

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

PRINTED: 04/18/2023
FORM APPROVED
OMB NO. 0938-0391

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|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155160 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED R 04/11/2023 | |
| NAME OF PROVIDER OR SUPPLIER STONEBROOKE REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| {K 000} | <p>INITIAL COMMENTS</p> <p>A Post Survey revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/16/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 04/11/23</p> <p>Facility Number: 000080 Provider Number: 155160 AIM Number: 100289330</p> <p>At this PSR Life Safety Code survey, Stonebrooke Rehabilitation Center was found in compliance with Requirements for Participation in 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</p> <p>This two-story facility was determined to be of Type II (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors and hard-wired smoke detectors in resident room 100, 101, 102, 103, 104, 105, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135 and 136. The facility has battery operated smoke detectors in resident rooms 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 238, 239, 240, 242, 243, 244, 245, 246, 247, 248, 249, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119. The facility has a capacity of 117 and had a census of 65 at the time of this PSR visit.</p> | | | {K 000} | | | |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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| {K 000} | Continued From page 1 All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had two detached wooden storage sheds and one detached metal storage shed which were not sprinklered. Quality Review completed on 04/17/23 | {K 000} | | | |