STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 45291 Based on interview and record review, the facility failed to complete a Minimum Data Set (MDS) Assessment for a resident discharged from hospice services (Resident 78) for 1 of 3 resident reviewed for timeliness of significant change assessments. Findings include: The clinical record for Resident 78 was reviewed on 3/21/2024 at 1:45 p.m. The medical diagnosis included dementia. A payor census for Resident 78 indicated she discharged from hospice services on 10/12/2023. A physician note, dated 10/12/2023, indicated that Resident 78 was .hospice is releasing her soon . No significant change MDS Assessment was completed for Resident 78 in October of 2023. A policy entitled, Significant Change in Status Assessments (SCSA), was provided by the Administrator on 3/22/2024 at 10:00 a.m. The policy indicated, .SCSA is required to be performed when a terminally ill resident enrolls or revokes hospice program . An interview with the MDS Coordinator on 3/22/2024 at 11:15 a.m. indicated that she coded to the Resident Assessment Instrument Manual for accuracy and timeliness of assessments. She stated that the Significant Change Assessment for Resident 78 was missed. 3.1-31(d)(1)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45291 Based on interview and record review, the facility failed to accurately indicate the use of hospice services (Resident 43) and failed to accurately code oxygen therapy (Resident 10 and 65) for 3 of 16 resident reviewed for MDS accuracy. Findings include: 1. The clinical record for Resident 43 was reviewed on 3/21/2024 at 2:30 p.m. The medical diagnosis included Alzheimer's disease with late onset. An Annual MDS Assessment for Resident 43, dated 2/18/2024, did not indicate the resident had a 6-month prognosis or received hospice services. A hospice certification, dated 1/30/2024, indicated that Resident 43 was terminally ill, elected the hospice benefit with a start of care date of 1/30/2024, and had a life expectancy of less than six months. An interview with MDS nurse on 3/21/2024 at 3:10 p.m., indicated that Resident 43 did not have a significant change completed due to not being sure when she was going to hospice because of the payor source confusion. 15909 2. On 3/19/24 at 2:06 p.m., Resident 10 was observed lying in bed, and received oxygen through a nasal cannula that was looped around her ears and connected to an oxygen concentrator. Resident 10's record was reviewed, on 3/21/24 at 1:49 p.m., and indicated diagnoses that included, but were not limited to, pneumonia, chronic respiratory failure with low oxygen in the blood, emphysema, and high blood pressure. A physician's order, dated 2/13/24, indicated oxygen at 4 liters per nasal cannula every shift. On 3/22/24, at 10:48 a.m., Resident 10 was observed lying in bed with her oxygen in place via nasal cannula. An Admission MDS assessment, dated 2/16/24, indicated Resident 10 was cognitively intact, was at risk for pressure ulcer development, and did not receive oxygen therapy. 3. Resident 65's record was reviewed, on 3/21/24 at 10:18 a.m., and indicated diagnoses that included, but were not limited to, dementia, high blood pressure, anemia, and atrial fibrillation. On 3/21/24 at 3:10 p.m., Resident 65 was observed in bed with her eyes closed, and oxygen was in use at 2 liters per minute with a nasal cannula. A Quarterly MDS assessment, dated 1/19/24, indicated Resident 65 did not receive oxygen therapy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, with a start date of 9/27/23, indicated an approach for as needed oxygen at 2 liters. An interview with the MDS Coordinator, on 3/22/2024 at 11:15 a.m., indicated that she coded to the Resident Assessment Instrument Manual for accuracy of assessments. She stated she would enter a modification of record for Resident 43's assessment dated [DATE] to reflect the hospice benefit and 6-month prognosis, and for Resident 10 and 65 for oxygen therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36942 Based on interview and record review, the facility failed to ensure continuation of treatment for a resident with pressure ulcers for Resident 55, and failed to ensure Resident 10 and 136's interventions were in place for pressure ulcer prevention and treatment. This affected 3 of 4 residents reviewed for pressure ulcers. Findings include: 1. The clinical record for Resident 55 was reviewed on 3/19/24 at 2:35 p.m. The diagnoses included, but were not limited to, cerebral infarction (or stroke, is a brain lesion in which a cluster of brain cells die when they don't get enough blood), hemiplegia (total or nearly complete paralysis on one side of the body), dementia, glaucoma, and weakness. A pressure ulcer care