

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

PRINTED: 02/08/2016
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155838 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 02/02/2016 |
| NAME OF PROVIDER OR SUPPLIER STONECROFT HEALTH CAMPUS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403 | | |
| (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 | |
| {F 000} | <p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00187607 and IN00189292 completed on December 22, 2015.</p> <p>Complaint IN00187607 - Corrected.</p> <p>Complaint IN00189292 - Corrected</p> <p>Survey date: February 2, 2016</p> <p>Facility number: 013409 Provider number: 155838 AIM number: 201312610</p> <p>Census bed type: SNF/NF: 36 Residential: 24 Total: 60</p> <p>Census payor type: Medicare: 19 Medicaid: 10 Other: 7 Total: 36</p> <p>Sample: 03</p> <p>Stonecroft Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00187607 and IN00189292.</p> <p>Q.R. completed by 14466 on February 05, 2016.</p> | {F 000} | | | |
| 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.