

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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	
W0000	<p>This visit was for investigation of complaint #IN00119436.</p> <p>Complaint #IN00119436: Substantiated. Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W318, W331 and W460.</p> <p>Dates of Survey: December 3, 4 and 5, 2012.</p> <p>Facility Number: 001094 Provider Number: 15G653 AIMS Number: 100235630</p> <p>Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/12/12 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: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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			
W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility to ensure the facility implemented their policy and procedures to prevent neglect of client A and to ensure the timely health needs of client A were met.</p> <p>Findings include:</p> <p>1. The governing body failed, for 1 of 3 sampled clients (client A), to implement the facility's policy and procedure to prevent neglect by failing to ensure the facility met the needs of client A, and ensured a client's health needs were not neglected. Please see W104.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation: Client Protections. The facility neglected to implement their neglect policy and neglected to provide timely health care, for 1 of 3 sampled clients (client A). Please see W122.</p>	W0102	<p>W 102 GOVERNING BODY AND MANAGEMENT</p> <p>Plan of Correction:</p> <p>Stone Belt Inc. ensures that specific governing body and management requirements are met. This includes prevention of neglect and timely health needs.</p> <p>Responsible Person:</p> <p>Elliott House Coordinator/SGL Director</p> <p>Date of Completion:</p> <p>January 4, 2013</p>	01/04/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>3. The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation, Health Care Services. The facility failed to provide adequate health care monitoring and nursing services for 1 of 3 sampled clients (client A). Please see W318.</p> <p>This federal tag relates to complaint #IN00119436.</p> <p>9-3-1(a)</p>		<p>Plan of Prevention:</p> <p>Stone Belt has an policy for prevention of Abuse, and Neglect. (Attachment # 1) Staff will be retrained on the Stone Belt policy of Prevention of Abuse and Neglect and report immediately to the Program Coordinator and/or Director of Group Homes. This training occurs at various inservices held by departments. SGL training was January 4, 2013. (Attachment # 1A).</p> <p>Stone Belt, Inc. has a Health Emergency Procedure (Attachment # 1) that was retrained on with all staff at each group home and day programming. (Attachments 2 – 2A)</p> <p>Quality Assurance Monitoring:</p> <p>The Coordinator will review on an annual basis the Health Emergency Procedure. It is also trained in new hire orientation as well as bi-annual First Aid/CPR recertification.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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	
W0104	<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, the governing body failed to provide timely nursing services and health care, by failing to initiate CPR timely, for 1 of 1 client death (client A), who needed emergency medical interventions. The facility also failed for 1 of 2 sample clients (client A) with identified choking risks to ensure he was safe from choking.</p> <p>Findings include:</p> <p>On 12/03/12 at 12:05 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>06/01/12: A BDDS report submitted 06/01/12 for an incident on 06/01/12 at 2:00 PM indicated the following regarding client A: "[Client A] was in the Man Cave walking around and come (sic) up to staff. Staff noticed he stumbled and staff asked him if he was ok. [Client A] said yes, then fell into (sic) staff. Staff caught him and he went down to the floor. Staff went into retirement room, which is adjoined, and asked about calling 911 and</p>	W0104	<p>W 104 STAFF TRAINING PROGRAM</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. operates and implements general policy, budget and operating direction over all residential facilities. In particular, staff are trained on Emergency Procedures and Risk Plans.</p> <p>Responsible Person:</p> <p>Elliott House Coordinator/SGL Director</p> <p>Date of Completion:</p> <p>January 4, 2013</p>	01/04/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>stated she didn't have the authority to call. Staff tried to find someone to call 911. Staff #2 called 911. Told to do compressions, but not breathing. 911 First responders and paramedics showed and took over CPR (Cardio-pulmonary Resuscitation)...Death investigation to be conducted."</p> <p>06/01/12: Agency Investigation Review indicated the following regarding client A: Diagnoses included but were not limited to: MR (Mental Retardation), Seizures, Obstructive Sleep Apnea, GERD (Gastroesophageal reflux disease), Dementia/Alzheimer's and Dysphagia (difficult swallowing) - Silent Aspiration. Interview with staff #1 indicated: "[Staff #1] reported that he was outside with two clients, smoking at the time that [client A] collapsed. [Staff #1] reported that when he came back in (inside the building) the EMTs (Emergency Medical Technicians) were there...[staff #1] reported that he got [client A's] snack out for him, before he left the room, he then told [staff #2] that he was taking [day service clients #1 and #2] out to smoke. [Staff #1] reported that [staff #2] acknowledged by saying, 'OK.' [Staff #1] reported that [client A] had peanut butter crackers for his 2:00 pm snack. [Staff #1] reported that [client A] will eat one cracker at a time. He (staff</p>		<p>Plan of Prevention:</p> <p>Stone Belt, Inc. has a Health Emergency Procedure (Attachment # 2) that was retrained on with all staff at each group home and day programming. (Attachments 2 – 2A)</p> <p>Additionally, staff in all areas of Stone Belt are trained on individual risk plans as changes are made. (Attachment # 3 and # 3A are examples.)</p> <p>Quality Assurance Monitoring:</p> <p>The Coordinator in each department ensures that as Risk Plans change, they are trained to the staff in the home and at day programming. Health Emergency Procedure is reviewed annually as well as during new hire orientation for all Stone Belt employees.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>#1) reported that [client A] will take two separate bites of the cracker independently. [Staff #1] reported that [client A] did not have a drink for his 2:00 PM snack. [Staff #1] stated that [client A] usually does not have a drink for his 2:00 PM snack...He reported that peanut butter crackers are not out of the ordinary."</p> <p>Interview with staff #2 indicated: "[Staff #2] reported that he was sitting at the desk in the Man Cave. He reported that [staff #1] had taken [day service clients #1 and #2] out to smoke. He (staff #2) reported that the smoke breaks are part of their plans, that there is a ten minute limit and they take a timer with them. [Staff #2] reported that [day service client #3] was sitting next to him, [day service client #4] was walking around in the room and [day service client #5] and [day service client #6] were also present. [Staff #2] reported that the group was on break, they had snack and were sitting around at the time of the incident...[staff #2] reported that [client A] had finished his snack...[Staff #2] reported that he did not give [client A] his snack. He reported that [client A] had cheese crackers. [Staff #2] reported he assumed [staff #1] gave [client A] his snack...When asked if staff do anything special when [client A] eats crackers, [staff #2] reported that he had never seen</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>that in the plan...[staff #2] reported that [client A] was walking around and stumbled. He reported that it was normal for [client A] to stumble. [Staff #2] reported that [client A] was walking toward him and stumbled again. [Staff #2] asked, '[client A], you okay?' [Client A] reportedly responded, 'Yeah!' [Staff #2] reportedly asked [client A], 'You got your Coke money?' [Client A] responded, 'Yeah, I got my Coke money.' [Staff #2] reported that he had stood up and [client A] stumbled into him. [Staff #2] asked him again, 'You okay?' [Staff #2] reported that [client A] faintly stated, 'Yeah,' as he fell into him. [Staff #2] reported that he lowered [client A] to the ground...[Staff #2] reported that the door to [staff #3's] room was open. He reported that he jumped up and said, 'I need help now.' He (staff #2) reported that [staff #4] was in the room but he thought [staff #3] may have been helping someone in the bathroom. [Staff #2] reported (to staff #4) that [client A] was on the ground. He reportedly asked [staff #4], 'Do we need to call 911?' [Staff #4] reportedly answered, 'I don't have the authority to call 911.' [Staff #2] reported that [staff #4] stayed with [client A] and he went to find someone who could call 911. [Staff #2] reported that [staff #4] had worked at [day service agency] for longer and he assumed that if she did not have the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>authority to call 911 than (sic) neither did he. [Staff #2] reported that he went to [staff #5's] desk to ask where the nurse's office was. [Staff #2] reported that he went to the nurses' office, knocked and no one answered. [Staff #2] reported that he was on his way back to the Man Cave when he saw [staff #6] by the lockers. [Staff #2] reported they went back to the Man Cave and [staff #3] was on the phone with 911. He reported that [staff #4] was standing above [client A]. [Staff #2] reported that he wanted to start CPR. He reported that he felt [client A] had a faint pulse. He reported that he held his hand in front of [client A's] mouth and felt breath. [Staff #2] reported that [client A] had not vomited but he was bleeding a little from his mouth. [Staff #2] reported that [QMRP (Qualified Mental Retardation Professional) came in and did chest compressions...."</p> <p>Interview with staff #3 indicated: "[Staff #3] indicated she was in her class room, behind the screen for med pass with a client. She reported that [staff #6] came in with the meds. [Staff #3] reported that [staff #4] must have been called over to the other room and then called for her and [staff #6]. [Staff #3] reported that [client A] was lying on his left side. She reported that she got close to him and was trying to talk to him. [Staff #3] reported</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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
