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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br>155727 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: --<br>B. WING: _____ | X3) DATE SURVEY COMPLETED<br>10/30/2024 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>STONEBRIDGE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP COD<br>3100 SHAWNEE DR S<br>BEDFORD, IN 47421 |
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| E 0000<br><br>Bldg. -- | <p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 10/30/24</p> <p>Facility Number: 003924<br/>Provider Number: 155727<br/>AIM Number: 200472040</p> <p>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</p> <p>The facility has 68 certified beds. At the time of the survey, the census was 60.</p> <p>Quality Review completed on 11/01/24</p> | E 0000        | <p>Submission of this Plan of Correction does not indicate an admission by Stonebridge Health Campus that the findings and allegations contained herein are accurate and true representation of the quality of care and services provided to the residents of Stonebridge Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for the comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the management of this facility. It is thus submitted as a matter of statute only. We respectfully request a paper review for this plan of submission.</p> <p>Sincerely,<br/>Megan Alldredge<br/>Executive Director</p> |                      |
| K 0000<br><br>Bldg. 01 | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR</p>   | K 0000        | <p>Submission of this Plan of Correction does not indicate an admission by Stonebridge Health</p>   |                      |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE              | (X6) DATE  |
| Megan Alldredge   | Executive Director | 11/15/2024 |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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| NAME OF PROVIDER OR SUPPLIER<br><br>STONEBRIDGE HEALTH CAMPUS |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3100 SHAWNEE DR S<br>BEDFORD, IN 47421 |   |   |                      |
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| K 0211<br>SS=E<br>Bldg. 01                                    | <p>483.90(a).</p> <p>Survey Date: 10/30/24</p> <p>Facility Number: 003924<br/>Provider Number: 155727<br/>AIM Number: 200472040</p> <p>At this Life Safety Code survey, Stonebridge 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.</p> <p>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 60 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 11/01/24</p> <p>NFPA 101<br/>Means of Egress - General</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 4 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the</p> |   |  | K 0211  | <p>Campus that the findings and allegations contained herein are accurate and true representation of the quality of care and services provided to the residents of Stonebridge Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for the comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the management of this facility. It is thus submitted as a matter of statute only. We respectfully request a paper review for this plan of submission.</p> <p>Sincerely,<br/>Megan Alldredge<br/>Executive Director</p> <p>K211 - Means of Egress - General<br/>Immediate intervention<br/>The Director of Plant Operations removed and disposed of the PPE cart that was near resident room #109.</p> |   | 11/11/2024           |

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|                          | <p>following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm).</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c)The wheeled equipment is limited to the following:</p> <p>i. Equipment in use and carts in use</p> <p>ii. Medical emergency equipment not in use</p> <p>iii. Patient lift and transport equipment</p> <p>This deficient practice affects 21 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Director of Plant Operations (DPO) on 10/30/24 between 1:45 p.m. and 3:20 p.m., near Resident Room #109, a Personal Protective Equipment (PPE) cart was in use but was not equipped with wheels allowing the cart to be moved out of the hall during an emergency. The DPO stated that this had been mentioned to the staff in recent days but the condition apparently was not permanently corrected.</p> <p>This finding was acknowledged by the DPO at the time of observation and again at the exit conference with the Executive Director and DPO present.</p> <p>3.1-19(b)</p> |                     | <p>The Director of Plant Operations was educated by the Executive Director on K211 NFPA 101 Means of Egress - General. Aisles, passageways, corridors, exits discharges, exit locations and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c) The wheeled equipment is limited to the following</p> <p>I Equipment in use and carts in use</p> <p>II Medical emergency equipment not in use</p> <p>III Patient lift and transport equipment.</p> <p>The Director of Plant Operations will inspect the deficient corridor for proper means of egress 1 X a week for 1 month and 1 X a month for 3 months.</p> <p>Results of these inspections will</p> |                            |

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| K 0222<br>SS=E<br>Bldg. 01 | <p>NFPA 101<br/>Egress Doors</p> <p>Based on observation and interview, the facility failed to ensure the means of egress for 1 of over 12 exit doors was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 25 staff, residents and visitor.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Director of Plant Operations (DPO) on 10/30/24 between 1:45 p.m. and 3:20 p.m., the 300 hall courtyard exit door was magnetically locked but no code was posted. The DPO stated that this was a new gate that was installed with the new addition and that they simply forgot to post the code in this new location.</p> <p>This finding was acknowledged by the DPO at the time of observation and again at the exit</p> | K 0222        | <p>be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.<br/>The deficient practice could affect 21 residents in the facility.</p> <p>K222 - Egress Door<br/>Compliance Date- 11/11/24<br/><b>Immediate intervention</b><br/>The Director of Plant Operations posted the code on the magnetically locked courtyard exit gate.<br/>The Director of Plant Operations was educated by the Executive Director on K222 NFPA 101 Egress doors.<br/>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.<br/>The Director of Plant Operations will inspect the deficient gate for code posted 1 X a week for 1 month and 1 X a month for 3</p> | 11/11/2024           |