plan, dated 1/3/24, indicated Resident 55 had pressure ulcers to the left and right heel, right hip, left intergluteal cleft, and left buttock. The approaches included, but were not limited to, treatments as ordered. A physician order, dated 3/5/24, indicated the utilization of Medihoney (sterile, hydrocolloidal dressing with 100% active Leptospermum honey that supports the removal of necrotic tissue and aids in wound healing) to the right heel and left buttock daily. The order was discontinued on 3/6/24. A physician order, dated 3/12/24, indicated the utilization of Medihoney to the left buttocks daily. The order was current. A physician order, dated 3/12/24, indicated the utilization of Medihoney to the right heel daily. The order was current. The electronic treatment administration record (ETAR) for March of 2024 indicated there were no treatment orders to Resident 55's right heel or left buttock from 3/6/24 until 3/12/24. An interview conducted with the Director of Nursing (DON), on 3/21/24 at 3:25 p.m., indicated she could not find any orders for Resident 55's pressure ulcer treatment of the right hip and left buttocks for the period of 3/6/24 to 3/12/24. Resident 55 was put on hospice effective 3/2/24 and they, hospice, were conducting a comprehensive review of Resident 55's orders. 15909 2. On 3/19/24 at 2:06 p.m., Resident 10 was observed in bed, and received oxygen through a nasal cannula that was looped around her ears, and connected to an oxygen concentrator. Resident 10's record was reviewed, on 3/21/24 at 1:49 p.m., and indicated diagnoses that included, but were not limited to, pneumonia, chronic respiratory failure with low oxygen in the blood, emphysema, and high blood pressure. A physician's order, dated 2/13/24, indicated oxygen at 4 liters per nasal cannula every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 2/13/24, indicated Ear protectors to O2 (oxygen) tubing, special instructions: check placement q (every) shift, every shift. On 3/22/24, at 10:48 a.m., Resident 10 was observed lying in bed with her oxygen in place via a nasal cannula. The tubing around her ears was not padded and Resident 10 indicated her right ear was sore when it rubs and stated it just got sore a couple of days ago. On 3/22/24 at 11:03 a.m., LPN 5 assessed Resident 10's ears and said the right ear was reddened and not open, and placed a folded tissue on the ear crease, then placed the oxygen tubing on the ear. She said she would get ear pads and place them on the tubing. An assessment of the right ear was completed by LPN 5 and a copy provided on 3/22/24 at 12:28 p.m. The assessment indicated Resident 10 had a reddened area on the back of the right eat, at the top, that was not present on admission, measured 0.05 by 0.05 cm and no depth, and was a dark/dull red in color. There was no drainage or odor and a new intervention was to ensure ear pads were on the oxygen tubing at all times. A care plan with a start date of 2/18/24, indicated a problem for Resident is at risk for skin breakdown or further skin breakdown due to: decreased mobility, incontinence, poor nutrition, declining health, COPD, oxygen use, sliding down in bed, sliding during transfers, refuses to get out of bed 3. During an interview, on 3/18/24 at 2:34 p.m., Resident 136 indicated she had developed pressure areas on both heels after she was admitted , and said she didn't move around very much. Both heels were observed to touch the bed, and the resident said the pillow was slick and slides, and her heels will touch the bed. Resident 136's record was reviewed, on 3/21/24 at 2:30 p.m., and indicated diagnoses that included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, infection and inflammatory reaction due to internal right hip prosthesis, generalized muscle weakness, and right artificial hip joint. On 3/21/24, at 2:52 p.m., LPN 6 indicated Resident 136 should be checked every 2 hours as she will slide down in the bed, and she does get out of her bed every day, and gets therapy daily. LPN 6 said there was a blister there, and it gets monitored for the left heel, it is changed every Friday and as needed. It is done with the wound doctor. The right heel didn't have any issues, it was just soft. A care plan with a start date of 3/14/24, indicated a problem for dissipated blister to bilateral heels: chronic pain, and recent surgical repair to right hip. The interventions included Heel offloading pillow. A policy titled Skin Management Program, revised 5/22, was provided by the DON on 3/21/24 at 3:24 p.m. The policy indicated the following, .PROCEDURE FOR ALTERATIONS IN SKIN INTEGRITY - PRESSURE AND NON-PRESSURE .2. Treatment order will be obtained from MD/NP 3.1-40(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36942 Based