PRINTED: 08/10/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155838	B. WING		07/17/2023	
NAME OF PROVIDER OR SUPPLIER STONECROFT HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		363 SC BLOOM	ADDRESS, CITY, STATE, ZIP COD DUTH FIELDSTONE BLVD MINGTON, IN 47403 PROVIDERS PLAN OF CORRECTION TO CHARGE PROPERTY ACCORDING TO BE RECEIVED A DESCRIPTION OF THE PROPERTY ACCORDING TO BE RECEIVED A DESCRIPTION OF THE PROPERTY ACCORDING TO BE RECEIVED A DESCRIPTION OF THE PROPERTY ACCORDING TO BE RECEIVED AS DESCRIPTION OF THE PROPERTY AS DESCRIPTION	(X5)		
PREFIX	,		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
E 0000 Bldg	conducted by the In accordance with 42 Survey Date: 07/17 Facility Number: 0 Provider Number: 201 At this Emergency Stonecroft Health C compliance with Er Requirements for M Participating Provided 483.73. The facility has 70 the survey, the censure with Er Survey, the censure of the survey	7/23 13409 155838 312610 Preparedness survey, Campus was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR	E 0000	Submission of this Plan of Correction does not indicate a admission by Stonecroft Hear Campus that the findings and allegations contained herein a accurate and true representa of the quality of care and services provided to the residents of A Place Health Campus. This farecognized it's obligation to provide legally and medically necessary care and services residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation comprehensive health care facilities (for Title 18/19 progrator To this end, this plan of correshall serve as the credible allegation of compliance with state and federal requirements governing the management of facility. It is thus submitted as matter of statute only. We respectfully request paper refor this plan of correction. If you need any information of paperwork, please do not hese to contact us at (812) 825-05. Sincerely, Dawn Black, Area Executive Director	Ith	
K 0000						

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

TITLE

08/04/2023

(X6) DATE

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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Dawn Black

