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	10/16/2024

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 the Investigation of Complaint IN00445149 and the State Residential Licensure Survey. Complaint IN00445149 - No deficiencies related to the allegations are cited. Survey dates: October 7, 8, 9, 11, 15, and 16, 2024 Facility number: 003924 Provider number: 155727 AIM number: 200472040 Census Bed Type: SNF/NF: 39 SNF: 22 Residential: 27 Total: 88 Census Payor Type: Medicare: 18 Medicaid: 33 Other: 10 Total: 61 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 22, 2024.	F 0000	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 16, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November, 1, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to ensure the posted nurse staffing information was accurate and	F 0732	1. No residents were negatively affected. The daily staffing was replaced and posted per policy	11/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kimberly Bales | Clinical Support RN | 10/30/2024

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	10/16/2024

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

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	current for 1 of 6 days during the survey. Findings include: During an observation on Tuesday, 10/16/24 at 10:10 a.m., the staff posting sheet was dated for Friday, 10/10/24. During an interview on 10/16/24 at 10:11 a.m., the Executive Director (ED) indicated the staffing sheets was posted by the nursing station. An observation at that time, indicated the staff posting sheet was posted for 10/10/24. The ED indicated the staffing sheet was not current and she would get an updated one posted to reflect that day. During an interview on 10/16/24 at 10:15 a.m., the Clinical Support Nurse indicated the scheduler was responsible for posting the daily staffing sheet. On 10/16/24 at 11:13 a.m., the ED provided the facility policy, "Guidelines for Staff Posting," reviewed on 12/31/23, and indicated it was the policy currently being used. A review of the policy indicated, "... 1. At the beginning of the day the number and amount of licensed nurses (RN and LPN) and the number and hours of nursing personnel, per shift, who provide direct care to residents will be posted ..."		moving forward. 2. All like residents have the potential to be affected. Scheduler educated on posting the daily staffing. 3. As a measure of ongoing compliance, the DHS or designee will perform daily staffing sheet audits to ensure it is posted and up to date. Audit will be 3x a week for 4 weeks, then weekly x 2 months, then every other week x 3 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.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00445149.	R 0000	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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	Complaint IN00445149 - No deficiencies related to the allegations are cited. Survey dates: October 7, 8, 9, 11, 15, and 16, 2024 Facility number: 003924 Residential Census: 27 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 16, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November, 1, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on interview and record review, the facility failed to attempt to hold a fire and disaster drill in conjunction with the local fire department at least every 6 months. Findings include: On 10/16/24 at 10:45 a.m., the Fire Drill Report indicated the following: - On 1/2/24 at 12:35 p.m., the fire department was not in attendance or directed the drill. - On 2/29/24 at 2:36 p.m., the fire department was not in attendance or directed the drill. - On 3/27/24 at 10:05 p.m., the fire department was not in attendance or directed the drill.	R 0092	1. No residents were negatively affected. The fire department was invited to the campus for fire drills every six months moving forward. 2. All residents have the potential to be affected. DPO educated on inviting the fire department to fire drills every six months. 3. As a measure of ongoing compliance, the ED or designee will perform fire drill audits to ensure the fire department has been invited monthly x 6 months. 4. As a quality measure, the ED or designee will review any	11/01/2024

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	- On 4/26/24 at 10:36 a.m., the fire department was not in attendance or directed the drill. - On 5/19/24 at 6:35 p.m., the fire department was not in attendance or directed the drill. - On 6/6/24 at 12:05 a.m., the fire department was not in attendance or directed the drill. - On 7/30/24 at 8:23 a.m., the fire department was not in attendance or directed the drill. - On 8/22/24 at 9:05 p.m., the fire department was not in attendance or directed the drill. - On 9/30/24 at 2:05 a.m., the fire department was not in attendance or directed the drill. The Fire Drill Documentation lacked documentation of any attempts to involve the local fire department in fire and disaster drills. During an interview on 10/16/24 at 11:41 a.m., the Executive Director indicated she had no documentation of any attempts to involve the local fire department in fire and disaster drills. On 10/16/24 at 12:00 p.m., the Executive Director provided a copy of the facility policy, "Fire Drills," revised date 9/13/18, and indicated it was the policy currently being used. A review of the policy did not indicate local fire department involvement.		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.	