

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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	<p>This visit was for a Post Certification Revisit (PCR) to the full recertification and state licensure survey completed on 6/25/14.</p> <p>This visit was in conjunction with the investigation of complaint #IN00153670.</p> <p>Survey Dates: August 1, 2, 4 and 5, 2014</p> <p>Facility Number: 001165 Provider Number: 15G650 AIM Number: 100240230</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/11/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 4 of 5 clients living at the group home (B, C, D and E), the facility's governing body failed to ensure the Qualified Intellectual</p>	W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p>	08/11/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>Disabilities Professional (QIDP) coordinated the clients' programs to address issues noted during evacuation drills.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 8/2/14 at 9:12 AM and indicated the issues noted during evacuation drills were not addressed by the QIDP:</p> <ol style="list-style-type: none"> On 4/23/14 at 7:53 AM, a fire drill was conducted. The form indicated the issues with the drill included client E needing assistance to go out the door to the van. The form indicated, "She would not go out on her own." The form indicated, "[Client C] had to be pushed (she was way too slow on her own)." On 4/18/14 at 10:30 AM, a fire drill was conducted. The form indicated the issues during the drill included, "[Client B] need multi (multiple) VP (verbal prompts) to get out the door. She seemed very scared and confused." The plan of correction indicated, "Continue regular scheduled drills." On 1/31/14 at 7:55 AM, a fire drill was conducted. The form indicated the issues noted during the drill included 		<p>Corrective action forresident(s) found to have been affected (Plan of correction): Facility Qidp / coordinatorcreated training objectives for clients C, D, and E (attachments w104a, w104b,w104c).</p> <p>Measures or systemicchanges facility put in place to ensure no recurrence (Plan of prevention) Staff have been trained on completing training objectives for clients C, D ,and E E (attachmentsw104d, w104e, w104f).</p> <p>How corrective actionswill be monitored to ensure no recurrence (Plan of monitoring) Facility Qidp or house manager will monitorthe completion of the training objectives no less than 3 times weekly. Thislevel of monitoring will be reviewed by team each quarter and may possiblydecrease.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
	<p>client C needing to be pushed in her wheelchair due to not trying to get herself out. The plan of correction section was blank.</p> <p>4. On 11/30/13 at 5:30 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client E] full physical assist with two staff. [Client E] slide (sic) down staff's body and wouldn't stand back up was scooted to front door and was stood up using the door as a guiding point (something she was familiar with)." The plan of correction section indicated, "Continue fire drills to help [client E] be prepared."</p> <p>5. On 11/5/13 at 6:35 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client E] didn't want to go outside, 2 staff assistance at the door. [Client D] exited her room and went to back door to evacuate. 'Fire' was in the back part of house. [Client D] was unsure if she could go through hall door to exit out of house. [Client D] needs to have some extra training on where to exit if fire is near preferred door." The plan of correction section was blank.</p> <p>6. On 9/25/13 at 10:50 PM, a fire drill was conducted. The form indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>issues noted during the drill included, "[Client E] did not attempt to get out of bed or exit the building. Staff had to bring her... [Client C] did not attempt to get out of bed and was very slow moving toward the exit. [Client B] stood at her bedroom door watching." The plan of correction section was blank.</p> <p>7. On 9/20/13 at 10:00 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client E] did not get out of bed when alarm went off. Needed extra prompting to get out safely. [Client C] was unable to get herself to the edge of bed in a quick manner." The plan of correction indicated, "Repeat drill."</p> <p>8. On 7/17/13 at 8:08 AM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client E] sat in her rocking chair. Staff had to prompt to get her up." The plan of correction section was blank.</p> <p>A review of client B's record was conducted on 8/4/14 at 11:38 AM. Client B's Individual Support Plan, dated 7/31/13, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>A review of client C's record was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421		
(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	
	<p>conducted on 8/4/14 at 11:55 AM. Client C's Individual Support Plan, dated 3/2/14, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>A review of client D's record was conducted on 8/4/14 at 12:30 AM. Client D's Individual Support Plan, dated 9/13/13, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>A review of client E's record was conducted on 8/4/14 at 12:45 PM. Client E's Individual Support Plan, dated 4/2/14, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>On 8/4/14 at 11:43 AM, the Supported Group Living Director indicated she missed the part in the 6/25/14 survey report indicating there were issues with the clients not having individualized program plans addressing evacuation drills. The Director indicated the clients needed to have plans addressing the issues noted during evacuation drills.</p> <p>This deficiency was cited on 6/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