	that [client A] was unresponsive. [Staff #3] reported that [staff #6] tried to call 911 from her cell phone. [Staff #3] reported that she called 911 from a land line (phone in the Man Cave). She (staff #3) reported telling the operator an ambulance was needed. [Staff #3] reported that she was transferred to another operator and had to tell her the same information. [Staff #3] reported that she stayed on the line. She reported that [staff #2] and [staff #6] said they thought [client A] was breathing. [Staff #3] reported that the operator instructed that just compressions should be given, no breaths...[Staff #3] reported that [client A] had blood on either his nose, mouth, or both. She (staff #3) thought that maybe he had hit the floor but found out later that [client A] did not fall. [Staff #3] reported there was no vomit or food. [Staff #3] reported that [client A] had soiled himself. She reported that he looked pale...When asked, [staff #3] reported that she was probably already on the phone with 911 when staff were looking for a mask. [Staff #3] reported by the time staff had a mask, 911 said to just do compressions. [Staff #3] reported the following suggestions: masks should be in all areas at [day service agency], the [day service agency] address should be posted by each phone, CPR refresher training would be helpful, staffing should			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>be addressed when clients or staff takes smoke breaks and staff need to understand that they can call 911."</p> <p>Interview with staff #4 indicated: "... [Staff #4] reported that she was called over at 1:59 PM by [staff #2]. She reported she went in the room and saw [client A] face down with blood on his face and not moving. [Staff #4] reported that she told [staff #2] to get the nurse. [Staff #4] reported that she told [staff #3] and [staff #6], 'Come here quick.' [Staff #4] reported that [staff #6] and [staff #3] called 911. [Staff #4] reported that she thought [client A] was gone by the time he was on the floor. She reported that she felt no pulse. [Staff #4] reported that she told [staff #6] she was afraid to turn him over. [Staff #4] stated that she did not want to do the wrong thing because of the blood and secretions on [client A's] face. [Staff #4] reported that [staff #2] said he felt a faint pulse but [client A] never moved. [Staff #4] reported that she held a mirror to [client A's] face to see if he was breathing. [Staff #4] reported that she thought [staff #3] gave her the mirror. [Staff #4] reported someone started looking for a mask. She reported that she thought [staff #6] started compressions and then [QMRP] took over. [Staff #4] reported that she never said, 'I don't have the authority to call 911.' [Staff #4]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>reported that she was afraid to start doing anything to [client A]. She reported she was afraid he would choke on his own blood...[Staff #4] reported that [client A's] face and ears were blue. She reported that his lips were chalky/white and his fingers were blue. [Staff #4] reported that she checked [client A's] neck and there was no pulse...."</p> <p>Interview with staff #5 indicated: "[Staff #5] stated that around 2:00 o'clock on 6-1-12 [staff #2] came into the front desk area and asked her where he could find the nurse. [Staff #5] stated that the nurse was not in the building. [Staff #2] left to go back to his room. [Staff #5] stated that [staff #2] did not tell her that there was a health emergency or that [client A] was down and unresponsive. He did not ask her to call 911. [Staff #5] stated that she did not know that there was a health crisis going on. She stated that if she would have been told she could have notified [QMRP] immediately. [Staff #5] stated that [staff #6] came into her area and [staff #6] asked her where [QMRP] was. [Staff #5] said that [QMRP] had gone to the back office...[staff #6] did not tell [staff #5] that [client A] was down...[Staff #5] stated that she was concerned that no one had told her what was going on, as she might have been able to assist by calling 911 and summoning help. I asked</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>[staff #5] if there was a procedure for medical emergencies at [day service program]. [Staff #5] stated that there had been a procedure for emergencies several years ago, however there was no planned procedure on how to handle a health emergency other than CPR training. She stated that she thought as she is a gatekeeper at the front desk, that she should be kept informed so that she can assist...she was concerned that when staff are outside smoking that this leaves the programs short staffed...."</p> <p>Interview with staff #6 indicated: "[Staff #6] reported it was around 2:00 PM and she was in [staff #3's] room giving [day service client #7] her meds. She reported [staff #3] wheeled [day service client #7] behind the screen in her room. [Staff #6] reported that she heard her name called. She reported she saw [staff #2] standing in the door between the two classrooms. [Staff #2] reportedly said, 'I need help.' [Staff #6] reported that [client A] was on the ground facing away from her. She reported [staff #4] on the other side of [client A], facing him. [Staff #6] reported that she thought [staff #4] was trying to wipe up blood. [Staff #6] reported that she didn't know what happened. [Staff #6] reported that she leaned over [client A] and thought she saw his face move. [Staff #2] reportedly thought [client A]</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>was breathing. [Staff #6] reported [client A] was lying still on the floor and she didn't know if he was unconscious. She reported that she thought she saw his jaw move and there were no sounds coming from him. [Staff #6] reported that everyone appeared to be in shock. She reported that [staff #2] said 'call 911'...The EMTs reportedly asked if [client A] had eaten lately. [Staff #2] reportedly said he had crackers...."</p> <p>Interview with the QMRP indicated: "... [QMRP] reported that she came through the kitchen toward the break room and [staff #6] began yelling, '[QMRP], come here. [QMRP] come here.' [QMRP] reported that he [client A] was down. [QMRP] said call 911. Someone reportedly told her that 911 was already called. [QMRP] reported that she put gloves on and got down on the floor. [QMRP] reported that she felt a faint pulse and some breath from [client A]. [QMRP] reported that (client A) was bleeding but she couldn't tell where it was coming from. She reported that he had blood on his nose and mouth and had been lying on his side. [QMRP] reported that she said we need to roll him over (client A) on his side. [QMRP] reported that [staff #4] held (client A's) wrist and they rolled him over on his back. [QMRP] reported that (client A's) lips</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>were not blue. She reported that his ears were a purplish blue but that color went away when they rolled him over. [QMRP] reported that she needed a mask. [QMRP] went to [staff #5's] desk to get a mask. [QMRP] reported that when she returned, (client A) had no pulse. She reported that [staff #3] was still on the phone with 911. [Staff #3] reportedly told her that 911 said to do compressions only. [QMRP] reported that she did compressions...[QMRP] reported that [staff #4] stayed beside her and kept checking (client A's) wrist for a pulse. [Staff #4] reportedly said (client A) still had a faint pulse. [QMRP] reported that at some point [staff #4] said, 'He's gone.'...."</p> <p>Interview with RN (Registered Nurse) Nurse Manager [agency] indicated: "[RN] stated that staff [staff #2] should not have left (client A). He should have called for someone to call 911 and get help. She stated that if [staff #4] had observed (client A) to be blue she could have immediately started compressions. [Staff #4] reported asking for a mirror to determine if (client A) was breathing, this is not taught as part of CPR training. If there is no breathing, CPR should be started immediately. If there is blood or secretions these should be wiped away. [RN] stated that staff did not follow CPR</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>procedures as trained. She stated that no where is it taught any individual staff 'does not have authority' to call 911. [RN] responded to the interviewers question about whether the nurse pager was contacted. [RN] stated that it was not."</p> <p>The "brief summary" of the investigation indicated: "...It appears that staff did not follow the [agency] Health Emergency Procedure that states in part: 'any staff member who feels that a client is in a serious health emergency is instructed to call an ambulance immediately.'"