STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		155160	B. W	NG		06/04/	2025
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	-			16TH ST		
STONED	DOOKE BEHVBILI	TATION CENTER			ASTLE, IN 47362		
STUNED	ROOKE REHABILI	TATION CENTER		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Preparedness Survey was		E 0	000			
		diana Department of Health in		700			
	accordance with 42 CFR 483.73.						
	Survey Date: 06/04	./25					
	Burvey Bute. 00/01	725					
	Facility Number: 0	00080					
	Provider Number:						
	AIM Number: 1002						
	Anvi Number. 1002	207330					
	At this Emergency Presented associations						
	At this Emergency Preparedness survey, Stonebrooke Rehabilitation Center was found in						
		nergency Preparedness					
		ledicare and Medicaid					
		lers and Suppliers, 42 CFR					
	483.73	iers and Suppliers, 42 CFK					
	463.73						
	The facility has 117	certified beds. At the time of					
	the survey, the cens	us was 76.					
	O1' D'	1-4-1 06/00/25					
	Quality Review con	npieted on 06/09/23					
K 0000							ļ
K 0000							
Bldg 01							
Bldg. 01	A Life Sefet C-1	Recertification and State	17.0	000			ĺ
			K 0	000			
	-	as conducted by the Indiana					
		th in accordance with 42 CFR					
	483.90(a).						
	G D : 06/04	/0.5					
	Survey Date: 06/04	1/23					
	T 117 NT 1 A	0000					
	Facility Number: 0						
	Provider Number: 155160						
	AIM Number: 1002	289330					
	A. d. 110 0 0 0						
	At this Life Safety (Code survey, Stonebrooke					
					l		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

keith davis Senior executive director 06/25/2025

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EIN321 Facility ID: 000080 If continuation sheet Page 1 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155160		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/04/2025				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 N 16TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	with Requirements Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I Health Care Occupa Bldg 01, which is the building, was su Safety Code (LSC), Care Occupancies a two-story facility w (111) construction a has a fire alarm syst levels including the corridors and has ba detectors in all resic facility has a capaci 76 at the time of thi All areas where resi were sprinkled and services were sprinkled and services were sprinkled and services were sprinkled metal stors sprinklered. Quality Review core	the and the 2012 edition of the etion Association (NFPA) 101, and and the 2012 edition of the etion Association (NFPA) 101, and and an array of the etion Association (NFPA) 101, and an array of the etion Association (NFPA) 101, and array of the etion o						
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress							
	failed to ensure 3 of continuously mainta or impediments to f fire or other emerge	on and interview, the facility if 8 means of egress were ained free of all obstructions full instant use in the case of ency. This deficient practice dents, staff and visitors if	K 0211	We respectfully request desi review in this matter. Thank you for your consideration. What corrective action(s) will lead to the second secon				
	needing to exit the			accomplished for those reside				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 2 of 29

06/26/2025 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/04/2025 155160 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 990 N 16TH ST STONEBROOKE REHABILITATION CENTER NEW CASTLE. IN 47362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE found to have been affected by the Findings include: deficient practice; no residents were affected b this alleged Based on observation with the Maintenance deficient practice. tables removed Supervisor during the initial walk through of the from corridor outside the first floor facility at 9:05 a.m. on 06/04/25, a long folding therapy room. linen carts and two table was upright and stored in the corridor stacked chairs were removed from outside the first floor Therapy Room. The table corridor outside laundry room. projected 36 inches into the eight foot wide three carts removed from corridor corridor. Two additional long folding tables were outside dietary. three wood pallets collapsed and stacked on top of the table. from corridor outside the nurse In addition, the following was noted: scheduler office on the second a. at 2:12 p.m. on 06/04/25, the long folding table floor have been removed. was still stored in the corridor outside the first floor Therapy Room. 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 How other residents having the observed stored in the corridor outside the potential to be affected by the Laundry room. same deficient practice will be c. at 1:15 p.m. and again at 2:08 p.m., three carts for identified and what corrective coffee serving were stored in the corridor outside action(s) will be taken; all Dietary. residents have he potential to be d. at 1:43 p.m. three wood pallets were stored in affected by this alleged deficient the corridor outside the Nurse Scheduler Office on practice, all items of concern the second floor. Based on interview at 1:43 p.m., listed have been removed from the Maintenance Supervisor stated the pallets are said corridors, maintenance from regular deliveries and would be picked back director educated on 6/18/25 by up twice per week but remain stored in the the senior executive director on corridor until the next delivery. . monitoring means of egress (see Based on interview at the time of each of the attachment 1). 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

the exit conference.

These findings were reviewed with the Executive Director and the Maintenance Supervisor during

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

What measures will be put into

place or what systemic changes will be made to ensure that the

Page 3 of 29

06/26/2025 PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì ′		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155160	A. BU B. WI	IILDING NG	<u>01</u>	06/04		
	PROVIDER OR SUPPLIEF			990 N	ADDRESS, CITY, STATE, ZIP COD			
STONEB	ROOKE REHABILI	TATION CENTER		NEW C	CASTLE, IN 47362			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	3.1-19(b)				deficient practice does not rec			
					maintenance director educat			
					by the senior executive direct			
					6/18/25 on maintaining means	s of		
					egress (see attachment 1).			
				appropriate corrections were				
				immediately by removing all it				
				of concern from said corridors				
					maintenance director/designe	e to		
					conduct audit to ensure	0)		
				compliance. (see attachment	2).			
					How the corrective action(s) v	vill he		
					monitored to ensure the defici			
					practice will not recur, what qu			
					assurance program will be pu	-		
					place;			
					Ongoing compliance with	า		
					this corrective action will be			
					monitored via facility QAPI			
					program, with meetings being	held		
					every other month, and is			
					overseen by the Executive			
					Director.			
					CQI tool identified as me	ans		
					of egress (see attachment 2)	will		
					be completed weekly x 4 wee	ks,		
					monthly times 6 months, and			
					quarterly thereafter until			
					compliance is achieved.			
					If Threshold of 100% is	not		
					met, an action plan will be			
					developed to ensure compliar	nce.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