W000149	<p>9-3-1(a)</p> <p>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 2 of 8 incident/investigative reports reviewed affecting client B, the facility neglected to implement its policies and procedures to ensure staff immediately contacted the administrator to report an incident of neglect, submit the incident to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, conduct an investigation of the incident, and prevent client to client abuse.</p> <p>Findings include:</p> <p>On 8/1/14 at 1:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 7/27/14 (no time indicated), an email sent from staff #5 to the Qualified Intellectual Disabilities Professional (QIDP) indicated, in part, "Earlier today [client B] decided to take the trash out without staff knowledge. We saw her</p>	W000149	<p>W149 Associate manager received a verbal warning and shortly after made the choice to terminate employment with Stone Belt. New appointed managers have been trained on reporting abuse and neglect immediately Coordinator received a warning W153 Associate manager received a performance review and is no longer employed with Stone Belt- new appointed manager and associate have been trained on reporting abuse and neglect immediately W331 Staff has been trained by director of nursing to prepare nectar thick - they were also emailed a link to utilize if needed - all meals are monitored by staff and any concerns related to not following plan will immediately be addressed W149 483.420(d)(1) STAFF TREATMENT OF CLIENTS Corrective action for resident(s) found to have been affected (Plan of correction): Staff were</p>	09/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>walk down the hall and assumed she was going to her room. I took [client A] to the bathroom, while in there I heard a door shut and thought it was [client B's] bedroom door. Once I had [client A] back in the front room [staff #8] came walking into the front door with [client B]. She said [client B] was standing at the back door waiting for it to open. This only lasted a matter of 2-3 minutes. [Staff #8] told [staff #4 - Associate Manager] about this incident and he spoke to me and [staff #6] separately then informed us both that we are to not say anything to anyone. Not to other staff or [client D. He even said he had told [staff #8] the same thing to keep it quiet. He asked me why I didn't know [client B] went out and I told him I had [client A] in the bathroom and heard a door shut but didn't realize it was the back door and he asked [staff #6] why she didn't know and she stated that she heard the door but thought it was her bedroom door and she couldn't rush to get up because she had been jerked the day before by him and has had to wear a back brace just to move."</p> <p>The facility did not have documentation indicating a Stone Belt ARC Incident Report, a Bureau of Developmental Disabilities Services (BDDS) report or an investigation was completed.</p>		<p>trained on prevention of abuse and neglect (attachment w149a w149b). Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility Qdip/ Coordinator received a warning concerning the failure to follow Stone Belt's policy concerning treatment of clients. Email was sent out specifying the guidelines of reporting abuse and neglect along with chain of command (attachment w149c). How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Director will continue to review all reports /allegations of abuse and neglect. They will investigate issues and provide support, training, and other changes as needed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
	<p>On 8/4/14 at 11:38 AM, there was no documentation in client B's record indicating the incident occurred.</p> <p>On 8/2/14 at 9:18 AM, staff #4 indicated he was not aware of any of the clients leaving the house unsupervised in the past few weeks.</p> <p>On 8/2/14 at 9:33 AM, staff #5 indicated on 7/27/14, she sent an email to the QIDP indicating staff #8 found client B standing at the back side door when staff #8 returned from dropping off another client at work. Staff #5 indicated she called the QIDP who asked staff #5 to send her an email with the information regarding the incident. Staff #5 indicated client B was outside for approximately 2 minutes in the fenced in back yard. Staff #5 indicated the side door could not be opened from the outside so when client B went out to take out the trash, she could not get back in. Staff #5 indicated she heard a door close but at the time thought it was client B's bedroom door and not the door to the outside. On 8/2/14 at 10:11 AM, staff #5 indicated staff #4 told her not to discuss the incident with anyone so staff #4 would not get into trouble.</p> <p>On 8/2/14 at 10:25 AM, staff #1</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
	<p>(Manager) indicated she was aware of the incident in which client B was found outside the group home by staff #8. Staff #1 indicated the QIDP was also aware of the incident. The Manager indicated she was not sure if an incident report was completed. The Manager indicated client B needed 24 hour supervision and the incident should have been documented on an incident report. The Manager stated the incident was "very unusual."</p> <p>On 8/4/14 at 11:43 AM, the Director of Supervised Group Living indicated she was not aware of the incident. The Director indicated the staff did not contact her (the administrator). The Director indicated the incident should have been documented on a Stone Belt ARC Incident Report, a report submitted to BDDS and an investigation conducted.</p> <p>2) On 7/14/14 at 8:15 AM at the facility-operated day program, client B was walking from the bathroom to the habilitation room when a female peer ran up and shoved client B. Client B shoved the peer. Neither client was injured.</p> <p>On 8/4/14 at 11:43 AM, the Director of Supervised Group Living indicated client to client aggression was considered abuse. The Director indicated the facility had policies and procedures prohibiting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