</p> <p>Client A's records were reviewed on 12/03/12 at 2:30 PM. Client A's record review included review of the following dated documents: 06/15/11: ISP (Individualized Service Plan) indicated client A's diagnoses included Dysphagia - Silent Aspiration and contained a choking risk plan. 02/01/12: Dietary Nutrition Review indicated: "Diet 1800 calorie, mech (mechanical) soft w/(with) chopped meat covered with gravy (or sauce) w/nectar thickened liquids, Skim milk. Portion control. Cut foods/meats into small bite sized pieces (1/2 inch size). Break cookies/crackers into 1/2 bite size bites. "Continue current diet plan."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>03/15/12: Medication Information Sheets indicated: "Diet: 1800 calorie; Mech soft w/chopped meats covered w/gravy (or sauce) with Nectar Thickened Liquids. Skim milk; portion control. Offer 6-8 oz (ounces) fluids before meals...May have coffee 1/2 caffeine 1/2 decaf (decaffeinated) - ALL fluids are to be Nectar Thick Consistency. "Cut foods/meats into small bite sized pieces (1/2 inch size). Break cookies/crackers into 1/2 inch bites...Choking: [client A] is at risk for choking because he eats his foods at a fast rate and takes large bites of food with minimal chewing...DSPs (Direct Support Personnel) need to sit next to (client A) to prompt and cue him to take small bits (sic) of food and chew all foods well before swallowing. DSPs' need to check his mouth every few bites to make sure that he is successfully chewing and swallowing. If food is still noted in his mouth, DSPs' should encourage him to continue to chew and swallow until all food is gone before picking up spoon to take another bite of food...DSPs' need to make sure that (client A) no longer is to use chin tucks when swallowing...On 5-5-11 Swallow Study Result and Speech Therapist recommended 1800 calorie Mech Soft diet w/Nectar thick consistency for all liquids, and use Dysphagia Regulator Cup...call 911 if (client A) continues to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>struggle to breathe with no improvement. If his face (around mouth or lips) become bluish color. If you believe his immediate health and safety are at stake. Start emergency procedures as trained abdominal thrusts (Heimlich Maneuver) (sic)...."</p> <p>05/22/12: Medication Information Sheets indicated: "Diet: 1800 calorie; Mech soft w/chopped meats covered w/gravy (or sauce) with Nectar Thickened Liquids. Skim milk; portion control. Offer 6-8 oz (ounces) fluids before meals...May have coffee 1/2 caffeine 1/2 decaf (decaffeinated) - ALL fluids are to be Nectar Thick Consistency. "Cut foods/meats into small bite sized pieces (1/2 inch size). Break cookies/crackers into 1/2 inch bites...Choking: [client A] is at risk for choking because he eats his foods at a fast rate and takes large bites of food with minimal chewing...DSPs' (Direct Support Personnel) need to sit next to (client A) to prompt and cue him to take small bits (sic) of food and chew all foods well before swallowing. DSPs' need to check his mouth every few bites to make sure that he is successfully chewing and swallowing. If food is still noted in his mouth, DSPs' should encourage him to continue to chew and swallow until all food is gone before picking up spoon to take another bite of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>food...DSPs' need to make sure that (client A) no longer is to use chin tucks when swallowing...On 5-5-11 Swallow Study Result and Speech Therapist recommended 1800 calorie Mech Soft diet w/Nectar thick consistency for all liquids, and use Dysphagia Regulator Cup...call 911 if (client A) continues to struggle to breathe with no improvement. If his face (around mouth or lips) become bluish color. If you believe his immediate health and safety are at stake. Start emergency procedures as trained abdominal thrusts (Heimlich Maneuver) (sic)...."</p> <p>06/01/12: Ambulance Report: "Patient: (Client A). Nature of call: Unconscious, found on floor; Airway/Breathing: Absent; Carotid Pulse: Absent; Lung Sounds: Absent; Pupils: Non-reactive; Primary Impression: Cardiac Respiratory Arrest: Narrative: Upon arrival male on floor with bystander CPR in progress. Had eaten a cracker snack and went unresponsive. CPR was initiated and 911 called...Life-pack 12 application with pads. The rhythm was Asystole (flatline/no cardiac electrical activity)...care rendered to [hospital] ER staff."</p> <p>06/01/12: Hospital ER (Emergency Room) Cardiac Resuscitation/Adult form</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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: "Chief Complaint: This is a [age] year old male who present as/in a state of cardiac arrest at [day service name] was eating peanut butter cracker when he was seen to collapse.</p> <p>Prehospital Findings: Airway obstructed; Circulation/Rhythm: Spontaneous pulses absent-Asystole; Neurological: Unresponsive. ED (Emergency Department): RT (Respiratory Therapist) intubated patient removing peanut butter cracker from oral airway and some from trachea. No response to resuscitative efforts."</p> <p>06/04/12: Certificate of Death indicated the following regarding client A's death: Date of Death: 06/01/12. Time of Death: 03:10 PM. Cause of Death and Approximate Interval (to) Onset of Death: A. Acute Cardio-Respiratory Arrest - 10 minutes B. Asphyxiation - 15 minutes C. Aspiration of Food - 15 minutes D. Severe Mental/Developmental Handicap - 60 years.</p> <p>On 12/04/12 at 10:25 AM, an interview was conducted with the QMRP. She indicated the agency had a responsibility to provide timely medical care. The QMRP indicated the investigation</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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 staff #1 and #2 neglected to follow client A's choking risk plan as neither staff reported to sit with client A during his snack or break the crackers into bite size pieces as ordered and they did not alter the texture of the crackers prior to client A's consumption. The QMRP indicated staff #2 should not have left client A unattended when he went to get help and she further indicated emergency medical intervention did not start immediately. She indicated client A was taken to the hospital by the ambulance. She indicated the death certificate cause of death included Asphyxiation and Aspiration of Food, which was the snack he had eaten prior to his collapse.</p> <p>The governing body failed to exercise general policy and operating direction over the facility as it neglected to implement their neglect policy and neglected to provide timely health care for 1 of 3 sampled clients (client A). Please refer to W149.</p> <p>The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation, Health Care Services. The facility failed to provide</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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	
	adequate health care monitoring and nursing services for 1 of 3 sampled clients (client A). Please see W318. This federal tag relates to complaint #IN00119436. 9-3-1(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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	
W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, for 1 of 3 sampled clients (client A), the Condition of Participation of Client Protections was not met as the facility neglected to implement their neglect policy to ensure client A was monitored according to his choking risk plan to ensure he ate safely and did not choke.</p> <p>Findings include:</p> <p>Please refer to W149. The facility failed to implement their neglect policy, for 1 of 3 sampled clients (client A). The facility neglected to ensure client A's dietary orders/guidelines and choking risk plan were followed to prevent choking.</p> <p>This federal tag relates to complaint #IN00119436.</p> <p>9-3-2(a)</p>	W0122	<p>W 122 CLIENT PROTECTIONS</p> <p>Plan of Correction:</p> <p>Stone Belt, Inc. ensures that specific client protection requirements are met. Specifically, risk plans are trained on when changes are made or when new staff begin to work with a client.</p> <p>Responsible Person:</p> <p>Elliott House Coordinator</p> <p>Date of Completion:</p> <p>January 4, 2013</p>	01/04/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>Plan of Prevention:</p> <p>Additionally, staff in all areas of Stone Belt are trained on individual risk plans as changes are made. (Attachment # 3 and # 3A are examples.)</p> <p>Quality Assurance Monitoring:</p> <p>Coordinators in specific areas will ensure that risk plans are trained on when changed or when new staff work with specific clients.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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			