Area Executive Director

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. Building <u>01</u>		COMPLETED	
		155838	B. W	ING		07/17	/2023
NAME OF F	DOMINED OF CLIPPLIES			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	X.			OUTH FIELDSTONE BLVD		
STONEC	ROFT HEALTH CA	MPUS		BLOOM	MINGTON, IN 47403		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01		D. J.C. J. S.		000	0		
	_	Recertification and State	K 0	000	Submission of this Plan of		
		vas conducted by the Indiana			Correction does not indicate a		
	-	Ith in accordance with 42 CFR			admission by Stonecroft Heal	th	
	483.90(a).				Campus that the findings and		
		/15/00			allegations contained herein a		
	Survey Date(s): 07	/1//23			accurate and true representat		
		12400			of the quality of care and serv		
	Facility Number: 0				provided to the residents of A		
	Provider Number:				Place Health Campus. This fa	cility	
	AIM Number: 201	312610			recognized it's obligation to		
		a 1 a a a a a a a a a a a a a a a a a a			provide legally and medically		
	-	Code survey, Stonecroft Health			necessary care and services	to its	
	-	not in compliance with			residents in an economic and		
	Requirements for P	-			efficient manner. The facility		
		, 42 CFR Subpart 483.90(a),			hereby maintains it is in		
	-	ire and the 2012 Edition of the			substantial compliance with the		
		ction Association (NFPA) 101,			requirements of participation t	or	
		LSC), Chapter 19, Existing			comprehensive health care	,	
	Health Care Occupa	ancies and 410 IAC 16.2.			facilities (for Title 18/19 progra		
	and a second				To this end, this plan of correct	ction	
	-	ity was determined to be of			shall serve as the credible		
		ruction and fully sprinklered.			allegation of compliance with		
		re alarm system with smoke			state and federal requirement		
		ridors, in all areas open to the			governing the management of		
		wired smoke detectors in all			facility. It is thus submitted as	а	
		e facility has a capacity of 70			matter of statute only. We		
	and had a census of	68 at the time of this visit.			respectfully request paper rev	iew	
	4.11				for this plan of correction.		
		idents have customary access			If you need any information or		
	-	All areas providing facility			paperwork, please do not hes		
	services were sprin	klered.			to contact us at (812) 825-055	01.	
	O 11/ P 1	1 4 1 07/10/22			Sincerely,		
	Quality Review cor	mpleted on 07/19/23			Dawn Black, Area Executive		
					Director		
K 0131	NFPA 101						
SS=E	Multiple Occupan	cies					
Bldg. 01	· ·	cies - Sections of Health					
J. • .	Care Facilities	5.55 Godanio di Fidaliti					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>01</u>	COMPLETED	
		155838	B. WING		07/17/2023	
NAME OF I	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP COD		
STONECROFT HEALTH CAMPUS				SOUTH FIELDSTONE BLVD DOMINGTON, IN 47403		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPR		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		n care facilities classified as s meet all of the following:				
	more inpatients for treatment, or cust on They are separate occupancies construction in fire resistance rate accordance with one of the entire built by an approved, so automatic spring with Section 9.7. Hospital outpatient required to be classed on observation failed to provide two of 1 of 2 separations living portion of the portion of the built health care facilities operated to minimic emergency requires occupants. LSC 8.3 fire barrier shall be fire and restrict the side of the fire barrier shall be fire and restrict the side	arated from areas of health by aving a minimum two hour ing in ith Chapter 8. ding is protected throughout supervised inkler system in accordance and surgical departments are saified as an Ambulatory upancy regardless of the its served. 482.41, 42 CFR 485.623 on and interview, the facility wo-hour fire-rated construction in walls between the assisted the building and the health care ling. LSC 19.1.1.3 requires all is to be maintained and itze the possibility of a fire and the evacuation of the interview of the	K 0131	K 131 – Multiple Occupant Compliance Date- 7/31/23 Immediate intervention The Director of Plant Opereplaced the damaged as with a new astragal to clougap. The Director of Plant Opewas educated by the Executive Director on K 131 – Multip Occupancies. LSC 19.1.1.3 requires all care facilities to be maintained operated to minimize possibility of a fire emergerequiring the evacuation occupants. LSC 8.3.4.1 stevery opening in a fire ball be protected to limit the significant contents.	erations etragal se the erations cutive ble health ained the ency of the tates rrier shall	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155838		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/17/2023	
STONEC	ROVIDER OR SUPPLIER		363 SC	ADDRESS, CITY, STATE, ZIP COD DUTH FIELDSTONE BLVD MINGTON, IN 47403	
(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)	DATE
	224 that separated had a half inch gap together. This condispread of smoke from the other. The astragular damaged, which can interview at the time of Plant Operations bottom of the doors and would not restrict.	n., the set of fire doors by room lealth care from assisted living where the doors came tion would not limit the m one side of the fire barrier to gal near the floor was used the gap. Based on le of observation, the Director agreed there was a gap at the where they come together tot the movement of smoke. Wiewed with the Director of the exit conference.		fire and restrict the movement smoke from one side of the fir barrier to the other. The Director of Plant Operatio will inspect the deficient fire do for compliance 1 x week for 1 month and 1 x a month for 3 months. Results of these inspections who be presented by Executive Director to the QA committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved. The deficient practice could after at least 30 residents in two smooth compartments. Exhibit A- K131 Multiple Occupancies audit Exhibit B- Photos and other documentation	e ns pors vill for een
K 0293 SS=E Bldg. 01	accordance with 7 illumination also so lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of eased on observation failed to ensure 2 of Unit were marked with 10 illumination of the control	al signs are displayed in .10 with continuous erved by the emergency ne-story existing less than 30 occupants exit travel is obvious.) on and interview, the facility 2 exit signs near the Legacy with directional indicators to an of travel to the public way.	K 0293	K 293 – Exit Signage Compliance Date- 7/31/23 Immediate intervention The Director of Plant Operatio	07/31/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED O7/17/202				
		155838	B. W	ING		07/17/	2023
	PROVIDER OR SUPPLIER			363 SO	ADDRESS, CITY, STATE, ZIP COD UTH FIELDSTONE BLVD		
STONEC	ROFT HEALTH CA	MPUS		BLOOM	IINGTON, IN 47403		
(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
	-	res exits, other than main exterior			replaced the two exit signs that		
		ously and clearly are			were not accurate with two ne	W	
		, shall be marked by an			exits signs that indicated		
		ly visible from any direction of			accurately the direction of trav	el to	
		ficient practice could affect at			the public way.		
	near the entrance to	taff and visitors in 300 Hall			The Director of Plant Operation		
	near the entrance to	the Legacy Onit.			was educated by the Executiv Director on K 293 – Exit Signa		
	Findings include:				Exit and directional signs are	ige.	
	r manigs metade.				displayed in accordance with	7 10	
	Based on observation	ons during a tour of the facility			with continuous illumination al		
		Plant Operations on 07/17/23			served by the emergency light		
		1:35 p.m., the corridor exit signs			system. LSC 7.10.1.2 requires		
		it had both directional arrows			exits, other than main exterior		
		been constructed in 300 Hall in			doors that obviously and clear		
		ure area for the Legacy Unit;			are identifiable as exits, shall l	-	
		ointed left, where a wall now			marked by an approved sign		
		it sign pointed right to the			readily visible from any direction	on of	
	entrance of the Lega	acy Unit where a badge is			exit access.		
	needed to gain acce	ss. Based on interview at the			The Director of Plant Operatio	ns	
	time of observation	s, the Director of Plant			will inspect the deficient exit		
	Operations agreed t	hat the two exit signs in 300			signage for compliance 1 x we	eek	
	_	y Unit did not accurately			for 1 month and 1 x a month for	or 3	
	identify the directio	n of travel to the public way.			months.		
					Results of these inspections w	vill .	
	-	viewed with the Director of			be presented by Executive		
	Plant Operations at	the exit conference.			Director to the QA committee	for	
	2.4.40(1)				further recommendations and		
	3.1-19(b)				continue until the Quality		
					Assurance Team determines		
					substantial compliance has be	een	
					achieved.	foot	
					The deficient practice could at		
					at least 20 residents, staff and visitors on the 300 hall.	'	
					Exhibit A – K293 – Exit Signa	- A	
					Audit	y G	
					Exhibit C- Photos and other		
					documentation		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155838		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 07/17/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403		
(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)	(X5) COMPLETION DATE
K 0331 SS=E Bldg. 01	exposed interior s as fixed or movab columns, and have Class A or Class E interior finish for a prescribed in 10.2 10.2, 19.3.3.1, 19. Indicate flame spread on observation review; the facility as an interior finish had a flame spread at LSC 101 10.2.3.4 st tested in accordance Method of Test of S Characteristics of B grouped in the followith their flame spread 0-25; smoke any material classiff spread test scale and scale. Any element not continue to prop (b) Class B Interior spread 26-75; smok any material classiff more than 75 on the 450 or less on the si (c) Class C Interior spread 76-200; smo Includes any materi but not more than 2	ceiling Finish ceiling finishes, including curfaces of buildings such the walls, partitions, the a flame spread rating of the walls, partitions, the a flame spread rating of the walls, partitions, the a flame spread rating of the reduction in class of sprinkler system as the second secon	K 0331	K 331 – Interior Wall and Ceil Finish Compliance Date- 7/31/23 Immediate intervention The Director of Plant Operation was able to obtain the product used on the wall from the build blueprints and then the flame spread rating from the manufacturer, Wilsonart. The Director of Plant Operation was educated by the Executive Director on K 331 – Interior Wand Ceiling Finish. Interior wall and ceiling finished including exposed interior sure of buildings such as fixed or movable walls, partitions, and columns have a flame spread rating of Class A or Class B. Treduction in class of interior fit for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3. Indicate flame spread ratings. The Director of Plant Operation	ons t ding ons ve /all es, faces The nish