	<p>abuse of the clients. The Director indicated the facility should prevent abuse.</p> <p>On 8/1/14 at 2:12 PM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law. Events Requiring Investigations. Stone Belt employees are</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
	<p>required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over client support; misuse of client or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct. This does not replace the obligation of employees to report immediately to supervisors, directors or to write incident reports. This provides for another level of notification beyond, and in addition to, incident reporting. The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days... Investigations must be started within 24 hours.</p> <p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
W000153	<p>social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events."</p> <p>This deficiency was cited on 6/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client B, the facility failed to ensure staff immediately contacted the administrator to report an incident of neglect and submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p>	W000153	<p>W153 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established</p>	08/11/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>Findings include:</p> <p>On 8/1/14 at 1:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/27/14 (no time indicated), an email sent from staff #5 to the Qualified Intellectual Disabilities Professional (QIDP) indicated, in part, "Earlier today [client B] decided to take the trash out without staff knowledge. We saw her walk down the hall and assumed she was going to her room. I took [client A] to the bathroom, while in there I heard a door shut and thought it was [client B's] bedroom door. Once I had [client A] back in the front room [staff #8] came walking into the front door with [client B]. She said [client B] was standing at the back door waiting for it to open. This only lasted a matter of 2-3 minutes. [Staff #8] told [staff #4 - Associate Manager] about this incident and he spoke to me and [staff #6] separately then informed us both that we are to not say anything to anyone. Not to other staff or [client D]. He even said he had told [staff #8] the same thing to keep it quiet. He asked me why I didn't know [client B] went out and I told him I had [client A] in the bathroom and heard a door shut but didn't realize it was the back door and he asked [staff #6] why</p>		<p>procedures.</p> <p>Corrective action for resident(s) found to have been affected (Plan of correction): Staff were trained on reporting abuse and neglect to administer and state report will be submitted in a timely manner (attachment w153a w153b).</p> <p>Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility Qdip/ Coordinator received a warning concerning the failure to follow Stone Belt's policy on reporting abuse and neglect to administer and submitting a report. Email was sent out specifying the guidelines of reporting abuse and neglect along with chain of command (attachment w149c).</p> <p>How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Director will continue to review all reports / allegations of abuse and neglect. They will investigate issues and provide support, training, and other changes as needed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
	<p>she didn't know and she stated that she heard the door but thought it was her bedroom door and she couldn't rush to get up because she had been jerked the day before by him and has had to wear a back brace just to move."</p> <p>On 8/4/14 at 11:38 AM, there was no documentation in client B's record indicating the incident occurred.</p> <p>On 8/2/14 at 9:18 AM, staff #4 indicated he was not aware of any of the clients leaving the house unsupervised in the past few weeks.</p> <p>On 8/2/14 at 9:33 AM, staff #5 indicated on 7/27/14, she sent an email to the QIDP indicating staff #8 found client B standing at the back side door when staff #8 returned from dropping off another client at work. Staff #5 indicated she called the QIDP who asked staff #5 to send her an email with the information regarding the incident. Staff #5 indicated client B was outside for approximately 2 minutes in the fenced in back yard. Staff #5 indicated the side door could not be opened from the outside so when client B went out to take out the trash, she could not get back in. Staff #5 indicated she heard a door close but at the time thought it was client B's bedroom door and not the door to the outside. On 8/2/14 at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421		
(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	
	<p>10:11 AM, staff #5 indicated staff #4 told her not to discuss the incident with anyone so staff #4 would not get into trouble.</p> <p>On 8/2/14 at 10:25 AM, staff #1 (Manager) indicated she was aware of the incident in which client B was found outside the group home by staff #8. Staff #1 indicated the QIDP was also aware of the incident. The Manager indicated she was not sure if an incident report was completed. The Manager indicated client B needed 24 hour supervision and the incident should have been documented on an incident report. The Manager stated the incident was "very unusual."</p> <p>On 8/4/14 at 11:43 AM, the Director of Supervised Group Living indicated she was not aware of the incident. The Director indicated the staff did not contact her (the administrator). The Director indicated the incident should have been documented on a Stone Belt ARC Incident Report and an incident report submitted to BDDS.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client B, the facility failed to conduct an investigation of an incident of neglect.