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.</p> <p>Based on record review and interview, the facility failed to implement their neglect policy, for 1 of 3 sampled clients (client A). The facility neglected to ensure client A's dietary orders/guidelines and choking risk plan were followed to prevent choking.</p> <p>Findings include:</p> <p>On 12/03/12 at 12:05 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>06/01/12: A BDDS report submitted 06/01/12 for an incident on 06/01/12 at 2:00 PM indicated the following regarding client A: "[Client A] was in the Man Cave walking around and come (sic) up to staff. Staff noticed he stumbled and staff asked him if he was ok. [Client A] said yes, then fell into (sic) staff. Staff caught him and he went down to the floor. Staff went into retirement room, which is adjoined, and asked about calling 911 and stated she didn't have the authority to call. Staff tried to find someone to call 911.</p>	W0149	<p>W149</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will ensure any incidents of Abuse, Neglect, and/or mistreatment of the consumers will be reported immediately.</p> <p>Person Responsible:</p> <p>Elliott Program Coordinator</p> <p>Date of Completion:</p> <p>January 4, 2013</p>	01/04/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>Staff #2 called 911. Told to do compressions, but not breathing. 911 First responders and paramedics showed and took over CPR (Cardio-pulmonary Resuscitation)...Death investigation to be conducted."</p> <p>06/01/12: Agency Investigation Review indicated the following regarding client A: Diagnoses included but were not limited to: MR (Mental Retardation), Seizures, Obstructive Sleep Apnea, GERD (Gastroesophageal reflux disease), Dementia/Alzheimer's and Dysphagia (difficult swallowing) - Silent Aspiration. Interview with staff #1 indicated: "[Staff #1] reported that he was outside with two clients, smoking at the time that [client A] collapsed. [Staff #1] reported that when he came back in (inside the building) the EMTs (Emergency Medical Technicians) were there...[staff #1] reported that he got [client A's] snack out for him, before he left the room, he then told [staff #2] that he was taking [day service clients #1 and #2] out to smoke. [Staff #1] reported that [staff #2] acknowledged by saying, 'OK.' [Staff #1] reported that [client A] had peanut butter crackers for his 2:00 pm snack. [Staff #1] reported that [client A] will eat one cracker at a time. He (staff #1) reported that [client A] will take two separate bites of the cracker</p>		<p>Plan of Prevention:</p> <p>Staff will be retrained on the Stone Belt policy of Prevention of Abuse and Neglect and report immediately to the Program Coordinator and/or Director of Group Homes. (Attachment # 1 and #1A). New staff receive same training during orientation week.</p> <p>Quality Assurance Monitoring:</p> <p>The Stone Belt Staff receive training during new hire orientation and annually on The Stone Belt Abuse, Mistreatment, Neglect and Incident Report Policies.</p> <p>The Program Coordinator and other administrative staff will conduct visits to the home, both announced and unannounced to assure appropriate reporting of incidents.</p>	
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>independently. [Staff #1] reported that [client A] did not have a drink for his 2:00 PM snack. [Staff #1] stated that [client A] usually does not have a drink for his 2:00 PM snack...He reported that peanut butter crackers are not out of the ordinary."</p> <p>Interview with staff #2 indicated: "[Staff #2] reported that he was sitting at the desk in the Man Cave. He reported that [staff #1] had taken [day service clients #1 and #2] out to smoke. He (staff #2) reported that the smoke breaks are part of their plans, that there is a ten minute limit and they take a timer with them. [Staff #2] reported that [day service client #3] was sitting next to him, [day service client #4] was walking around in the room and [day service client #5] and [day service client #6] were also present. [Staff #2] reported that the group was on break, they had snack and were sitting around at the time of the incident...[staff #2] reported that [client A] had finished his snack...[Staff #2] reported that he did not give [client A] his snack. He reported that [client A] had cheese crackers. [Staff #2] reported he assumed [staff #1] gave [client A] his snack...When asked if staff do anything special when [client A] eats crackers, [staff #2] reported that he had never seen that in the plan...[staff #2] reported that [client A] was walking around and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>stumbled. He reported that it was normal for [client A] to stumble. [Staff #2] reported that [client A] was walking toward him and stumbled again. [Staff #2] asked, '[client A], you okay?' [Client A] reportedly responded, 'Yeah!' [Staff #2] reportedly asked [client A], 'You got your Coke money?' [Client A] responded, 'Yeah, I got my Coke money.' [Staff #2] reported that he had stood up and [client A] stumbled into him. [Staff #2] asked him again, 'You okay?' [Staff #2] reported that [client A] faintly stated, 'Yeah,' as he fell into him. [Staff #2] reported that he lowered [client A] to the ground...[Staff #2] reported that the door to [staff #3's] room was open. He reported that he jumped up and said, 'I need help now.' He (staff #2) reported that [staff #4] was in the room but he thought [staff #3] may have been helping someone in the bathroom. [Staff #2] reported (to staff #4) that [client A] was on the ground. He reportedly asked [staff #4], 'Do we need to call 911?' [Staff #4] reportedly answered, 'I don't have the authority to call 911.' [Staff #2] reported that [staff #4] stayed with [client A] and he went to find someone who could call 911. [Staff #2] reported that [staff #4] had worked at [day service agency] for longer and he assumed that if she did not have the authority to call 911 than (sic) neither did he. [Staff #2] reported that he went to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>[staff #5's] desk to ask where the nurse's office was. [Staff #2] reported that he went to the nurses' office, knocked and no one answered. [Staff #2] reported that he was on his way back to the Man Cave when he saw [staff #6] by the lockers. [Staff #2] reported they went back to the Man Cave and [staff #3] was on the phone with 911. He reported that [staff #4] was standing above [client A]. [Staff #2] reported that he wanted to start CPR. He reported that he felt [client A] had a faint pulse. He reported that he held his hand in front of [client A's] mouth and felt breath. [Staff #2] reported that [client A] had not vomited but he was bleeding a little from his mouth. [Staff #2] reported that [QMRP (Qualified Mental Retardation Professional) came in and did chest compressions...."</p> <p>Interview with staff #3 indicated: [Staff #3] indicated she was in her class room, behind the screen for med pass with a client. She reported that [staff #6] came in with the meds. [Staff #3] reported that [staff #4] must have been called over to the other room and then called for her and [staff #6]. [Staff #3] reported that [client A] was lying on his left side. She reported that she got close to him and was trying to talk to him. [Staff #3] reported that [client A] was unresponsive. [Staff #3] reported that [staff #6] tried to call</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>911 from her cell phone. [Staff #3] reported that she called 911 from a land line (phone in the Man Cave). She (staff #3) reported telling the operator an ambulance was needed. [Staff #3] reported that she was transferred to another operator and had to tell her the same information. [Staff #3] reported that she stayed on the line. She reported that [staff #2] and [staff #6] said they thought [client A] was breathing. [Staff #3] reported that the operator instructed that just compressions should be given, no breaths...[Staff #3] reported that [client A] had blood on either his nose, mouth, or both. She (staff #3) thought that maybe he had hit the floor but found out later that [client A] did not fall. [Staff #3] reported there was no vomit or food. [Staff #3] reported that [client A] had soiled himself. She reported that he looked pale...When asked, [staff #3] reported that she was probably already on the phone with 911 when staff were looking for a mask. [Staff #3] reported by the time staff had a mask, 911 said to just do compressions. [Staff #3] reported the following suggestions: masks should be in all areas at [day service agency], the [day service agency] address should be posted by each phone, CPR refresher training would be helpful, staffing should be addressed when clients or staff takes smoke breaks and staff need to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>understand that they can call 911."</p> <p>Interview with staff #4 indicated: "... [Staff #4] reported that she was called over at 1:59 PM by [staff #2]. She reported she went in the room and saw [client A] face down with blood on his face and not moving. [Staff #4] reported that she told [staff #2] to get the nurse. [Staff #4] reported that she told [staff #3] and [staff #6], 'Come here quick.' [Staff #4] reported that [staff #6] and [staff #3] called 911. [Staff #4] reported that she thought [client A] was gone by the time he was on the floor. She reported that she felt no pulse. [Staff #4] reported that she told [staff #6] she was afraid to turn him over. [Staff #4] stated that she did not want to do the wrong thing because of the blood and secretions on [client A's] face. [Staff #4] reported that [staff #2] said he felt a faint pulse but [client A] never moved. [Staff #4] reported that she held a mirror to [client A's] face to see if he was breathing. [Staff #4] reported that she thought [staff #3] gave her the mirror. [Staff #4] reported someone started looking for a mask. She reported that she thought [staff #6] started compressions and then [QMRP] took over. [Staff #4] reported that she never said, 'I don't have the authority to call 911.' [Staff #4] reported that she was afraid to start doing anything to [client A]. She reported she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>was afraid he would choke on his own blood...[Staff #4] reported that [client A's] face and ears were blue. She reported that his lips were chalky/white and his fingers were blue. [Staff #4] reported that she checked [client A's] neck and there was no pulse...."</p> <p>Interview with staff #5 indicated: "[Staff #5] stated that around 2:00 o'clock on 6-1-12 [staff #2] came into the front desk area and asked her where he could find the nurse. [Staff #5] stated that the nurse was not in the building. [Staff #2] left to go back to his room. [Staff #5] stated that [staff #2] did not tell her that there was a health emergency or that [client A] was down and unresponsive. He did not ask her to call 911. [Staff #5] stated that she did not know that there was a health crisis going on. She stated that if she would have been told she could have notified [QMRP] immediately. [Staff #5] stated that [staff #6] came into her area and [staff #6] asked her where [QMRP] was. [Staff #5] said that [QMRP] had gone to the back office...