STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155838	A. BUILDING 00 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 13, 14, 15, 16, and 19, 20, 2025 Facility number: 013409 Provider number: 155838 AIM number: 201312610 Census Bed Type: SNF/NF: 18 SNF: 33 Residential: 34 Total: 85 Census Payor Type: Medicare: 18 Medicaid: 18 Other: 15 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 22, 2025.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted June 8, 2025 Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 8, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility failed to ensure a resident's choice of code status was documented accurately for 1 of 2 residents reviewed for advanced directives. (Resident 13) Finding includes:	F 0578	1. Resident #13 choice of code status was affected by the alleged deficient practice. The resident's code status reviewed and updated with resident, physician, and family. No adverse reactions noted.	06/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Black	ED	06/05/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155838	A. BUILDING 00 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(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
	On 5/15/25 at 2:34 p.m., Resident 13's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, acute respiratory failure with hypoxia (condition where you don't have enough oxygen in the tissues in your body), and chronic kidney disease (condition where the kidneys are damaged and can't properly filter waste and fluid from the blood). An Out of Hospital Do Not Resuscitate declaration and order, a choice of treatment document, dated 7/28/23, was signed by the Resident's POA (power of attorney) and the resident's physician, the document indicated no CPR (cardiopulmonary resuscitation) to be performed. The CPR consent, dated 5/4/24, indicated to perform CPR while the resident was in the facility. The CPR consent was obtained by verbal phone consent of the Resident's POA and witnessed by two nurses on 5/4/24. A review of the physician orders indicated the following: On 7/27/23 Code Status: Full Code (all possible life-saving measures taken in the event of a medical emergency, such as cardiac or respiratory arrest, including CPR). The order was discontinued on 8/18/23. On 8/18/23: Code Status: DNR (Do Not Resuscitate). The order was discontinued on 5/4/24. On 5/4/24: Code Status: DNR. The order was discontinued on 5/9/25. On 5/9/25: Code Status: DNR.		2. All residents have the potential to be affected. Social Services (SS) staff and the Interdisciplinary Team (IDT) have been educated on requirements for code status related to advanced directives and ensuring the facility is following resident wishes for their advance directives. A house wide audit has been completed as well to ensure the campus is following all guidelines and requirements related to advanced directives care planning. 3. As a measure of ongoing compliance, all new admissions' code status will be reviewed by SSD weekly x4 weeks, then biweekly x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155838	A. BUILDING 00 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(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
	A Social Service Comprehensive Note, dated 8/2/23, indicated the resident was a full code. A Social Service Comprehensive Note, dated 8/29/23, indicated the resident was a DNR. A Resident First Meeting Minutes Note, dated 5/17/24, indicated the Resident's code status remained a DNR. A Resident First Meeting Minutes Note, dated 5/15/25, indicated the Resident's code status remained a DNR. A Hospital History and Physical, dated 5/6/25, indicated the resident was a full code. No additional documentation was in the clinical record to reflect the change in advanced directive. During an interview with the DON (Director of Nursing) on 5/16/25 at 11:55 a.m., she indicated she was unsure why the advanced directive order was changed. The DON indicated there was no further documentation in the record that indicated a request from the POA to change the resident's advanced directive. On 5/13/25 at 11:45 a.m., the Administrator provided the facility's admission packet, dated 3/23/22. The Administrator indicated this was the current admission packet used by the facility. The document indicated "...Out of Hospital Do Not Resuscitate Declaration and Order...is used to state your wishes...The declaration may be canceled by you at any time by a signed and dated writing...or by communicated to health care providers at the scene the desire to cancel the order..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155838	A. BUILDING 00 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(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
	On 5/20/25 at 1:08 p.m., the DON provided the Guidelines for DNR Order policy. The policy was dated, 12/17/24, the DON indicated this was a current policy used by the facility. The policy indicated, "...2. A Do Not resuscitate Form shall be completed and signed...and placed in medical record...5. The interdisciplinary care planning team will review advance directives with the resident during quarterly Resident First Conference to determine if the resident wishes to make changes in such directives..." 3.1-4(f)(5)			
F 0641 SS=D Bldg. 00	483.20(g)(h)(i)(j) Accuracy of Assessments Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 1 residents reviewed for Resident Assessment. (Resident 55) Findings includes: On 5/19/25 at 11:21 a.m., Resident 55's clinical record was reviewed. The diagnoses included, but were not limited to, lung cancer and lupus (disease when your body's immune system attacks your own organs and tissue). The progress notes, dated 4/18/25 at 3:01 p.m., indicated Resident 55 was discharged home with her husband. The discharge MDS assessment, dated 4/18/25, indicated Resident 55 was discharged to a short term general hospital. During an interview on 5/19/25 at 3:07 p.m., the	F 0641	1. Residents #55 was affected. MDS section A2015 “Discharge Status ” was corrected on resident #55’s Discharge ARD 4/18/25 to reflect residents discharge to home. No adverse effects noted. 2. All discharged residents have the potential to be affected. The past 6 months of Discharge resident’s coding have been reviewed for accuracy related to MDS section A2015 “Discharge Status ” coding. MDS coordinator has been educated on accurate completion of A2015 “Discharge Status” 3. As a measure of ongoing compliance, the MDSC or designee will conduct an audit of five residents for correct coding of A2015 “Discharge Status ” of the MDS weekly x4 weeks, then twice	06/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155838	A. BUILDING 00 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(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
	Social Services Director (SSD) indicated Resident 55 was discharged home. During an interview on 5/20/25 at 10:52 a.m., the MDS nurse indicated Resident 55 was discharged home. The MDS was coded wrong. During an interview on 5/20/25 at 12:24 p.m., the MDS Consultant indicated they did not have a MDS coding policy. The facility followed the RAI (Resident Assessment Instrument) manual. 3.1-31(d)		per month x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 13, 14, 15, 16, 19 and 20, 2025 Facility number: 013409 Residential Census: 34 Stonecroft Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted June 8, 2025 Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 8, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155838	A. BUILDING 00 B. WING	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(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