</p> <p>Findings include:</p> <p>On 8/1/14 at 1:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/27/14 (no time indicated), an email sent from staff #5 to the Qualified Intellectual Disabilities Professional (QIDP) indicated, in part, "Earlier today [client B] decided to take the trash out without staff knowledge. We saw her walk down the hall and assumed she was going to her room. I took [client A] to the bathroom, while in there I heard a door shut and thought it was [client B's] bedroom door. Once I had [client A] back in the front room [staff #8] came walking into the front door with [client B]. She said [client B] was standing at the back door waiting for it to open. This only lasted a matter of 2-3 minutes. [Staff #8] told [staff #4 - Associate Manager] about this incident and he spoke to me and [staff #6]</p>	W000154	<p>W154 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Corrective action for resident(s) found to have been affected (Plan of correction): Investigation was completed regarding allegation of abuse and neglect that was unsubstantiated (attachment 154a).</p> <p>Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Staff were trained on reporting abuse and neglect to administer and state report will be submitted in a timely manner (attachment w153b w153c). Facility Qdip/ Coordinator received a warning concerning the failure to follow Stone Belt's policy on reporting abuse and neglect to administer and submitting a report (w153c).</p> <p>How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Director will continue to review all reports / allegations of abuse and neglect. They will investigate</p>	08/11/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>separately then informed us both that we are to not say anything to anyone. Not to other staff or [client D. He even said he had told [staff #8] the same thing to keep it quiet. He asked me why I didn't know [client B] went out and I told him I had [client A] in the bathroom and heard a door shut but didn't realize it was the back door and he asked [staff #6] why she didn't know and she stated that she heard the door but thought it was her bedroom door and she couldn't rush to get up because she had been jerked the day before by him and has had to wear a back brace just to move."</p> <p>The facility did not have documentation indicating a Stone Belt ARC Incident Report or an investigation was completed.</p> <p>On 8/4/14 at 11:38 AM, there was no documentation in client B's record indicating the incident occurred.</p> <p>On 8/2/14 at 9:18 AM, staff #4 indicated he was not aware of any of the clients leaving the house unsupervised in the past few weeks.</p> <p>On 8/2/14 at 9:33 AM, staff #5 indicated on 7/27/14, she sent an email to the QIDP indicating staff #8 found client B standing at the back side door when staff</p>		issues and provide support, training, and other changes as needed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
	<p>#8 returned from dropping off another client at work. Staff #5 indicated she called the QIDP who asked staff #5 to send her an email with the information regarding the incident. Staff #5 indicated client B was outside for approximately 2 minutes in the fenced in back yard. Staff #5 indicated the side door could not be opened from the outside so when client B went out to take out the trash, she could not get back in. Staff #5 indicated she heard a door close but at the time thought it was client B's bedroom door and not the door to the outside. On 8/2/14 at 10:11 AM, staff #5 indicated staff #4 told her not to discuss the incident with anyone so staff #4 would not get into trouble.</p> <p>On 8/2/14 at 10:25 AM, staff #1 (Manager) indicated she was aware of the incident in which client B was found outside the group home by staff #8. Staff #1 indicated the QIDP was also aware of the incident. The Manager indicated she was not sure if an incident report was completed. The Manager indicated client B needed 24 hour supervision and the incident should have been documented on an incident report. The Manager stated the incident was "very unusual."</p> <p>On 8/4/14 at 11:43 AM, the Director of Supervised Group Living indicated she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
W000159	<p>was not aware of the incident. The Director indicated the staff did not contact her (the administrator). The Director indicated the incident should have been documented on a Stone Belt ARC Incident Report and an investigation conducted.</p> <p>This deficiency was cited on 6/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 4 of 5 clients living at the group home (B, C, D and E), the Qualified Intellectual Disabilities Professional (QIDP) failed to coordinate the clients' programs to ensure 1) issues noted during evacuation drills were addressed, 2) staff received training on client B's order for nectar thickened liquids, 3) client C's progress on her program plans was reviewed regularly</p>	W000159	<p>Addendum Each meal will be monitored to ensure the texture and consistency of the food items that are prepared nectar thick Level of supervision may be tapered off once staff demonstrate they are aware of proper consistency W159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be</p>	08/11/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>and 4) client D's comprehensive functional assessment (CFA) was reviewed and updated at least annually.</p> <p>Findings include:</p> <p>1) A review of the facility's evacuation drills was conducted on 8/2/14 at 9:12 AM and indicated the issues noted during evacuation drills were not addressed by the QIDP:</p> <p>1. On 4/23/14 at 7:53 AM, a fire drill was conducted. The form indicated the issues with the drill included client E needing assistance to go out the door to the van. The form indicated, "She would not go out on her own." The form indicated, "[Client C] had to be pushed (she was way too slow on her own)."</p> <p>2. On 4/18/14 at 10:30 AM, a fire drill was conducted. The form indicated the issues during the drill included, "[Client B] need multi (multiple) VP (verbal prompts) to get out the door. She seemed very scared and confused." The plan of correction indicated, "Continue regular scheduled drills."