[staff #6] did not tell [staff #5] that [client A] was down...[Staff #5] stated that she was concerned that no one had told her what was going on, as she might have been able to assist by calling 911 and summoning help. I asked [staff #5] if there was a procedure for medical emergencies at [day service</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>program]. [Staff #5] stated that there had been a procedure for emergencies several years ago, however there was no planned procedure on how to handle a health emergency other than CPR training. She stated that she thought as she is a gatekeeper at the front desk, that she should be kept informed so that she can assist...she was concerned that when staff are outside smoking that this leaves the programs short staffed...."</p> <p>Interview with staff #6 indicated: "[Staff #6] reported it was around 2:00 PM and she was in [staff #3's] room giving [day service client #7] her meds. She reported [staff #3] wheeled [day service client #7] behind the screen in her room. [Staff #6] reported that she heard her name called. She reported she saw [staff #2] standing in the door between the two classrooms. [Staff #2] reportedly said, 'I need help.' [Staff #6] reported that [client A] was on the ground facing away from her. She reported [staff #4] on the other side of [client A], facing him. [Staff #6] reported that she thought [staff #4] was trying to wipe up blood. [Staff #6] reported that she didn't know what happened. [Staff #6] reported that she leaned over [client A] and thought she saw his face move. [Staff #2] reportedly thought [client A] was breathing. [Staff #6] reported [client A] was lying still on the floor and she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>didn't know if he was unconscious. She reported that she thought she saw his jaw move and there were no sounds coming from him. [Staff #6] reported that everyone appeared to be in shock. She reported that [staff #2] said 'call 911'...The EMTs reportedly asked if [client A] had eaten lately. [Staff #2] reportedly said he had crackers...."</p> <p>Interview with the QMRP indicated: "... [QMRP] reported that she came through the kitchen toward the break room and [staff #6] began yelling, '[QMRP], come here. [QMRP] come here.' [QMRP] reported that [client A] was down. [QMRP] said call 911. Someone reportedly told her that 911 was already called. [QMRP] reported that she put gloves on and got down on the floor. [QMRP] reported that she felt a faint pulse and some breath from [client A]. [QMRP] reported that (client A) was bleeding but she couldn't tell where it was coming from. She reported that he had blood on his nose and mouth and had been lying on his side. [QMRP] reported that she said we need to roll him over (client A) on his side. [QMRP] reported that [staff #4] held (client A's) wrist and they rolled him over on his back. [QMRP] reported that (client A's) lips were not blue. She reported that his ears were a purplish blue but that color went</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>away when they rolled him over. [QMRP] reported that she needed a mask. [QMRP] went to [staff #5's] desk to get a mask. [QMRP] reported that when she returned, (client A) had no pulse. She reported that [staff #3] was still on the phone with 911. [Staff #3] reportedly told her that 911 said to do compressions only. [QMRP] reported that she did compressions...[QMRP] reported that [staff #4] stayed beside her and kept checking (client A's) wrist for a pulse. [Staff #4] reportedly said (client A) still had a faint pulse. [QMRP] reported that at some point [staff #4] said, 'He's gone.'...."</p> <p>Interview with RN (Registered Nurse) Nurse Manager [agency] indicated: "[RN] stated that staff [staff #2] should not have left (client A). He should have called for someone to call 911 and get help. She stated that if [staff #4] had observed (client A) to be blue she could have immediately started compressions. [Staff #4] reported asking for a mirror to determine if (client A) was breathing, this is not taught as part of CPR training. If there is no breathing, CPR should be started immediately. If there is blood or secretions these should be wiped away. [RN] stated that staff did not follow CPR procedures as trained. She stated that no where is it taught any individual staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>'does not have authority' to call 911. [RN] responded to the interviewers question about whether the nurse pager was contacted. [RN] stated that it was not."</p> <p>The "brief summary" of the investigation indicated: "...It appears that staff did not follow the [agency] Health Emergency Procedure that states in part: 'any staff member who feels that a client is in a serious health emergency is instructed to call an ambulance immediately.'"</p> <p>Client A's records were reviewed on 12/03/12 at 2:30 PM. Client A's record review included review of the following dated documents:</p> <p>06/15/11: ISP (Individualized Service Plan) indicated client A's diagnoses included Dysphagia - Silent Aspiration and contained a choking risk plan.</p> <p>02/01/12: Dietary Nutrition Review indicated: "Diet 1800 calorie, mech (mechanical) soft w (with)/chopped meat covered with gravy (or sauce) w/nectar thickened liquids, Skim milk. Portion control. Cut foods/meats into small bite sized pieces (1/2 inch size). Break cookies/crackers into 1/2 bite size bites. "Continue current diet plan."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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
	03/15/12: Medication Information Sheets indicated: "Diet: 1800 calorie; Mech soft w/chopped meats covered w/gravy (or sauce) with Nectar Thickened Liquids. Skim milk; portion control. Offer 6-8 oz (ounces) fluids before meals...May have coffee 1/2 caffeine 1/2 decaf (decaffeinated) - ALL fluids are to be Nectar Thick Consistency. "Cut foods/meats into small bite sized pieces (1/2 inch size). Break cookies/crackers into 1/2 inch bites...Choking: [client A] is at risk for choking because he eats his foods at a fast rate and takes large bites of food with minimal chewing...DSPs (Direct Support Personnel) need to sit next to (client A) to prompt and cue him to take small bits (sic) of food and chew all foods well before swallowing. DSPs' need to check his mouth every few bites to make sure that he is successfully chewing and swallowing. If food is still noted in his mouth, DSPs' should encourage him to continue to chew and swallow until all food is gone before picking up spoon to take another bite of food...DSPs' need to make sure that (client A) no longer is to use chin tucks when swallowing...On 5-5-11 Swallow Study Result and Speech Therapist recommended 1800 calorie Mech Soft diet w/Nectar thick consistency for all liquids, and use Dysphagia Regulator Cup...call 911 if (client A) continues to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>struggle to breathe with no improvement. If his face (around mouth or lips) become bluish color. If you believe his immediate health and safety are at stake. Start emergency procedures as trained abdominal thrusts (Heimlich Maneuver) (sic)...."</p> <p>05/22/12: Medication Information Sheets indicated: "Diet: 1800 calorie; Mech soft w/chopped meats covered w/gravy (or sauce) with Nectar Thickened Liquids. Skim milk; portion control. Offer 6-8 oz (ounces) fluids before meals...May have coffee 1/2 caffeine 1/2 decaf (decaffeinated) - ALL fluids are to be Nectar Thick Consistency. *Cut foods/meats into small bite sized pieces (1/2 inch size). Break cookies/crackers into 1/2 inch bites...Choking: [client A] is at risk for choking because he eats his foods at a fast rate and takes large bites of food with minimal chewing...DSPs' (Direct Support Personnel) need to sit next to (client A) to prompt and cue him to take small bits (sic) of food and chew all foods well before swallowing. DSPs' need to check his mouth every few bites to make sure that he is successfully chewing and swallowing. If food is still noted in his mouth, DSPs' should encourage him to continue to chew and swallow until all food is gone before picking up spoon to take another bite of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>food...DSPs' need to make sure that (client A) no longer is to use chin tucks when swallowing...On 5-5-11 Swallow Study Result and Speech Therapist recommended 1800 calorie Mech Soft diet w/Nectar thick consistency for all liquids, and use Dysphagia Regulator Cup...call 911 if (client A) continues to struggle to breathe with no improvement. If his face (around mouth or lips) become bluish color. If you believe his immediate health and safety are at stake. Start emergency procedures as trained abdominal thrusts (Heimlich Maneuver) (sic)...."</p> <p>06/01/12: Ambulance Report: "Patient: (Client A). Nature of call: Unconscious, found on floor; Airway/Breathing: Absent; Carotid Pulse: Absent; Lung Sounds: Absent; Pupils: Non-reactive; Primary Impression: Cardiac Respiratory Arrest: Narrative: Upon arrival male on floor with bystander CPR in progress. Had eaten a cracker snack and went unresponsive. CPR was initiated and 911 called...Life-pack 12 application with pads. The rhythm was Asystole (flatline/no cardiac electrical activity)...care rendered to [hospital] ER staff."</p> <p>06/01/12: Hospital ER (Emergency Room) Cardiac Resuscitation/Adult form</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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: "Chief Complaint: This is a [age] year old male who present as/in a state of cardiac arrest at [day service name] was eating peanut butter cracker when he was seen to collapse.