STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155727	A. BUILDING 00 B. WING	10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONEBRIDGE HEALTH CAMPUS	3100 SHAWNEE DR S BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 2, 3, 4, 5, 6 and 10, 2023 Facility number: 003924 Provider number: 155727 AIM number: 200472040 Census Bed Type: SNF/NF: 41 SNF: 13 Residential: 28 Total: 82 Census Payor Type: Medicare: 10 Medicaid: 33 Other:11 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 12, 2023.	F 0000	**Plan of Correction FOR STONEBRIDGE HEALTH CAMPUS** **R000 INITIAL COMMENTS** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted October 10, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of October 25, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Bales	Clinical Support RN	10/19/2023

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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	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure implementation of a blue bunny boot (used to prevent and heal pressure ulcers) was utilized for 1 of 4 residents reviewed for pressure ulcers. (Resident 27) Findings include: On 10/4/23 at 11:00 a.m., Resident 27 was observed to be sitting in a positioning wheelchair in his room. He had a white dressing on his left foot. The blue bunny boots were not observed to be on his left or right heel. No bunny boots were observed to be on the floor near his positioning wheelchair. On 10/4/23 at 2:39 p.m., Resident 27 was observed to be sitting in a positioning wheelchair in his room. He had a white dressing on his left foot. The blue bunny boots were not observed to be on his left or right heel. No bunny boots were observed to be on the floor near his positioning wheelchair. On 10/5/23 at 10:08 a.m., Resident 27 was observed to be sitting in a positioning wheelchair in the day room on the unit. He had a white dressing on his left foot. The blue bunny boots were not observed to be on his left or right heel. No bunny boots were observed to be on the floor near his positioning wheelchair.	F 0686	1.Resident 27 was affected. No adverse reactions noted. Blue bunny boots were placed on the resident. 2.All like residents have the potential to be affected. Nursing staff educated on implementation of blue bunny boots and offloading devices per care plan. 3.As a measure of ongoing compliance, the DHS or designee will perform random bunny boot audits to ensure intervention is place per care plan. Audit will be completed weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4.As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	10/25/2023

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	On 10/5/23 at 12:32 p.m., Resident 27 was observed to be sitting in a positioning wheelchair in the restorative dining room. He had a white dressing on his left foot. The blue bunny boots were not observed to be on his left or right heel. No bunny boots were observed to be on the floor near his positioning wheelchair. On 10/6/23 at 9:56 a.m., Resident 27 was observed to be sitting in a positioning wheelchair in the day room on the unit. He had a white dressing on his left foot. The blue bunny boots were not observed to be on his left or right heel. No bunny boots were observed to be on the floor near his positioning wheelchair. On 10/5/23 at 11:08 a.m., Resident 27's clinical record was reviewed. The diagnoses included, but were not limited to cerebrovascular disease, dementia, anxiety, and hemiplegia (paralysis of one side of the body). A care plan, initiated on 6/1/23 and current through target date 10/31/23, indicated Resident 27 had a pressure ulcer to left heel. The staff would observe for healing/non-healing; signs of infections; and apply treatment as ordered. The care plan lacked documentation of how to relieve pressure on his left heel if Resident 27 removed the bunny boots or crossing his legs and causing additional pressure on his heels. A Physician's Order, dated 9/6/23 through 10/6/23, indicated resident to wear blue bunny boots at all times for wound and prevention (start date 6/5/23). Wound Management Report, dated 10/3/23 at 11:22 a.m., indicated Resident 27 had a Stage 3			