</p> <p>3. On 1/31/14 at 7:55 AM, a fire drill was conducted. The form indicated the issues noted during the drill included client C needing to be pushed in her</p>		<p>integrated, coordinated and monitored by a qualified mental retardation professional. 1) Corrective action for resident(s) found to have been affected (Plan of correction): Facility Qidp / coordinator created training objectives for clients C, D, and E (attachments w104a, w104b, w104c). Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Staff have been trained on completing training objectives for clients C, D, and E (attachments w104d, w104e, w104f). How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility Qidp or house manager will monitor the completion of the training objectives no less than 3 times weekly. This level of monitoring will be reviewed by team each quarter and may possibly decrease. 2) Corrective action for resident(s) found to have been affected (Plan of correction): Facility Director emailed staff immediately following the survey a link explaining what nectar sweet looks like and how to prepare it properly (attachment w159a). Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Staff have been trained by DON at a staff meeting</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>wheelchair due to not trying to get herself out. The plan of correction section was blank.</p> <p>4. On 11/30/13 at 5:30 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client E] full physical assist with two staff. [Client E] slide (sic) down staff's body and wouldn't stand back up was scooted to front door and was stood up using the door as a guiding point (something she was familiar with)." The plan of correction section indicated, "Continue fire drills to help [client E] be prepared."</p> <p>5. On 11/5/13 at 6:35 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client E] didn't want to go outside, 2 staff assistance at the door. [Client D] exited her room and went to back door to evacuate. 'Fire' was in the back part of house. [Client D] was unsure if she could go through hall door to exit out of house. [Client D] needs to have some extra training on where to exit if fire is near preferred door." The plan of correction section was blank.</p> <p>6. On 9/25/13 at 10:50 PM, a fire drill was conducted. The form indicated the issues noted during the drill included,</p>		<p>how to properly prepare clientB's thick it – nectar thick (attachment w159b). How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility Qidp or house manager will monitor and document mealtimes - no less than 2 times weekly – to make certain staff are following dining plans as ordered. This level of monitoring will be reviewed by team each quarter and may possibly decrease. 3) Corrective action for resident(s) found to have been affected (Plan of correction): Qidp completed quarterlies on client C's (attachment 159c), Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Qidp have been trained to complete assessments, quarterlies, and annuals as scheduled. How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility director will monitor and document Qidp's completion of plans per scheduled due dates on a monthly basis. This level of monitoring will be reviewed by team each quarter and may possibly decrease. 4) Corrective action for resident(s) found to have been affected (Plan of correction): Qidp completed assessment (CFA) on client D's (attachment 159d), Measures or</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>"[Client E] did not attempt to get out of bed or exit the building. Staff had to bring her... [Client C] did not attempt to get out of bed and was very slow moving toward the exit. [Client B] stood at her bedroom door watching." The plan of correction section was blank.</p> <p>7. On 9/20/13 at 10:00 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client E] did not get out of bed when alarm went off. Needed extra prompting to get out safely. [Client C] was unable to get herself to the edge of bed in a quick manner." The plan of correction indicated, "Repeat drill."</p> <p>8. On 7/17/13 at 8:08 AM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client E] sat in her rocking chair. Staff had to prompt to get her up." The plan of correction section was blank.</p> <p>A review of client B's record was conducted on 8/4/14 at 11:38 AM. Client B's Individual Support Plan, dated 7/31/13, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>A review of client C's record was conducted on 8/4/14 at 11:55 AM. Client</p>		<p>systemicchanges facility put in place to ensure no recurrence (Plan of prevention) Qidp have been trained to complete assessments, quarterlies, and annuals asscheduled. How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility director will monitor and document Qidp's completion of plansper scheduled due dates on a monthly basis. This level of monitoring will be reviewed byteam each quarter and may possibly decrease.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>C's Individual Support Plan, dated 3/2/14, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>A review of client D's record was conducted on 8/4/14 at 12:30 AM. Client D's Individual Support Plan, dated 9/13/13, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>A review of client E's record was conducted on 8/4/14 at 12:45 PM. Client E's Individual Support Plan, dated 4/2/14, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>On 8/4/14 at 11:43 AM, the Supported Group Living Director indicated she missed the part in the 6/25/14 survey report indicating there were issues with the clients not having individualized program plans addressing evacuation drills. The Director indicated the clients needed to have plans addressing the issues noted during evacuation drills.</p> <p>2) On 8/2/14 at 10:05 AM, staff #5 was observed to prepare a drink with Thick It for client B.</p> <p>On 8/2/14 at 10:05 AM, staff #5</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
