| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155160 | A. BUILDING -- B. WING | 06/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| STONEBROOKE REHABILITATION CENTER | 990 N 16TH ST NEW CASTLE, IN 47362 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 06/04/25<br><br>Facility Number: 000080<br>Provider Number: 155160<br>AIM Number: 100289330<br><br>At this Emergency Preparedness survey, Stonebrooke Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 117 certified beds. At the time of the survey, the census was 76.<br><br>Quality Review completed on 06/09/25 | E 0000 | | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 06/04/25<br><br>Facility Number: 000080<br>Provider Number: 155160<br>AIM Number: 100289330<br><br>At this Life Safety Code survey, Stonebrooke | K 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| keith davis | Senior executive director | 06/25/2025 |

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.

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| | 155160 | A. BUILDING 01<br>B. WING | 06/04/2025 |

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| | Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>Bldg 01, which is the original two story portion of the building, was surveyed using (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 and has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 117 and had a census of 76 at the time of this visit.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had one detached wooden storage sheds and one detached metal storage shed which were not sprinklered.<br><br>Quality Review completed on 06/09/25 | | | |
| K 0211<br>SS=E<br>Bldg. 01 | NFPA 101<br>Means of Egress - General<br><br>Based on observation and interview, the facility failed to ensure 3 of 8 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors if needing to exit the facility. | K 0211 | **We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents | 06/20/2025 |

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| | Findings include:<br><br>Based on observation with the Maintenance Supervisor during the initial walk through of the facility at 9:05 a.m. on 06/04/25, a long folding table was upright and stored in the corridor outside the first floor Therapy Room. The table projected 36 inches into the eight foot wide corridor. Two additional long folding tables were collapsed and stacked on top of the table.<br>In addition, the following was noted:<br>a. at 2:12 p.m. on 06/04/25, the long folding table was still stored in the corridor outside the first floor Therapy Room.<br>b. at 1:15 p.m. and again at 2:08 p.m. on 06/04/25, four linen carts and two stacked chairs were observed stored in the corridor outside the Laundry room.<br>c. at 1:15 p.m. and again at 2:08 p.m., three carts for coffee serving were stored in the corridor outside Dietary.<br>d. at 1:43 p.m. three wood pallets were stored in the corridor outside the Nurse Scheduler Office on the second floor. Based on interview at 1:43 p.m., the Maintenance Supervisor stated the pallets are from regular deliveries and would be picked back up twice per week but remain stored in the corridor until the next delivery. .<br>Based on interview at the time of each of the observations, the Maintenance Supervisor agreed the aforementioned means of egress on each floor was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. | | found to have been affected by the deficient practice; no residents were affected b this alleged deficient practice. tables removed from corridor outside the first floor therapy room. linen carts and two stacked chairs were removed from corridor outside laundry room. three carts removed from corridor outside dietary. three wood pallets from corridor outside the nurse scheduler office on the second floor have been removed.<br><br>-<br><br>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 he potential to be affected by this alleged deficient practice. all items of concern listed have been removed from said corridors. maintenance director educated on 6/18/25 by the senior executive director on monitoring means of egress ( see attachment 1).<br><br>.<br><br>What measures will be put into place or what systemic changes will be made to ensure that the | |

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| | 3.1-19(b) | | deficient practice does not recur;<br>maintenance director educated by the senior executive director on 6/18/25 on maintaining means of egress (see attachment 1).<br>appropriate corrections were made immediately by removing all items of concern from said corridors.<br>maintenance director/designee to conduct audit to ensure compliance. (see attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as means of egress (see attachment 2) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>Completion date: 6/20/25 | |

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| K 0300 SS=F Bldg. 01 | NFPA 101<br>Protection - Other<br><br>1. Based on record review, observation and interview; the facility failed to ensure preventative maintenance for all battery operated smoke alarms in resident rooms was documented. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of Direct Supply TELS Logbook Documentation "Detectors: Test battery operated smoke detectors" documentation for the most recent twelve month period with the Maintenance Supervisor at 11:23 a.m. on 06/04/25, battery operated smoke detector cleaning documentation was not available for review. Based on interview at 11:23 a.m. on 06/04/25, the Maintenance Director stated the facility tests the battery operated smoke detectors in resident sleeping rooms on a weekly basis but agreed cleaning documentation was not available for review at the time of the survey. At 2:04 p.m. on 06/04/25 during a tour of the facility, manufacturer's documentation affixed to the smoke detector installed in resident sleeping Room 243 stated clean the detector annually. Based on interview at 2:04 p.m. on 06/04/25, the Maintenance Supervisor stated similar types of battery operated smoke detectors are installed in each resident sleeping room.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during | K 0300 | **We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. cleaning of smoke detector documentation via Tels system currently being utilized. smoke detector in room 243 has been replaced.<br><br>-<br><br>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;<br><br>All residents/staff have the same potential to be affected by this alleged deficient practice. cleaning of smoke detector documentation is currently being utilized via the tels system. smoke detector in room 243 has been replaced. maintenance director educated by the senior executive director on 6/18/25 on smoke detector preventative | 06/20/2025 |

