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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155727	A. BUILDING -- B. WING	01/11/2022

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/11/2022 Facility Number: 003924 Provider Number: 155727 AIM Number: 200472040 At this Emergency Preparedness survey, Stonebridge Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 68 certified beds. At the time of the survey, the census was 44. Quality Review completed on 01/13/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/11/2022 Facility Number: 003924 Provider Number: 155727 AIM Number: 200472040 At this Life Safety Code survey, Stonebridge	K 0000		

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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	Health Campus was found not 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. This one story facility was determined to be of Type V (111) construction and was sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors and all resident sleeping rooms. The facility has a capacity of 68 and had a census of 44 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Due to the COVID-19 PHE, 1135 waivers for ITM were available at the time of the survey. 1135 waivers allow for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The survey process was modified during this COVID-19 PHE as allowed by QSO Memo 20-31- All. The process revisions excluded the 300 Hall and portions of the barriers.			

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	Quality Review completed on 01/13/22			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4			

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	DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure 1 of 9 egress doors equipped for delayed egress was equipped as required by LSC 7.2. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 15 residents	K 0222	K 222 Egress Doors Compliance date – 1/12/22 Immediate intervention The Director of Plant Operations installed signage of not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads "Push until alarm sounds. Door can be opened in 15 seconds". The Director of Plant Operations was educated by the Executive Director on K222 NFPA 101	01/12/2022

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	in the dining room. Findings include: Based on observations during tour of the facility on 01/11/2022 with the Director of Plant Operations and Regional Support person from 1:15 p.m. to 2:10 p.m., the single door exit in the corridor across from the dining room was provided with delayed egress but lacked the proper signage indicating the door can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Director of Plant Operations agreed the egress door was equipped with a delayed egress and lacked the proper signage. This finding was reviewed with the Executive Director, Director of Plant Operations and Regional Support person at the exit conference. 3.1-19(b)		Egress Doors. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. high and not less than 1/8 in. in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: “PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS”. The Director of Plant Operations will inspect the deficient delayed egress signage 1x week for 1 month and then 1 x month for 3 months. . The Executive Director will present documentation to the OAPI team for further recommendations The deficient practice could affect 15 residents in the dining rooms	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems	K 0345	K 345 Fire Alarm System – Testing and Maintenance	01/21/2022

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	was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.5 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. NFPA 72, 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Plant Operations and Regional Support person on 01/11/2022 from 10:15 a.m. to 1:15 p.m., the "Detector Inspection Report" dated 06/18/2020 indicated that the smoke detector ranges were 1.50 - 3.65%. The following devices failed / were outside the indicated range: a) Hall Supply Storage, Zone 13; 5.23% b) 300 Hall Medical Records, Zone 13; 3.71% c) 300 Hall Nurse Station, Zone 13; 3.89% Based on interview at the time of record review, the Director of Plant Operations confirmed the aforementioned devices were outside their listed sensitivity range and had no documentation of replacement or cleaning/recalibration at the time of the survey. This finding was reviewed with the Executive		Compliance date – 1/21/22 Immediate intervention The Director of Plant Operations contacted Koorsen to have the smoke detectors in the hall supply storage, 300 hall medical records and the 300 hall nurse station replaced with new detectors. The Director of Plant Operations was educated by the Executive Director on K 345 NFPA 101 Fire Alarm System – Testing and Maintenace. A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements if NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5 NFPA 70, NFPA 72 The Director of Plant Operations will inspect the deficient practice for 1x week for 1 month and then 1 x month for 3 months. The Executive Director will present documentation to the OAPI team for further recommendations The deficient practice could affect all	

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	Director, Director of Plant Operations, and Regional Support person at the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure sprinkler all heads were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the	K 0353	K 353 Sprinkle System – Maintenance and Testing Compliance date – 1/21/22 Immediate intervention The Director of Plant Operations contacted his sprinkler system contractor Safe Care to come and replace the two sprinkler heads in the dish area of the kitchen with new ones. The Director of Plant Operations was educated by the Executive Director on K 353 NFPA 101 Sprinkler System – Maintenance	01/21/2022

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	sprinkler manufacturer. This deficient practice could affect staff in the kitchen. Findings include: Based on observation with the Director of Plant Operations and Regional Support person on 01/11/2022 during a tour of the facility from 1:15 p.m. to 2:10 p.m., two sprinkler heads in the dish area of the kitchen were covered with corrosion. Based on interview at the time of observation, the Director of Plant Operations agreed the aforementioned automatic sprinkler heads were corroded and stated he has a request for their vendor to provide a quote for replacement of all sprinkler heads in the kitchen, but they won't enter the building currently due to COVID19 concerns. This finding was reviewed with the Executive Director, Director of Plant Operations, and Regional Support person at the exit conference. 3.1-19(b)		and Testing. LSC 9.7.5 NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g. up-right, pendent or sidewall). Furthermore at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. The Director of Plant Operations will inspect the deficient practice for 1x week for 1 month and then 1 x month for 3 months. The Executive Director will present documentation to the OAPI team for further recommendations The deficient practice could affect staff in the kitchen.	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 14 portable fire extinguishers was given maintenance at periods	K 0355	K 355 Portable Fire Extinguishers Compliance date – 1/26/22 Immediate intervention	01/26/2022

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	not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect staff in the laundry room. Findings include: Based on an observation during a tour of the facility on 01/11/2022 with the Director of Plant Operations and Regional Support person 1:55 p.m., the tag on the fire extinguisher in the laundry room had an annual inspection date of September 2020. Based on interview at the time of observation, the Director of Plant Operations agreed the fire extinguisher in the laundry room was past due for it's annual inspection. This finding was reviewed with the Executive Director, Director of Plant Operations and Regional Support person at the exit conference. 3.1-19(b)		The Director of Plant Operation called his portable fire extinguisher contractor (Koorsen) to come and perform an annual inspection of the fire extinguisher in the laundry room. The Director of Plant Operations was educated by the Executive Director on K 355 NFPA 101 Portable Fire Extinguishers. Portable fire extinguishers are selected, installed, inspected and maintained in accordance with NFPA 10, standard for portable fire extinguishers 18.3.5.12, 19.3.5.12, NFPA 10 The Director of Plant Operations will audit fire extinguisher inspections 1 x week for 1 month and 1 x a month for 3 months. The deficient practice could affect staff in the laundry room.	

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