	<p>indicated the staff had not received training on using Thick It to thicken client B's drinks. Staff #5 indicated she asked the Licensed Practical Nurse (LPN) for training on what nectar thickened liquids looked like and the LPN told her to follow the instructions on the container. Staff #5 indicated she wanted to be shown what nectar thickened liquids looked like to ensure she was implementing the order. Staff #5 stated nectar thickened was "less than honey but I'm guessing."</p> <p>On 8/2/14 at 10:25 AM, the Group Home Manager initially indicated the staff were trained at a meeting on how to thicken client B's liquids. The Manager indicated the staff were instructed to follow the instructions on the container. The Manager indicated there was no documentation of the training. The Manager indicated the staff were not shown what nectar thickened liquids looked like.</p> <p>On 8/4/14 at 11:38 AM, a review of client B's record was conducted. A 7/2/14 Nursing Consultation note indicated, in part, "Client had a Barium Swallow Study on 6/27/14 @ [name of hospital]. According to study, 'the upper swallowing appears normal,' and there is 'no penetration or aspiration of barium.'</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>It also stated that there was 'reflux of barium....which was rapidly cleared by secondary peristalsis (The rippling motion of muscles in the digestive tract).' Today, client was seen by her PCP (primary care physician), [name of doctor]. Staff reportedly told [name of doctor] about client's coughing episodes and asked for recommendations based upon the Swallow Study. Staff also brought a copy of recent recommendations from the dietician for the PCP to view. Orders given that client is to have Nectar-thickened liquids and that client should have Speech therapy. PCP's office is to order the Speech therapy." There was no documentation in client B's record indicating the staff were trained on her nectar thickened liquid order.</p> <p>On 8/5/14 at 11:00 AM, the Nurse Manager (NM) indicated the staff should have received training on client B's nectar thickened liquids. The NM indicated the training should have included a visual demonstration so the staff knew exactly was nectar thickened liquids looked like.</p> <p>3) A review of client C's record was conducted on 8/4/14 at 11:55 AM. Client C's record indicated the QIDP conducted quarterly reviews of her progress on her training objectives on 9/12/13, 11/30/13</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
W000189	<p>and 2/28/14. There was no documentation the QIDP reviewed client C's progress on her training objectives since 2/28/14.</p> <p>On 8/4/14 at 11:43 AM, the Director of Supervised Group Living indicated the QIDP was to conduct quarterly reviews of the clients' training objectives every quarter (every 90 days).</p> <p>4) A review of client D's record was conducted on 6/19/14 at 11:54 AM. Client D's most recent CFA was dated 2/24/13. There was no documentation in client D's record indicating the CFA was reviewed and updated since 2/24/13.</p> <p>On 8/4/14 at 12:41 PM, the Director of Supervised Group Living indicated client D's CFA should be updated and revised at least annually.</p> <p>This deficiency was cited on 6/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>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.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (B), the facility failed to ensure staff received competency based training to perform their duties effectively, efficiently and competently.</p> <p>Findings include:</p> <p>On 8/2/14 at 10:05 AM, staff #5 was observed to prepare a drink with Thick It for client B.</p> <p>On 8/2/14 at 10:05 AM, staff #5 indicated the staff had not received training on using Thick It to thicken client B's drinks. Staff #5 indicated she asked the Licensed Practical Nurse (LPN) for training on what nectar thickened liquids looked like and the LPN told her to follow the instructions on the container. Staff #5 indicated she wanted to be shown what nectar thickened liquids looked like to ensure she was implementing the order. Staff #5 stated nectar thickened was "less than honey but I'm guessing."</p> <p>On 8/2/14 at 10:25 AM, the Group Home Manager initially indicated the staff were</p>	W000189	<p>W189 483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initialand continuing training that enables the employee to perform his or her dutieseffectively, efficiently, and competently.</p> <p>Corrective action forresident(s) found to have been affected (Plan of correction): Facility Qidp / coordinatorcreated training objectives for clients C, D, and E (attachments w104a, w104b,w104c).</p> <p>Measures or systemicchanges facility put in place to ensure no recurrence (Plan of prevention) Staff have been trained on completing training objectives for clients C, D ,and E E (attachmentsw104d, w104e, w104f).</p> <p>How corrective actionswill be monitored to ensure no recurrence (Plan of monitoring) Facility Qidp or house manager will monitor the completion of thetraining objectives no less than 3 times weekly. This level of monitoring willbe reviewed by team each quarter and may possibly decrease.</p>	08/11/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>trained at a meeting on how to thicken client B's liquids. The Manager indicated the staff were instructed to follow the instructions on the container. The Manager indicated there was no documentation of the training. The Manager indicated the staff were not shown what nectar thickened liquids looked like.</p> <p>On 8/4/14 at 11:38 AM, a review of client B's record was conducted. A 7/2/14 Nursing Consultation note indicated, in part, "Client had a Barium Swallow Study on 6/27/14 @ [name of hospital]. According to study, 'the upper swallowing appears normal,' and there is 'no penetration or aspiration of barium.' It also stated that there was 'reflux of barium....which was rapidly cleared by secondary peristalsis (The rippling motion of muscles in the digestive tract).' Today, client was seen by her PCP (primary care physician), [name of doctor]. Staff reportedly told [name of doctor] about client's coughing episodes and asked for recommendations based upon the Swallow Study. Staff also brought a copy of recent recommendations from the dietician for the PCP to view. Orders given that client is to have Nectar-thickened liquids and that client should have Speech therapy. PCP's office is to order the Speech</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