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| | the exit conference.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 1 of over 50 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.2.1.1.1 states inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 243.<br><br>Findings include:<br><br>Based on observations with the Maintenance Supervisor at 2:04 p.m. on 06/04/25, manufacturer's documentation affixed to the Kidde Model i9010 battery operated smoke alarm installed on the wall in resident sleeping Room 243 indicated it was manufactured 12/11/11. The manufacturer's documentation also stated, "replace within 10 years of installation date". A sticker was also affixed to the battery operated smoke detector indicating the detector was installed in the room in March 2020. Based on interview at 2:04 p.m. on 06/04/25, the Maintenance Supervisor stated newer smoke alarms are installed in sleeping rooms but agreed the manufacture date for the battery operated smoke alarm installed in resident sleeping Room 243 was more than ten years old. | | maintenance documentation and smoke detector usage including the 10 year life. (se attachment 1).<br><br>.<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>cleaning documentation of smoke detectors is currently being utilized via the tels system. smoke detector in room 243 has been replaced. maintenance director was educated on 6/18/25 by the senior executive director on smoke detector preventative maintenance documentation and smoke detector usage including the 10 year life (see attachment 1). maintenance director designee to conduct audit to ensure compliance (see attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be | |

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| | These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as smoke detector compliance (see attachment 2) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>Completion date: 6/20/25 | |
| K 0311 SS=E Bldg. 01 | NFPA 101<br>Vertical Openings - Enclosure<br><br>Based on observation and interview, the facility failed to ensure the protection of 1 of 4 stairwells in accordance of 19.3.1. LSC 19.3.1.1 states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall be in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or 8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing fire door assemblies having a minimum ¾-hour fire protection rating shall be permitted to continue to be used in vertical openings and exit enclosures in lieu of the minimum 1-hour fire protection rating required in Table 8.3.4.2. This deficient practice could affect 32 residents who | K 0311 | **We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. The fire doors in question are scheduled for recertification. Temporary waiver request attached to allow for the facility time to correct this concern (see attachment 3). | 09/20/2025 |

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| | reside on the third floor and staff, and visitors in the third floor and basement.<br><br>Findings include:<br><br>Based on observations on 06/04/25 with the Maintenance Supervisor, the following was noted:<br>a. at 1:14 p.m., the corridor door to the stairwell on the first floor by Dietary was not equipped with a fire resistance rating label on the hinge side of the door. At 2:20 p.m., while using a ladder, the corridor door to the stairwell on the first floor by Dietary was also not equipped with a fire resistance rating label on the top of the door.<br>b. at 1:43 p.m., the corridor door to the stairwell on the second floor by the Nurse Scheduler Office was not equipped with a fire resistance rating label on the hinge side of the door. At 1:52 p.m., while using a ladder, on the corridor door to the stairwell on the second floor by the Nurse Scheduler Office was also not equipped with a fire resistance rating label on the top of the door.<br>Based on interview at 2:20 p.m. on 06/04/25, the Maintenance Supervisor agreed that fire resistance rating documentation for the aforementioned two stairwell door locations was not available for review.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | -<br><br>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;<br><br>All residents/staff have the same potential to be affected by this alleged deficient practice. The fire doors in question are scheduled for recertification. Temporary waiver request attached to allow the facility time to correct concern (see attachment 3). Maintenance director educated by the senior executive director on 6/18/25 on vertical openings/fire resistant rating labels and documentation (see attachment 1).<br><br>.<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; the fire doors in question are scheduled for recertification. Temporary waiver request attached to allow the facility time to correct this concern (see attachment 3). maintenance director educated by the senior | |

