

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 08/21/2012
--	---	--	---

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
W0000	<p>This visit was for a post certification revisit (PCR) to the PCR completed on 7/16/12 to the recertification and state licensure survey completed on 5/30/12.</p> <p>Survey Dates: August 20 and 21, 2012.</p> <p>Facility Number: 000888 Provider Number: 15G374 AIM Number: 100239700</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/27/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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: 15G374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2012	
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			
W0149	<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 affecting clients #1, #2 and #5, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/20/12 at 12:50 PM.</p> <p>1) On 8/10/12 at 3:20 PM, client #5 hit client #1 as soon as he returned home from a school open house. Staff #2 stepped in and he "flipped" her onto the ground. Client #5 was escorted to his room where he threw his VCR, TV, and entertainment center onto the ground. The home manager called the pager to get approval for client #5's as needed medication.</p> <p>2) On 7/25/12 at 6:20 AM (reported to the Bureau of Developmental Disabilities Services on 7/28/12), staff #6 arrived to work at 6:00 AM. Staff #6 found client #2 about to fall out of his bed. His hips, legs and feet were completely out of bed</p>	W0149	<p>W 149</p> <p>GOVERNING BODY & MANAGEMENT</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that specific governing body and management requirements are met. Specifically, Stone Belt will ensure that policies and procedures that prohibit mistreatment, abuse and neglect are followed.</p> <p>Responsible Person:</p> <p>Maxwell House Coordinator & SGL Director</p> <p>Date of Completion:</p> <p>September 14, 2012</p> <p>Plan of Prevention:</p> <p>House Staff and all SGL staff were retrained on Stone Belt's policy of prevention of abuse and neglect. (Attachment # 1). This training was conducted for house staff and will be reviewed at the SGL In-Service. (Attachment # 2 and #2A) Direct Support Staff and Coordinator have been terminated from Stone Belt</p>	09/14/2012			

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 08/21/2012	
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			
	with his legs on the floor. His head was not elevated per his risk plan. He had a heavy blanket partially folded and wadded up only covering his head. The blanket was completely covering his face, mouth and nose. Client #2 also had on two sweatshirts, the sleeves of which were tied behind his back in double knots. Client #2's arms were inside his sweatshirt. He was not wearing pants, only underwear. He had been given a pair of denim shorts to use as a pillow. Staff #6 immediately uncovered client #2's face and found his nasal cannula was not in his nose. The nasal cannula was laying across his eyes. Staff #6 fixed the cannula and sat client #2 back up in bed. Staff removed the sweatshirts and checked his oxygen level, which was in the 90's (per Individual Support Plan, dated 1/12/12, plan in place to receive oxygen if level drops below 88% during sleep). Staff redressed client #2 in appropriate pajamas (a shirt and pajama pants). Staff then assisted client #2 to the restroom and got him back into bed using two pillows to keep his head elevated per risk plan. Staff #6 asked the overnight staff (#9) what time it was when he last checked on client #2. Staff #9 replied "5:00 AM." Staff #6 reminded staff #9 that client #2 was to receive a bed check every half hour. Staff #9 disagreed. Staff #6 immediately notified the home		employment. (Attachment # 3 and # 3A). House Manager and Day Aide received disciplinary action for not reporting allegation of abuse/neglect. (Attachment # 4and # 4A.) Client specific training was conducted with house staff on night time routine (# 5), client Behavior Support Plan (# 6). Quality Assurance Monitoring: Training staff on Stone Belt's policy of prevention of abuse and neglect will continue as needed with current staff and covered during initial staff orientation of new hires. Administrative staff will make unannounced visits at Maxwell House to ensure that the health and safety of the clients is being monitored.				

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 08/21/2012
--	---	--	---

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
	<p>manager of the situation and emailed the director. It was not known initially both the director and Program Coordinator would be out of the office for the duration of the week. The Social Worker was notified on 7/27/12 when this was realized.</p> <p>The investigative report's findings, dated 8/2/12, indicated the facility substantiated abuse and neglect of client #2. The report indicated, "The allegation that [client #2] was neglected when he was found by staff with a blanket over his face, dressed in two tied sweatshirts, and half way out of his bed is substantiated. It was confirmed that [staff #9] had been trained to prepare [client #2] for bed, according to his risk plan protocol, and routine. [Staff #9] did not follow the protocol of checking on [client #2] at 1/2 hour intervals, to make sure that he was positioned appropriately in bed according to his hypoxia (a pathological condition in which the body as a whole or a region of the body is deprived of adequate oxygen supply) risk plan. [Staff #9] did not know that [client #2's] head was to be elevated by a pillow. The inadequate care resulted in [client #2] being is (sic) a situation of unknown duration where his oxygen cannula was not positioned correctly in his nose, and his face was covered with a folded blanket. He also was not able to use his</p>			

