

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| W0000              | <p>This visit was for a post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on July 14, 2011.</p> <p>Survey Dates: October 25, 26 and 27, 2011.</p> <p>Facility Number: 001221<br/>Provider Number: 15G643<br/>AIM Number: 100240220</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/2/11 by Ruth Shackelford, Medical Surveyor III.</p> | W0000         |   |                      |
| W0149              | <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 1 incident report affecting client #6, the facility neglected to implement its policies and procedures to prevent neglect in regard to a choking incident.</p> <p>Findings include:</p>  | W0149         | <p><b>W149Plan of Correction:</b> The coordinator will investigate all possible cases of abuse and neglect<br/><b>Date of Completion:</b> 11/7/11<br/><b>Person Responsible:</b> Ryan Perry<br/><b>Plan of Prevention:</b> Training was completed by the director on the prevention of abuse and neglect.<br/><b>Quality Assurance Monitoring:</b>The</p> | 11/07/2011           |

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:<br><br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404                                 |                      |   |
| (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 review of the facility's incident reports was conducted on 10/25/11 at 2:39 PM. On 7/23/11 at 1:15 PM, client #6 was eating a sub sandwich and pretzels for lunch. The report indicated, "Prior to the incident [client #6] is sitting at dining room table enjoying his 1/2 - 1 inch cut up sub sandwich and pretzels for lunch. Three staff sitting at the table eating lunch (sic) a staff prompted [client #6] to drink fluids between his bites, noticed food dripping down [client #6's] mouth, staff prompted him to use a napkin. Staff then noticed more food coming out of [client #6's] mouth. Then staff could hear noisy breathing coming from [client #6]. Afterwhile (sic) staff asked [client #6] 'are you choking?' Staff noted client #6 was unable to speak. [Client #6's] airway was totally obstructed (sic) staff then started to finger swipe [client #6's] mouth to clear all the food which he could then breathe." The Bureau of Developmental Disabilities Services (BDDS) report, dated 7/24/11, indicated the following, "He will be taken to [walk-in clinic] to rule (out) any aspirations... [Client #6] has a history of choking and the team will review incident to make appropriate changes to dining plan." The BDDS follow-up report, dated 7/29/11, indicated the most recent choking episode was on 11/3/10. The incident packet did not include an investigation into the incident. There</p> |   | <b>director will review all incidents of abuse and neglect</b>  |                      |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404                                 |                      |   |
| (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 no witness statements from the three staff present during the incident or the client.</p> <p>A review of client #6's record was conducted on 10/25/11 at 4:38 PM. His Behavior Intervention Plan, dated 7/5/11, indicated he had a targeted behavior of mealtime delay and risk of choking. The plan indicated, "Operational Definition: At times, [client #6] has been observed to overfill his mouth when consuming food. This increases his risk for choking. Behavior Assessment: Due to a choking episode at [client #6's] day program, [client #6's] team is recommending that he be visually supervised whenever he is eating. While [client #6] does not require verbal prompting to ensure that he eats appropriately, [client #6] does need to be monitored for overfilling his mouth to prevent choking."</p> <p>A review of the facility's Investigation Protocol, dated 8/2010, was conducted on 10/26/11 at 7:51 PM. The protocol indicated the following, "Stone Belt will provide the highest quality direct service to our consumers and to the community, and will provide on going training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and</p> |   |   |                      |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404                                 |                      |   |
| (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>encouraging open and on-going dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of consumers, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law." The policy indicated, "Situations involving suspected or alleged abuse, neglect or exploitation of consumers or any rights issue as described in agency policies will be investigated by staff designated and trained by the agency for this role. Contact the Manger of Social Work Services for assessment of consumer rights questions."</p> <p>An interview with Administrative Staff (AS) #3 was conducted on 10/25/11 at 3:58 PM. AS #3 indicated an investigation was not conducted. AS #3 indicated the incident was not treated as neglect since the staff present indicated they were following his dining plan. AS #3 indicated he spoke to the staff who were present but did not document their statements.</p> <p>9-3-2(a)</p> |   |   |                      |   |