</p> <p>Prehospital Findings: Airway obstructed; Circulation/Rhythm: Spontaneous pulses absent-Asystole; Neurological: Unresponsive. ED (Emergency Department): RT (Respiratory Therapist) intubated patient removing peanut butter cracker from oral airway and some from trachea No response to resuscitative efforts."</p> <p>06/04/12: Certificate of Death indicated the following regarding client A's death: Date of Death: 06/01/12. Time of Death: 03:10 PM. Cause of Death and Approximate Interval (to) Onset of Death: A. Acute Cardio-Respiratory Arrest - 10 minutes B. Asphyxiation - 15 minutes C. Aspiration of Food - 15 minutes D. Severe Mental/Developmental Handicap - 60 years.</p> <p>The agency "Human Rights Policy," dated 10/2008 was reviewed on 12/03/12 at 12:45 PM. The policy indicated, "All consumers served...shall have the following rights: ...To be safeguarded by staff...More specifically, the following is</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>prohibited: ...Neglect: Any action or behavioral interventions that risks the physical or emotional safety and well being of an individual, and results in potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party...."</p> <p>On 12/04/12 at 10:25 AM, an interview was conducted with the QMRP. The QMRP indicated the investigation indicated staff #1 and #2 neglected to follow client A's choking risk plan as neither staff reported to sit with client A during his snack or break the crackers into bite size pieces as ordered and they did not alter the texture of the crackers prior to client A's consumption. The QMRP indicated staff #2 should not have left client A unattended when he went to get help and she further indicated emergency medical intervention did not start immediately. She indicated client A was taken to the hospital by the ambulance. She indicated the death certificate cause of death included Asphyxiation and Aspiration of Food, which was the snack he had eaten prior to his collapse.</p> <p>This federal tag relates to complaint #IN00119436.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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			
W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the the facility failed to provide timely nursing services and health care, by failing to initiate CPR timely, for 1 of 1 client death (client A), who needed emergency medical interventions. The facility also failed for 1 of 2 sample clients (client A) with identified choking risks to ensure he was safe from choking.</p> <p>Findings include:</p> <p>Please refer to W331. The facility failed to provide timely nursing services, failed to initiate CPR timely, for 1 of 1 client death (client A), who needed emergency medical interventions. The facility also failed for 1 of 2 sample clients (client A) with identified choking risks to ensure he was safe from choking.</p> <p>This federal tag relates to complaint #IN00119436.</p> <p>9-3-6(a)</p>	W0318	<p>W 318 HEALTH CARE SERVICES</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that specific health care service requirements are met.</p> <p>Responsible Person:</p> <p>Elliott House Coordinator</p> <p>Date of Completion:</p> <p>January 4, 2013</p> <p>Plan of Prevention:</p>	01/04/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>Stone Belt, Inc. has a Health Emergency Procedure (Attachment # 2) that was retrained on with all staff at each group home and day programming. (Attachments 2 – 2A)</p> <p>Quality Assurance Monitoring:</p> <p>Health Emergency Procedures are reviewed on a annual basis with all staff and during orientation training for new employees.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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	
W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed to provide timely nursing services and health care, by failing to initiate CPR timely, for 1 of 1 client death (client A), who needed emergency medical interventions. The facility also failed for 1 of 2 sample clients (client A) with identified choking risks to ensure he was safe from choking.</p> <p>Findings include:</p> <p>On 12/03/12 at 12:05 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>06/01/12: A BDDS report submitted 06/01/12 for an incident on 06/01/12 at 2:00 PM indicated the following regarding client A: "[Client A] was in the Man Cave walking around and come (sic) up to staff. Staff noticed he stumbled and staff asked him if he was ok. [Client A] said yes, then fell into (sic) staff. Staff caught him and he went down to the floor. Staff went into retirement room, which is adjoined, and asked about calling 911 and stated she didn't have the authority to call.</p>	W0331	<p>W 331 NURSING SERVICES</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will provide nursing services in accordance with the clients needs to ensure proper health and safety.</p> <p>Responsible Person:</p> <p>Elliott Coordinator and Nursing Manager</p> <p>Date of Completion:</p> <p>January 4, 2013</p> <p>Plan of Prevention:</p>	01/04/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>Staff tried to find someone to call 911. Staff #2 called 911. Told to do compressions, but not breathing. 911 First responders and paramedics showed and took over CPR (Cardio-pulmonary Resuscitation)...Death investigation to be conducted."</p> <p>06/01/12: Agency Investigation Review indicated the following regarding client A: Diagnoses included but were not limited to: MR (Mental Retardation), Seizures, Obstructive Sleep Apnea, GERD (Gastroesophageal reflux disease), Dementia/Alzheimer's and Dysphagia (difficult swallowing) - Silent Aspiration. Interview with staff #1 indicated: "[Staff #1] reported that he was outside with two clients, smoking at the time that [client A] collapsed. [Staff #1] reported that when he came back in (inside the building) the EMTs (Emergency Medical Technicians) were there...[staff #1] reported that he got [client A's] snack out for him, before he left the room, he then told [staff #2] that he was taking [day service clients #1 and #2] out to smoke. [Staff #1] reported that [staff #2] acknowledged by saying, 'OK.' [Staff #1] reported that [client A] had peanut butter crackers for his 2:00 pm snack. [Staff #1] reported that [client A] will eat one cracker at a time. He (staff #1) reported that [client A] will take two</p>		<p>Stone Belt, Inc. has a Health Emergency Procedure (Attachment # 2) that was retrained on with all staff at each group home and day programming. (Attachments 2 – 2A)</p> <p>Additionally, staff in all areas of Stone Belt are trained on individual risk plans as changes are made. (Attachment # 3 and # 3A are examples.)</p> <p>Quality Assurance Monitoring:</p> <p>Nursing Manager and Support Team will monitor risk plans on a annual basis and will ensure training of plans. Health Emergency Procedures are trained annually as well as new hire orientation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>separate bites of the cracker independently. [Staff #1] reported that [client A] did not have a drink for his 2:00 PM snack. [Staff #1] stated that [client A] usually does not have a drink for his 2:00 PM snack...He reported that peanut butter crackers are not out of the ordinary."</p> <p>Interview with staff #2 indicated: "[Staff #2] reported that he was sitting at the desk in the Man Cave. He reported that [staff #1] had taken [day service clients #1 and #2] out to smoke. He (staff #2) reported that the smoke breaks are part of their plans, that there is a ten minute limit and they take a timer with them. [Staff #2] reported that [day service client #3] was sitting next to him, [day service client #4] was walking around in the room and [day service client #5] and [day service client #6] were also present. [Staff #2] reported that the group was on break, they had snack and were sitting around at the time of the incident...[staff #2] reported that [client A] had finished his snack...[Staff #2] reported that he did not give [client A] his snack. He reported that [client A] had cheese crackers. [Staff #2] reported he assumed [staff #1] gave [client A] his snack...When asked if staff do anything special when [client A] eats crackers, [staff #2] reported that he had never seen that in the plan...[staff #2] reported that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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