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 08/21/2012
--	---	--	---

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
	hands or arms to reposition himself. This resulted in a situation where [client #2] was at risk for respiratory distress or smothering. [Staff #9] had been advised of the availability of the House Manager to assist him, if he had problems during the night shift. [Staff #9] admitted that he had proceeded to tie the sweat shirts around [client #2], when '[client #2] was fighting with him about putting on clothes for the night,' but only after the social worker showed him a photo of how the sweat shirts were tied did he acknowledge that this is what [client #2] was actually wearing in bed. Manager [name of staff] stated that [client #2] was appropriately dressed for bed when he left the house at 10:00 PM on Tuesday night, so there is a discrepancy in why [staff #9] would have needed to replace or 'fight' with [client #2] over his clothing." The report indicated, "There is a clear possibility that the tied sweat shirts may have been used to restrain [client #2], possibly from SIB (self-injurious behavior). [Staff #9] described using a punitive-type technique with [client #2] when [client #2] would not keep his breathing treatment mask in position. He described turning off [client #2's] Barney video when he would not comply with keeping his breathing treatment mask on. [Staff #9] did not seem to know or understand that this would be considered a coercive and			

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 08/21/2012	
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			
	<p>punitive technique. He also did not understand that he should have written an incident report for the apparent fall that [client #2] had on the night of 7/26/12, which resulted (sic) a bruise to [client #2's] head. These failures of judgment indicate that although a more intensive and consistent training program for the difficult night aide position at [name of group home] is needed, that a lack of training alone, can not account for these incidents. It was also identified that [client #2's] MIS (Medication Information Sheet) does not include head elevation as part of his hypoxia risk plan. It is recommended that the nurse review the current procedure for head elevation and update the procedure in the MIS so that staff are doing this in a consistent manner. The technique described by [staff #9] in his statement of putting two pillows next to [client #2's] head to support his head on either side, was reviewed with [name of nurse], [group home name] nurse who stated that this would be an unsafe technique to use his [client #2], and is not likely the technique currently being used to elevate [client #2's] head." The investigative report indicated staff #9 did not document conducting bed checks until his final night on 7/26/12 (The report did not indicate the nights staff #9 worked in the home). Staff #9 and the former Program Coordinator were terminated.</p>						

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 08/21/2012
--	---	--	---

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
	<p>On 7/27/12 at (no time), staff was assisting [client #2] getting cleaned up. A small bruise on his hairline and scalp on the left side of his head was found. The investigative report, dated 8/2/12, addressing the abuse and neglect by staff #9 indicated, "During the investigation, [staff #9], sub staff who worked the night shift admitted that [client #2] hit his head against the floor in the living room which had padded floors. [Staff #9] stated to staff that he thought [client #2] was allowed to SIB in the living room because of the padding in the room."</p> <p>An email, dated 7/25/12 at 10:47 PM, sent from staff #2 to the home manager, Director of Group Homes and the Program Coordinator was reviewed on 8/21/12 at 11:23 AM. The email indicated, "[staff #9] worked the Tues/Wed overnight at [name of group home]. When dayshift arrived they found [client #2] in bed with 2 sweatshirts on with the sleeves tied behind his back in bed. Also his legs and feet were completely off of the bed (as if [client #2] had fallen asleep setting (sic) on the side of the bed). He was also sleeping with (sic) folded blankets over his head and face. It was very dangerous for [client #2] and I feel like it was neglectful! [Staff #9] has not been officially trained on</p>			

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 08/21/2012	
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			
	<p>overnights but was shown how to put [client #2] to bed properly. ([Staff #9] definitely has not given very much effort either). I would like this to be addressed with [staff #9]. I have a write up prepared if anyone would like me to give that to him. But in the mean time he definitely doesn't need to work at [name of group home]. He is scheduled again for the Thursday (sic) overnight. Please let me know what I need to do."</p> <p>A review of staff #9's employee file was conducted on 8/21/12 at 11:25 AM. Staff #9 received training at the group home on 7/5/12 from staff #2. This training included client #2's oximeter, nebulizer and treatments and risk plans. Staff #9 initialed he received the training. He received training on the prevention of abuse and neglect on 6/21/12.</p> <p>A review of staff #9's work schedule at the group home was conducted on 8/21/12 at 12:17 PM. Staff #9 worked at the group home on 7/5/12 for 11 hours, 7/6/12 for 8 hours, 7/8/12 for 3.5 hours, 7/22/12 to 7/23/12 for 11 hours, 7/24/12 for 7.5 hours, 7/25/12 to 7/26/12 for 8 hours and 7/26/12 for 8 hours.</p> <p>A review of the facility's abuse and neglect policy, dated 10/17/11, was conducted on 8/20/12 at 11:11 AM. The</p>						

