STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G653	A. BUILDING -- B. WING	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONE BELT ARC INC	1118 22ND ST BEDFORD, IN 47421

(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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 10/20/22 Facility Number: 001094 Provider Number: 15G653 AIM Number: 100235630 At this Emergency Preparedness survey, Stone Belt ARC Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. At the time of the survey, the census was 6. Quality Review completed on 10/21/22	E 0000		
E 0035 Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Miller	Executive Clinical Director	11/18/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the QIDP on 10/20/22 between 1:30 p.m. and 3:00 p.m., the plan provided did not address a method for sharing information with clients and their families. Based on interview at the time of records review, the QIDP agreed the aforementioned policy was not in the provided EPP and that they were working to add this to the plan. The finding was acknowledged by the QIDP at the time of discovery and again during the exit conference with the QIDP present at 3:30 p.m.	E 0035	Corrective action for resident(s) found to have been affected Stone Belt's Emergency Preparedness Plan will be updated and shared with all clients and or guardians at least annually. All Wedgewood clients and guardians will be presented with a copy of the EPP for review. The QIDP will provide assistance to each client/guardian as needed. How facility will identify other residents potentially affected All clients are potentially affected. Measures or systemic changes facility put in place to ensure no recurrence Each year, clients have an annual meeting. During this meeting, the QIDP will present the EPP for review to the client and or guardian. The client and or guardian will sign a form indicating they have had the opportunity to review the EPP and request a copy if wanted. This form will become a part of the annual case conference summary.	11/18/2022

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			How corrective actions will be monitored to ensure no recurrence The Client Service Coordinator conducts a monthly audit to ensure a variety of documents are present and updated. The audit will be updated to include that the EPP receipt/review form is present and current.	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training			

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	at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and			

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	existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services			

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	under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation			

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	of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of	E 0037	Corrective action for resident(s) found to have been affected Stone Belt's Emergency Preparedness Plan will be updated and shared with all employees upon hire and annually thereafter. All facility staff will receive training on the EPP during the next all staff meeting. How facility will identify other residents potentially affected All Clients are potentially affected.	11/18/2022

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	emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the QIDP on 10/20/22 between 1:30 p.m. and 3:00 p.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of records review, the QIDP did not know if staff were trained on the EPP and stated no documentation for staff training could not be found during the survey. The finding was acknowledged by the QIDP at the time of discovery and again during the exit conference with the QIDP present at 3:30 p.m.		Measures or systemic changes facility put in place to ensure no recurrence Stone Belt uses an electronic training system called Relias to ensure that regular topics are trained on an annual basis. The EPP has been added to Relias. Upon hire each staff will utilize Relias to access the EPP and sign off on its review. How corrective actions will be monitored to ensure no recurrence Relias will send notification emails to each employee when their annual review of the EPP is due. Upon notification, the employee will have a deadline to complete the review. Relias will notify HR of any delinquent employees who will then ensure that the review is completed.	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).			

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	*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct			

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	exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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	facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires			

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	activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual,			

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	facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.			

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	(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is	E 0039	Corrective action for resident(s) found to have been affected The Associate Director for SGL will hold an all employee meeting for this facility. During this meeting, the Associate Director will review the Emergency Preparedness Plan and discuss table top exercises with all employees. Subsequent to this, two times per year, exercises will be conducted to test this plan. As available, one of these exercises will be a community-wide drill. If this is not available, there will be at least one full scale facility based exercise. How facility will identify other	12/02/2022

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	community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the QIDP on 10/20/22 between 1:30 p.m. and 3:00 p.m., the facility was able to provide documentation of its response to the COVID-19 Public Health Emergency, however, was unable to provide documentation of a second exercise of choice to test the emergency preparedness plan. Based on interview at the time of record review, the QIDP agreed that a second exercise of choice was not conducted. The finding was acknowledged by the QIDP at the time of discovery and again during the exit conference with the QIDP present at 3:30 p.m.		residents potentially affected All Clients are potentially affected. Measures or systemic changes facility put in place to ensure no recurrence The QIDP will be re-trained to ensure she understands table top exercises, what is required, and how to document them. The SGL Director and Associate Director will work with their team to conduce two drills annually to test the plan. How corrective actions will be monitored to ensure no recurrenceThe Client Services Coordinator conducts a monthly audit to ensure a whole host of activities are completed when due. The Associate Director will add Table top exercises to the audit form so that they will be audited each month to ensure completion. These audits are in turn reviewed by SGL Administration to ensure completion. In addition to this, Stone Belt will work with the Lawrence County Healthcare Foundation on community training and drills that support this plan.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).	K 0000		