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155838		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SU COMPLET 07/17/20	ED	
	PROVIDER OR SUPPLIEF		363 SC	ADDRESS, CITY, STATE, ZIP CO DUTH FIELDSTONE BLVI MINGTON, IN 47403		
(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 CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
	staff, and visitors we compartment. Findings include: Based on observation a.m. and 1:35 p.m. of the Director of Plant entrance lobby by the a wood finish. Durit to 11:45 a.m., no flad ocumentation was wood finish. Based of Plant Operations spread rating documentation was word finish. The spread rating documentation was wood finish. Based of Plant Operations spread rating documentation was spread rating documentation. This finding was re	ons on 07/17/23 between 11:45 during a tour of the facility with the Operations, a wall at the me dining room was covered in the dining room was covered in		will inspect for the flame ratings for compliance 1 for 1 month and 1 x a m months. Results of these inspect be presented by Execut Director to the QA commonth further recommendation continue until the Qualit Assurance Team determ substantial compliance achieved. The deficient practice of up to 25 residents, staff visitors while in the same compartment. Exhibit A – K 331 Interior Ceiling finish audit Exhibit D – Photos and documentation	x week onth for 3 tions will ive nittee for is and y nines has been ould affect and e smoke	
K 0363 SS=E Bldg. 01	than required enci- exits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containir combustible mate hardware. Roller I	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in its grire for at least 20 fully sprinklered smoke enonly required to resist the enough of the corridor doors and doors in its flammable or rials have positive latching atches are prohibited by these requirements do not				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155838		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 07/17/2023	
	ROVIDER OR SUPPLIEF		363 SO	ADDRESS, CITY, STATE, ZIP COD OUTH FIELDSTONE BLVD MINGTON, IN 47403	
(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
	flammable or com Clearance between covering is not ext doors complying wif provided with a wind the door closed with a group of the door release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.4 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratio devices, etc. Based on observation	en bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire s or frames in window Parts 403, 418, 460, 482, AS details of doors such as angs, automatics closing	K 0363	K 363 – Corridor – Doors	07/31/2023
	provided with a me door closed, had no latching and would This deficient pract	f over 100 corridor doors were ans suitable for keeping the impediment to closing, resist the passage of smoke. ice could affect 15 residents, the vicinity of the Rehab		Compliance Date- 7/17/23 Immediate intervention The Director of Plant Operatio removed the hand held weigh holding the propping the door to the Rehab Room.	t
	Room. Findings include:			The Director of Plant Operatio was educated by the Executiv Director on K 363 – Corridor – Doors.	е
		on with the Director of Plant tour of the facility at 12:14		Doors protecting corridor oper in other than required enclosu	_