By what date the systemic changes will be completed;

Completion date: 6/20/25

If continuation sheet Page 4 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155160		A. BU	A. BUILDING <u>01</u> C		COMPL	3) DATE SURVEY COMPLETED 06/04/2025	
	PROVIDER OR SUPPLIED			990 N 1	ADDRESS, CITY, STATE, ZIP COD 16TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 0300 SS=F Bldg. 01	interview; the facilimaintenance for all in resident rooms with 4.6.12.3 states exist to the public, if not maintained. This diresidents, staff and Findings include: Based on review of Documentation "Documentation "Documentation" are recent twelve mont Supervisor at 11:23 operated smoke detwas not available for at 11:23 a.m. on 06 Director stated the operated smoke detrooms on a weekly documentation was time of the survey. during a tour of the documentation afficinstalled in resident clean the detector a 2:04 p.m. on 06/04 stated similar types detectors are install room. These findings were	review, observation and ity failed to ensure preventative battery operated smoke alarms vas documented. NFPA 101 in ting life safety features obvious required by the Code, shall be efficient practice could affect all	K 0.	300	We respectfully request des review in this matter. Thank you for your consideration. What corrective action(s) will accomplished for those reside found to have been affected deficient practice; no resided were affected by this alleged deficient practice. cleaning of smoke detector documentation. Tels system currently being utilized, smoke detector in row 243 has been replaced. 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/staff have the same potential to be affected this alleged deficient practice cleaning of smoke detector documentation is currently be utilized via the tels system, smoke detector in room 243 leading to the senience director educated by the senience director educated by the senience director reventative director preventative	be ents by the ents fon via om	06/20/2025

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155160 155160 A. BUILDING 01 COMPLETED 06/04/2025 STREET ADDRESS, CITY, STATE, ZIP COD 990 N 16TH ST NEW CASTLE, IN 47362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION A. BUILDING 01 COMPLETED 06/04/2025 STREET ADDRESS, CITY, STATE, ZIP COD 990 N 16TH ST NEW CASTLE, IN 47362 (X5) CRACH CORRECTION CRACH CORRECTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY) DATE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER STONEBROOKE REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP COD 990 N 16TH ST NEW CASTLE, IN 47362 (X5) PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
NAME OF PROVIDER OR SUPPLIER STONEBROOKE REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION			155160	B. W	NG		06/04/	/2025
NAME OF PROVIDER OR SUPPLIER STONEBROOKE REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION					STREET A	ADDRESS, CITY, STATE, ZIP COD		
STONEBROOKE REHABILITATION CENTER NEW CASTLE, IN 47362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL STONEBROOKE REHABILITATION CENTER ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	NAME OF F	PROVIDER OR SUPPLIEI	R					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION CROSS-REFERENCED TO THE APPROPRIATE COMPLETION)	STONEB	BROOKE REHABILI	ITATION CENTER		NEW CASTLE, IN 47362			
CROSS-REFERENCED TO THE APPROPRIATE	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
the exit conference. maintenance documentation and		the exit conference	•					
smoke detector usage including						_	-	
3.1-19(b) the 10 year life. (se attachment		3.1-19(b)					nt	
1).						1).		
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. What measures will be put into			•			•		
Section 14.4.8.1 states unless otherwise place or what systemic changes						1 -		
		recommended by the manufacturer's published						
instructions, single- and multiple-station smoke deficient practice does not recur;		_	-				cur;	
alarms shall be replaced when they fail to respond cleaning documentation of		_				_		
to operability tests but shall not remain in service smoke detectors is currently being						-	being	
longer than 10 years from the date of manufacture. utilized via the tels system.						-		
This deficient practice could affect over 10 smoke detector in room 243 has		_					ıas	
residents, staff and visitors in the vicinity of been replaced. maintenance						· · · · · · · · · · · · · · · · · · ·		
resident sleeping Room 243. director was educated on 6/18/25		resident sleeping R	oom 243.					
by the senior executive director on		F: 1: : 1 1				<u> </u>	or on	
Findings include: smoke detector preventative		Findings include:				•		
maintenance documentation and		Donad or street (one with the Maint					
Based on observations with the Maintenance smoke detector usage including the 10 year life (see attachment						_	-	
			-			,		
documentation affixed to the Kidde Model i9010 battery operated smoke alarm installed on the wall 1). maintenance director designee to conduct audit to ensure							yı i ce	
							2)	
in resident sleeping Room 243 indicated it was compliance (see attachment 2).						Compliance (see allachment /	<i>- J</i> .	
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 How the corrective action(s) will be						How the corrective action(s)	will he	
March 2020. Based on interview at 2:04 p.m. on monitored to ensure the deficient		_						
06/04/25, the Maintenance Supervisor stated practice will not recur, what quality		=						
newer smoke alarms are installed in sleeping assurance program will be put into		· ·	•			I	-	
rooms but agreed the manufacture date for the place;							. ano	
battery operated smoke alarm installed in resident Ongoing compliance with		_					h	
sleeping Room 243 was more than ten years old. this corrective action will be								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 6 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155160	B. WI	NG		06/04/	/2025
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t.			6TH ST		
STONEB	ROOKE REHABILI	TATION CENTER	NEW CASTLE, IN 47362				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	e reviewed with the Executive aintenance Supervisor during			monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as smodetector compliance (see attachment 2) will be completed weekly x 4 weeks, monthly tim 6 months, and quarterly therea until compliance is achieved. If Threshold of 100% is rimet, an action plan will be developed to ensure compliant. By what date the systemic changes will be completed;	oke ed les after not ce.	
K 0311 SS=E Bldg. 01	failed to ensure the in accordance of 19 enclosure is provide not less than a 1-ho 8.3.4.2 states the fir protectives shall be 8.3.4.2 except as ot 8.3.4.4. Table 8.3.4 in vertical shafts, in 1-hour fire resistance existing fire door as 3/4-hour fire protectic continue to be used enclosures in lieu or protection rating records.	- Enclosure on and interview, the facility protection of 1 of 4 stairwells .3.1. LSC 19.3.1.1 states where ed, the construction shall have ur fire resistance rating. LSC reprotection rating for opening in accordance with Table therwise permitted in 8.3.4.3 or .2 requires fire door assemblies cluding stairways, to have a retaing. LSC 8.3.4.3 states resemblies having a minimum on rating shall be permitted to in vertical openings and exit of the minimum 1-hour fire quired in Table 8.3.4.2. This rould affect 32 residents who	K 0.	311	We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; no residen were affected by this alleged deficient practice. The fire does question are scheduled for recertification. Temporary waive request attached to allow for the facility time to correct this condicion (see attachment 3).	oe nts y the ts rs in ver	09/20/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 7 of 29