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	Survey Date: 10/20/22 Facility Number: 001094 Provider Number: 15G653 AIM Number: 100235630 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 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. 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 presence of heat detection in the attic, connected to the fire alarm system was unclear at the time of this survey. The facility has a capacity of 6 and had a census of 6 at the time of this survey. 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 .52. Quality Review completed on 10/21/22			
K S341 Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less			

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	than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on records review and interview the facility failed to ensure 1 of 1 attics not used for storage, for living purposes, or containing fuel-fired equipment had installed sprinklers or heat detection connected to the fire alarm system. LSC 33.2.3.5.7.1 states where an automatic sprinkler system is installed, attics used for living purposes, storage, or fuel-fired equipment shall be protected with automatic sprinklers that are part of the required, approved automatic sprinkler system in accordance with 9.7.1.1. LSC 33.2.3.5.7.2 states where an automatic sprinkler system is installed, attics not used for living purposes, storage, or fuel-fired equipment shall meet one of the following criteria: (1) Attics shall be protected throughout by a heat detection system arranged to activate the building fire alarm system in accordance with Section 9.6. (2) Attics shall be protected with automatic sprinklers that are part of the required, approved automatic sprinkler system in accordance with 9.7.1.1. (3) Attics shall be of noncombustible or limited-combustible construction. (4) Attics shall be constructed of fire-retardant-treated wood in accordance with NFPA 703, Standard for Fire Retardant- Treated Wood and Fire-Retardant Coatings for Building Materials. This deficient practice could affect all clients. Findings include: Based on records review and interview with the QIDP on 10/20/22 between 1:30 p.m. and 3:00 p.m., Documentation in the form of estimates from 2019	K S341	Corrective action for resident(s) found to have been affected The facility installed attic heat sensors in 2019 however appropriate documentation was not available at the time of survey. CSC, the contracted provider, is schedule to perform new inspections on all homes beginning November 8, 2022, and will specifically include the attic heat sensors in the updated documentation. This will be immediately added to the electronic records for the home. How facility will identify other residents potentially affected All Clients are potentially affected. Measures or systemic changes facility put in place to ensure no recurrence The Client Services Support Coordinator will be responsible to ensure the updated forms have been updated in the electronic records upon completion of inspection. The facility contracts with CSC to perform this inspection. CSC submits these reports to the CFO and head of	11/18/2022

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	indicate the intent of the facility's vendor (at that time) to install heat detection in the attic. However, the only provided fire alarm system inspection report dated 06/01/22 indicated the attic is not protected with heat detection, the aforementioned report mentions only 2 heat detecting devices (kitchen and near the kitchen). No access was made available to the surveyor to the attic space, no access points could be accessed. Based on interview at the time of records review, the QIDP called their maintenance department but no one knew for sure if the attic had heat detection, or how to access the space. The finding was acknowledged by the QIDP at the time of discovery and again during the exit conference with the QIDP present at 3:30 p.m.		maintenance who review them and complete the electronic upload. Any deficiencies noted will be addressed with a plan at that time. How corrective actions will be monitored to ensure no recurrence /p>	
K S346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written fire watch policy for when the fire alarm system is out of service for more than four hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include:	K S346	Corrective action for resident(s) found to have been affected The facility staff presented the incorrect Fire Watch Plan at the time of survey. The correct form was presented to the facility staff on 10/16/22. The Client Services Support Coordinator will ensure the correct form is utilized and	11/18/2022

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	Based on records review and interview with the QIDP on 10/20/22 between 1:30 p.m. and 3:00 p.m., the QIDP provided an updated fire watch plan however the fire alarm system impairment was incomplete. The plan failed to include language stating that at the beginning of the fire watch the appropriate agencies would be contacted. And again, at the conclusion of the fire watch and restoration of the impaired system the same agencies would be contacted and notified the system was restored to normal service. Based on interview at the time of record review, the QIDP agreed the fire watch did not include the aforementioned notifications. The finding was acknowledged by the QIDP at the time of discovery and again during the exit conference with the QIDP present at 3:30 p.m.		available to all staff. How facility will identify other residents potentially affected All Clients are potentially affected. Measures or systemic changes facility put in place to ensure no recurrence The Client Services Support Coordinator will be responsible to ensure the incorrect forms have been removed from all binders located in the facilities. All staff will have access to the most up-to-date plans and utilize such in case of emergency. How corrective actions will be monitored to ensure no recurrence /p>	
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested			

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	and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through			

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	their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation	K S353	Corrective action for resident(s) found to have been affected The facility will ensure that all sprinklers are equipped with an appropriate spare sprinkler head, and that there is a spare sprinkler cabinet and wrench available on site. In addition, the facility will ensure that all sprinkler heads are open/uncovered and free of debris. This will be addressed by facility maintenance in obtaining, placing and cleaning the equipment as needed and monitored by the Coordinator during monthly house audits. How facility will identify other residents potentially affected All Clients are potentially	12/02/2022

