

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G655	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2025
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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP COD 2606 H ST BEDFORD, IN 47421
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 05/20/25</p> <p>Facility Number: 001166 Provider Number: 15G655 AIM Number: 100445440</p> <p>At this Emergency Preparedness survey, Stone Belt ARC Inc was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has a capacity of six and had a census of four at the time of this survey.</p> <p>Quality Review completed on 05/22/25</p>	E 0000		
K 0000  Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 05/20/25</p> <p>Facility Number: 001166 Provider Number: 15G655 AIM Number: 100445440</p> <p>At this Life Safety Code survey, Stone Belt ARC Inc. was found not in compliance with Requirements for Participation in Medicaid, 42</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keisha Boyce	Associate Director	06/13/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

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NAME OF PROVIDER OR SUPPLIER  STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2606 H ST BEDFORD, IN 47421			
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K S100 Bldg. 01	<p>CFR Subpart 483.470(j), Life Safety from Fire and the 2012 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 facility was fully sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors, sleeping rooms, and common living areas, and heat detection in the unused attic space connected to the fire alarm system. The facility has a capacity of six and had a census of four at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.24.</p> <p>Quality Review completed on 05/22/25</p> <p>NFPA 101 General Requirements - Other</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier doors arranged to self-close or automatic close and latch with fire alarm system activation were not prevented from closing and latching. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as smoke barrier doors, arranged to close and latch to be either maintained or removed. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the on 05/20/25 at 2:35 p.m., the door separating the living area from the</p>	K S100	K0100 Corrective action for resident(s) found to have been affected: The facility failed to ensure 1 of 1 smoke barrier doors arranged to self-close or automatically close and latch with fire alarm system activation were not prevented from closing and latching.	05/29/2025			

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	<p>sleeping area corridor, equipped with a self-closing device, failed to close and latch positively into the door frame. There was a gap of about two inches along the latching edge of the door when closed to the fullest. Based on interview at 2:37 p.m, the Coordinator agreed that the self closing door did not latch when tested.</p> <p>This finding was reviewed with the Coordinator at the exit conference.</p>		<p>address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence: This latch has been repaired by our Maintenance department.</p> <p>How corrective actions will be monitored to ensure no recurrence: Our maintenance department has created a maintenance log and ticket order for repairs. All Sgl Coordinators where trained on 5/29/25 to check and monitor all things related to drill safety including the fire door and latch</p>		