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| | | | executive director on 6/18/25 on vertical openings/ fire resistant rating labels and documentation (see attachment 1). maintenance director /designee to audit to ensure compliance (see attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as fire door ratings/documentation will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>Completion date: 9/20/25 | |
| K 0345 SS=C | NFPA 101<br>Fire Alarm System - Testing and | | | |

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| Bldg. 01 | Maintenance<br>Based on observation and interview, the facility failed to maintain the fire alarm system to ensure that it had accurate time and date information in accordance with the requirements of NFPA 101, 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72, 2010 edition, Sections 14.1 and 14.1.1. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Maintenance Supervisor at 12:55 p.m. on 06/04/25, the fire alarm system control panel read the time of day as 1:11 p.m. at 12:55 p.m. Based on interview at 12:55 p.m. on 06/04/25, the Maintenance Supervisor agreed the fire alarm system control panel for the facility displayed the incorrect time of day.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | K 0345 | **We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. the accurate time of day and date has been set on the fire alarm system control panel.<br><br>-<br><br>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;<br><br>All residents/staff have the same potential to be affected by this alleged deficient practice. the accurate time of day and date has been set on the fire alarm system control panel. maintenance director educated on 6/18/25 by the senor executive director on fire alarm system maintenance (see attachment 1).<br><br>. | 06/20/2025 |

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| | | | What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>the accurate time of day and date has been set on the fire alarm system control panel.<br>maintenance director educated on 6/18/25 by the senior executive director on fire alarm system maintenance (see attachment 1).<br>maintenance director/designee to conduct audit to ensure compliance (see attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as fire alarm system maintenance date/time will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance. | |

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| K 0353 SS=F Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br><br>Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.<br><br>Findings include:<br><br>Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 08/14/24 with the Maintenance Supervisor at 11:23 a.m. on 06/04/25, deficiencies were noted for the facility's two wet sprinkler systems during the inspection for the facility's two wet sprinkler systems. The | K 0353 | By what date the systemic changes will be completed;<br>Completion date: 6/20/25<br><br>**We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. sprinkler head replacement to be completed with IEI already providing a quote for replacement of 169 sprinkler heads and the freezer cooler sprinkler heads. A temporary waiver request is attached to allow for the facility time to correct this concern (see attachment ).<br><br>-<br><br>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;<br><br>All residents/staff have the same potential to be affected by this alleged deficient practice. | 09/20/2025 |

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| | 155160 | A. BUILDING 01<br>B. WING | 06/04/2025 |

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| STONEBROOKE REHABILITATION CENTER | 990 N 16TH ST<br>NEW CASTLE, IN 47362 |

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| | "Deficiency Summary" section of the 08/14/24 sprinkler system inspection report stated "Technicians performed a site survey for this building earlier this year and quoted to replace 169 total heads for being painted. IEI has already provided a quote for this work to be completed". In addition, "Freezer/cooler heads are dated 2019 and due to be replaced". In addition, review of the sprinkler system inspection contractor's letter dated 05/21/25 indicated "recently, facility staff performed a walk-through of your property and noted multiple painted sprinkler heads throughout the building need to be replaced. Parts have been ordered and once they are received, we will return to replace these painted heads". Based on interview at 11:23 a.m. on 06/04/25, the Maintenance Supervisor stated deficiencies noted by the contractor on 08/14/24 had not yet been corrected, the 08/14/24 inspection report deficiencies are related to the 05/21/25 contractor letter and agreed the correction of sprinkler head deficiencies had not yet been performed on or after 08/14/24.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | sprinkler head replacement to be completed with IEI already providing quote for replacement of 169 sprinkler heads and the freezer cooler sprinkler heads. A temporary waiver request is attached to allow for the facility time to correct this concern (see attachment 3). maintenance director was educated by the senior executive director on 6/18/25 on sprinkler system maintenance (see attachment 1).<br><br>.<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; sprinkler head replacement to be completed with IEI already providing quote for replacement of 169 sprinkler heads and the freezer cooler sprinkler heads. A temporary waiver request is attached to allow the facility ample time to correct this concern (see attachment 3). maintenance director was educated by the senior executive director on 6/18/25 on sprinkler system maintenance (see attachment 1). maintenance director/designee to audit to ensure compliance (see | |