W000259	<p>therapy." There was no documentation in client B's record indicating the staff were trained on her nectar thickened liquid order.</p> <p>On 8/5/14 at 11:00 AM, the Nurse Manager (NM) indicated the staff should have received training on client B's nectar thickened liquids. The NM indicated the training should have included a visual demonstration so the staff knew exactly was nectar thickened liquids looked like.</p> <p>This deficiency was cited on 6/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 clients in the sample (D), the facility failed to review, at least annually, client D's comprehensive functional assessment (CFA) for relevancy and updated as needed.</p>	W000259	<p>W259 483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p>	08/11/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
W000331	<p>Findings include:</p> <p>A review of client D's record was conducted on 8/4/14 at 12:30 PM. Client D's most recent CFA was dated 2/24/13. There was no documentation in client D's record indicating the CFA was reviewed and updated since 2/24/13.</p> <p>On 8/4/14 at 12:41 PM, the Director of Supervised Group Living indicated client D's CFA should be updated and revised at least annually.</p> <p>This deficiency was cited on 6/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 3 clients in the sample (A), the facility's nursing services failed to ensure</p> <p>1) client A had a plan for staff to administer an as needed pain medication and 2) staff received training to implement client B's order for nectar</p>	W000331	<p>Corrective action for resident(s) found to have been affected (Plan of correction): Qidp completed assessment (CFA) on client D's (attachment 159d),</p> <p>Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Qidp have been trained to complete assessments, quarterlies, and annuals as scheduled.</p> <p>How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility director will monitor and document Qidp's completion of plans per scheduled due dates on a monthly basis. This level of monitoring will be reviewed by team each quarter and may possibly decrease.</p> <p>Addendum Each meal will be monitored to ensure the texture and consistency of the food items that are prepared nectar thick Level of supervision may be tapered off once staff demonstrate they are aware of proper</p>	08/11/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>thickened liquids.</p> <p>Findings include:</p> <p>1) A review of client A's Medication Administration Record, dated June 2014, July 2014 and August 2014, was conducted on 8/2/14 at 9:23 AM. Client A received hydrocodone on 6/10/14, 6/14/14, 6/15/14 (twice), 6/16/14, 6/20/14, 6/21/14, 6/23/14, 7/1/14, 7/12/14, 7/13/14, 7/16/14, 7/18/14, 7/20/14, and 7/25/14.</p> <p>Client A's Medication Information Sheet (MIS), dated 7/23/14, indicated client A's medications include the use of hydrocodone (Norco) as needed for pain. The MIS did not include specific instructions to staff on when to administer the medication. Client A's Behavior Plan, dated 4/4/14, indicated client A had a targeted behavior of screaming/yelling. The plan indicated, in part, "Proactive or Preventative Strategies: Staff should be aware that if [client A] is exhibiting screaming/yelling this is many times her way of expressing that she is in pain. Staff can offer [client A] Tylenol or her PRN (as needed) medication for pain."</p> <p>On 8/4/14 at 1:35 PM, the Director of Supervised Group Living forwarded an</p>		<p>consistency W331</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing 1) Corrective action for resident(s) found to have been affected (Plan of correction): MIS / HRP have been developed for staff to administer client A's medication for pain PRN (attachment w331a). Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention): Nurse has been trained to complete assessments on all clients to create accurate MIS/HRP plans. How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility Qidp or house manager will review MIS/HRP - no less than 2 times weekly – to make certain staff are following plans and that they have been written correctly. This level of monitoring will be reviewed by team each quarter and may possibly decrease. 2) Corrective action for resident(s) found to have been affected (Plan of correction): Facility Director emailed staff immediately following the survey a link explaining what nectar sweet looks like and how to prepare it properly (attachment w159a). Measures or systemic changes facility put in place to ensure no recurrence (Plan of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>email from the Licensed Practical Nurse to client A's interdisciplinary team. On 8/1/14 at 1:08 PM, the LPN indicated, "For all of you that were at the meeting today, I want to clarify that I DO NOT want [client A] to be in pain, I just want you to be more discriminant (sic). I am aware that many times [client A] has more pain the day AFTER she receives her patch. This is probably do (sic) to medication absorbtion (sic) issues due to her age. (Remember CORE B?) I just want you to be more aware and ask the following questions FIRST, (as discussed at the meeting:) When did she have her LAST Fentanyl patch? When does she receive the patch again? Is this REALLY 'breakthrough pain,' or she upset about something? How many doses of Hydrocodone has she received in the last 2 days? Is she just being loud? Once these questions have been asked AND you know it is safe to give her PRN, then you may proceed with giving her the medication." There was no documentation this information was included in a plan for administering client A's pain medication.