STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155838	A. BUILDING -- B. WING	07/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/17/23 Facility Number: 013409 Provider Number: 155838 AIM Number: 201312610 At this Emergency Preparedness survey, Stonecroft Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 70 certified beds. At the time of the survey, the census was 68. Quality Review completed on 07/19/23	E 0000	Submission of this Plan of Correction does not indicate an admission by Stonecroft Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Aspen Place Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 825-0551. Sincerely, Dawn Black, Area Executive Director	
K 0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Black	Area Executive Director	08/04/2023

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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Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date(s): 07/17/23 Facility Number: 013409 Provider Number: 155838 AIM Number: 201312610 At this Life Safety Code survey, Stonecroft Health Campus was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridors with hard wired smoke detectors in all resident rooms. The facility has a capacity of 70 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/19/23	K 0000	Submission of this Plan of Correction does not indicate an admission by Stonecroft Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Aspen Place Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 825-0551. Sincerely, Dawn Black, Area Executive Director	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities			

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	Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to provide two-hour fire-rated construction of 1 of 2 separation walls between the assisted living portion of the building and the health care portion of the building. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect at least 30 residents in two smoke compartments. Findings include: Based on an observation during a tour of the facility with the Director of Plant Operations on	K 0131	K 131 – Multiple Occupancies Compliance Date- 7/31/23 Immediate intervention The Director of Plant Operations replaced the damaged astragal with a new astragal to close the gap. The Director of Plant Operations was educated by the Executive Director on K 131 – Multiple Occupancies. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of	07/31/2023

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	07/17/23 at 1:31 p.m., the set of fire doors by room 224 that separated health care from assisted living had a half inch gap where the doors came together. This condition would not limit the spread of smoke from one side of the fire barrier to the other. The astragal near the floor was damaged, which caused the gap. Based on interview at the time of observation, the Director of Plant Operations agreed there was a gap at the bottom of the doors where they come together and would not restrict the movement of smoke. This finding was reviewed with the Director of Plant Operations at the exit conference. 3.1-19(b)		fire and restrict the movement of smoke from one side of the fire barrier to the other. The Director of Plant Operations will inspect the deficient fire doors for compliance 1 x week for 1 month and 1 x a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect at least 30 residents in two smoke compartments. Exhibit A- K131 Multiple Occupancies audit Exhibit B- Photos and other documentation	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 2 of 2 exit signs near the Legacy Unit were marked with directional indicators to identify the direction of travel to the public way.	K 0293	K 293 – Exit Signage Compliance Date- 7/31/23 Immediate intervention The Director of Plant Operations	07/31/2023

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	LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice could affect at least 20 residents, staff and visitors in 300 Hall near the entrance to the Legacy Unit. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations on 07/17/23 from 11:45 a.m. to 1:35 p.m., the corridor exit signs near the Legacy Unit had both directional arrows visible. A wall had been constructed in 300 Hall in order to make a secure area for the Legacy Unit; and one exit sign pointed left, where a wall now exists. The other exit sign pointed right to the entrance of the Legacy Unit where a badge is needed to gain access. Based on interview at the time of observations, the Director of Plant Operations agreed that the two exit signs in 300 Hall near the Legacy Unit did not accurately identify the direction of travel to the public way. This finding was reviewed with the Director of Plant Operations at the exit conference. 3.1-19(b)		replaced the two exit signs that were not accurate with two new exits signs that indicated accurately the direction of travel to the public way. The Director of Plant Operations was educated by the Executive Director on K 293 – Exit Signage. Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. The Director of Plant Operations will inspect the deficient exit signage for compliance 1 x week for 1 month and 1 x a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect at least 20 residents, staff and visitors on the 300 hall. Exhibit A – K293 – Exit Signage Audit Exhibit C- Photos and other documentation	

