PRINTED: 11/07/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155727	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY COMPLETED 10/16/2024		
STONEBRIDGE HEALTH CAMPUS			3100 SHAWNEE DR S BEDFORD, IN 47421				
(X4) ID PREFIX TAG F 0000	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 0732 SS=C			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.			
Bldg. 00	review, the facility	on, interview, and record failed to ensure the posted mation was accurate and	F 0732	No residents were negative affected. The daily staffing wareplaced and posted per police.	ıs	11/01/2024	

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

TITLE

(X6) DATE 10/30/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PRPU11 Facility ID: 003924 If continuation sheet

Kimberly Bales

Clinical Support RN

PRINTED: 11/07/2024 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 00		00	COMPLETED		
	155727		B. W	B. WING			2024	
NAME OF PROVIDER OR SUPPLIER STONEBRIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 3100 SHAWNEE DR S BEDFORD, IN 47421				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	BROWNERS N. AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	, L	DATE	
	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.				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 desig will perform daily staffing shee audits to ensure it is posted at up to date. Audit will be 3x a w for 4 weeks, then weekly x 2 months, then every other wee months.	et nd veek		
	Clinical Support Nu was responsible for sheet. On 10/16/24 at 11:1 facility policy, "Gui reviewed on 12/31/. policy currently bei policy indicated, " day the number and (RN and LPN) and	on 10/16/24 at 10:15 a.m., the arse indicated the scheduler posting the daily staffing 3 a.m., the ED provided the idelines for Staff Posting," 23, and indicated it was the ng used. A review of the 1. At the beginning of the amount of licensed nurses the number and hours of per shift, who provide direct libe posted"	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	Survey. This visit in	State Residential Licensure neluded a Recertification and vey and the Investigation of \$149.	R 0	0000	Preparation or execution of the plan of correction does not constitute admission or agreed of provider of the truth of the falleged or conclusions set forted.	ment acts		

State Form Event ID: PRPU11 Facility ID: 003924 If continuation sheet Page 2 of 4

PRINTED: 11/07/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION To statement of deficiencies (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155727)		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/16/2024		
NAME OF PROVIDER OR SUPPLIER STONEBRIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	.TE CO	(X5) MPLETION DATE
	Complaint IN00445149 - No deficiencies related to the allegations are cited.			the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federa		
	Survey dates: October 7, 8, 9, 11, 15, and 16, 2024 Facility number: 003924			and State Law. The Plan of Correction is submitted to resp to the allegation of noncomplia	oond	
	Residential Census: 27 This State Residential Finding is cited in			cited during the Complaint Su conducted October 16, 2024. Please accept this Plan of		
	accordance with 410 IAC 16.2-5.			Correction as the provider's credible allegation of compliar as of November, 1, 2024. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance.	desk to	
R 0092	410 IAC 16.2-5-1.					·
Bldg. 00	failed to attempt to	and record review, the facility hold a fire and disaster drill in e local fire department at least	R 0092	No residents were negative affected. The fire department invited to the campus for fire devery six months moving forw	was drills	/01/2024
	Findings include: On 10/16/24 at 10:4 indicated the follow	5 a.m., the Fire Drill Report ing:		2. All residents have the poter to be affected. DPO educated inviting the fire department to drills every six months.	on	
	not in attendance or	p.m., the fire department was directed the drill.		3. As a measure of ongoing compliance, the ED or design will perform fire drill audits to ensure the fire department ha		
	not in attendance or - On 3/27/24 at 10:0 not in attendance or	5 p.m., the fire department was		been invited monthly x 6 months 4. As a quality measure, the E or designee will review any	ths.	

State Form Event ID: PRPU11 Facility ID: 003924 If continuation sheet Page 3 of 4

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

PRINTED: 11/07/2024 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>00</u>		COMPLETED		
		155727	B. WING			10/16/2024	
		1.00.00				10, 10,	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					HAWNEE DR S		
STONEB	RIDGE HEALTH C	AMPUS		BEDFO	PRD, IN 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
					findings and corrective action	at	
	- On 4/26/24 at 10:3	36 a.m., the fire department was			least quarterly and ongoing u	ntil	
	not in attendance or	r directed the drill.			campus achieves one hundre	d	
					percent compliance in the car	npus	
	- On 5/19/24 at 6:3:	5 p.m., the fire department was			Quality Assurance Performan	ce	
	not in attendance or	r directed the drill.			Improvement meetings. The p		
					will be reviewed and updated	as	
	- On 6/6/24 at 12:05 a.m., the fire department was				warranted.		
	not in attendance or directed the drill.						
		3 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.						
	0 0/20/24 + 2.0	e .1 ° 1					
		5 a.m., the fire department was					
	not in attendance or directed the drill.						
	The Fire Drill Docu	Imentation lacked					
	documentation of any attempts to involve the local fire department in fire and disaster drills.						
	local ine departmen	in in the and disaster drins.					
	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.						
	a comparation						
	On 10/16/24 at 12:0	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						
		ing used. A review of the					
	policy did not indicate local fire department						
	involvement.						

State Form Event ID: PRPU11 Facility ID: 003924 If continuation sheet Page 4 of 4