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	12/20/2021

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00368519. This visit included a State Residential Licensure Survey. Complaint IN00368519- Unsubstantiated due to lack of evidence. Survey dates: December 14, 15, 16, 17, and 20, 2021. Facility number: 003924 Provider number: 155727 AIM number: 200472040 Census Bed Type: SNF/NF: 39 SNF: 15 Residential: 26 Total: 80 Census Payor Type: Medicare: 20 Medicaid: 22 Other: 12 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on December 21, 2021.	F 0000	This plan of correction is to serve as Stonebridge's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Stonebridge or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find our plan of correction for StoneBridge's Recertification and State Licensure Survey conducted on 12/14/21 – 12/21/21. We initiated immediate interventions when concerns were identified on this date. We respectfully request a "desk review" for this plan of correction. If you need any information or paperwork, please contact me at (812) 675 4154. Sincerely, Dawn Black, Administrator.	
F 0641 SS=D	483.20(g) Accuracy of Assessments			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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Bldg. 00	§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to accurately complete an admission Minimum Data Set (MDS) assessment for 1 of 21 residents reviewed for Minimum Data Set Assessment. (Resident 47) Findings include: Resident 47's clinical record was reviewed on 12/20/2021 at 2:00 p.m. Diagnoses included, but were not limited to sepsis and heart failure. The admission Minimum Data Set (MDS), dated 11/27/2021, assessed Resident 47 as having one unstageable pressure ulcers/injuries due to non-removable dressing/device. During an interview, on 12/20/2021 at 3:02 p.m., the corporate MDS consultant indicated the admission MDS for Resident 47 was coded incorrectly. The resident did not have an unstageable pressure ulcers/injury. The facility did not have a policy related to the MDS. They use the Resident Assessment Instrument (RAI) manual. A review of the Resident Assessment Instrument (RAI) Version 3.0 Manual, Section M0300E indicated, "... Enter 0 if no unstageable pressure ulcers/injuries related to non-removable dressing/device are present ..." 3.1-31(d)	F 0641	**Citation #1** **F 641 Accuracy of Assessments** **CFR(s): 483.20(g)** **SS= D** *Findings: This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately complete an admission Minimum Data Set (MDS) assessment for 1 of 21 residents reviewed for Minimum Data Set Assessment. (Resident 47)* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · The Clinical Assessment Support team completed a modification of Resident #47's MDS ARD of 11/27/2021 to code section M0300 to indicate resident's pressure injury was healed at the time of the assessment. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · The Campus Clinical Assessment Support team completed a review of all residents residing at StoneBridge identified as having pressure ulcers to ensure accuracy in coding of	01/07/2022

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			section M0300 on 12/30/2021. · There were no findings from the review completed on 12/30/2021. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · The MDS Clinical Assessment Team provided education as to accurate coding of pressure ulcer/injuries, using information from the MDS 3.0 RAI User's Manual, Ch. 3, Section M0300 pgs. M-1 – M25. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · The Campus Clinical Assessment Support Nurse and/or Designee, will audit 3 MDS assessments weekly x 8 weeks for accuracy of section M300 referencing Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. · The Campus Clinical Assessment Support Nurse, will then audit 3 MDS assessments monthly x 6 months for accuracy of section M300 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage · The findings from our audits will be reviewed during the	

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			campus regularly scheduled QUAPI meeting for determination to our ongoing frequency of our monitoring plan. Findings suggestive of 100% compliance may result in cessation of our monitoring plan once compliance has been determined to have been achieved. **5. Date of completion:** 1/7/2022	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure residents' transfer equipment was free from disrepair for 14 of 54 residents reviewed for transfer equipment status (Residents 8, 32, 40, 102, 44, 21, 103, 15, 10, 7, 17, 43, 36, and 4) and failed to ensure residents' bedroom furniture was free from disrepair for 2 of 24 residents reviewed environment (Residents 6 and 20). Findings include: During a facility tour, on 12/20/21 at 11:00 a.m., the following was observed: 1a.) Resident 8's wheelchair back and bottom cushion were observed to have multiple cracks in the outer layer. 1b.) Resident 32's left armrest was observed to	F 0921	**Citation #2** **F 921** **Safe/Functional/Sanitary/Comfortable Environment** **SS=E** ***Findings: This REQUIREMENT is not met as evidenced by:*** ***Based on observation, interview, and record review, the facility failed to ensure residents' transfer equipment was free from disrepair for 14 of 54 residents reviewed for transfer equipment status (Residents 8, 32, 40, 102, 44, 21, 103, 15, 10, 7, 17, 43, 36, and 4) and failed to ensure residents' bedroom furniture was free from disrepair for 2 of 24 residents reviewed environment***	01/07/2022

