STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMPLETE			ETED
		155727	B. WI	NG		12/20/	′2021
				CED FEET	ADDRESS OF A STATE OF SORE		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
OTONIED		AA45110			HAWNEE DR S		
STONER	RIDGE HEALTH C	AMPUS		BEDFORD, IN 47421			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE .	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
			F 00	000	This plan of correction is to se	rve	
	This visit was for a	Recertification and State			as Stonebridge's credible		
	Licensure Survey a	nd the Investigation of			allegation of compliance.		
	Nursing Home Cor	nplaint IN00368519. This			Submission of this plan of		
	visit included a Sta	te Residential Licensure			correction does not constitute	an	
	Survey.				admission by Stonebridge or it	S	
					management company that the	е	
	Complaint IN0036	8519- Unsubstantiated due to			allegations contained in the su	rvey	
	lack of evidence.				report is a true and accurate		
					portrayal of the provision of		
	Survey dates: December 14, 15, 16, 17, and 20,				nursing care and other service	s in	
	2021.				this facility, nor does this		
					submission constitute an		
	Facility number: 00				agreement or admission of the		
	Provider number: 1			survey allegations. Attached you			
	AIM number: 2004	72040			will find our plan of correction		
	C D 1 T				StoneBridge's Recertification a	and	
	Census Bed Type:				State Licensure Survey		
	SNF/NF: 39 SNF: 15				conducted on 12/14/21 –	-4-	
	_				12/21/21. We initiated immedi		
	Residential: 26				interventions when concerns v	vere	
	Total: 80				identified on this date. We respectfully request a "desk		
	Census Payor Type	••			review" for this plan of correcti	on	
	Medicare: 20	··			If you need any information or	O.1.	
	Medicaid: 22				paperwork, please contact me	at	
	Other: 12				(812) 675 4154. Sincerely, Da		
	Total: 54				Black, Administrator.	•••	
	1041.51				Black, Administrator.		
	These deficiencies	reflect State Findings cited in					
	accordance with 41	_					
	Quality Review con	mpleted on December 21,					
	2021.	1					
F 0641	483.20(g)						
SS=D	Accuracy of Asse	ssments					

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

(X6) DATE

TITLE

Any defiency statement 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155727		A. BU	A. BUILDING <u>00</u> COMP		(X3) DATE S COMPLI 12/20/	PLETED	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
Bldg. 00	§483.20(g) Accura The assessment resident's status. Based on interview facility failed to acc admission Minimur Set (MDS) assessment reviewed for Minimur (Resident 47) Findings include: Resident 47's clinica 12/20/2021 at 2:00 givere not limited to accurate to the corporate MDS admission MDS for incorrectly. The resunstageable pressur did not have a polic use the Resident Assemanual. A review of the Res (RAI) Version 3.0 Mindicated, " Enter	acy of Assessments. must accurately reflect the and record review, the curately complete an m Data ent for 1 of 21 residents num Data Set Assessment. al record was reviewed on p.m. Diagnoses included, but sepsis and heart failure. imum Data Set (MDS), dated ad Resident 47 as having one re ulcers/injuries due to ssing/device. 7, on 12/20/2021 at 3:02 p.m., consultant indicated the resident 47 was coded ident did not have an re ulcers/injury. The facility ry related to the MDS. They seessment Instrument (RAI) sident Assessment Instrument Manual, Section M0300E 0 if no unstageable pressure ed to non-removable	F 06		Citation #1 F 641 Accuracy of Assessment CFR(s): 483.20(g) SS= D Findings: This REQUIREMENT not met as evidenced by: Base on interview and record review the facility failed to accurately complete an admission Minimus Data Set (MDS) assessment for 1 of 21 residents reviewed for Minimum Data Set Assessment (Resident 47) 1: What corrective action(s) to 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 consection 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 where identified and what corrective action will be take to the campus Clinical Assessment Support team completed a review of all residing at StoneBridge identified as having pressure ulcers to	ents T is ed y, um for nt. will nt ode	01/07/2022
					as having pressure ulcers to ensure accuracy in coding of		

