

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G643	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404
--	--

(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
--------------------	--	---------------	---	----------------------

K 0000  Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 02/26/16</p> <p>Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220</p> <p>At this Life Safety Code survey, Stone Belt Arc Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, sleeping rooms and in all living areas. The facility has a capacity of 6 and had a census of 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,</p>	K 0000		
------------------------	---	--------	--	--

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:  15G643	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404
--	--

(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
K 0130  Bldg. 01	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 2.5.</p> <p>Quality Review completed on 03/03/16 - DA</p> <p>Based on record review, observation and interview; the facility failed to ensure 2 of 2 portable fire extinguishers located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition, NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p>	K 0130	<p>K130 The facility must ensure that specific life safety requirements are met. <b>Corrective action for resident(s) found to have been affected</b>A training of all life safety issues will be conducted ensure that the agency's life safety procedures are followed. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b>All residents potentially are affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b>QIDP training will be conducted to ensure life safety requirements are being met</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b> The QIDP is responsible for</p>	03/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G643	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404
--	--

(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
	Based on review of "Drill Safety Report (Monthly) Fire Extinguishers/Water Temperature Tracking/Smoke Detector & Emergency Light/Fire Alarm Panel (SGL Only)" documentation with the Home Manager during record review from 11:15 a.m. to 12:10 p.m. on 02/26/16, monthly portable fire extinguisher inspection documentation for the most recent twelve month period for each facility fire extinguisher was not available for review. Based on interview at the time of record review, the Home Manager stated monthly checks are documented on the aforementioned monthly report but are not itemized by location to ensure all facility fire extinguishers would be checked each month. Based on observations with the Home Manager during a tour of the facility from 12:10 p.m. to 12:45 p.m. on 02/26/15, the portable fire extinguisher located in the hallway and in the kitchen each had an affixed inspection and maintenance tag lacking documentation of monthly inspections for April, May, June, August, September, October and November 2015 and January 2016. Based on interview at the time of the observations, the Home Manager stated no other documentation of monthly portable fire extinguisher inspections was available for review and acknowledged documentation of monthly inspections for		program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G643		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2016	
NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404			
(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			
K S152  Bldg. 01	<p>each facility fire extinguisher for each month in the most recent twelve month period was not available for review.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted</p>	K S152	K130 The facility must ensure that specific life safety requirements are met. <b>Corrective action for resident(s) found to have been</b>	03/20/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G643	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2016
NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>on the third shift for 3 of 4 quarters. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Drill Report-Type of Drill: Fire" documentation with the Home Manager during record review from 11:15 a.m. to 12:10 p.m. on 02/26/16, fire drills conducted on the third shift in the first, second and third quarter of 2015 were not available for review. Based on interview at the time of record review, the Home Manager acknowledged documentation of a fire drill conducted on the third shift in the first, second and third quarter of 2015 was not available for review.</p>		<p><b>affected</b>A training of all life safety issues will be conducted ensure that the agency's life safety procedures are followed. The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b>All residents potentially are affected, and corrective measures address the needs of all clients.<b>Measures or systemic changes facility put in place to ensure no recurrence</b>QIDP training will be conducted to ensure life safety requirements are being met</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b>The QIDP is responsible for program implementation and monitoring of the facility. The QIDP is supervised by the SGL Director, they meet regularly. The SGL Director will provide all documented training of the QIDP. The SGL Director will ensure that all corrections are in place and that documentation is available at resurvey.</p>		