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155838	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY PLETED 7/2023
	PROVIDER OR SUPPLIEI		363 SC	ADDRESS, CITY, STATE, ZIP CO DUTH FIELDSTONE BLVE MINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF p.m. on 07/17/23, t entrance to the Reh fully open position on interview at the Director of Plant Of corridor door was p position with a han floor. This finding was re	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION the corridor door serving as the ab Room was propped in the with a handheld weight. Based time of observation, the perations confirmed the propped in the fully open dheld weight placed on the viewed with the Director of the exit conference.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRIGIAND CROSS-REFERENCED TO THE APDEFICIENCY) of vertical openings, exit hazardous areas resist in passage of smoke and a of 1 3/4 inch solid-bonded wood or other material capable of fire for at least 20 minut. Powered doors complying 7.2.1.9 are permissible in with a device capable of the door closed when a lbs is applied. There is not impediment to the closing doors. Hold open device release when the door is or pulled are permitted. The Director of Plant Opwill inspect for the deficience.	ts, or the are made d core of resisting es. ng with if provided f keeping force of 5 no ng of the es that is pushed perations	(X5) COMPLETION DATE
K 0372	NFPA 101	ildings Congago, Congles		practice of propping the for compliance 1 x week month and 1 x a month months. Results of these inspect be presented by Execut Director to the QA comr further recommendation continue until the Qualit Assurance Team determ substantial compliance achieved. The deficient practice of 15 residents, staff and with the vicinity of the Rehab Exhibit A -K 363 Corridor audit. Exhibit E- Photos and or documentation	of for 1 for 3 tions will ive mittee for is and y mines has been ould affect visitors in o Room. or – Doors	
SS=E	Subdivision of Bu	ilding Spaces - Smoke				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155838	B. WI	NG		07/17/	/2023
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	L			UTH FIELDSTONE BLVD		
STONEC	ROFT HEALTH CA	MPUS	BLOOMINGTON, IN 47403				
OTONEO				BLOON			
(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
Bldg. 01	Barrie						
		lding Spaces - Smoke					
	Barrier Construction	on					
	2012 EXISTING						
		nall be constructed to a					
		tance rating per 8.5. Smoke					
	·	ermitted to terminate at an					
		e dampers are not required					
	-	ns in fully ducted HVAC					
	_	approved sprinkler system					
		oke compartments adjacent					
	to the smoke barri						
	19.3.7.3, 8.6.7.1(1	•					
		hanical smoke control					
	system in REMAR						
		on and interview, the facility	K 0372		K 372 – Subdivision of Building Spaces – Smoke Barriers		07/31/2023
		penetrations caused by the					
		/or conduit through 1 of 4			Compliance Date- 7/18/23		
		were protected to maintain the			Immediate intervention		
		each smoke barrier. LSC			The Director of Plant Operation		
		quires smoke barriers to be			filled the penetration where the		
		rdance with LSC Section 8.5			stop material had pulled away	with	
		nimum ½ hour fire resistive			new fire stop to fill the		
		nt practice could affect at least			approximate ½ inch gap arour	nd	
		, and 2 visitors between the			the cables above the smoke		
	two compartments.				barrier doors by resident room	1	
					201.		
	Findings include:				The Director of Plant Operatio		
					was educated by the Executiv		
		on made during a tour of the			Director on K 372 – Subdivision		
	-	rector of Plant Operations on			Building Spaces- Smoke Barri		
		5 a.m. to 1:35 p.m., the smoke			LSC Section 19.3.7.5 requires		
		he smoke barrier doors by			smoke barriers to be construc		
		nad penetrations of cables			in accordance with LSC Section		
		parrier wall. The penetration			8.5 and shall have a minimum	1 1/2	
		at the fire stop material had			hour fire resistive rating.		
	pulled away from th	-			The Director of Plant Operatio		
		f inch of annular space around			will inspect for the deficient fire		
		hrough the smoke barrier.			stop for compliance 1 x week	for 1	
Based on interview at the time of observation, the				month and 1 x a month for 3			

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LCH521 Facility ID: 013409

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155838	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SI COMPLE 07/17/2	ETED
	PROVIDER OR SUPPLIE		363 SC	ADDRESS, CITY, STATE, ZIP COD DUTH FIELDSTONE BLVD MINGTON, IN 47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	penetration was no This finding was re	eviewed with the Director of the exit conference.		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 Barraudit Exhibit F – Photos and other documentation	en fect nd	

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