</p> <p>On 8/4/14 at 2:46 PM, the Behavior Specialist indicated in an email to client A's interdisciplinary team, "The team is currently revising [client A's] plans to make it easier for staff identify when it is</p>		<p>prevention) Staff have been trained by DON at a staff meeting how to properly prepare clientB's thick it – nectar thick (attachment w159b). How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility Qidp or house manager will monitor and document mealtimes - no less than 2 times weekly – to make certain staff are following dining plans asordered. This level of monitoring will be reviewed by team each quarter and maypossibly decrease.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
--	--

(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
	<p>appropriate to give her a PRN for pain. As many of you have worked with [client A] much longer than I have, I wanted to ask you all about any warning signs that let you know [client A] is in pain. How can you tell when [client A] is in pain and when she may just be exhibiting attention-seeking behaviors? How does she communicate that she is in pain? Does she show certain facial expressions or body language when she is in pain? Also, are there certain signs that suggest her screaming/yelling may be attention-seeking behavior? Does the behavior stop if it is ignored?...".</p> <p>On 8/4/14 at 1:33 PM, the Director of Supervised Group Living indicated client A should have a plan included on her Medication Information Sheet (MIS) for the use of the pain medication. The Director indicated the facility used the MIS as the risk plan therefore the use of client A's pain medication should be included on the MIS. The Director indicated the nurse sent her an email recently discussing client A's pain pill. The Director indicated the nurse had a conversation with the staff regarding when to administer client A's pain pill. The Director indicated the information presented to the staff in the email needed to be included in a plan. The Director indicated the staff needed written</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421			
(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			
	<p>instructions defining when to administer the pain pill.</p> <p>On 8/5/14 at 11:00 AM, the Nurse Manager (NM) indicated he was not aware of written instructions to staff as to when the staff should administer client A's pain medication with the exception of the doctor's order (oral pain medication every 6 hours as needed for pain). The NM indicated the facility needed to get clarifying information from the physician to know when staff were to administer the medication. The NM indicated the order was subjective as when to given the medication. The NM indicated client A needed a plan for staff to follow to know when her pain medication should be administered.</p> <p>2) On 8/2/14 at 10:05 AM, staff #5 was observed to prepare a drink with Thick It for client B.</p> <p>On 8/2/14 at 10:05 AM, staff #5 indicated the staff had not received training on using Thick It to thicken client B's drinks. Staff #5 indicated she asked the Licensed Practical Nurse (LPN) for training on what nectar thickened liquids looked like and the LPN told her to follow the instructions on the container. Staff #5 indicated she wanted to be shown what nectar thickened</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421		
(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	
	<p>liquids looked like to ensure she was implementing the order. Staff #5 stated nectar thickened was "less than honey but I'm guessing."</p> <p>On 8/2/14 at 10:25 AM, the Group Home Manager initially indicated the staff were trained at a meeting on how to thicken client B's liquids. The Manager indicated the staff were instructed to follow the instructions on the container. The Manager indicated there was no documentation of the training. The Manager indicated the staff were not shown what nectar thickened liquids looked like.</p> <p>On 8/4/14 at 11:38 AM, a review of client B's record was conducted. A 7/2/14 Nursing Consultation note indicated, in part, "Client had a Barium Swallow Study on 6/27/14 @ [name of hospital]. According to study, 'the upper swallowing appears normal,' and there is 'no penetration or aspiration of barium.' It also stated that there was 'reflux of barium....which was rapidly cleared by secondary peristalsis (The rippling motion of muscles in the digestive tract).' Today, client was seen by her PCP (primary care physician), [name of doctor]. Staff reportedly told [name of doctor] about client's coughing episodes and asked for recommendations based</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/05/2014
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421		
(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	
W009999	<p>upon the Swallow Study. Staff also brought a copy of recent recommendations from the dietician for the PCP to view. Orders given that client is to have Nectar-thickened liquids and that client should have Speech therapy. PCP's office is to order the Speech therapy." There was no documentation in client B's record indicating the staff were trained on her nectar thickened liquid order.</p> <p>On 8/5/14 at 11:00 AM, the Nurse Manager (NM) indicated the staff should have received training on client B's nectar thickened liquids. The NM indicated the training should have included a visual demonstration so the staff knew exactly was nectar thickened liquids looked like.</p> <p>This deficiency was cited on 6/25/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>	W009999	empty	09/10/2014	