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Facility ID: 003924

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155727	A. BUILDING B. WING	00	COMPLETED 12/20/2021		
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				section M0300 on 12/30/2021 There were no findings from the review completed on 12/30/2021. 3: What measures will be purinto place or what systemic changes will be made to ensith the deficient practice do not recur? The MDS Clinical Assessment Team provided education as to accurate coding for pressure ulcer/injuries, using information from the MDS 3.00 User's Manual, Ch. 3, Section M0300 pgs. M-1 – M25. 4: How the corrective action will be monitored to ensure deficient practice will not recipie. what quality assurance program will be put into place. The Campus Clinical Assessment Support Nurse and Designee, will audit 3 MDS assessments weekly x 8 week accuracy of section M300 referencing Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. The Campus Clinical Assessment Support Nurse, with a naudit 3 MDS assessment monthly x 6 months for accurate of section M300 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. The findings from our audits will be reviewed during undits will be reviewed during	t sure pes ng ng ng RAI n the cur ce? nd/or ks for of uries will ts acy ber		

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Event ID:

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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. BUILDING 00 COMPLETED			ETED	
		155727	B. WI	NG		12/20/	2021
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		3100 SHAWNEE DR S				
STONER	RIDGE HEALTH CA	AMDUS					
STONED	NIDGE HEALTH CA	-ivii 03	BEDFORD, IN 47421				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					campus regularly scheduled QUAPI meeting for determinat to our ongoing frequency of oumonitoring plan. Findings suggestive of 100% compliance	ır	
					may result in cessation of our		
					monitoring plan once complian	ice	
					has been determined to have		
				been achieved.			
					5. Date of completion: 1/7/202	22	
F 0921 SS=E Bldg. 00	Environ §483.90(i) Other E The facility must p sanitary, and comf residents, staff and Based on observation review, the facility of transfer equipment of 14 of 54 residents re- equipment status (R 21, 103, 15, 10, 7, 1 to ensure residents of from disrepair for 2 environment (Resident Findings include: During a facility tout the following was of	on, interview, and record failed to ensure residents' was free from disrepair for eviewed for transfer esidents 8, 32, 40, 102, 44, 7, 43, 36, and 4) and failed bedroom furniture was free of 24 residents reviewed ents 6 and 20).	F 09	921	Citation #2 F 921 Safe/Functional/Sanitary/Contable 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 14-54 residents reviewed for transfer equipment status (Residents 8, 32, 40, 102, 44, 103, 15, 10, 7, 17, 43, 36, and and failed to ensure resident bedroom furniture was free from disrepair for 2 of 24	NT et 4 of 21, 4)	01/07/2022
	1b.) Resident 32's le	eft armrest was observed to			residents reviewed environm	ent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155727	B. WI			12/20/	
		100721		_		12/20/	
NAME OF I	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					HAWNEE DR S		
STONEB	RIDGE HEALTH C	AMPUS		BEDFC	PRD, IN 47421		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	have multiple crack	s.			(Residents 6 and 20).		
					1: What corrective action(s)	will	
	1c.) Resident 40's w	heelchair back was observed			be accomplished for those		
	with multiple crack	s.			residents found to have		
					affected by the deficient		
	1d.) Resident 102's right wheelchair armrest was				practice?		
	observed with multiple cracks.				· Resident #8's wheelcha	air	
					back and bottom cushion wer	е	
	1e.) Resident 44's left wheelchair armrest was				ordered, removed and replace	ed.	
	observed with multiple cracks.				Resident #32's left arm	rest	
					was ordered, removed, and		
	1f.) Resident 21's le	eft and right wheelchair			replaced.		
	armrest were observed with multiple cracks. The			· Resident #40's wheelchair			