PRINTED: 06/26/2025 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC		OMB NO. 0938-039				
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155160	B. WING		06/04/2025		
			CER PEG	TARRESS COMMA CITATE SUR COR			
NAME OF I	ROVIDER OR SUPPLIEI	R		T ADDRESS, CITY, STATE, ZIP COD			
				16TH ST			
STONEB	ROOKE REHABILI	ITATION CENTER	NEW	CASTLE, IN 47362			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
1110		floor and staff, and visitors in	1110	_	5.112		
	the third floor and l			_			
	the tima noor and t	basement.		Llavo ethan masidanta havina t	h -		
	E' 1' ' 1 1			How other residents having the			
	Findings include:			potential to be affected by the			
				same deficient practice will b			
		ons on 06/04/25 with the		identified and what corrective)		
	-	visor, the following was noted:		action(s) will be taken;			
	-	corridor door to the stairwell on					
	the first floor by Di	ietary was not equipped with a		All residents/staff have t	he		
	fire resistance ratin	g label on the hinge side of the		same potential to be affected	by		
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			this alleged deficient practice	. The			
			fire doors in question are				
			scheduled for recertification.				
	-	bel on the top of the door.		Temporary waiver request			
		corridor door to the stairwell on		attached to allow the facility t	ime		
	-	the Nurse Scheduler Office		to correct concern (see			
	-	vith a fire resistance rating		attachment 3). Maintenance			
		side of the door. At 1:52 p.m.,		•	ior.		
		_		director educated by the seni			
	while using a ladde			executive director on 6/18/25			
		second floor by the Nurse		vertical openings/fire resistan			
		vas also not equipped with a fire		rating labels and documentat	cion		
	_	bel on the top of the door.		(see attachment 1).			
		at 2:20 p.m. on 06/04/25, the					
		visor agreed that fire					
	_	ocumentation for the					
	aforementioned two	o stairwell door locations was					
	not available for re	view.					
	These findings wer	e reviewed with the Executive					
	Director and the M	aintenance Supervisor during		What measures will be put in	to		
	the exit conference	•		place or what systemic chang			
				will be made to ensure that the	-		
	3.1-19(b)			deficient practice does not re			
	. '			the fire doors in question are			
				scheduled for recertification.			
				Temporary waiver request			
				attached to allow the facility t	ime		
				-	iiiic		
				to correct this concern (see			
				attachment 3). maintenance			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

director educated by the senior

If continuation sheet

Page 8 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155160	A. BUILDING B. WING	01	COMPLETED 06/04/2025
	PROVIDER OR SUPPLIER BROOKE REHABILI		990 N ²	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				executive director on 6/18/25 vertical openings/ fire resistar rating labels and documentati (see attachment 1). maintena director /designee to audit to ensure compliance (see attachment 2).	nt on
				How the corrective action(s) we monitored to ensure the defic practice will not recur, what quassurance program will be purplace; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as fire door ratings/documentation who be completed weekly x 4 weemonthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is met, an action plan will be developed to ensure compliant By what date the systemic changes will be completed; Completion date: 9/20/25	ient uality t into n held viill ks,
K 0345 SS=C	NFPA 101 Fire Alarm System	a - Testing and			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 9 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155160		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/04/2025	
	ROVIDER OR SUPPLIER		•	990 N 1	ADDRESS, CITY, STATE, ZIP COD 6TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤЕ	(X5) COMPLETION DATE
Bldg. 01	failed to maintain the that it had accurate to accordance with the 2012 edition, Section 2010 edition, Section deficient practice control particles and visitors. Findings include: Based on observation Supervisor at 12:55 system control pane p.m. at 12:55 p.m. on 06/04/25, the Matthe fire alarm system displayed the incorron. These findings were	on and interview, the facility are fire alarm system to ensure time and date information in requirements of NFPA 101, and 19.3.4 and 9.6 and NFPA 72, and 14.1 and 14.1.1. This could affect all residents, staff ons with the Maintenance p.m. on 06/04/25, the fire alarm 1 read the time of day as 1:11 Based on interview at 12:55 p.m. sintenance Supervisor agreed in control panel for the facility eet time of day. The reviewed with the Executive content of the executive	K 0	345	We respectfully request desireview in this matter. Thank you for your consideration. What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; no resident were affected by this alleged deficient practice. the accurate time of day and date has been on the fire alarm system contribution panel. 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/staff have the same potential to be affected this alleged deficient practice. accurate time of day and date been set on the fire alarm system residents altered the senor executive director of alarm system maintenance (sea attachment 1).	be ents y the lits en set lool le by the has tem by n fire	06/20/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 10 of 29

	OF HEALTH AND HUN					TED: 06/26/2025 RM APPROVED B NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155160	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/04/2025	
	ROOKE REHABILI		STREET A 990 N 1 NEW C			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤЕ	(X5) COMPLETION DATE
				What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not receive the accurate time of day and date has been set on the fire alarm system control panel. maintenance director educate 6/18/25 by the senior executive director on fire alarm system maintenance (see attachment maintenance director/designer conduct audit to ensure compliance (see attachment 2)	es e cur; d d on re	

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;

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.