on interview and record review, the facility failed to ensure fall interventions were in place after a fall had occurred for 1 of 2 residents reviewed for accidents. (Resident 55) Findings include: The clinical record for Resident 55 was reviewed on 3/19/24 at 2:35 p.m. The diagnoses included, but were not limited to, cerebral infarction (or stroke, is a brain lesion in which a cluster of brain cells die when they don't get enough blood), hemiplegia (total or nearly complete paralysis on one side of the body), dementia, glaucoma, and weakness. A care plan for fall risk, dated 4/6/23, indicated Resident 55 was at risk for falls due to history of falls, medication usage, incontinence, and weakness. The approach included, but were not limited to, a bedside mat while resting in bed that was started on 11/20/23. A fall event, dated 2/15/24 at 11:42 p.m., indicated Resident 55 fell out while sleeping and the [NAME] [sic] not at bedside. A progress note, dated 2/15/24 at 11:52 p.m., indicated the following, .This nurse alerted to resident's room per roommate yelling for help, Resident found lying on his L [left] side at bedside wearing gown and socks .2 s/t [skin tears] noted 5x3cm [centimeters] to L [left] hand and 1x1cm to R [right] pinky finger .Matt [sic] now at bedside A policy titled Fall Management Policy, revised 8/2022, was provided by the Administrator on 3/21/24 at 9:08 a.m. The policy indicated the following, .3. A care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors 3.1-45(a)(1) 3.1-45(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25054 Based on interview and record review the facility failed to have an ongoing activity program on the dementia care unit for 2 of 3 residents reviewed for activities (Resident C and Resident D). Findings include: 1.) During an interview with CNA 3 on 3/20/24 at 11:58 a.m., indicated she normally worked the dementia care unit. CNA 3 indicated there was not enough activities on the dementia care unit until recently when an activity assistant started working. The dementia unit went a long time without activity staff. During an interview with the Dementia Care Coordinator on 3/20/24 at 12:21 p.m., indicated the facility had not had an activity assistant since June 2023. The Dementia Care Coordinator was working in three different roles on the dementia care unit, the Dementia Care Coordinator, Social Services and activities. The facility did hire someone the end of February 2024 for activities. The staff did the best they could with activities, providing self initiated packets and coloring. During an interview with CNA 4 on 3/20/24 at 12:30 p.m., indicated she normally worked the dementia care unit. The staff did the best they could with activities without having an activity assistant. The staff were happy to have an activity assistant now. During an interview with LPN 6 on 3/21/24 at 1:08 p.m., indicated it was tough for the dementia care unit to go without activity staff. The staff did the best they could to provide some activities, but ultimately resident care had to come first. The dementia care unit had a lot residents who required assistance with their care. During an interview with Resident C's family member on 3/20/24 at 3:50 p.m., indicated the dementia care unit did not have any activities. The residents would sit around in the dining room with nothing to do. Review of the record of Resident C on 3/22/24 at 10:47 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, anxiety, mood disturbance, major depressive disorder psychotic disturbance. The Significant Change Minimum Data Set (MDS) assessment for Resident C, dated 4/7/23, indicated the resident was severely cognitively impaired for daily decision making. It was very important for the resident have books, newspapers, magazines, listen to music, be around animals, keep up with the news, do things in groups of people, attend her favorite activity, go outside to get fresh air, participate in religious services The plan of care for Resident C, dated 5/17/24, indicated the resident exhibited severe cognitive impairment related to dementia. The interventions included, but were not limited to, encourage participation in daily activities particularly regarding orientation, socialization and stimulation and encourage social interaction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The plan of care for Resident C, dated 5/17/24, indicated the resident enjoyed the following activities, spending time with family, sewing, bingo and socialization. The interventions were encourage activities of interest such as spending time with family, sewing, bingo, socialization, verbal reminders of activities and may participate in therapeutic structured work activities. 