	right armrest holder was observed to be broken				back was ordered, removed a	ind	
	with a sharp plastic edge exposed to the resident.				replaced.		
	1 1				· Resident #102's right		
	1g.) Resident 103's	right wheelchair armrest was			wheelchair armrest was order	ed.	
	observed with mult			removed, and replaced.			
		•			Resident #44's left		
	1h.) Resident 15's lo	eft wheelchair armrest was			wheelchair armrest was order	ed,	
	observed with mult				removed, and replaced.	,	
					Resident #21's left and		
	1i.) Resident 10's w	heelchair back and bottom			right wheelchair armrest were		
	were observed with				ordered, removed, and replace		
		•			The right armrest holder was		
	1j.) Resident 7's lef	t and right wheelchair			ordered, removed, and replace		
		rved with multiple cracks.		Resident #103's right			
		-			wheelchair armrest was order	ed,	
	1k.) Resident 17's le	eft wheelchair armrest was			removed, and replaced.		
	observed with mult				Resident #15's left		
		•			wheelchair armrest was order	ed,	
	11.) Resident 43's le	ft and right wheelchair			removed, and replaced.	,	
	,	rved with multiple cracks.			Resident #10's wheelch	nair	
		•			back and bottom were ordere	d,	
	1m.) Resident 36's	left and right wheelchair			removed, and replaced.	•	
	1	rved with multiple cracks.			· Resident #7's left and r	ight	
		•			wheelchair armrests were	-	
	ln.) Resident 4's let	ft and right wheelchair			ordered, removed, and replace	ed.	
		rved with multiple cracks.			· Resident #17's left		
		1			wheelchair armrest was order	ed,	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	N (X3) DATE SURVE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155727	B. W	ING		12/20/	2021
				CEDEE	A DDDDGG GITYL GTA TO GID GODE		
NAME OF P	ROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					HAWNEE DR S		
STONEB	RIDGE HEALTH C	AMPUS		BEDFO	PRD, IN 47421		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					removed, and replaced.		
					· Resident #43's left and		
	2a.) Resident 6's be	dside table was observed			right wheelchair armrests were	е	
	missing two large a	reas of veneer exposing the			ordered, removed, and replace	ed.	
	compressed wood u	ınderneath.			· Resident #36's left and		
					right wheelchair armrests were	е	
	2b.) Resident 20's b	edside table was observed			ordered, removed, and replace	ed.	
	missing a large area of veneer exposing the				· Resident #4's left and ri	ight	
	compressed wood u	inderneath.			wheelchair armrests were		
					ordered, removed, and replace	ed.	
	On 12/20/21 at 2:30 p.m., an environmental tour				· Resident #6's bedside t	able	
	was completed with the Maintenance Director				was discarded and a new one	was	
	and the Administra	tor present. Both staff			provided that was evaluated a	ınd	
	members indicated	the wheelchairs and bedside			determined to be free from		
	tables were in disre	pair and needed fixed.			disrepair.		
					· Resident #20's bedside		
	On 12/20/21 at 3:50	p.m., the Director of			table was discarded and a nev	W	
	Nursing Services pr	rovided the facility policy,			one was provided that was		
	"Resident Rights G	uidelines," revised 5/11/21,			evaluated and determined to b	oe	
	and indicated it was	s the policy currently being			free from disrepair.		
	used by the facility.	A review of the policy			2: How other residents having	ng	
	indicated the policy	did not address the residents'			the potential to be affected b	у	
	environment.				the same deficient practice v	vill	
					be identified and what		
	3.1-19(f)(5)				corrective action will be take	n?	
					· All residents have the		
					potential to be affected by the		
					alleged deficient practice.		
					· The campus Director of		
					Plant Operations and assigned		
					designated individuals evaluat		
					all resident's wheelchairs, trar		
					equipment, and bedside table		
					ensure equipment was free from	om	
					disrepair.		
					· Equipment found to be		
					state of disrepair was repaired		
					discarded, or replaced to ensu		
					continued compliance with the)	
					above cited deficiency		