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.

If Threshold of 100% is not met, an action plan will be developed to ensure compliance.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 11 of 29

PRINTED: 06/26/2025 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155160 B. WING 06/04/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 990 N 16TH ST STONEBROOKE REHABILITATION CENTER NEW CASTLE. IN 47362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE By what date the systemic changes will be completed; Completion date: 6/20/25 K 0353 **NFPA 101** SS=F Sprinkler System - Maintenance and Testing Bldg. 01 Based on record review and interview, the facility K 0353 We respectfully request desk 09/20/2025 failed to maintain automatic sprinkler systems in review in this matter. Thank accordance with NFPA 25. LSC 9.7.5 requires all you for your consideration. sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of What corrective action(s) will be Water-Based Fire Protection Systems. NFPA 25, accomplished for those residents 2011 Edition, Section 4.1.4.1 states the property found to have been affected by the owner or designated representative shall correct deficient practice; no residents or repair deficiencies or impairments that are were affected by this alleged found during the inspection, test and maintenance deficient practice. sprinkler head required by this standard. Corrections and repairs replacement to be completed with shall be performed by qualified maintenance IEI already providing a quote for personnel or a qualified contractor. NFPA 25, replacement of 169 sprinkler 4.3.1 requires records shall be made for all heads and the freezer cooler inspections, tests, and maintenance of the system sprinkler heads. A temporary components and shall be made available to the waiver request is attached to allow authority having jurisdiction upon request. This for the facility time to correct this deficient practice could affect all residents, staff concern (see attachment). and visitors in the facility. Findings include: How other residents having the Based on review of the sprinkler system potential to be affected by the inspection contractor's "Form for Inspection, same deficient practice will be Testing and Maintenance of Wet Pipe Fire identified and what corrective Sprinkler Systems" documentation dated 08/14/24 action(s) will be taken; with the Maintenance Supervisor at 11:23 a.m. on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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

EIN321

Facility ID: 000080

If continuation sheet

All residents/staff have the

same potential to be affected by

this alleged deficient practice.

Page 12 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/04/2025 155160 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 990 N 16TH ST STONEBROOKE REHABILITATION CENTER NEW CASTLE. IN 47362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE "Deficiency Summary" section of the 08/14/24 sprinkler head replacement to be sprinkler system inspection report stated completed with IEI already "Technicians performed a site survey for this providing quote for replacement of building earlier this year and quoted to replace 169 169 sprinkler heads and the total heads for being painted. IEI has already freezer cooler sprinkler heads. A provided a quote for this work to be completed". temporary waiver request is In addition, "Freezer/cooler heads are dated 2019 attached to allow for the facility and due to be replaced". In addition, review of time to correct this concern (see the sprinkler system inspection contractor's letter attachment 3). maintenance dated 05/21/25 indicated "recently, facility staff director was educated by the performed a walk-through of your property and senior executive director on noted multiple painted sprinkler heads throughout 6/18/25 on sprinkler system the building need to be replaced. Parts have been maintenance (see attachment 1). 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 What measures will be put into after 08/14/24. place or what systemic changes will be made to ensure that the These findings were reviewed with the Executive deficient practice does not recur; Director and the Maintenance Supervisor during sprinkler head replacement to be the exit conference. completed with IEI already providing quote for replacement of 3.1-19(b) 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 13 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155160		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 COMPL B. WING 06/04/		LETED		
	PROVIDER OR SUPPLIE	R ITATION CENTER	•	990 N ²	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) attachment 2).	λΤΕ	(X5) COMPLETION DATE
					How the corrective action(s) we monitored to ensure the defici practice will not recur, what que assurance program will be put place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as sprinkler head maintenance we completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is a met, an action plan will be developed to ensure compliance by what date the systemic changes will be completed; Completion date: 9/20/25	ent uality t into held vill be not nce.	
K 0355 SS=E Bldg. 01	failed to ensure 1 c was given mainten	nguishers ation and interview, the facility of 22 portable fire extinguishers ance at periods not more than PA 10, the Standard for	K 0	355	We respectfully request desl review in this matter. Thank you for your consideration.	k	06/20/2025
		guishers, at Section 7.3.1.1.1					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 14 of 29