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	have multiple cracks. 1c.) Resident 40's wheelchair back was observed with multiple cracks. 1d.) Resident 102's right wheelchair armrest was observed with multiple cracks. 1e.) Resident 44's left wheelchair armrest was observed with multiple cracks. 1f.) Resident 21's left and right wheelchair armrest were observed with multiple cracks. The right armrest holder was observed to be broken with a sharp plastic edge exposed to the resident. 1g.) Resident 103's right wheelchair armrest was observed with multiple cracks. 1h.) Resident 15's left wheelchair armrest was observed with multiple cracks. 1i.) Resident 10's wheelchair back and bottom were observed with multiple cracks. 1j.) Resident 7's left and right wheelchair armrests were observed with multiple cracks. 1k.) Resident 17's left wheelchair armrest was observed with multiple cracks. 1l.) Resident 43's left and right wheelchair armrests were observed with multiple cracks. 1m.) Resident 36's left and right wheelchair armrests were observed with multiple cracks. 1n.) Resident 4's left and right wheelchair armrests were observed with multiple cracks.		***(Residents 6 and 20).*** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident #8's wheelchair back and bottom cushion were ordered, removed and replaced. · Resident #32's left armrest was ordered, removed, and replaced. · Resident #40's wheelchair back was ordered, removed and replaced. · Resident #102's right wheelchair armrest was ordered, removed, and replaced. · Resident #44's left wheelchair armrest was ordered, removed, and replaced. · Resident #21's left and right wheelchair armrest were ordered, removed, and replaced. The right armrest holder was also ordered, removed, and replaced. · Resident #103's right wheelchair armrest was ordered, removed, and replaced. · Resident #15's left wheelchair armrest was ordered, removed, and replaced. · Resident #10's wheelchair back and bottom were ordered, removed, and replaced. · Resident #7's left and right wheelchair armrests were ordered, removed, and replaced. · Resident #17's left wheelchair armrest was ordered,	

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	2a.) Resident 6's bedside table was observed missing two large areas of veneer exposing the compressed wood underneath. 2b.) Resident 20's bedside table was observed missing a large area of veneer exposing the compressed wood underneath. On 12/20/21 at 2:30 p.m., an environmental tour was completed with the Maintenance Director and the Administrator present. Both staff members indicated the wheelchairs and bedside tables were in disrepair and needed fixed. On 12/20/21 at 3:50 p.m., the Director of Nursing Services provided the facility policy, "Resident Rights Guidelines," revised 5/11/21, and indicated it was the policy currently being used by the facility. A review of the policy indicated the policy did not address the residents' environment. 3.1-19(f)(5)		removed, and replaced. · Resident #43's left and right wheelchair armrests were ordered, removed, and replaced. · Resident #36's left and right wheelchair armrests were ordered, removed, and replaced. · Resident #4's left and right wheelchair armrests were ordered, removed, and replaced. · Resident #6's bedside table was discarded and a new one was provided that was evaluated and determined to be free from disrepair. · Resident #20's bedside table was discarded and a new one was provided that was evaluated and determined to be free from disrepair. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · The campus Director of Plant Operations and assigned designated individuals evaluated all resident's wheelchairs, transfer equipment, and bedside tables to ensure equipment was free from disrepair. · Equipment found to be in a state of disrepair was repaired, discarded, or replaced to ensure continued compliance with the above cited deficiency.	

