STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155727	A. BUILDING _____ B. WING _____	C 12/04/2024

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 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	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00447278. Complaint IN00447278 - State deficiencies related to the allegations are cited at F9999. Survey date: December 4, 2024 Facility number: 003924 Provider number: 155727 AIM number: 200472040 Census Bed Type: SNF/NF: 42 SNF: 20 Residential: 29 Total: 91 Census Payor Type: Medicare: 15 Medicaid: 36 Other: 11 Total: 62 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 6, 2024.	F 000		
F9999	FINAL OBSERVATIONS 3.1-13 Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a department, for example, director of nursing or food service supervisor, during the same hours, The responsibilities of the administrator shall include, but are not limited to,	F9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155727	A. BUILDING _____ B. WING _____	C 12/04/2024

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 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
F9999	Continued From page 1	F9999		

the following:
(1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any:
(D) major accidents
If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number (317) 383-6144) of the division.

This State rule was not met as evidenced by:

Based on interview and record review the facility failed to inform the division within 24 hours of a major accident for 1 of 3 residents reviewed for falls. A resident fell and sustained a subarachnoid hemorrhage and a laceration that required five staples. (Resident B)

Findings include:

On 12/4/24 at 11:49 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, fractured right wrist, acute kidney failure, insomnia, anemia, chronic pain, adult failure to thrive, and long term use of anticoagulants.

An observation note, dated 9/23/24 at 2:37 a.m., indicated a CNA notified the nurse the resident was on floor and was bleeding from the head. The nurse entered Resident B's room to see he was lying on the floor, actively bleeding, while the CNA applied pressure to the head wound. Resident B was unable to voice what happened. The resident was transported to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155727	A. BUILDING _____ B. WING _____	C 12/04/2024

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 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
F9999	Continued From page 2	F9999		

An observation note, dated 9/23/24 at 11:34 a.m., indicated Resident B fell around 2:00 a.m. He was found on the floor beside his bed and was bleeding from head. Pressure was applied and an ambulance was called to transport Resident B to the hospital.

During an interview on 12/4/24 at 12:40 p.m., Resident B's family member indicated the family had went to the facility after the resident had the fall and Resident B's room was covered in copious amounts of blood on the floor.

An Emergency Medicine note, dated 9/23/24, indicated the resident was found lying in a pool of blood and his shirt was soaked after he fell and hit his head. He had a 3 centimeter irregular laceration to the right scalp which required 5 staples. A CT (computed tomography) scan indicated he had a small amount of acute right insular traumatic subarachnoid hemorrhage (a life-threatening medical emergency that occurs when a blood vessel in the brain bursts and bleeds into the space between the brain and its protective membranes).

During an interview on 12/4/24 at 1:44 p.m., the Executive Director (ED) indicated the facility only reported falls if they had a major injury. She indicated the facility would run it through "clinical" to see if it would need to be reported and the fall did not meet their criteria of reporting to the State. She indicated they held a "pow-wow" for the girls because there was a lot of blood afterwards, they were in some shock, and needed to process it with the help of the chaplains. Lastly, she did not know if the resident sustained any injuries after the fall because he did not readmit to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155727	A. BUILDING _____ B. WING _____	C 12/04/2024

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 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
F9999	Continued From page 3	F9999		

During an interview on 12/4/24 at 1:54 p.m., RN 1 indicated she was working the night of the fall. She walked into his room and saw a nurse applying pressure to his head with a towel. He was bleeding quite a bit, and they could not figure out where the bleeding was coming from. She indicated the blood was all over the floor, which included the carpet area. To her, it looked like he may have tried to reposition himself because it was smeared around. All he kept saying was he felt like he was in a plane crash.

During an interview on 12/4/24 at 2:05 p.m., the Clinical Support Nurse indicated they would report when someone sustained a fall with major injury (such as a fracture) or needed anything beyond first aid. When asked about the amount of blood loss and would that be considered greater than first aid, she indicated that he was on a blood thinner and believed they were waiting on him to come back to determine what happened.

On 12/4/24 at 2:00 p.m., the Clinical Support Nurse provided the "Long-Term Care Abuse and Incident Reporting Policy," dated 12/6/22, and indicated it was the policy currently being used by the facility. A review of the policy included reporting major accidents.

This citation relates to Complaint IN00447278.