PRINTED: 06/26/2025 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPL	ETED
		155160	B. WING		06/04/	/2025
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	L		16TH ST		
STONEE	ROOKE REHABILI	TATION CENTER	NEW (CASTLE, IN 47362		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	_	tinguishers shall be subjected		What corrective action(s) will be		
		ntervals of not more than 1		accomplished for those reside		
	-	hydrostatic test, or when		found to have been affected b	-	
		ed by an inspection or		deficient practice; no resident	S	
		on. Section 3.3.15 defines		were affected by this alleged		
		nance as a thorough		deficient practice. maintenanc		
		fire extinguisher that is		performed on fire extinguisher		
	_	ximum assurance that a fire		first floor soiled utility room an		
		perate effectively and safely		storage room in therapy room	and	
		physical damage or condition		now up to date.		
	will prevent its operation, if any repair or replacement is necessary, and if hydrostatic					
	_			-		
		naintenance is required.			_	
		that each fire extinguisher		How other residents having th	е	
	_	abel securely attached that		potential to be affected by the		
		and year the maintenance was		same deficient practice will be		
	_	es the person performing the		identified and what corrective		
		the name of the agency		action(s) will be taken;		
		k. This deficient practice could		All : 1 / / 651		
	affect over 10 reside	ents, staff and visitors.		All residents/staff have th		
	F' 1' ' 1 1			same potential to be affected	by	
	Findings include:			this alleged deficient practice.		
	Događar store d	ons with the Maintenance		maintenance performed on fire		
				extinguishers on first floor soil		
	_	p.m. on 06/04/25, the fire tion contractor had affixed a		utility room and storage room		
		the wall mounted ABC type		therapy room and now up to d		
	_	uisher installed in the first floor		maintenance director educate	-	
		across from the Lounge/Dining		the senior executive director of)I I	
	room indicating the			6/18/25 on portable fire extinguisher maintenance (see	۵.	
		erformed in August 2020.		attachment 1).	5	
		at 12:49 p.m. on 06/04/25, the		attaciiiiciit i j.		
		visor stated he did not know a				
	_	as located in the room and				
		ent annual maintenance				
	-	forementioned portable fire				
		n was more than one year old.				
	CAMINGUISHEI IOCAHO	n was more man one year old.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

These findings were reviewed with the Executive

Director and the Maintenance Supervisor during

EIN321

Facility ID: 000080

If continuation sheet

What measures will be put into

place or what systemic changes

Page 15 of 29

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155160	B. W	ING		06/04/2025	
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R					
STONED	ROOKE REHABILI	ITATION CENTER		990 N 16TH ST NEW CASTLE, IN 47362			
STUNEB	NOUNE REPABILI	TIATION CENTER		INLAN CHOILE, IN 47 302			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	the exit conference.				will be made to ensure that the	е	
					deficient practice does not rec	ur;	
	3.1-19(b)				maintenance performed on fir	re .	
					extinguishers on first floor soil	ed	
		ation and interview, the facility			utility room and storage room	in	
		f 22 portable fire extinguishers			the therapy room and now up	to	
		rent 6-year maintenance			date. maintenance director wa	as	
		extinguisher in accordance			educated by the senior execut	tive	
		FPA 10, 2010 Edition, Section			director on 6/18/25 on portable	e fire	
		extinguishers shall be internally			extinguisher maintenance (see	е	
		als not exceeding those			attachment 1). Maintenance		
	specified in Table 7	7.3.1.1.2. Section 7.3.1.2.1 states			director/designee to audit to		
	every six years, stor	red pressure fire extinguishers			ensure compliance (see		
	that require a 12-ye	ear hydrostatic test shall be			attachment 2).		
		ted to the applicable internal					
	examination proced	dure as detailed in the					
	manufacturer's serv	vice manual and this standard.					
	Sections 7.3.3.1 thr	rough 7.3.3.2 state fire					
	extinguishers that p	pass the applicable 6-year			How the corrective action(s) w	ill be	
	requirement shall h	ave the maintenance			monitored to ensure the defici-	ent	
	information records	ed on a durable weatherproof			practice will not recur, what qu	ıality	
	label that is a minin	num size of 2 inches by 3.5			assurance program will be put	tinto	
		hall be affixed to the shell and			place;		
		onth and year the maintenance			Ongoing compliance with	1	
		ne label shall include the initials			this corrective action will be		
		rming the maintenance and the			monitored via facility QAPI		
	1	performing the maintenance.			program, with meetings being	held	
		ervice collar shall be located			every other month, and is		
		the container indicating the			overseen by the Executive		
	I -	service and the name of the			Director.		
	0 11	the maintenance or recharge.			CQI tool identified as		
		tice could affect over 20			portable fire extinguisher		
	residents, staff and	visitors.			maintenance (see attachment	2)	
					will be completed weekly x 4		
	Findings include:				weeks, monthly times 6 month	ıs,	
					and quarterly thereafter until		
		ons with the Maintenance			compliance is achieved.		
	Supervisor at 12:10	-			If Threshold of 100% is r	not	
		xed to the wall mounted ABC			met, an action plan will be		
	type portable fire ex	xtinguisher installed by the			developed to ensure complian	ice.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet Page 16 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155160	B. W	ING	NG 06/04		2025
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			I6TH ST		
STONER	ROOKE REHABILI	TATION CENTER		NEW CASTLE, IN 47362			
OTONED		TATION CENTER		INLVV			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Storage Room in the Therapy Room indicated it was manufactured in 2016. The portable fire						
					By what date the systemic		
	-	affixed 6-year maintenance			changes will be completed;		
	sticker indicating the most recent 6-year maintenance was performed June 2023, but the				6/20/25		
					Completion date:		
	_	ot equipped with a verification					
		Based on interview at 12:10 p.m.					
		aintenance Supervisor agreed					
		portable fire extinguisher was					
		a verification of service collar.					
		ons with the Maintenance					
	-	3 p.m. on 06/04/25, the					
		r and verification service collar					
		type portable fire extinguisher					
		dor wall by the elevator					
		the first floor indicated the					
		maintenance was performed in					
		on interview at 12:48 p.m. on					
		tenance Supervisor agreed the					
		maintenance for the					
	_	rtable fire extinguisher was not					
	current.						
	Trl (* 1'	: 1 M A E &					
	_	e reviewed with the Executive					
	the exit conference.	aintenance Supervisor during					
	the exit conference.	•					
	3.1-19(b)						
	3.1-19(0)						
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Comaci Boord						
ug. v .	Based on observation	on and interview, the facility	$ _{K0}$	363	We respectfully request desk	«	06/20/2025
		f over 50 corridor doors to	10	303	review in this matter. Thank	`	00/20/2023
	resident sleeping ro	ooms had no impediment to			you for your consideration.	ļ	
		g into the door frame and				ļ	
	-	ssage of smoke. This deficient				ļ	
	_	et over 20 residents, staff and			What corrective action(s) will be	эе	
	visitors.	•			accomplished for those reside		
					found to have been affected b		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet Page 17 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155160	A. BUILDING B. WING	<u>01</u>	COMPLETED 06/04/2025
	PROVIDER OR SUPPLIER		990 N	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	Findings include: Based on observation Supervisor at 1:24 pure door to resident sleet 236 were each proper with a trash can place door. Based on interest the Maintenance Surdoor to resident sleet each had an impediment of the door frame. These findings were	ons with the Maintenance o.m. on 06/04/25, the corridor eping Room 235 and to Room ped in the fully open position ced on the floor up against the erview at 1:24 p.m. on 06/04/25, pervisor agreed the corridor eping Room 235 and Room 236 ment to closing and latching	IAU	deficient practice; no resident were affected by this alleged deficient practice. Doors to re 235 and 236 have been correct and open/close correctly and positively latch. 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/staff have the same potential to be affected this alleged deficient practice. Doors to resident rooms 235 at 236 have been corrected an open/close and positively latch Maintenance director educate the senior executive director of 6/18/25 on corridor door maintenance and positive later (see attachment 1). What measures will be put interplace or what systemic change will be made to ensure that the deficient practice does not recommon doors to 235 and 236 resident	e e e e e e e e e e e e e e e e e e e
				rooms have been corrected.	d by