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K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish in 1 of 4 smoke compartments had a flame spread rating of Class A or Class B. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This	K 0331	K 331 – Interior Wall and Ceiling Finish Compliance Date- 7/31/23 Immediate intervention The Director of Plant Operations was able to obtain the product used on the wall from the building blueprints and then the flame spread rating from the manufacturer, Wilsonart. The Director of Plant Operations was educated by the Executive Director on K 331 – Interior Wall and Ceiling Finish. Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, and columns have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread ratings. The Director of Plant Operations	07/31/2023

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	deficient practice could affect up to 25 residents, staff, and visitors while in the same smoke compartment. Findings include: Based on observations on 07/17/23 between 11:45 a.m. and 1:35 p.m. during a tour of the facility with the Director of Plant Operations, a wall at the entrance lobby by the dining room was covered in a wood finish. During record review from 9:42 a.m. to 11:45 a.m., no flame spread rating documentation was available for review for the wood finish. Based on interview with the Director of Plant Operations, he was unable to locate flame spread rating documentation at the time of the survey, and stated it is in the Executive Director's office. This finding was reviewed with the Director of Plant Operations during the exit conference. 3.1-19(b)		will inspect for the flame spread ratings for compliance 1 x week for 1 month and 1 x a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect up to 25 residents, staff and visitors while in the same smoke compartment. Exhibit A – K 331 Interior Wall and Ceiling finish audit Exhibit D – Photos and other documentation	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not			

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	apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 15 residents, staff and visitors in the vicinity of the Rehab Room. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility at 12:14	K 0363	K 363 – Corridor – Doors Compliance Date- 7/17/23 Immediate intervention The Director of Plant Operations removed the hand held weight holding the propping the door open to the Rehab Room. The Director of Plant Operations was educated by the Executive Director on K 363 – Corridor – Doors. Doors protecting corridor openings in other than required enclosures	07/31/2023

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	p.m. on 07/17/23, the corridor door serving as the entrance to the Rehab Room was propped in the fully open position with a handheld weight. Based on interview at the time of observation, the Director of Plant Operations confirmed the corridor door was propped in the fully open position with a handheld weight placed on the floor. This finding was reviewed with the Director of Plant Operations at the exit conference. 3.1-19(b)		of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 ¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbs is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. The Director of Plant Operations will inspect for the deficient practice of propping the door open for compliance 1 x week for 1 month and 1 x a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect 15 residents, staff and visitors in the vicinity of the Rehab Room. Exhibit A -K 363 Corridor – Doors audit. Exhibit E- Photos and other documentation	
K 0372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

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Bldg. 01	Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect at least 30 residents, 4 staff, and 2 visitors between the two compartments. Findings include: Based on observation made during a tour of the facility with the Director of Plant Operations on 07/17/23 from 11:45 a.m. to 1:35 p.m., the smoke barrier wall above the smoke barrier doors by resident room 201 had penetrations of cables through the smoke barrier wall. The penetration was fire stopped, but the fire stop material had pulled away from the cables, leaving approximately a half inch of annular space around the cables passing through the smoke barrier. Based on interview at the time of observation, the	K 0372	K 372 – Subdivision of Building Spaces – Smoke Barriers Compliance Date- 7/18/23 Immediate intervention The Director of Plant Operations filled the penetration where the fire stop material had pulled away with new fire stop to fill the approximate ½ inch gap around the cables above the smoke barrier doors by resident room 201. The Director of Plant Operations was educated by the Executive Director on K 372 – Subdivision of Building Spaces- Smoke Barriers. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. The Director of Plant Operations will inspect for the deficient fire stop for compliance 1 x week for 1 month and 1 x a month for 3	07/31/2023

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	Director of Plant Operations confirmed the barrier penetration was not completely firestopped. This finding was reviewed with the Director of Plant Operatoins at the exit conference. 3.1-19(b)		months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect at least 30 residents, 4 staff, and 2 visitors between the two compartments. Exhibit A – K 372 Subdivision of Building Spaces – Smoke Barriers audit Exhibit F – Photos and other documentation	