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			3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·The campus acting Administrator conducted an in-service with the Director of Plant Operations, Directory of Therapy, Director of Health Services, and the Assistant Director of Health Services regarding the cited deficiency “F 921 Safe/Functional/Sanitary/Comfortable Environment”. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · The Director of Plant Operations and/or assigned designated individuals will be responsible for conducting walking rounds of the campus, three days per week, for a period of six months to ensure residents wheelchairs, transfer equipment, and bedside tables are in a state of good repair and in continued compliance with the above cited deficiency. Findings suggestive of any wheelchairs, transfer equipment, or bedside tables will be repaired, discarded, or replaced. · Findings will be reviewed during the campus regularly	

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			scheduled QUAPI meetings for determination regarding the ongoing frequency of our monitoring plan. Findings suggestive of 100% compliance may result in cessation of our monitoring plan once compliance has been determined to be achieved. **5. Date of completion:** 1/7/2022	
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 Nursing Home Complaint IN00368519. Complaint IN00368519 - Unsubstantiated due to lack of evidence. Survey dates: December 14, 15, 16, 17, and 20, 2021. Facility number: 003924 Residential Census: 26 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality Review completed on December 21, 2021.	R 0000	This plan of correction is to serve as Stonebridge's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Stonebridge or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find our plan of correction for StoneBridge's Recertification and State Licensure Survey conducted on 12/14/21 – 12/21/21. We initiated immediate interventions when concerns were identified on this date. We respectfully request a "desk review" for this plan of correction. If you need any information or	

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			paperwork, please contact me at (812) 675 4154. Sincerely, Dawn Black, Administrator.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a minimum of 1 employee with a current First Aid certification worked on each shift for 7 of the 7 days for 26 of 26 residents who reside at the Facility. Findings include:	R 0117	**Citation #1** **R 117 410 IAC 16.2-5-1.4(b)** **Personnel - Deficiency** *Findings: This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure a minimum of 1 employee with a*	01/07/2022

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	On 12/20/21 at 2:45 p.m., the staffing schedule for the week of 12/5/21 - 12/11/21 and copies of the First Aid certification cards for employees on the schedule for the week were reviewed. The schedule indicated there were no First Aid certified staff working for the following dates and shifts: 12/5/21: day/evening/night 12/6/21: evening/night 12/7/21: night 12/8/21: evening/night 12/9/21: night 12/10/21: evening/night 12/11/21: day/night During an interview, on 12/20/21 at 3:25 p.m., the Assistant Director of Nursing Services indicated there were no First Aid certification cards for staff working on the above documented dates on the schedule.		*current First Aid certification worked on each shift for 7 of the 7 days for 26 of 26 residents who reside at the Facility.* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · No residents were found to be affected by the deficient practice. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · The campus scheduled CPR/ First Aide certification classes that were offered to campus nursing staff to ensure continued compliance with cited deficiency R 117 410 IAC 16.2-5-1.4(b) Personnel. · The Nurse Leadership Team & Scheduler were provided a listing of all staff who had successfully completed their CPR/ First Aide certification along with expiration dates. · Nursing Leaders assuming "on call" rotation and the campus scheduler will be responsible to ensure a minimum of one (1) awake staff person, with current CPR and first aid certification, is on site at all times in order to maintain continued compliance with the above cited deficiency.	

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			3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · The Campus Clinical Support provided re-education on 1/4/22 to the Campus Scheduler, Nurse leadership Team, Director of Health Services, Assistant Director of Health Services, Director of Assisted Living, and acting Administrator as to the above Residential Licensed requirements referencing Rule 117 410 IAC 16.2-5-1.4(b) Personnel. · The Director of Health Services developed and implemented a “Staff CPR/ First Aide Certification Binder” that contains a copy of each employee’s CPR/First Aide certification card. · The Staff CPR/ First Aide Certification Binder” will have a listing in the front of the binder identifying all employees who have active CPR/ First Aide certification along with their corresponding expiration dates. The DHS will review the binder weekly and update accordingly and distribute to the Campus Scheduler and Nurse Leadership Team to continued compliance when scheduling staff with Rule 117 410 IAC 16.2-5-1.4(b) Personnel · The CPR/ First Aide	

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			Binder" will be kept in a designated location that is accessible to the scheduler and nurse leadership team assuming "on call" rotation to ensure continued compliance with the above cited violation. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · The Campus Scheduler and/or assigned designated individuals will be responsible for reviewing the weekly staffing schedule a minimum of three times a week, for a period of six months to ensure continued compliance with R117 410 IAC 16.2-5-1.4 (b) Personnel regarding scheduling a minimum of one (1) awake staff person, with current CPR/ First aid certification on site at all times. · The findings from our audits will be reviewed during the campus regularly scheduled QUAPI meeting for determination to our ongoing frequency of our monitoring plan. Findings suggestive of 100% compliance may result in cessation of our monitoring plan once compliance has been determined to have been achieved. **5. Date of completion:** 1/7/2022	

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