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 18 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

	PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COMP		1	e survey pleted 4/2025		
	PROVIDER OR SUPPLIEF		990 N ²	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
IAU	REGULATORY OF	A LOC IDENTIFITING INFURMATION	IAU	the senior executive director 6/18/25 on corridor door maintenance and positive later (see attachment 1). Maintenant director/designee to audit to ensure compliance (see attachment 2). How the corrective action(s) we monitored to ensure the defici practice will not recur, what que assurance program will be purplace; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as corrective. CQI tool identified as corrective. CQI tool identified as corrective. If Threshold of 100% is and quarterly thereafter until compliance is achieved. If Threshold of 100% is and action plan will be developed to ensure compliant. By what date the systemic changes will be completed; Completion date: 6/20/25	hing nice vill be ent uality to into the held ridor ly x niths, the hot nice.	DATE
K 0511 SS=D	NFPA 101 Utilities - Gas and	Electric				

FORM CMS-2567(02-99) Previous Versions Obsolete

Bldg. 01

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 19 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155160	B. W	ING	_	06/04/2	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L	990 N 16TH ST				
STONEB	ROOKE REHABILI	TATION CENTER		NEW CASTLE, IN 47362			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		on and interview, the facility	K 0	511	We respectfully request desi	K	06/20/2025
		eptacles in 1 of over 50			review in this matter. Thank		
		oms were properly grounded			you for your consideration.		
		NFPA 70. LSC 19.5.1.1					
	-	mply with Section 9.1. LSC					
	-	rical wiring and equipment to			What corrective action(s) will I		
		70, National Electrical Code.			accomplished for those reside		
		tion at 406.4 General Installation receptacle outlets shall be			found to have been affected b	· .	
	-	receptacte outlets snall be reuits in accordance with Part			deficient practice; no residen	iis	
		General installation requirements			were affected by this alleged deficient practice. The electric		
		ice with 406.4(A) through (F).			wall receptacle in question in		
		e. Receptacles installed on 15-			229 has been corrected.	100111	
		ich circuits shall be of the			223 rias been corrected.		
	grounding type.	ion chedita shan ac at the			_		
		eptacles shall be installed only					
		oltage class and current for			How other residents having th	e l	
		d, except as provided in Table			potential to be affected by the		
	210.21(B)(2) and Ta				same deficient practice will be		
		anding-type receptacles			identified and what corrective		
	installed in accorda				action(s) will be taken;		
	(B) To Be Grounde	d. Receptacles and cord					
	connectors that have	e equipment grounding			All residents/staff have th	ne	
	conductor contacts	shall have those contacts			same potential to be affected	by	
	-	ipment grounding conductor.			this alleged deficient practice.	The	
		eceptacles mounted on portable			electrical wall receptacle in		
		d generators in accordance			question in room 229 has bee	n	
	with 250.34.				corrected. The maintenance		
		eplacement receptacles as			director was educated by the		
	permitted by 406.4(senior executive director on		
		ounding. The equipment			6/18/25 on utilities and		
		or contacts of receptacles and			receptacles meeting required		
		ill be grounded by connection			guidelines (see attachment 1)	.	
		ounding conductor of the					
		e receptacle or cord connector.					
		wiring method shall include or					
		ent grounding conductor to					
		nt grounding conductor					
		ptacle or cord connector are					
	connected.		1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet Page 20 of 29