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	ulcer to left heel. The Clinically at Risk Individual Monitoring lacked documentation of how to relieve pressure on his left heel if Resident 27 removed the bunny boots or crossing his legs and causing additional pressure on his heels. During an interview on 10/6/23 at 11:09 a.m., Certified Nursing Assistant (CNA) 1 indicated Resident 27 had a pressure ulcer to his left ankle. His interventions were to wear blue bunny boots to his left foot. He would not remove them. During an interview on 10/6/23 at 11:48 a.m., the Assistant Director of Nursing (ADON) indicated Resident 27 had a pressure ulcer to his left heel. His interventions were to wear blue bunny boots to his left heel. He did not remove them. On 10/10/23 at 12:24 p.m., the Minimum Data Set Consultant provided the facility's policy, "Pressure/Stasis/Arterial/Diabetic Wound Guidelines," dated 12/31/22, and indicated it was the policy being used by the facility. A review of the policy did not address ensuring implementation of pressure ulcer interventions. 3.1-40(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure a medication was stored in a locked compartment for 1 out of 1 medications observed during a random observations while observing medication administration. (Resident 155) Findings include: On 10/6/23 at 12:50 p.m., during medication administration with Registered Nurse (RN) 1, a round, pink pill was observed to be lying on the medication cart behind the computer. RN 1 was observed to look the pill up using a pill identifier website and identified the pill as citalopram (an antidepressant). RN 1 indicated at that time she did not have any residents on citalopram and did not know why the pill was on the medication cart. During an interview on 10/10/23 at 11:22 a.m., the Assistant Director of Nursing (ADON) indicated	F 0761	1. Resident 155 was affected. No adverse reactions noted. The pill was properly disposed of. 2. All residents have the potential to be affected. All medication carts were audited to ensure no loose pills present. 3. As a measure of ongoing compliance, the DHS or designee will perform medication cart audits to ensure no loose tablets are present in carts weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance	10/25/2023

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	they had done some research and they had a resident who had been taking citalopram. The resident was identified as Resident 155. On 10/10/23 at 11:30 a.m., Resident 155's clinical record was reviewed. The diagnosis included, but were not limited to depression. Current physician orders, dated 10/10/23, indicated Resident 155's orders included, but were not limited to: citalopram tablet 20 mg (milligram) once a day for depression. On 10/6/23 at 2:33 p.m., the Corporate Support Nurse provided the facility policy titled, "Medication Storage in the Facility" with a revised date of January 2019, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "Storage of Medications: Policy: Medications and biologicals are stored safely, securely and properly ... A. The provider pharmacy dispenses medications in containers ... Medications are kept in these containers ..." 3.1-25(m)		Improvement meetings. The plan will be reviewed and updated as warranted.	
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this			

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	subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. Based on interview and record review, the facility failed to ensure radiological services were provided immediately, as indicated by the physician's order, to a resident who sustained a fall with injury for 1 of 1 resident reviewed for radiological services. (Resident 31) Findings include: During an interview with Resident 31's Power of Attorney (POA) on 10/4/23 at 10:09 a.m., they were informed she fell while going to the bathroom around 8:00 p.m., on a Wednesday (7/26/23), and the facility would get an x-ray because she had complained of right hip pain. The POA was not informed of the x-ray results so they called the facility on Friday (7/28/23) around 9:00 a.m., and was told the resident did not have a fracture. Around 3:00 p.m. that same day, the POA received a phone call from the facility stating their mother had a broken hip and she was sent to the hospital. The POA did not know what caused the confusion nor the delay in the x-ray results. On 10/5/23 at 2:05 p.m., Resident 31's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, abnormalities of gait and mobility, and muscle weakness. Resident 31's Event Report, dated 7/26/23 at 6:40 p.m., indicated the resident sustained an unwitnessed fall in her bathroom.	F 0776	1. 1. Resident 31 was affected. Resident was sent to the hospital for treatment. 2. 2. All like residents have the potential to be affected. Nurses were educated on importance of obtaining xrays in a timely manner and notifying the physician if the xray cannot obtained in a timely manner. 3. 3. As a measure of ongoing compliance, the DHS or designee will review in-house xrays to ensure they were obtained in a timely manner and physician notification is documented appropriately. Audit will be conducted weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	10/25/2023