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| | | | attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as sprinkler head maintenance will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>Completion date: 9/20/25 | |
| K 0355<br>SS=E<br>Bldg. 01 | NFPA 101<br>Portable Fire Extinguishers<br><br>1. Based on observation and interview, the facility failed to ensure 1 of 22 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 | K 0355 | **We respectfully request desk review in this matter. Thank you for your consideration.** | 06/20/2025 |

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| | requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states that each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 10 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Maintenance Supervisor at 12:49 p.m. on 06/04/25, the fire extinguisher inspection contractor had affixed a maintenance tag to the wall mounted ABC type portable fire extinguisher installed in the first floor soiled utility room across from the Lounge/Dining room indicating the most recent annual maintenance was performed in August 2020. Based on interview at 12:49 p.m. on 06/04/25, the Maintenance Supervisor stated he did not know a fire extinguisher was located in the room and agreed the most recent annual maintenance performed for the aforementioned portable fire extinguisher location was more than one year old.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during | | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. maintenance performed on fire extinguishers on first floor soiled utility room and storage room in therapy room and now up to date.<br><br>-<br><br>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;<br><br>All residents/staff have the same potential to be affected by this alleged deficient practice. maintenance performed on fire extinguishers on first floor soiled utility room and storage room in therapy room and now up to date. maintenance director educated by the senior executive director on 6/18/25 on portable fire extinguisher maintenance (see attachment 1).<br><br>.<br><br>What measures will be put into place or what systemic changes | |

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| | the exit conference.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 2 of 22 portable fire extinguishers had the date of current 6-year maintenance documented on the extinguisher in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Sections 7.3.3.1 through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect over 20 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Maintenance Supervisor at 12:10 p.m. on 06/04/25, documentation affixed to the wall mounted ABC type portable fire extinguisher installed by the | | will be made to ensure that the deficient practice does not recur; maintenance performed on fire extinguishers on first floor soiled utility room and storage room in the therapy room and now up to date. maintenance director was educated by the senior executive director on 6/18/25 on portable fire extinguisher maintenance (see attachment 1). Maintenance director/designee to audit to ensure compliance (see attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as portable fire extinguisher maintenance (see attachment 2) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance. | |

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| | Storage Room in the Therapy Room indicated it was manufactured in 2016. The portable fire extinguisher had an affixed 6-year maintenance sticker indicating the most recent 6-year maintenance was performed June 2023, but the extinguisher was not equipped with a verification of service collar. Based on interview at 12:10 p.m. on 06/04/25, the Maintenance Supervisor agreed the aforementioned portable fire extinguisher was not equipped with a verification of service collar. Based on observations with the Maintenance Supervisor at 12:48 p.m. on 06/04/25, the maintenance sticker and verification service collar affixed to the ABC type portable fire extinguisher affixed to the corridor wall by the elevator equipment room on the first floor indicated the most recent 6-year maintenance was performed in June 2016. Based on interview at 12:48 p.m. on 06/04/25, the Maintenance Supervisor agreed the most recent 6-year maintenance for the aforementioned portable fire extinguisher was not current.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | By what date the systemic changes will be completed; 6/20/25<br>Completion date: | |
| K 0363<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br><br>Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. | K 0363 | **We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the | 06/20/2025 |

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| | Findings include:<br><br>Based on observations with the Maintenance Supervisor at 1:24 p.m. on 06/04/25, the corridor door to resident sleeping Room 235 and to Room 236 were each propped in the fully open position with a trash can placed on the floor up against the door. Based on interview at 1:24 p.m. on 06/04/25, the Maintenance Supervisor agreed the corridor door to resident sleeping Room 235 and Room 236 each had an impediment to closing and latching into the door frame.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | deficient practice; no residents were affected by this alleged deficient practice. Doors to rooms 235 and 236 have been corrected and open/close correctly and positively latch.<br><br>-<br><br>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;<br><br>All residents/staff have the same potential to be affected by this alleged deficient practice. Doors to resident rooms 235 and 236 have been corrected an open/close and positively latch. Maintenance director educated by the senior executive director on 6/18/25 on corridor door maintenance and positive latching (see attachment 1).<br><br>.<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; doors to 235 and 236 resident rooms have been corrected. maintenance director educated by | |

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| | | | the senior executive director on 6/18/25 on corridor door maintenance and positive latching (see attachment 1). Maintenance director/designee to audit to ensure compliance (see attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as corridor doors will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>Completion date: 6/20/25 | |
| K 0511<br>SS=D<br>Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric | | | |

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| | Based on observation and interview, the facility failed to ensure receptacles in 1 of over 50 resident sleeping rooms were properly grounded in accordance with NFPA 70. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F).<br>(A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type.<br>Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3).<br>Exception: Nongrounding-type receptacles installed in accordance with 406.4(D).<br>(B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor.<br>Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34.<br>Exception No. 2: Replacement receptacles as permitted by 406.4(D).<br>(C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. | K 0511 | **We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. The electrical wall receptacle in question in room 229 has been corrected.<br><br>-<br><br>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;<br><br>All residents/staff have the same potential to be affected by this alleged deficient practice. The electrical wall receptacle in question in room 229 has been corrected. The maintenance director was educated by the senior executive director on 6/18/25 on utilities and receptacles meeting required guidelines (see attachment 1).<br><br>. | 06/20/2025 |

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| | Informational Note No. 1: See 250.118 for acceptable grounding means.<br>Informational Note No. 2: For extensions of existing branch circuits, see 250.130.<br>This deficient practice could affect one resident and staff in resident sleeping Room 229.<br><br>Findings include:<br><br>Based on observations with the Maintenance Supervisor at 1:22 p.m. on 06/04/25, the four electrical receptacles in the wall mounted quad outlet box installed at the head of the resident bed nearest the corridor door in resident sleeping Room 229 were found to have a "hot neutral" when tested with an Ideal Industries UL listed circuit tester testing device. Based on interview at 1:22 p.m. on 06/04/25, the Maintenance Supervisor agreed the testing device showed the aforementioned electrical receptacle location needed repair.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>The electrical wall receptacle in question in room 229 has been corrected(see attachment 1). maintenance director/designee to audit to ensure compliance (see attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as electrical wall receptacles (see attachment 2) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>Completion date: 6/20/25 | |

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| K 0918 SS=F Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br><br>Based on record review, observation and interview; the facility failed to ensure a complete written record of monthly testing of emergency generator starting batteries was maintained for 11 months of the most recent 12 month period in accordance with NFPA 99. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. NFPA 110, Section 8.3.7.1 states the maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of the generator inspection contractor's "Inspection Report" documentation dated 03/10/25 with the Maintenance Supervisor at 11:23 a.m. on 06/04/25, the results of emergency generator starting battery testing was listed as passing. Review of Direct Supply TELS Logbook Documentation "Emergency Generators: Test generator under load" documentation dated 05/06/25 and 06/03 stated "N/A" in response to "Battery Specific Gravity" and "Battery Conductance Test". Based on interview at 11:23 a.m. on 06/04/25, the Maintenance Supervisor stated additional emergency generator starting battery testing documentation for the most recent twelve month period was not available for review | K 0918 | **We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. a complete written record of monthly testing of emergency generator starting batteries is currently being documented.<br><br>-<br><br>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;<br><br>All residents/staff have the same potential to be affected by this alleged deficient practice. record of monthly testing on generator starting batteries is currently being documented. maintenance director educated on 6/18/25 by the senior executive director on generator maintenance testing/documentation (see attachment 1). | 06/20/2025 |

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| STONEBROOKE REHABILITATION CENTER | 990 N 16TH ST<br>NEW CASTLE, IN 47362 |

| (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 |
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| | and stated he does not perform battery electrolyte testing or monthly conductance testing. Based on observations with the Maintenance Supervisor at 1:00 p.m. on 06/04/25, the facility has one diesel-fuel fired emergency generator located outside the building on the south east side of the property. Manufacturer's nameplate documentation affixed to the generator indicated it was rated at 500 kW.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | .<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>record of monthly testing on generator starting batteries is currently being documented. maintenance director educated on 6/18/25 by the senior executive director on generator maintenance testing/documentation (see attachment 1). maintenance director/designee to audit to ensure compliance (see attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as generator starting batteries will be | |

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|---|---|---|---|
| | 155160 | A. BUILDING 01<br>B. WING | 06/04/2025 |

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| | | | completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>Completion date: 6/20/25 | |
| K 0923<br>SS=E<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Cylinder and Container Storag<br>Based on observation and interview, the facility failed to ensure 1 of 1 indoor oxygen storage areas was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 3000 cubic feet shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section 5.1.3.3.2 states, if indoors, storage locations of positive-pressure gases shall be constructed and use interior finishes of noncombustible or limited combustible materials such that all walls, floor, ceilings, and doors are of minimum 1-hour fire resistant rating. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room on the second floor.<br><br>Findings include:<br><br>Based on observations with Maintenance Supervisor while using a ladder at 2:01 p.m. on 06/04/25, a horizontal sprinkler pipe penetrated the wall of the oxygen storage and transfilling room on the second floor above the suspended ceiling | K 0923 | **We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. the sprinkler pipe in question is now firestopped.<br><br>-<br><br>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;<br><br>All residents/staff have the same potential to be affected by | 06/20/2025 |