PRINTED: 06/26/2025 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155160	B. WING		06/04/2025
	PROVIDER OR SUPPLIE		990 N	ADDRESS, CITY, STATE, ZIP COD	
STONE	BROOKE REHABIL	ITATION CENTER	NEW (CASTLE, IN 47362	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Informational Note	No. 1: See 250.118 for			
	acceptable groundi	ng means.		What measures will be put into	o
	Informational Note	No. 2: For extensions of		place or what systemic change	
	existing branch circ	cuits, see 250.130.		will be made to ensure that the	•
	_	tice could affect one resident		deficient practice does not rec	
	_	t sleeping Room 229.		The electrical wall receptac	
				question in room 229 has bee	
	Findings include:			corrected(see attachment 1).	
				maintenance director/designe	e to
	Based on observati	ons with the Maintenance		audit to ensure compliance (se	
		p.m. on 06/04/25, the four		attachment 2).	
		es in the wall mounted quad			
	1	at the head of the resident bed			
		r door in resident sleeping			
		und to have a "hot neutral"			
		n Ideal Industries UL listed		How the corrective action(s) w	ill he
		g device. Based on interview at		monitored to ensure the defici	
	1	/25, the Maintenance Supervisor		practice will not recur, what qu	
	agreed the testing of	_		assurance program will be put	-
		ectrical receptacle location		place;	
	needed repair.			Ongoing compliance with	
				this corrective action will be	'
	These findings wer	re reviewed with the Executive		monitored via facility QAPI	
		aintenance Supervisor during		program, with meetings being	held
	the exit conference			every other month, and is	Tiolu
				overseen by the Executive	
	3.1-19(b)			Director.	
	0.1 15(0)			CQI tool identified as	
				electrical wall receptacles (see	<u> </u>
				attachment 2) will be complete	
				weekly x 4 weeks, monthly tim	
				6 months, and quarterly there	•
				until compliance is achieved.	
				If Threshold of 100% is a	not
				met, an action plan will be	
				developed to ensure complian	ice
				developed to ensure compilar	
				By what date the systemic	
				changes will be completed;	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Completion date: 6/20/25

Page 21 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155160 B. WING 06/04/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 990 N 16TH ST STONEBROOKE REHABILITATION CENTER NEW CASTLE. IN 47362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE K 0918 **NFPA 101** SS=F Electrical Systems - Essential Electric Syste Bldg. 01 Based on record review, observation and K 0918 06/20/2025 We respectfully request desk interview; the facility failed to ensure a complete review in this matter. Thank written record of monthly testing of emergency you for your consideration. 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 What corrective action(s) will be 2012 NFPA 99 requires batteries for on-site accomplished for those residents generators shall be maintained in accordance with found to have been affected by the NFPA 110, 2010 Edition, Standard for Emergency deficient practice; no residents and Standby Power Systems. NFPA 110, Section were affected by this alleged 8.3.7.1 states the maintenance of lead-acid deficient practice. a complete batteries shall include the monthly testing and written record of monthly testing of recording of electrolyte specific gravity. Battery emergency generator starting conductance testing shall be permitted in lieu of batteries is currently being the testing of specific gravity when applicable or documented. warranted. This deficient practice could affect all residents, staff and visitors. Findings include: How other residents having the potential to be affected by the Based on review of the generator inspection same deficient practice will be contractor's "Inspection Report" documentation identified and what corrective dated 03/10/25 with the Maintenance Supervisor action(s) will be taken; at 11:23 a.m. on 06/04/25, the results of emergency generator starting battery testing was listed as All residents/staff have the passing. Review of Direct Supply TELS Logbook same potential to be affected by Documentation "Emergency Generators: Test this alleged deficient practice. generator under load" documentation dated record of monthly testing on 05/06/25 and 06/03 stated "N/A" in response to generator starting batteries is "Battery Specific Gravity" and "Battery currently being documented. Conductance Test". Based on interview at 11:23 maintenance director educated on a.m. on 06/04/25, the Maintenance Supervisor 6/18/25 by the senior executive stated additional emergency generator starting director on generator maintenance

FORM CMS-2567(02-99) Previous Versions Obsolete

battery testing documentation for the most recent

twelve month period was not available for review

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

testing/documentation (see

attachment 1).

Page 22 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155160	A. BUILDING B. WING	01	COMPLETED 06/04/2025	
	F PROVIDER OR SUPPLIEF BROOKE REHABILI		990 N	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	testing or monthly of on observations with at 1:00 p.m. on 06/0 diesel-fuel fired emoutside the building property. Manufact documentation affir was rated at 500 kV. These findings were	xed to the generator indicated it V. e reviewed with the Executive aintenance Supervisor during		What measures will be put int place or what systemic chang will be made to ensure that th deficient practice does not record of monthly testing or generator starting batteries is currently being documented. maintenance director educate 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).	es e cur; n ed on	
				How the corrective action(s) we monitored to ensure the deficit practice will not recur, what que assurance program will be purplace; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as generator starting batteries with monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director.	ient uality t into	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 23 of 29

