

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155160	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362
--	--

(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 and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/25/15</p> <p>Facility Number: 000080 Provider Number: 155160 AIM Number: 100289330</p> <p>At this Life Safety Code survey, Stonebrooke Rehabilitation Centre &amp; Suites was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility was determined to be of Type II (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors, battery operated smoke detectors in resident rooms 223, 224, 225, 226, 227, 228, 229, 230, 231, 232,</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:  155160		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/25/2015	
NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTRE & SUITES				STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362			
(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 0027 SS=E Bldg. 01	<p>233, 234, 238, 239, 240, 242, 243, 244, 245, 246, 247, 248, 249, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119 and hard wired smoke detectors in resident room 100, 101, 102, 103, 104, 105, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135 and 136. The facility has a capacity of 117 and had a census of 96 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had two detached wooden storage sheds and one detached metal storage shed which were not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20</p>	K 0027	Please find enclosed a plan of correction from our annual life safety code survey that was conducted on June 25,2015 We respectfully request a desk review	06/25/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155160	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  06/25/2015
NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTRE & SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362		
(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>minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 26 residents who reside on the second floor C Hall.</p> <p>Findings include:</p> <p>Based on observations on 06/25/15 at 11:30 a.m. with the administrator and maintenance supervisor, the second floor C Hall set of smoke barrier doors did not close completely, leaving a three inch gap where the doors came together. This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged at the exit conference on 06/25/15 at 1:00 p.m.</p> <p>3.1-19(b)</p>		<p>and paper compliance in this matter. Thank you for your consideration in this matter. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; None of the 22 residents on C Hall were affected by this alleged deficient practice. To regain the required smoke barrier for door openings the C Hall set of smoke barrier doors has been repaired as of June 25,2015. 2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the same potential to be affected by this alleged deficient practice. All smoke barrier doors have been inspected by the Maintenance Director to ensure that they close properly. Through facility maintenance inspections is such issues as the above are found they will be repaired immediately. 3)What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Through the facility Maintenance director's building inspections which will be completed 5 days per week, if such issues as the above are found they will be repaired immediately. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155160	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362
--	--

(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 0038 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the sidewalk surface on 2 of 9 exit sidewalks were maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 12 residents who receive therapy at a time and would use the Therapy Hall exit.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor and administrator on 06/25/15 during a tour of the first</p>	K 0038	<p>put into place; The integrity of all smoke barrier doors are a part of our inspections and the data collected by the Maintenance director through his inspections will be submitted to our CQI committee for review and follow up. 5) By what date the systemic changes will be completed. Compliance date: June 25, 2015</p> <p>Please find enclosed a plan of correction from our annual life safety code survey that was conducted on June 25,2015. We respectfully request a desk review and paper compliance in this matter. Thank you for your consideration in this matter. It is the practice of this provider to ensure that sidewalk surfaces on all exit sidewalks are maintained to prevent elevation changes. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; None of the 12 residents participating in therapy were affected by this alleged deficient practice. To ensure exit sidewalks are maintained to prevent elevation changes the surface on 2 sidewalk surfaces will be replaced on or before August 14,2015 2) How other residents having the potential to be affected by the</p>	08/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155160	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  06/25/2015
NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTRE & SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362		
(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>floor outside exits from 11:45 a.m. to 12:15 p.m., the Therapy Hall exit sidewalk had a sixty foot section of concrete sidewalk extending from the fence to the parking lot pitted with one inch depressions on the sidewalk surface along the sixty foot length of sidewalk. Furthermore, the kitchen exit sidewalk had a three inch area of sidewalk pitted east and west of the "T" section with one inch depressions on the sidewalk surface. The Therapy Hall exit and kitchen exit sidewalk surfaces pitting was acknowledged by the administrator at the exit conference on 06/25/15 at 1:00 p.m.</p> <p>3.1-19(b)</p>		<p>same deficient practice will be identified and what corrective action(s) will be taken; All residents of the facility have the same potential to be affected by this deficient practice. All sidewalks were inspected by the Maintenance director to ensure that no other elevation changes exist. Through facility maintenance inspections if issues such as the above are found they will be repaired. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Through the facility's Maintenance director's building inspections that are completed 5 days per week, if such issues such as the above are found they will be repaired. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; All sidewalks will be inspected monthly to ensure compliance. Data collected by the Maintenance director through his inspections will be submitted to the CQI committee for review and follow up. 5) By what date the systemic changes will be complete. Compliance date: August 14, 2015.</p>		