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| | above the entrance door to the room. The annular space surrounding the sprinkler pipe was not firestopped to ensure the room was enclosed with a minimum 1-hour fire resistance rating. Five liquid oxygen containers and eleven 'E' type oxygen cylinders were stored in the room. Based on interview at 2:01 p.m. on 06/04/25, the Maintenance Supervisor agreed the annular space surrounding the sprinkler pipe penetration was not firestopped to ensure the room was enclosed with a minimum 1-hour fire resistance rating.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | this alleged deficient practice. the sprinkler pipe in question is now fire stopped. maintenance director was educated on 6/18/25 b the senior executive director on gas equipment and indoor oxygen storage areas (see attachment 1).<br><br>.<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>the sprinkler pipe in question is now fire stopped. maintenance director educated on 6/18/25 by the senior executive director on gas equipment ad indoor oxygen storage areas (see attachment 1). maintenance director/designee to audit to ensure compliance (see attachment 2).<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI | |

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| | | | program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as sprinkler pipe fire stoppage/oxygen storage will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>Completion date: 6/20/25 | |
| K 0927<br>SS=E<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br><br>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfilling locations was in accordance with NFPA 99 Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) a designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction mechanically vented and was provided with a precautionary sign indicating that smoking in the immediate area is not permitted. Section 11.5.2.3.1(2) states the area is mechanically vented. Section 11.5.2.3.1(3) states the transfilling of liquid oxygen area shall be posted with a sign indicating that transfilling is occurring. This deficient practice could affect over 10 residents, staff and visitors in the vicinity | K 0927 | **We respectfully request desk review in this matter. Thank you for your consideration.**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. the sprinkler pipe in question is now firestopped.<br><br>-<br><br>How other residents having the | 06/20/2025 |

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| | of the oxygen storage and transfilling room on the second floor.<br><br>Findings include:<br><br>Based on observations with Maintenance Supervisor while using a ladder at 2:01 p.m. on 06/04/25, a horizontal sprinkler pipe penetrated the wall of the oxygen storage and transfilling room on the second floor above the suspended ceiling above the entrance door to the room. The annular space surrounding the sprinkler pipe was not firestopped to ensure the room was enclosed with a minimum 1-hour fire resistance rating. Five liquid oxygen containers and eleven 'E' type oxygen cylinders were stored in the room. Based on interview at 2:01 p.m. on 06/04/25, the Maintenance Supervisor agreed the annular space surrounding the sprinkler pipe penetration was not firestopped to ensure the oxygen storage and transfilling room was enclosed with a minimum 1-hour fire resistance rating.<br><br>These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;<br><br>All residents/staff have the same potential to be affected by this alleged deficient practice. the sprinkler pipe in question is now firestopped. the maintenance director was educated by the senior executive director on 6/18/25 on indoor oxygen storage areas (see attachment 1).<br><br>.<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; the sprinkler pipe in question is now firestopped. the maintenance director was educated by the senior executive director on 6/18/25 on indoor oxygen storage areas (see attachment 1). the maintenance director/designee to audit to ensure compliance (see attachment 2).<br><br>How the corrective action(s) will be | |

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| | | | monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director.<br>CQI tool identified as indoor oxygen storage areas will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If Threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>Completion date: 6/20/25 | |
| K 0000<br><br>Bldg. 02 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 06/04/25<br><br>Facility Number: 000080<br>Provider Number: 155160<br>AIM Number: 100289330 | K 0000 | | |

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| | At this Life Safety Code survey, Stonebrooke Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.<br><br>Bldg 02, which is the renovated portion of the A Wing on the second floor for the conversion of offices to resident sleeping rooms 201, 203, 205, 207 and 209 through 217 in 2017. Bldg 02 was surveyed using (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. 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 and has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 117 and had a census of 76 at the time of this visit.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had one detached wooden storage sheds and one detached metal storage shed which were not sprinklered.<br><br>Quality Review completed on 06/09/25. | | | |