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155727	A. BUILDING B. WING	00	COMPLETED 12/20/2021		
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				3: What measures will be purinto place or what systemic changes will be made to ensithat the deficient practice do 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 921 Safe/Functional/Sanitary/Conable Environment". 4: How the corrective action will be monitored to ensure deficient practice will not reive. what quality assurance program will be put into plate. The Director of Plant Operations and/or assigned designated individuals will be responsible for conducting walking rounds of the campust three days per week, for a period of six months to ensure resid wheelchairs, transfer equipment and bedside tables are in a sof good repair and in continuous compliance with the above of deficiency. Findings suggesting any wheelchairs, transfer equipment, or bedside tables be repaired, discarded, or replaced. Findings will be review during the campus regularly	sure pes f f the cur ce? s, riod ents ent, tate ed ted ve of will		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155727		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/20/2021		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HAWNEE DR S		
STONEB	RIDGE HEALTH CA	AMPUS			RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
					scheduled QUAPI meetings for determination regarding the ongoing frequency of our monitoring plan. Findings suggestive of 100% compliant may result in cessation of our monitoring plan once compliant has been determined to be achieved. 5. Date of completion: 1/7/202	e ice	
R 0000							
Bldg. 00							
	Survey. This visit in State Licensure Sur Nursing Home Com Complaint IN00368 lack of evidence. Survey dates: Decer 2021. Facility number: 00 Residential Census: This State Residential accordance with 416	2519 - Unsubstantiated due to mber 14, 15, 16, 17, and 20, 3924 26	R 0	JUU	This plan of correction is to set as Stonebridge's credible allegation of compliance. Submission of this plan of correction does not constitute admission by Stonebridge or it management company that the allegations contained in the sureport is a true and accurate portrayal of the provision of nursing care and other service this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find our plan of correction of StoneBridge's Recertification at State Licensure Survey conducted on 12/14/21 – 12/21/21. We initiated immediate interventions when concerns we identified on this date. We respectfully request a "desk review" for this plan of correction of the survey and the surv	an s e rvey s in ou or and ate vere	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			E SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		155727	B. W	ING	 	12/20/	/2021	
		.00		_	-	.=,=0,		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
				3100 SI	HAWNEE DR S			
STONEB	RIDGE HEALTH CA	AMPUS		BEDFO	PRD, IN 47421			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
1.1.0	ALGOLITORI GR		+		paperwork, please contact me	ot.	2.112	
					1			
					(812) 675 4154. Sincerely, Da	IWI		
					Black, Administrator.			
D 0447	440 140 40 0 5 4	4/5)						
R 0117	410 IAC 16.2-5-1.							
DI 1 00	Personnel - Defici	•						
Bldg. 00	, ,	ufficient in number,						
	•	training in accordance						
		ate laws and rules to meet						
		4) hour scheduled and						
		ls of the residents and						
	services provided.							
qualifications, and training of staff shall								
	depend on skills required to provide for the							
	•	he residents. A minimum						
	of one (1) awake s	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 regularl	y receive residential						
	nursing services o	r administration of						
	medication, or bot	h, at least one (1) nursing						
	staff person shall l	be on site at all times.						
	Residential facilitie	es with over one hundred						
		gularly receiving residential						
	, ,	r administration of						
	-	h, shall have at least one						
		ing staff person awake and						
		s for every additional fifty						
	-	rsonnel shall be assigned						
	` '	for which they are trained						
	-	yee duties shall conform						
	with written job de	=						
	with without job de	conputitions.	D A	117	Citation #1		01/07/2022	
	Rosed on intermiero	and record review, the	R 0	11/	R 117 410 IAC 16.2-5-1.4(b)		01/07/2022	
	facility failed to ens				Personnel - Deficiency	_4		
		rrent First Aid certification			Findings: This RULE is not me	Σ		
		ft for 7 of the 7 days for 26			as evidenced by: Based on			
	of 26 residents who	reside at the Facility.			interview and record review, th	те		
					facility failed to ensure a			
	Findings include:				minimum of 1 employee with a	1		
	i		1				1	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		155727	B. W	NG		12/20/	2021	
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	4						
OTONED	DIDOE LIEALTILO	ANADLIO			HAWNEE DR S			
STONER	RIDGE HEALTH C	AMPUS		BEDLO	RD, IN 47421			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	L	DATE	
					current First Aid certification			
	On 12/20/21 at 2:45	p.m., the staffing schedule			worked on each shift for 7 of th	ne		
		5/21 - 12/11/21 and copies			7 days for 26 of 26 residents w			
	of the First Aid cert	-			reside at the Facility.			
	employees on the schedule for the week were				1: What corrective action(s) v	vill		
		dule indicated there were no			be accomplished for those	****		
	First Aid certified s	taff working for the			residents found to have			
	following dates and	_			affected by the deficient			
	Š				practice?			
	12/5/21: day/evenin	ıg/night			No residents were found	l to		
	12/6/21: evening/night				be affected by the deficient			
	12/7/21: night				practice.			
	12/8/21: evening/ni	ght			2: How other residents havir	.a		
	12/9/21: night	5			the potential to be affected by	_		
	12/10/21: evening/n	night			the same deficient practice w			
	12/11/21: day/night	_			be identified and what	, III		
					corrective action will be take	n2		
	During an interview	y, on 12/20/21 at 3:25 p.m.,			· The campus scheduled			
	_	or of Nursing Services			CPR/ First Aide certification			
		e no First Aid certification			classes that were offered to			
		ing on the above documented			campus nursing staff to ensure	,		
	dates on the schedu				continued compliance with cite			
					deficiency R 117 410 IAC	;u		
					16.2-5-1.4(b) Personnel.			
					The Nurse Leadership			
					·	dod		
					Team & Scheduler were provided	ueu		
					a listing of all staff who had	DD/		
					successfully completed their C			
					First Aide certification along wi	u I		
					expiration dates.	ina		
					Nursing Leaders assum "on coll" rotation and the comp	_		
					"on call" rotation and the camp			
					scheduler will be responsible t	U		
					ensure a minimum of one (1)	nt		
					awake staff person, with curre			
					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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	OF CORRECTION	IDENTIFICATION NUMBER: 155727	A. BUILDING 00 B. WING		COMPLETED 12/20/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
STONEB	RIDGE HEALTH CA	AMPUS		HAWNEE DR S DRD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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	
	•			3: What measures will be put into place or what systemic changes will be made to ens that the deficient practice do not recur? The Campus Clinical Support provided re-education 1/4/22 to the Campus Schedu Nurse leadership Team, Direct of Health Services, Assistant Director of Health Services, Director of Assisted Living, an 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/ Fir 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 date: The DHS will review the binder weekly and update accordingly and distribute to the Campus Scheduler and Nurse Leaders Team to continued compliance when scheduling staff with Ru 117 410 IAC 16.2-5-1.4(b) Personnel The CPR/ First Aide	t ure es non ler, tor d le a	