|  |   |   |   |                      |   |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404   |                      |   |
| (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 |   |
| W0154  | <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 1 incident report affecting client #6, the facility failed to investigate a choking incident.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 10/25/11 at 2:39 PM. On 7/23/11 at 1:15 PM, client #6 was eating a sub sandwich and pretzels for lunch. The report indicated, "Prior to the incident [client #6] is sitting at dining room table enjoying his 1/2 - 1 inch cut up sub sandwich and pretzels for lunch. Three staff sitting at the table eating lunch (sic) a staff prompted [client #6] to drink fluids between his bites, noticed food dripping down [client #6's] mouth, staff prompted him to use a napkin. Staff then noticed more food coming out of [client #6's] mouth. Then staff could hear noisy breathing coming from [client #6]. Afterwhile (sic) staff asked [client #6] 'are you choking?' Staff noted client #6 was unable to speak. [Client #6's] airway was totally obstructed (sic) staff then started to finger swipe [client #6's] mouth to clear all the food which he could then breathe." The Bureau of Developmental Disabilities Services (BDDS) report, dated 7/24/11, indicated the following, "He will be taken</p> | W0154   | <p><b>W154</b></p> <p><b>Plan of Correction: The coordinator will investigate all choking incidents to ensure the is no neglect</b></p> <p><b>Date of Completion: 11/7/11</b></p> <p><b>Person Responsible: Bridgewaters coordinator</b></p> <p><b>Plan of Prevention: The director completed training with coordinator on insetigation procedures.</b></p> <p><b>Quality Assurance Monitoring: The director will ensure all choking incidents are investigating.</b></p> | 11/07/2011           |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>10/27/2011 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br>STONE BELT ARC INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>to [walk-in clinic] to rule (out) any aspirations... [Client #6] has a history of choking and the team will review incident to make appropriate changes to dining plan." The BDDS follow-up report, dated 7/29/11, indicated the most recent choking episode was on 11/3/10. The incident packet did not include an investigation into the incident. There were no witness statements from the three staff present during the incident or the client.</p> <p>A review of client #6's record was conducted on 10/25/11 at 4:38 PM. His Behavior Intervention Plan, dated 7/5/11, indicated he had a targeted behavior of mealtime delay and risk of choking. The plan indicated, "Operational Definition: At times, [client #6] has been observed to overfill his mouth when consuming food. This increases his risk for choking. Behavior Assessment: Due to a choking episode at [client #6's] day program, [client #6's] team is recommending that he be visually supervised whenever he is eating. While [client #6] does not require verbal prompting to ensure that he eats appropriately, [client #6] does need to be monitored for overfilling his mouth to prevent choking."</p> <p>An interview with Administrative Staff (AS) #3 was conducted on 10/25/11 at</p> |               |   |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |
|--|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404  |                      |   |
| (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 |   |
| W0240  | <p>3:58 PM. AS #3 indicated an investigation was not conducted. AS #3 indicated the incident was not treated as neglect since the staff present indicated they were following his dining plan. AS #3 indicated he spoke to the staff who were present but did not document their statements.</p> <p>9-3-2(a)</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence. Based on interview and record review for 1 of 3 clients in the sample (#6), the facility failed to ensure his Behavior Intervention Plan (BIP), dated 7/5/11, included specific instructions to staff on how to address his meal delay behavior at the group home.</p> <p>Findings include:</p> <p>A review of client #6's BIP was conducted on 10/25/11 at 4:06 PM. His BIP indicated he had a targeted behavior of mealtime delay and risk of choking. The plan did not indicate specific instructions to staff for use at the group home. The plan addressed the day program but not the group home. There was no specific time to allow client #6 to complete a meal</p> | W0240   | <p><b>W240Plan of Correction: The behavior specialist will ensure all updated BSP's are in Fortis</b><br/> <b>Date of Completion: 11/3/11</b><br/> <b>Person Responsible: The behavior specialist</b><br/> <b>Plan of Prevention: The beahvior specialist was trained on Fortis record keeping Quality Assurance Monitoring: House Managers are conducted a monthly audit on consumers documents</b></p> | 11/03/2011           |   |