	[client A] was walking around and stumbled. He reported that it was normal for [client A] to stumble. [Staff #2] reported that [client A] was walking toward him and stumbled again. [Staff #2] asked, '[client A], you okay?' [Client A] reportedly responded, 'Yeah!' [Staff #2] reportedly asked [client A], 'You got your Coke money?' [Client A] responded, 'Yeah, I got my Coke money.' [Staff #2] reported that he had stood up and [client A] stumbled into him. [Staff #2] asked him again, 'You okay?' [Staff #2] reported that [client A] faintly stated, 'Yeah,' as he fell into him. [Staff #2] reported that he lowered [client A] to the ground...[Staff #2] reported that the door to [staff #3's] room was open. He reported that he jumped up and said, 'I need help now.' He (staff #2) reported that [staff #4] was in the room but he thought [staff #3] may have been helping someone in the bathroom. [Staff #2] reported (to staff #4) that [client A] was on the ground. He reportedly asked [staff #4], 'Do we need to call 911?' [Staff #4] reportedly answered, 'I don't have the authority to call 911.' [Staff #2] reported that [staff #4] stayed with [client A] and he went to find someone who could call 911. [Staff #2] reported that [staff #4] had worked at [day service agency] for longer and he assumed that if she did not have the authority to call 911 than (sic) neither did			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>he. [Staff #2] reported that he went to [staff #5's] desk to ask where the nurse's office was. [Staff #2] reported that he went to the nurses' office, knocked and no one answered. [Staff #2] reported that he was on his way back to the Man Cave when he saw [staff #6] by the lockers. [Staff #2] reported they went back to the Man Cave and [staff #3] was on the phone with 911. He reported that [staff #4] was standing above [client A]. [Staff #2] reported that he wanted to start CPR. He reported that he felt [client A] had a faint pulse. He reported that he held his hand in front of [client A's] mouth and felt breath. [Staff #2] reported that [client A] had not vomited but he was bleeding a little from his mouth. [Staff #2] reported that [QMRP (Qualified Mental Retardation Professional) came in and did chest compressions...."</p> <p>Interview with staff #3 indicated: [Staff #3] indicated she was in her class room, behind the screen for med pass with a client. She reported that [staff #6] came in with the meds. [Staff #3] reported that [staff #4] must have been called over to the other room and then called for her and [staff #6]. [Staff #3] reported that [client A] was lying on his left side. She reported that she got close to him and was trying to talk to him. [Staff #3] reported that [client A] was unresponsive. [Staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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
	#3] reported that [staff #6] tried to call 911 from her cell phone. [Staff #3] reported that she called 911 from a land line (phone in the Man Cave). She (staff #3) reported telling the operator an ambulance was needed. [Staff #3] reported that she was transferred to another operator and had to tell her the same information. [Staff #3] reported that she stayed on the line. She reported that [staff #2] and [staff #6] said they thought [client A] was breathing. [Staff #3] reported that the operator instructed that just compressions should be given, no breaths...[Staff #3] reported that [client A] had blood on either his nose, mouth, or both. She (staff #3) thought that maybe he had hit the floor but found out later that [client A] did not fall. [Staff #3] reported there was no vomit or food. [Staff #3] reported that [client A] had soiled himself. She reported that he looked pale...When asked, [staff #3] reported that she was probably already on the phone with 911 when staff were looking for a mask. [Staff #3] reported by the time staff had a mask, 911 said to just do compressions. [Staff #3] reported the following suggestions: masks should be in all areas at [day service agency], the [day service agency] address should be posted by each phone, CPR refresher training would be helpful, staffing should be addressed when clients or staff takes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>smoke breaks and staff need to understand that they can call 911."</p> <p>Interview with staff #4 indicated: "... [Staff #4] reported that she was called over at 1:59 PM by [staff #2]. She reported she went in the room and saw [client A] face down with blood on his face and not moving. [Staff #4] reported that she told [staff #2] to get the nurse. [Staff #4] reported that she told [staff #3] and [staff #6], 'Come here quick.' [Staff #4] reported that [staff #6] and [staff #3] called 911. [Staff #4] reported that she thought [client A] was gone by the time he was on the floor. She reported that she felt no pulse. [Staff #4] reported that she told [staff #6] she was afraid to turn him over. [Staff #4] stated that she did not want to do the wrong thing because of the blood and secretions on [client A's] face. [Staff #4] reported that [staff #2] said he felt a faint pulse but [client A] never moved. [Staff #4] reported that she held a mirror to [client A's] face to see if he was breathing. [Staff #4] reported that she thought [staff #3] gave her the mirror. [Staff #4] reported someone started looking for a mask. She reported that she thought [staff #6] started compressions and then [QMRP] took over. [Staff #4] reported that she never said, 'I don't have the authority to call 911.' [Staff #4] reported that she was afraid to start doing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>anything to [client A]. She reported she was afraid he would choke on his own blood...[Staff #4] reported that [client A's] face and ears were blue. She reported that his lips were chalky/white and his fingers were blue. [Staff #4] reported that she checked [client A's] neck and there was no pulse...."</p> <p>Interview with staff #5 indicated: "[Staff #5] stated that around 2:00 o'clock on 6-1-12 [staff #2] came into the front desk area and asked her where he could find the nurse. [Staff #5] stated that the nurse was not in the building. [Staff #2] left to go back to his room. [Staff #5] stated that [staff #2] did not tell her that there was a health emergency or that [client A] was down and unresponsive. He did not ask her to call 911. [Staff #5] stated that she did not know that there was a health crisis going on. She stated that if she would have been told she could have notified [QMRP] immediately. [Staff #5] stated that [staff #6] came into her area and [staff #6] asked her where [QMRP] was. [Staff #5] said that [QMRP] had gone to the back office...[staff #6] did not tell [staff #5] that [client A] was down...[Staff #5] stated that she was concerned that no one had told her what was going on, as she might have been able to assist by calling 911 and summoning help. I asked [staff #5] if there was a procedure for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>medical emergencies at [day service program]. [Staff #5] stated that there had been a procedure for emergencies several years ago, however there was no planned procedure on how to handle a health emergency other than CPR training. She stated that she thought as she is a gatekeeper at the front desk, that she should be kept informed so that she can assist...she was concerned that when staff are outside smoking that this leaves the programs short staffed...."</p> <p>Interview with staff #6 indicated: "[Staff #6] reported it was around 2:00 PM and she was in [staff #3's] room giving [day service client #7] her meds. She reported [staff #3] wheeled [day service client #7] behind the screen in her room. [Staff #6] reported that she heard her name called. She reported she saw [staff #2] standing in the door between the two classrooms. [Staff #2] reportedly said, 'I need help.' [Staff #6] reported that [client A] was on the ground facing away from her. She reported [staff #4] on the other side of [client A], facing him. [Staff #6] reported that she thought [staff #4] was trying to wipe up blood. [Staff #6] reported that she didn't know what happened. [Staff #6] reported that she leaned over [client A] and thought she saw his face move. [Staff #2] reportedly thought [client A] was breathing. [Staff #6] reported [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>A] was lying still on the floor and she didn't know if he was unconscious. She reported that she thought she saw his jaw move and there were no sounds coming from him. [Staff #6] reported that everyone appeared to be in shock. She reported that [staff #2] said 'call 911'...The EMTs reportedly asked if [client A] had eaten lately. [Staff #2] reportedly said he had crackers...."</p> <p>Interview with the QMRP indicated: "... [QMRP] reported that she came through the kitchen toward the break room and [staff #6] began yelling, '[QMRP], come here. [QMRP] come here.' [QMRP] reported that he (client A) was down. [QMRP] said call 911. Someone reportedly told her that 911 was already called. [QMRP] reported that she put gloves on and got down on the floor. [QMRP] reported that she felt a faint pulse and some breath from [client A]. [QMRP] reported that (client A) was bleeding but she couldn't tell where it was coming from. She reported that he had blood on his nose and mouth and had been lying on his side. [QMRP] reported that she said we need to roll him over (client A) on his side. [QMRP] reported that [staff #4] held (client A's) wrist and they rolled him over on his back. [QMRP] reported that (client A's) lips were not blue. She reported that his ears</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>were a purplish blue but that color went away when they rolled him over. [QMRP] reported that she needed a mask. [QMRP] went to [staff #5's] desk to get a mask. [QMRP] reported that when she returned, (client A) had no pulse. She reported that [staff #3] was still on the phone with 911. [Staff #3] reportedly told her that 911 said to do compressions only. [QMRP] reported that she did compressions...[QMRP] reported that [staff #4] stayed beside her and kept checking (client A's) wrist for a pulse. [Staff #4] reportedly said (client A) still had a faint pulse. [QMRP] reported that at some point [staff #4] said, 'He's gone.'...."</p> <p>Interview with RN (Registered Nurse) Nurse Manager [agency] indicated: "[RN] stated that staff [staff #2] should not have left (client A). He should have called for someone to call 911 and get help. She stated that if [staff #4] had observed (client A) to be blue she could have immediately started compressions. [Staff #4] reported asking for a mirror to determine if (client A) was breathing, this is not taught as part of CPR training. If there is no breathing, CPR should be started immediately. If there is blood or secretions these should be wiped away. [RN] stated that staff did not follow CPR procedures as trained. She stated that no</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>where is it taught any individual staff 'does not have authority' to call 911. [RN] responded to the interviewers question about whether the nurse pager was contacted. [RN] stated that it was not."