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		X1) PROVIDER/SUPPLIER/CLIA			INSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	ı	JILDING	00	COMPL	
		155727	B. WI	NG		12/20/	2021
NAME OF P	ROVIDER OR SUPPLIER	-		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
William Of 11	NO VIDER OR SOLITEIER			3100 SI	HAWNEE DR S		
STONEB	RIDGE HEALTH CA	AMPUS		BEDFO	RD, IN 47421		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					Binder" will be kept in a		
					designated location that is		
					accessible to the scheduler an	ıd	
					nurse leadership team assumi	ng	
					on call" rotation to ensure	Ü	
					continued compliance with the		
					above cited violation.		
					4: How the corrective action		
				will be monitored to ensure t	-		
					deficient practice will not rec	ur	
					i.e. what quality assurance	_	
					program will be put into plac		
					The Campus Scheduler		
					and/or assigned designated	•	
					individuals will be responsible	IOI	
					reviewing the weekly staffing		
					schedule a minimum of three	i.,	
					times a week, for a period of s months to ensure continued	IX	
					compliance with R117 410 IAC		
					16.2-5-1.4 (b) Personnel	,	
					regarding scheduling a minimu	ım	
					of one (1) awake staff person,	4111	
					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 determinat	ion	
					to our ongoing frequency of ou		
					monitoring plan. Findings		
					suggestive of 100% compliand	е	
					may result in cessation of our		
					monitoring plan once compliar	nce	
					has been determined to have		
					been achieved.		
					5. Date of completion: 1/7/20	22	

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STATEMEN	VT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	RECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED		
	155727		B. WING		12/20/2021			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S				
STONEBRIDGE HEALTH CAMPUS				BEDFORD, IN 47421				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		DDOVIDED'S DI AN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			VIE	DATE		

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