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 08/21/2012
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	
	<p>policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a Client, parent/guardian, advocate, staff member, or other involved party."</p> <p>An interview in the investigative report with staff #2 indicated she was contacted</p>				

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 08/21/2012	
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			
	<p>by staff #6 on 7/25/12. Staff #6 told her when she arrived to work, staff #9 was lying on the couch and the housework was not done. Staff #6 informed staff #2 of her concerns about client #2 falling out of bed, tied sweat shirts, nasal cannula and had a blanket over his face. Staff #2 indicated staff #6 took pictures of how she found client #2. Staff #6 informed staff #2 that staff #9 indicated he had not checked on client #2 since 5:00 AM. Staff #2 told staff #6 she thought this was neglect and staff #6 should report it to the home manager. Staff #2 indicated staff #6 reported the concerns to the Program Coordinator on 7/25/12. Staff #2 indicated she informed the home manager on the 26th of her concerns and showed him the pictures. Staff #2 told the home manager she did not think staff #9 should work the overnight shift on the 26th. Staff #2 indicated the home manager told her he would take care of it.</p> <p>An interview with staff #6 in the investigative report indicated she worked on 7/25/12. Staff #6 indicated she arrived to work on 7/25/12 at 6:00 AM and when she went into client #2's room he was partially off the bed with a blanket over his face. His oxygen cannula was up near his eye and he was wearing two sweat shirts. When she got him up, he was not wearing any pants and had no pillow</p>						

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 08/21/2012	
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			
	<p>under his head. The blanket was double folded and covered his face, mouth and nose. Staff #6 indicated his arms were down at his sides and a black, long sleeved shirt with arms tied behind his back was over his arms. He was also wearing a red, heavy weight sweat shirt over the other sweat shirt with the arms empty and double knotted behind client #2's back. Staff #6 indicated staff #9 told her the last time he checked on client #2 was at 5:00 AM. Staff #6 indicated she contacted the home manager at around 8:00 AM to inform him of what she found. The home manager told her when he came into work he would make sure it was taken care of. She indicated no one informed her to write an incident report. Staff #6 indicated she informed the Program Coordinator of the incident at 7:00 AM when he arrived to work direct care that morning.</p> <p>An interview in the investigative report with the Program Coordinator (PC) indicated he did not recall working the morning of 7/25/12 at the home. The PC indicated during his interview now that the social worker mentioned it, he remembered staff #6 reporting client #2 had two sweat shirts on. The PC indicated he was not informed of client #2's sleeves being tied and there was a blanket covering his face. The PC</p>						

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 08/21/2012	
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			
	<p>indicated he did not instruct staff to write an incident report due to not having the information regarding these issues.</p> <p>An interview in the investigative report with the home manager (HM) indicated staff #9 worked the night shift on 7/22/12 and there were no concerns about his work. On 7/23/12 he discovered staff #9 did not clean or do the client checks. The HM indicated staff #9 watched television all night. The HM did not report the concerns to anyone and decided to work with staff #9 during the evening shift on 7/23/12 to train him. The HM indicated on 7/25/12 he contacted the scheduling staff to discuss his concerns (staff #9 was negligent) and he was told it was too late to fill the shift. The HM indicated the Director was on vacation and the Program Coordinator was sick. The HM indicated he should have contacted the pager to report his concerns. The HM indicated on 7/27/12 after staff #9 worked the night shift, staff #9 had moved a desk in front of the back door to block the door and the fire door between the clients' rooms and the living room was closed. On 7/27/12 a bruise was found on client #2's head. The HM indicated he contacted the PC who informed him to conduct an investigation of the unknown bruise. The PC instructed staff #2 to contact the social worker.</p>						

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 08/21/2012	
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			
	<p>An interview with the home manager (HM) was conducted on 8/20/12 at 3:13 PM. The HM stated staff #9, "Probably wasn't properly trained to do an overnight." The HM indicated staff #9 was neglectful regarding his care of client #2. The HM indicated he was made aware of the situation by staff #6. The HM indicated he called the staffing office to get staff #9 removed from the schedule however he was told it was too late to change the schedule. The HM indicated on 7/27/12 when client #2 was found to have a bruise of unknown origin, staff #9 indicated he let client #2 bang his head on the mats. The HM indicated staff #9 shut the fire door between the bedrooms and the living room on 7/26/12 to 7/27/12 and he moved a piece of furniture to block the back door exit. The HM indicated he should have immediately contacted the administrator upon learning of the incident. The HM indicated he was fully trained on how to respond however he did not respond correctly.</p> <p>An interview with the staff (#10) from the staffing office was conducted on 8/21/12 at 11:40 AM. Staff #10 indicated although she received the email from staff #2, she did not fully read the email and did not take action to address staff #2's concerns. Staff #10 indicated she assumed the other staff listed on the email</p>						