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155160	î ´	ILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/04/2025	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 6TH ST		
STONEB	ROOKE REHABILI	TATION CENTER	_		ASTLE, IN 47362		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	TE	DATE
					completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is r met, an action plan will be developed to ensure compliant. By what date the systemic changes will be completed; Completion date: 6/20/25	ce.	
K 0923 SS=E Bldg. 01	Based on observation failed to ensure 1 of was in accordance of Facilities Code. NF 11.3.1 states storage equal to or greater the comply with 5.1.3.3 5.1.3.3.2 states, if it positive-pressure gas use interior finishes combustible material ceilings, and doors are resistant rating. The affect over 10 reside vicinity of the oxygoroom on the second Findings include:	Oylinder and Container on and interview, the facility of 1 indoor oxygen storage areas with NFPA 99, Health Care of PA 99, 2012 Edition, Section of for nonflammable gases than 3000 cubic feet shall of and 5.1.3.3.3. Section adoors, storage locations of of sees shall be constructed and of noncombustible or limited als such that all walls, floor, are of minimum 1-hour fire of deficient practice could cents, staff and visitors in the en storage and transfilling floor. ons with Maintenance ing a ladder at 2:01 p.m. on	K 09	923	We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; no resident were affected by this alleged deficient practice. the sprinkle pipe in question is now firestopped. 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;	nts y the s r	06/20/2025
	wall of the oxygen s	tal sprinkler pipe penetrated the storage and transfilling room			All residents/staff have th		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 24 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155160	A. BUILDING B. WING	01	COMPLETED 06/04/2025
	PROVIDER OR SUPPLIER		990 N 1	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	space surrounding the firestopped to ensure a minimum 1-hour fliquid oxygen contate oxygen cylinders were on interview at 2:01 Maintenance Supervisurrounding the sprinot firestopped to ensure with a minimum 1-hour firest findings were	door to the room. The annular me sprinkler pipe was not ethe room was enclosed with are resistance rating. Five iners and eleven 'E' type ere stored in the room. Based p.m. on 06/04/25, the visor agreed the annular space nkler pipe penetration was assure the room was enclosed frour fire resistance rating. The reviewed with the Executive intenance Supervisor during		this alleged deficient practice. sprinkler pipe in question is not fire stopped. maintenance dire was educated on 6/18/25 b the senior executive director on gar equipment and indoor oxygen storage areas (see attachment). What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recent the sprinkler pipe in question now fire stopped. maintenance director educated on 6/18/25 b the senior executive director or gas equipment ad indoor oxygstorage areas (see attachment maintenance director/designed audit to ensure compliance (seattachment 2).	ow ector e as t 1). o es e ur; is e oy n gen t 1).
				How the corrective action(s) we monitored to ensure the deficie practice will not recur, what que assurance program will be put place; Ongoing compliance with this corrective action will be monitored via facility QAPI	ent uality : into

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 25 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155160	A. BUILDING B. WING	01	COMPLETED 06/04/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 990 N 16TH ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0927 SS=E	NFPA 101 Gas Equipment - 7	Fransfilling Cylinders		program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as sprinkler pipe fire stoppage/oxygen storage will completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is met, an action plan will be developed to ensure compliant By what date the systemic changes will be completed; Completion date: 6/20/25	be not nce.		
Bldg. 01	Based on observation failed to ensure 1 of was in accordance version of the failed to ensure 1 of was in accordance version of the failed to ensure the facilities Code. NFI 11.5.2.3.1(1) states, designated area separated area separated by a fire barriconstruction mechan provided with a present of the failed with a present of the transfilling of lie posted with a sign in occurring. This definition of the state of the transfilling of the posted with a sign in occurring. This definition was in accordance to the state of the failed with a sign in occurring. This definition was in accordance very state of the state of the failed with a sign in occurring. This definition was in accordance very state of the state of the failed was accordance very state of the state of	on and interview, the facility 1 oxygen transfilling locations with NFPA 99 Health Care PA 99, 2012 Edition, Section (transfilling shall occur in) a parated from any portion of a dients are housed, examined, or rier of 1 hour fire-resistive nically vented and was cautionary sign indicating that lediate area is not permitted.	K 0927	We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will the accomplished for those reside found to have been affected by deficient practice; no resident were affected by this alleged deficient practice, the sprinkle pipe in question is now firestopped.	pe ents y the es		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 26 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155160)	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/04/2025
PROVIDER OR SUPPLIER ROOKE REHABILITATION CENTER	990 N	ADDRESS, CITY, STATE, ZIP COD 16TH ST CASTLE, IN 47362	
		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY) potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents/staff have the same potential to be affected this alleged deficient practice sprinkler pipe in question is infirestopped. The maintenance director was educated by the senior executive director on 6/18/25 on indoor oxygen sto areas (see attachment 1). What measures will be put intiplace or what systemic change will be made to ensure that the deficient practice does not receive the sprinkler pipe in question now firestopped. The maintenance director was educated by the senior executive director on 6/18/25 on indoor oxygen sto areas (see attachment 1). The maintenance director/designer audit to ensure compliance (see	to ges ne cur; is ance
		attachment 2). How the corrective action(s) v	will be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EIN321

Facility ID: 000080

If continuation sheet

Page 27 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039				
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u> COMPLETED			
		155160	B. WI	ING		06/04	/2025	
NAME OF E	PROVIDER OR SUPPLIER	,		STREET A	ADDRESS, CITY, STATE, ZIP COD			
					I6TH ST			
STONEB	ROOKE REHABILI	TATION CENTER		NEW C	ASTLE, IN 47362			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					monitored to ensure the defici			
					practice will not recur, what qu	-		
					assurance program will be put	Into		
					place; 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.			
					CQI tool identified as inde	oor		
					oxygen storage areas will be			
					completed weekly x 4 weeks,			
					monthly times 6 months, and			
					quarterly thereafter until			
					compliance is achieved.			
					If Threshold of 100% is r	not		
					met, an action plan will be			
					developed to ensure complian	ce.		
					By what date the systemic			
					changes will be completed;			
					Completion date: 6/20/25	j		
K 0000								
Bldg. 02	A Life Sefety C-1-	Departification and State	17.0	000				
	I	Recertification and State vas conducted by the Indiana	K 0	UUU				
		th in accordance with 42 CFR						
	483.90(a).	m accordance with 12 Crit						
	(-).							
	Survey Date: 06/04	1/25						
	-							
	Facility Number: 0	00080						
	Provider Number:	155160						

FORM CMS-2567(02-99) Previous Versions Obsolete

AIM Number: 100289330

Event ID:

EIN321

Facility ID: 000080

30

If continuation sheet

Page 28 of 29

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED	
		155160	B. WING		06/04/2025	
NAME OF PROVIDER OR SUPPLIER STONEBROOKE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPR DEFICIENCY)	ACH CORRECTIVE ACTION SHOULD BE COMPLET OSS-REFERENCED TO THE APPROPRIATE	
TAG			TAG	DEFICIENCE		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EIN321 Facility ID: 000080 If continuation sheet Page 29 of 29