|  |  |   |  |                      |   |
|--|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404  |                      |   |
| (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>at the group home or whether or not a timer was to be used. The plan did not indicate the intervals staff were to remind client #6 of when the meal would be finished. The 7/5/11 plan was the current BIP according to client #6's record.</p> <p>An interview with the Administrative staff (AS) #3 was conducted on 10/25/11 at 4:06 PM. AS #3 indicated client #6's BIP was updated since the 7/5/11. AS #3 indicated he was unsure why the plan was not part of client #6's record.</p> <p>This deficiency was cited on 7/14/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's nursing services failed to ensure: 1) nursing quarterly documentation for clients #1, #2, #3, #4, #5 and #6 was in the record to review and 2) documentation of client #6's stasis ulcer treatment were received and reviewed.</p> <p>Findings include:</p> | W0331   | <p><b>W331</b></p> <p><b>Plan of Correction: All attachment given to staff from medical facility will be turned into Fortis. The bridgewater nurse will ensure all quarterly's are completed on time</b></p> <p><b>Date of Completion: 11/7/11</b></p> <p><b>Person Responsible: The nursing manager</b></p> | 11/07/2011           |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404   |                      |   |
| (X4) ID PREFIX TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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. A review of client #1, #2, #3, #4, #5 and #6's records was conducted on 10/25/11 at 4:06 PM. The records did not contain documentation of the nursing quarterlies since 6/14/11.</p> <p>An interview was attempted with the nurse on 10/25/11 at 4:12 PM and 10/26/11 at 5:10 PM. The nurse was not able to be interviewed.</p> <p>An interview with Administrative Staff (AS) #3 was conducted on 10/25/11 at 4:09 PM. AS #3 indicated he spoke to the nurse on 10/25/11. AS #3 indicated the nurse got the months incorrect for the nursing quarterlies. The nurse indicated she completed the quarterlies in October 2011 however they were not in the clients' records. The nurse indicated the quarterlies would be placed into the record on 10/28/11.</p> <p>2. A review of client #6's record was conducted on 10/25/11 at 4:38 PM. The Outside Services Report form, dated 6/2/11, indicated the reason for visit was "sore on feet." The diagnosis was cellulitis. The treatment/tests ordered section indicated the following, "See my order form." There was no order form in client #6's record to review. On 6/16/11, an Outside Services Report form, dated</p> |   | <p><b>Plan of Prevention: Staff were trained to ensure all attachment were sent in to Fortis with each OSR. The nurses were trained on getting the quarterly's done on time.</b></p> <p><b>Quality Assurance Monitoring: The house manager is conducted a monthly audit to ensure all quarterly's are done on time.</b></p> |                      |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G643 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                    |  | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |  |
|--|--|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404 |  |   |  |
| (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>6/16/11, indicated he was seen at [name of medical center]. The diagnosis was "Stasis ulcer." The treatment/tests ordered section indicated, "See wound care orders." There were no wound care orders in client #6's record to review. On 6/23/11, an Outside Services Report form for [name of medical center] indicated the following, "Ulcer LE (lower extremity) (R - right), open wound R foot complicated." The treatment/tests ordered section indicated, "See order sheet." There was no order sheet in client #6's record to review. The form indicated a follow-up appointment was scheduled on 7/7/11. There was no documentation in the record indicating the follow-up appointment was held on 7/7/11 or on another date.</p> <p>An interview was attempted with the nurse on 10/25/11 at 4:12 PM and 10/26/11 at 5:10 PM. The nurse was not able to be interviewed.</p> <p>An interview with Administrative Staff (AS) #3 was conducted on 10/25/11 at 4:38 PM. AS #3 indicated he was unsure why the documentation was not in client #6's record. AS #3 indicated the information should have been put into client #6's record.</p> <p>This deficiency was cited on 7/14/11. The facility failed to implement a systemic</p> |   |   |   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G643 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>10/27/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>STONE BELT ARC INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1006 W 11TH ST<br>BLOOMINGTON, IN47404                                 |                      |   |
| (X4) ID PREFIX TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |   |
|  | plan of correction to prevent recurrence.<br><br>9-3-6(a)  |   |   |                      |   |