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 08/21/2012
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	
	<p>would address the situation. Staff #10 indicated she should have removed staff #9 from his shift at the group home after receiving the email. Staff #10 stated, "I was negligent for sure. It was my mistake for sure."</p> <p>An interview with the Director of Group Homes (DGH) was conducted on 8/21/12 at 12:51 PM. The DGH indicated he did not respond to staff #2's email on 7/25/12 due to being on vacation. He indicated he was available by phone however no one contacted him. The DGH indicated the HM and the former Program Coordinator were informed of the incident but failed to take appropriate action. The DGH indicated the staffing office staff should have addressed the issue since she was informed of the incident and contacted by staff. The DGH indicated the monitoring of the home was increased but not during the night shift.</p> <p>This deficiency was cited on 7/16/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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 08/21/2012	
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			
W0153	<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 #2, the facility failed to ensure an incident of abuse was immediately reported to the administrator, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 8/20/12 at 12:50 PM. On 7/25/12 at 6:20 AM (reported to the Bureau of Developmental Disabilities Services on 7/28/12), staff #6 arrived to work at 6:00 AM. Staff #6 found client #2 about to fall out of his bed. His hips, legs and feet were completely out of bed with his legs on the floor. His head was not elevated per his risk plan. He had a heavy blanket partially folded and wadded up only covering his head. The blanket was completely covering his face, mouth and nose. Client #2 also had on two sweatshirts, the sleeves of which were tied behind his back in double knots. Client #2's arms were inside his</p>	W0153	<p>W153 STAFF TREATMENT OF CLIENTS Plan of Correction Stone Belt will ensure that allegations of mistreatment, neglect or abuse are reported immediately to the Director of SGL or other administrators as designated. Date of Completion September 14, 2012 Responsible Person Maxwell Coordinator/SGL Director Plan of Prevention House staff were retrained on incident reporting (Attachment # 7) and the House Manager and Day Aide received disciplinary action for not reporting specific incident. (Attachment # 4 and # 4A)</p>	09/14/2012			

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 08/21/2012	
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			
	<p>sweatshirt. He was not wearing pants, only underwear. He had been given a pair of denim shorts to use as a pillow. Staff #6 immediately uncovered client #2's face and found his nasal cannula was not in his nose. The nasal cannula was laying across his eyes. Staff #6 fixed the cannula and sat client #2 back up in bed. Staff removed the sweatshirts and checked his oxygen level, which was in the 90's (per Individual Support Plan, dated 1/12/12, plan in place to receive oxygen if level drops below 88% during sleep). Staff redressed client #2 in appropriate pajamas (shirt and pajama pants). Staff then assisted client #2 to the restroom and got him back into bed using two pillows to keep his head elevated per risk plan. Staff #6 asked the overnight staff (#9) what time it was when he last checked on client #2. Staff #9 replied "5:00 AM." Staff #6 reminded staff #9 that client #2 was to receive a bed check every half hour. Staff #9 disagreed. Staff #6 immediately notified the home manager of the situation and emailed the director. It was not known initially both the director and Program Coordinator would be out of the office for the duration of the week. The Social Worker was notified on 7/27/12 when this was realized.</p> <p>An interview with the Director of Group</p>		<p>Quality Assurance Monitoring</p> <p>The SGL Director and House Coordinator will ensure that allegations of abuse/neglect are reported immediately. Staff received annual retraining and Incident Reporting is apart of Orientation Training for new staff.</p>				

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 08/21/2012	
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			
W9999	<p>Homes (DGH) was conducted on 8/21/12 at 12:51 PM. The DGH indicated he did not respond to staff #2's email on 7/25/12 due to being on vacation. He indicated he was available by phone however no one contacted him. The DGH indicated the HM and the former Program Coordinator were informed of the incident but failed to take appropriate action. The DGH indicated the staffing office staff should have addressed the issue since she was informed of the incident and contacted by staff. The DGH indicated the monitoring of the home was increased but not during the night shift.</p> <p>This deficiency was cited on 7/16/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>	W9999	No citations in W9999	09/14/2012			