STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155727	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE HEALTH CAMPUS	3100 SHAWNEE DR S BEDFORD, IN 47421

(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
K0000	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). Survey Date: 06/11/12 Facility Number: 003924 Provider Number: 155727 AIM Number: 200472040 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Stonebridge Health Campus 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 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and in all resident sleeping rooms. The facility has a capacity of 68 and had a	K0000	The submission of this plan of correction does not indicate an admission by StoneBridge Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of StoneBridge Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility herby maintains it is in substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction shall serve as the credibel allegation of compliance with all state requirements governing the management of this facility. It is thus submitted as a matter of statue only. We respectfully request from the Department paper compliance. All corrections have been submitted to this POC as attachments.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	census of 51 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/15/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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NAME OF PROVIDER OR SUPPLIER STONEBRIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421	

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 06/11/12 at 2:48	K0064	No residents suffered ill effects from this alleged deficiency. There was a K-class extinguisher conspicuously placed next to the entry door to the kitchen, and a red placard was in place during the survey that read "WARNING in case of appliance fire use this extinguisher after fixed suppression system has been activated!" Under Fire Safety and Disaster Preparedness-Operational Procedures "Fighting the Fire" has been revised to include the K-class Extinguisher.	07/10/2012

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	p.m. with the Maintenance Supervisor, there was a K-class extinguisher conspicuously placed next to the entry door to the kitchen, but it lacked a placard. Based on interview on 06/11/12 at 2:50 p.m. with the Maintenance Supervisor, it was acknowledged the K-class portable fire extinguisher was not provided with a placard. 3.1-19(b)			

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation of generator equipment on 06/11/12 at 12:45 p.m. with the Maintenance Supervisor, a remote	K0144	No residents suffered ill effects from this alleged deficiency. Completion Date 7-10-12. On 6-15-12 Vanguard Sales of Evansville, INC Installed and tested Emergency Stop Switch on emergency generator.	07/10/2012

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	shut off device was not found for the generator. Based on review of Generator Maintenance records on 06/11/12 at 3:30 p.m. with the Maintenance Supervisor, the generator was installed in 2004 and a remote means to shut the generator off was not provided. Based on interview on 06/11/12 at 12:48 p.m. with the Maintenance Supervisor, it was acknowledged the facility was aware a remote shut off for the generator was required, but it has not been installed. 3.1-19(b)			

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K0155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a written policy in the event the fire alarm system is out of service for 4 or more hours in a 24 hour period for the protection of 51 of 51 residents. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents as well as staff and visitors. Findings include:	K0155	No residents suffered ill effects from the alleged deficiency. Completion Date is 7-10-12. All residents have the potential to be affected by the deficient practice and through revision of Fire Watch Policy ensures there is a written plan for the protection of all patients in the event the sprinkler system and/or fire alarm system is not operational or has an interruption in service for 4 or more hours in a 24hr period. All staff will be inservice with reviewing Revised Fire Watch Policy by Plant Ops/designee. Revised policy will be reviewed at monthly QA Meeting and yearly thereafter.	07/10/2012

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	Based on Fire Alarm record review on 06/11/12 at 3:37 p.m. with the Maintenance Supervisor, the facility did not have a written policy and procedure for an impaired fire alarm protection system available for review. Based on interview on 06/11/12 at 3:38 p.m. with the Maintenance Supervisor, it was acknowledged a policy which would address an impairment of the fire alarm system was not available for review. 3.1-19(b)			