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| K 0345<br>SS=E<br>Bldg. 01 | <p>conference with the Executive Director and DPO present.</p> <p>3.1-19(b)</p> <p><b>NFPA 101</b><br/><b>Fire Alarm System - Testing and Maintenance</b><br/>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect 2 staff.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Director of Plant Operations (DPO) on 10/30/24 between 1:45 p.m. and 3:20 p.m., the Phone Room had a hard wired smoke detector connected to the building's main Fire alarm Control Panel that was dangling from the ceiling being supported by the red control wire. The DPO stated that he had not been in this room in awhile and was unaware the smoke detector had fallen from the ceiling.</p> <p>This finding was acknowledged by the DPO at the time of observation and again at the exit conference with the Executive Director and DPO present.</p> | K 0345        | <p>months.</p> <p>Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>The deficient practice could affect 25 staff, residents and visitors.</p> <p><b>K345 - Fire Alarm System - Testing and Maintenance</b><br/><b>Compliance Date- 11/11/24</b><br/><b>Immediate intervention</b><br/>The Director of Plant Operations installed a new electrical box in the ceiling and reinstalled smoke detector flush with the ceiling. The Director of Plant Operations was educated by the Executive Director on K345 NFPA 101 Fire Alarm System – Testing and Maintenance.</p> <p>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</p> | 11/11/2024           |

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| K 0363<br>SS=E<br>Bldg. 01 | <p>3.1-19(b)</p> <p>NFPA 101<br/>Corridor - Doors</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Director of Plant Operations (DPO) on 10/30/24 between 1:45 p.m. and 3:20 p.m., the corridor door to the Work Room failed to close and latch positively into the door frame. Based on interview at the time of the observations, the DPO agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke.</p> <p>This finding was acknowledged by the DPO at the time of observation and again at the exit conference with the Executive Director and DPO</p> | K 0363        | <p>The Director of Plant Operations will inspect the deficient smoke detector for compliance 1 X a week for 1 month and 1 X a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect 2 staff.</p> <p><b>K363 – Corridor - Doors</b><br/>Compliance Date- 11/11/24<br/><b>Immediate intervention</b><br/>The Director of Plant Operations adjusted the Work Room door and lockset so that it closes and latches positively into the door frame.<br/>The Director of Plant Operations was educated by the Executive Director on K363 NFPA 101 Corridor – Doors.<br/>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 ¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully</p> | 11/11/2024           |

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| K 0920<br>SS=E<br>Bldg. 01                                    | <p>present.</p> <p>3.1-19(b)</p> <p><b>NFPA 101</b><br/><b>Electrical Equipment - Power Cords and Extens</b><br/>Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw.<br/>NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 3 staff.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Director of Plant Operations (DPO) on 10/30/24 between 1:45 p.m.</p> | K 0920  | <p>sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware.</p> <p>The Director of Plant Operations will inspect the deficient corridor door for compliance 1 X a week for 1 month and 1 X a month for 3 months.</p> <p>Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>The deficient practice could affect 2 staff.</p> <p><b>K920 – Electrical Equipment – Power Cords and Extension Cords</b><br/>Compliance Date- 11/11/24<br/><b>Immediate intervention</b><br/>The Director of Plant Operations removed and disposed of the power strip from the Director of Health Services office and plugged the dorm style refrigerator into the wall outlet.<br/>The Director of Plant Operations was educated by the Executive Director on K920 NFPA 101</p> | 11/11/2024           |   |

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|                    | <p>and 3:20 p.m., in the Director of Health Services Office a power strip was being used to power a dorm style refrigerator (high power draw equipment).</p> <p>This finding was acknowledged by the DPO at the time of observation and again at the exit conference with the Executive Director and DPO present.</p> <p>3.1-19(b)</p> |               | <p>Electrical Equipment – Power Cords and Extension Cords.</p> <p>Power strips can not be used as a substitute for fixed wiring to provide power equipment with high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring.</p> <p>The Director of Plant Operations will inspect for the use of a power strip for compliance 1 X a week for 1 month and 1 X a month for 3 months.</p> <p>Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>The deficient practice could affect up to 3 staff.</p> |                      |