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	Resident 31's progress notes indicated the following: - On 7/26/23 at 8:05 p.m., the resident started to complain of right hip pain related to the fall. - On 7/26/23 at 8:21 p.m., the nurse received an order for a STAT (immediate) x-ray for the resident's right hip. - On 7/26/23 at 8:33 p.m., the resident complained of right hip pain when getting up from her wheelchair. - On 7/26/23 at 9:38 p.m., the radiological services company called the facility and stated there was no technician working so the STAT x-ray was delayed to the next day. - On 7/28/23 at 8:48 a.m., an IDT (interdisciplinary team) note indicated the resident sustained a skin tear to her right elbow. There was no mention of the x-ray results. - On 7/28/23 at 3:01 p.m., the x-ray results were received and indicated the resident had an impacted fracture of the right femoral neck. - On 7/28/23 at 3:27 p.m., the resident was sent to the hospital. Resident 31's Radiology Report, dated 7/27/23 at 8:42 p.m., indicated acute impacted fracture of the right femoral neck. During an interview on 10/6/23 at 12:42 p.m., Licensed Practical Nurse 1 indicated she was working the night the resident fell. The resident initially did not complain of pain, but as the evening went on she began to show limitations in			

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	range in motion to her right hip and complained of pain. She obtained an order for a STAT x-ray but she could not remember when the x-ray was taken, however, the company was known to not come on time. During an interview on 10/6/23 at 12:58 p.m., Certified Medication Aide 1 indicated she was working the 7/28/23 shift when the resident was sent out the the hospital for her hip fracture. She indicated she did not know why the radiological services company did not call with the x-ray results because that was the standard practice. The facility had two fax machines and it was likely the company faxed over the results and did not call. On 10/10/23 12:30 p.m., the Clinical Support Nurse provided the "[Radiology Services Name] PORTABLE IMAGING AND DIAGNOSTIC TESTING SERVICES AGREEMENT," dated 4/19/23, and indicated it was the contract currently being used by the facility. A review of the contract indicated no specific time frames in regard to service response time. 3.1-49(g)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 2, 3, 4, 5, 6 and 10, 2023 Facility number: 003924 Residential Census: 28	R 0000	**Plan of Correction FOR STONEBRIDGE HEALTH CAMPUS** **R000 INITIAL COMMENTS** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on	

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	This State Residential Finding is cited in accordance with 410 IAC 16.2-5.		the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted October 10, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of October 25, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy			

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	of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were signed and dated by the resident or resident's representative for 7 of 7 residents reviewed for service plans. (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7) Findings include: 1. On 10/10/23 at 10:45 A.M., Resident 1's clinical record was reviewed. The diagnosis was syncope. The the resident's Individual Service Plan, dated 6/27/23, was not signed or dated by the resident or resident's representative. 2. On 10/10/23 at 11:20 A.M., Resident 2's clinical record was reviewed. The diagnosis was transient ischemic attack. The the resident's Individual Service Plan, dated 10/4/23, was not signed or dated by the resident or resident's representative. 3. On 10/10/23 at 11:10 A.M., Resident 3's clinical record was reviewed. The diagnosis was hypokalemia. The the resident's Individual Service Plan, dated	R 0217	1. Residents 1, 2, 3, 4, 5, 6, and 7 were affected. No adverse reactions noted. Service plans were signed. 2. All like residents have the potential to be affected. AL Director and nurses educated on service plans and required signatures. 100% audit of service plans was conducted to ensure they are signed. 3. As a measure of ongoing compliance, the DHS or designee will audit service plans completion per policy weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	10/25/2023

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	7/13/23, was not signed or dated by the resident or resident's representative. 4. On 10/10/23 at 10:05 A.M., Resident 4's clinical record was reviewed. The diagnosis was dementia. The the resident's Individual Service Plan, dated 12/1/22, was not signed or dated by the resident or resident's representative. 5. On 10/10/23 at 10:50 A.M., Resident 5's clinical record was reviewed. The diagnosis was confusion. The the resident's Individual Service Plan, dated 9/15/23, was not signed or dated by the resident or resident's representative. 6. On 10/10/23 at 10:00 A.M., Resident 6's clinical record was reviewed. The diagnosis was congestive heart failure. The the resident's Individual Service Plan, dated 10/4/23, was not signed or dated by the resident or resident's representative. 7. On 10/10/23 at 11:00 A.M., Resident 7's clinical record was reviewed. The diagnosis was major depressive disorder. The the resident's Individual Service Plan, dated 6/1/23, was not signed or dated by the resident or resident's representative. During an interview on 10/10/23 at 1:15 P.M., the Administrator indicated the resident service plans were were not signed by the resident or residents' representatives.			