take the supplement "around an hour" after the meal instead of before. 9-3-6(a)			
W000441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3),	W000441	Addendum 12/15: Plan of Correction: Facility overnight staff	11/07/2014

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	and two additional clients (#4 and #5), the facility failed to conduct varied evacuation drills for the night shift. Findings include: A review of the facility's evacuation drills was conducted on 10/16/14 at 9:30 AM. There were six night shift (10:00 PM to 6:00 AM) drills during the past 12 months: 10/8/14, 6/20/14, 3/28/14, 12/22/13, 9/27/13, and 9/5/13. None of the drills said to be sleep time drills was conducted with the single nightshift staff. There were two to four staff present at every evacuation drill. There was no evidence the facility had conducted sleeptime drills with the clients and the single nightshift staff to ensure safe evacuations. This affected clients #1, #2, #3, #4 and #5. Qualified Intellectual Disabilities Professional/QIDP #1 indicated on 10/16/14 at 10:30 AM the facility had not conducted any drills while the clients were supervised by the single nightshift staff. 9-3-7(a)		are conducting drills as scheduled. Schedule has been devised to implement drills and ensure they are conducted as scheduled (Attachment X) Plan of prevention: Training occurred at Shiloh (Attachment Y) Plan monitoring: House manager will monitor schedule and make sure that drills are being conducted as scheduled (Attachment Y) W441 483.470 (i) (1) Evacuation Drills 1.Plan ofcorrection: Overnight staff has been trained to conduct varied drillsthroughout the night **(Attachment E).** Plan of Prevention: Facility house manager /associate manager or day aid/fmps will be present for all medication passes toensure client #3 is receiving his Jevity as ordered and reflected on MAR. Plan of Monitoring: Facility coordinator / QDIPwill conduct random monthly observations during medication administration toensure staff are following physician orders.	

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