</p> <p>The "brief summary" of the investigation indicated: "...It appears that staff did not follow the [agency] Health Emergency Procedure that states in part: 'any staff member who feels that a client is in a serious health emergency is instructed to call an ambulance immediately.'"</p> <p>Client A's records were reviewed on 12/03/12 at 2:30 PM. Client A's record review included review of the following dated documents: 06/15/11: ISP (Individualized Service Plan) indicated client A's diagnoses included Dysphagia - Silent Aspiration and contained a choking risk plan. 02/01/12: Dietary Nutrition Review indicated: "Diet 1800 calorie, mech (mechanical) soft w (with)/chopped meat covered with gravy (or sauce) w/nectar thickened liquids, Skim milk. Portion control. Cut foods/meats into small bite sized pieces (1/2 inch size). Break cookies/crackers into 1/2 bite size bites. "Continue current diet plan." 03/15/12: Medication Information Sheets indicated: "Diet: 1800 calorie; Mech soft</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>w/chopped meats covered w/gravy (or sauce) with Nectar Thickened Liquids. Skim milk; portion control. Offer 6-8 oz (ounces) fluids before meals...May have coffee 1/2 caffeine 1/2 decaf (decaffeinated) - ALL fluids are to be Nectar Thick Consistency. "Cut foods/meats into small bite sized pieces (1/2 inch size). Break cookies/crackers into 1/2 inch bites...Choking: [client A] is at risk for choking because he eats his foods at a fast rate and takes large bites of food with minimal chewing...DSPs (Direct Support Personnel) need to sit next to (client A) to prompt and cue him to take small bits (sic) of food and chew all foods well before swallowing. DSPs' need to check his mouth every few bites to make sure that he is successfully chewing and swallowing. If food is still noted in his mouth, DSPs' should encourage him to continue to chew and swallow until all food is gone before picking up spoon to take another bite of food...DSPs' need to make sure that (client A) no longer is to use chin tucks when swallowing...On 5-5-11 Swallow Study Result and Speech Therapist recommended 1800 calorie Mech Soft diet w/Nectar thick consistency for all liquids, and use Dysphagia Regulator Cup...call 911 if (client A) continues to struggle to breathe with no improvement. If his face (around mouth or lips) become</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>bluish color. If you believe his immediate health and safety are at stake. Start emergency procedures as trained abdominal thrusts (Heimlich Maneuver) (sic)...."</p> <p>05/22/12: Medication Information Sheets indicated: "Diet: 1800 calorie; Mech soft w/chopped meats covered w/gravy (or sauce) with Nectar Thickened Liquids. Skim milk; portion control. Offer 6-8 oz (ounces) fluids before meals...May have coffee 1/2 caffeine 1/2 decaf (decaffeinated) - ALL fluids are to be Nectar Thick Consistency. *Cut foods/meats into small bite sized pieces (1/2 inch size). Break cookies/crackers into 1/2 inch bites...Choking: [client A] is at risk for choking because he eats his foods at a fast rate and takes large bites of food with minimal chewing...DSPs' (Direct Support Personnel) need to sit next to (client A) to prompt and cue him to take small bits (sic) of food and chew all foods well before swallowing. DSPs' need to check his mouth every few bites to make sure that he is successfully chewing and swallowing. If food is still noted in his mouth, DSPs' should encourage him to continue to chew and swallow until all food is gone before picking up spoon to take another bite of food...DSPs' need to make sure that (client A) no longer is to use chin tucks</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>when swallowing...On 5-5-11 Swallow Study Result and Speech Therapist recommended 1800 calorie Mech Soft diet w/Nectar thick consistency for all liquids, and use Dysphagia Regulator Cup...call 911 if (client A) continues to struggle to breathe with no improvement. If his face (around mouth or lips) become bluish color. If you believe his immediate health and safety are at stake. Start emergency procedures as trained abdominal thrusts (Heimlich Maneuver) (sic)...."</p> <p>06/01/12: Ambulance Report: "Patient: (Client A). Nature of call: Unconscious, found on floor; Airway/Breathing: Absent; Carotid Pulse: Absent; Lung Sounds: Absent; Pupils: Non-reactive; Primary Impression: Cardiac Respiratory Arrest: Narrative: Upon arrival male on floor with bystander CPR in progress. Had eaten a cracker snack and went unresponsive. CPR was initiated and 911 called...Life-pack 12 application with pads. The rhythm was Asystole (flatline/no cardiac electrical activity)...care rendered to [hospital] ER staff."</p> <p>06/01/12: Hospital ER (Emergency Room) Cardiac Resuscitation/Adult form indicated: "Chief Complaint: This is a [age] year old male who present as/in a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>state of cardiac arrest at [day service name] was eating peanut butter cracker when he was seen to collapse.</p> <p>Prehospital Findings: Airway obstructed; Circulation/Rhythm: Spontaneous pulses absent-Asystole; Neurological: Unresponsive. ED (Emergency Department): RT (Respiratory Therapist) intubated patient removing peanut butter cracker from oral airway and some from trachea No response to resuscitative efforts."</p> <p>06/04/12: Certificate of Death indicated the following regarding client A's death: Date of Death: 06/01/12. Time of Death: 03:10 PM. Cause of Death and Approximate Interval (to) Onset of Death: A. Acute Cardio-Respiratory Arrest - 10 minutes B. Asphyxiation - 15 minutes C. Aspiration of Food - 15 minutes D. Severe Mental/Developmental Handicap - 60 years.</p> <p>On 12/04/12 at 10:25 AM, an interview was conducted with the QMRP. The QMRP indicated the investigation indicated staff #1 and #2 neglected to follow client A's choking risk plan as neither staff reported to sit with client A during his snack or break the crackers into bite size pieces as order and there was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>nothing altered about the crackers prior to client A's consumption. The QMRP indicated staff #2 should not have left client A unattended when he went to get help and she further indicated emergency medical intervention did not start immediately. She indicated client A was taken to the hospital by the ambulance. She indicated the death certificate cause of death included Asphyxiation and Aspiration of Food, which was the snack he had eaten prior to his collapse.</p> <p>This federal tag relates to complaint #IN00119436.</p> <p>9-3-6(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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			
W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 3 sample clients (clients B and C) who were on a modified diet to follow diet orders.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/03/12 from 4:30 PM until 5:45 PM. At 5:40 PM clients B and C were seated at the table with their meal in front of them. Client B and C's meal looked the same and the food had been altered in texture. One of the food items was tan in color and contained dark specks. Staff #7 was interviewed at 5:43 PM and asked what the food item was and what the specks were. Staff #7 indicated the food was a pureed baked potato and the dark specks were either the potato skins or bacon bits. Staff #7 indicated clients B and C were to have pureed food.</p> <p>Client B's records were reviewed on 12/04/12 at 9:30 AM. Client B's record review included review of the following dated documents: 09/21/12: ISP (Individual Support Plan) indicated client B was: "at high risk of</p>	W0460	<p>W 460</p> <p>FOOD AND NUTRITION SERVICES</p> <p>Plan of Correction:</p> <p>Each Stone Belt client will receive a nourishing, well balanced diet including modified and specially-prescribed diets.</p> <p>Responsible Person:</p> <p>Elliott Coordinator</p> <p>Date of Completion:</p>	01/04/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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>choking due to delayed swallowing...also tends to eat his foods at a fast rate making him more at risk of choking." 11/21/12: Monthly Medication Information Sheet indicated client B was on a Pureed diet.</p> <p>Client C's records were reviewed on 12/04/12 at 9:45 AM. Client C's record review included review of the following dated documents: 11/08/12: ISP (Individual Support Plan) indicated client C's diagnoses included, but were not limited to: Gastroparesis, delayed gastric emptying, a disorder in which the stomach takes too long to empty its contents." 11/21/12: Monthly Medication Information Sheet indicated client C was on a Pureed diet (for the Gastroparesis).</p> <p>On 12/04/12 at 10:00 PM, an interview was conducted with the Licensed Practical Nurse (LPN). The LPN indicated clients B and C's meals should have been pureed and there should not have been any dark specks in the food. She stated pureed was a "smooth, pudding like/baby food like" consistency.</p> <p>This federal tag relates to complaint #IN00119436.</p> <p>9-3-8(a)</p>		<p>January 4, 2013</p> <p>Plan of Prevention:</p> <p>Training was conducted on the preparation of modified and specially-prescribed diets. This training occurred on 12/14/2012. (Attachment # 4 an # 4A)</p> <p>Quality Assurance Monitoring:</p> <p>During announced and unannounced visits by the Coordinator and other administrative staff, preparation of meals will be observed to ensure meals are prepared properly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1118 22ND 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