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	of sprinklers. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observations and interview with the QIDP on 10/20/22 between 3:00 p.m. and 3:30 p.m., there were a total of 5 spare sprinklers in the cabinet, not the required minimum of 6. Two of the 5 spare sprinkler heads were laying loose, not seated into compartments inside the cabinet and did not appear to fit inside the openings in the cabinet. Based on interview at the time of the observations, the QIDP acknowledged spare sprinklers were not the correct number and not placed properly inside the spare sprinkler box. The finding was acknowledged by the QIDP at the time of discovery and again during the exit conference with the QIDP present at 3:30 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in the kitchen were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. Findings include: Based on observations and interview with the		affected. Measures or systemic changes facility put in place to ensure no recurrence The Client Services Support Coordinator will be responsible to ensure the appropriate equipment is updated and available in good working order in the home via agency maintenance department, which is supervised by the CFO. The Coordinator will monitor for such equipment during monthly house audits and immediately notify facility maintenance of any issues. These issues may include but are not limited to available spare equipment such as sprinkler heads, cleanliness/maintenance of equipment such as active sprinkler heads being uncovered and free from debris, and records of annual contracted inspection. How corrective actions will be monitored to ensure no recurrence =”” p=””> Facility maintenance will include these sprinkler head issues on their checklist for visits to the home. The Coordinator will monitor during monthly audits to ensure appropriate equipment is in place and in good condition. These audits are then reviewed by SGL Leadership to ensure compliance.	

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	15G653	A. BUILDING 01 B. WING	10/20/2022

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	QIDP on 10/20/22 between 3:00 p.m. and 3:30 p.m., 1 of 2 sprinkler heads in the kitchen was coved in dust or showed signs of loading. The finding was acknowledged by the QIDP at the time of discovery and again during the exit conference with the QIDP present at 3:30 p.m.			
K S354 Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making	K S354	Corrective action for resident(s) found to have been affected The facility staff presented the incorrect Fire Watch Plan at the time of survey. The correct form was presented to the facility staff on 10/16/22. The Client Services Support Coordinator will ensure the correct form is utilized and available to all staff. How facility will identify other residents potentially affected All Clients are potentially affected.	11/18/2022

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	sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review and interview with the QIDP on 10/20/22 between 1:30 p.m. and 3:00 p.m., the QIDP provided an updated fire watch plan however the sprinkler system impairment was incomplete. The plan failed to include language stating that at the beginning of the fire watch the appropriate agencies would be contacted. And again, at the conclusion of the fire watch and restoration of the impaired system the same agencies would be contacted and notified the system was restored to normal service. Based on interview at the time of record review, the QIDP agreed the fire watch did not include the aforementioned notifications. The finding was acknowledged by the QIDP at the time of discovery and again during the exit conference with the QIDP present at 3:30 p.m.		Measures or systemic changes facility put in place to ensure no recurrence The Client Services Support Coordinator will be responsible to ensure the incorrect forms have been removed from all binders located in the facilities. All staff will have access to the most up-to-date plans and utilize such in case of emergency. How corrective actions will be monitored to ensure no recurrence /p>	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must:			

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	a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. 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. 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. 42 CFR 483.470(i)			
	Based on record review and interview, the facility failed to conduct 1 of 12 quarterly shift fire drills in accordance with 42 CFR 483.470(i), which states the following: (1) The facility must hold 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 fire protection features. Or, per 2019 Novel Coronavirus Disease (COVID-19) 1135 Waiver allowances, a documented orientation training program related to the current fire plan, which considers current facility conditions. This deficient practice could affect all clients. Findings include: Based on records review and interview with the QIDP on 10/20/22 between 1:30 p.m. and 3:00 p.m.,	K S712	Corrective action for resident(s) found to have been affected Staff will utilize a drill schedule as implemented by the Coordinator for the site. This schedule will include drills during each shift for every quarter. The Coordinator will ensure that all staff are aware of this schedule. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Staff training on drill requirements, Coordinator scheduling and implementing drills as well as reviewing on a quarterly basis.	11/18/2022

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	the facility could not provide fire drills or allowed training documentation for the Second and Shift during the Fourth Quarter of 2021 or 2022. Based on interview at the time of record review, the QIDP agreed documentation for the drill or training for the period previously mentioned were not conducted. The finding was acknowledged by the QIDP at the time of discovery and again during the exit conference with the QIDP present at 3:30 p.m.		How corrective actions will be monitored to ensure no recurrence The Director of Supervised Group Living (SGL) will monitor the corrective action. The Director also supervises the QIDP and Coordinator who will implement these corrections. This will be reviewed during team meetings at least monthly.	