2.) During an interview with Resident D's family member on 3/18/24 at 11:50 a.m., indicated the facility was dishonest with him when he admitted his family member to the dementia care unit in August 2023. The family member indicated they were told the facility would provide lots of activities such as bingo etc. The facility did no activities for the resident and she would sit around all day until recently. The resident enjoyed cards, board games, bingo, being outside and live music. The resident was a [NAME] when she was younger. Review of the record of Resident D on 3/22/24 at 11:10 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety and major depressive order. The plan of care for Resident D, dated 8/25/23, indicated the resident was severely cognitively impaired related to dementia. The interventions included, but were not limited to, encourage to participate in daily activities particularly regarding orientation, socialization and stimulation and encourage social interaction. The plan of care for Resident D, dated 8/25/23, indicated the resident enjoyed the following type of activities: cooking, sitting outside, playing with her dog, spending time with family. The interventions included, but were not limited to, give verbal reminders to activities of interest and provide assistance to activities as needed. The Significant Change MDS assessment for Resident D, dated 1/23/24, indicated the resident was severely cognitively impaired for daily decision making. It was somewhat important to have books, newspapers and magazines, keep up with news, do things in groups of people It was was very important to listen to music, be around animals and attend her favorite activity, go outside and get fresh air and participate in religious services. During an interview with the Administrator on 3/21/24 at 11:41 a.m., indicated the facility had no documentation of Resident C and Resident D participating in any activities for the past 3 months. During an interview with the Administrator on 3/21/24 at 1:47 p.m., indicated the facility did not have a dementia care policy. The facility followed the State guidelines with dementia training. The activity policy provided by the Director Of Nursing on 3/21/24 at 12:30 p.m., indicated the facility would provide an ongoing program of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident. This Federal tag relates to Complaint IN00430463. 3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on observation, interview, and record review, the facility failed to ensure to maintain a clean, sanitary kitchen, ensure the holding refrigerator didn't contain unlabeled and/or expired foods, ensure bread was discarded that contained a fuzzy green, yellow substance, and ensure a cup was not present in the bulk storage bin. This had the potential to affect all 72 residents who receive food from the kitchen. Findings include: A kitchen tour was conducted on [DATE] at 10:45 a.m. with Cook 2. The holding fridge had a container of diced ham with a date of [DATE] and a use by date of [DATE]. Cook 2 indicated she wasn't sure why they would make the use by date 10 days after the preparation date. The date was usually 7 days after the preparation date. There was prepared salad that contained cubed ham that did not have a date. There was a container of bacon bits underneath the cubed ham that was not dated. Cook 2 indicated she would add the label on the bacon bits due to them being prepared over the weekend. There were multiple boxes stored on the floor of the main freezer. The dry storage room had 11 boxes observed to be stacked while placed directly on the floor. Cook 2 indicated the food shipments come on Tuesdays and Fridays and the boxes were stacked from the delivery this past Friday. There were not enough staff to put the items away. There was a bulk storage bin that contained a food substance along with a plastic cup located inside the bin and contacting the food substance. Outside of the kitchen was a rack that contained bread and buns. A total of 3 packages each containing 8 buns was noted to have a green, yellow fuzzy substance on all 3 packages of buns. Another kitchen observation was conducted on [DATE] at 5:20 p.m. The plastic cup remained in the bulk storage container, the boxes continued to be stacked on the floor in the dry storage room, boxes were stacked on the floor of the main freezer, and the buns were still present on the rack and noted with the yellow, green fuzzy substance. Another kitchen observation was conducted on [DATE] at 4:30 p.m. The plastic cup was no longer located in the bulk storage bin, there were no stacked boxes along the floor of the dry storage room, and there were still boxes stacked on the floor of the main freezer. An interview conducted with the Dietary Manager (DM), on [DATE] at 2:53 p.m., indicated that she was at the facility on [DATE] and put away the food shipment that came on Friday, [DATE]. The bulk storage bin contained oats, but the facility was in the process of getting rid of it since they now receive their oats in a smaller bag that doesn't require the need for a bulk storage bin. She was unaware that the buns were moldy. The bread is stored on the rack located outside of the kitchen due to the environment in the dry storage room making the bread become moldy quicker. The freezer does not have enough room to store the delivered food without it being placed on the floor. They are working on a plan to have the space, so items don't have to be stored in boxes, on the floor of the freezer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A policy titled Food Storage, revised ,d+[DATE], was provided by the Administrator on [DATE] at 9:08 a.m. The policy indicated the following, .Procedure .3. Food items will be stored on shelves, with heavier and bulkier items stored on the lower shelves 7. Scoops must be provided for flour, sugar, cereals, dried vegetables, and spices. Scoops are not stored in the food containers, but may be kept covered in a protected area near the containers .10. Food is stored a minimum of 6" above the floor and 18" below the sprinkler heads on clean racks or other clean surfaces, and is protected from splash, overhead pipes, or other contaminations .12. Leftover prepared foods are to be stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded. Leftover foods can be held at 41 [symbol for degrees] or less for nor more than 3 days .13. Refrigerated, ready-to-eat, potentially hazardous food purchased from approved vendors, shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded. This opened food can be held at 41 [symbol for degrees] or less for no more than 7 days and the date marked may not exceed the manufacturer's use-by-date 3XXX,d+[DATE](i)(2) 3XXX,d+[DATE](i)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36942 Based on interview and record review, the facility failed to ensure a dietary staff member did not work while experiencing signs and symptoms of a gastrointestinal illness and ensure 48 hours had passed since symptoms started. Findings include: A kitchen tour was conducted on 3/18/24 at 10:45 a.m. with Cook 2. Cook 2 indicated the Dietary Manager was out ill. An interview conducted with the Dietary Manager (DM), on 3/20/24 at 2:53 p.m., indicated that she was having symptoms of a gastrointestinal illness while at work on 3/18/24 and so she went home. She did return to work on 3/19/24 and was putting away the food shipment that came on Friday, 3/15/24. A policy titled Employee Illness, revised 12/2023, was provided by the Administrator on 3/21/24 at 3:30 p.m. The policy indicated the following, .Purpose of Policy: Resident(s) will not be exposed to employee(s) who show signs and symptoms of illness or infectious disease .Employees returning to duty after an infectious illness will consult the DNS [Director of Nursing Services], Infection Preventionist/designee before returning to work. If the absence has been related to an infectious illness, a physician's statement of fitness to return to work is required A Centers for Disease Control and Prevention (CDC) document, titled Norovirus, reviewed 5/10/23, indicated the following, .Prevention .Do not prepare and handle food or care for others when you are sick .You should not prepare food for others or provide healthcare while you are sick and for at least 2 days (48 hours) after symptoms stop. This also applies to sick workers in restaurants, schools, daycares, long-term care facilities, and other places where they may expose people to norovirus 3.1-18(b)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36942 Based on observation, interview, and record review, the facility failed to ensure resident rooms were in good repair related to the walls, headboard, and cove base (soft flexible material along the bottom part of the wall) in a bathroom for 6 of 72 residents reviewed for environment. (Resident 283, 40, 18, 44, 11, and 28) Findings include: An observation conducted on 3/19/24 at 9:38 a.m. noted Resident 283's room with the cove base peeling in the bathroom. An observation conducted on 3/18/24 at 12:23 p.m. noted Resident 40's room with missing paint alongside the wall behind the headboard. An observation conducted on 3/18/24 at 12:34 p.m. noted Resident 18's room with missing paint and drywall behind the headboard. An observation conducted on 3/19/24 at 9:46 a.m. noted Resident 44's room with a flexible strip of material hanging down her headboard and onto her bed. She was lying in bed during the observation. An observation conducted on 3/19/24 at 1:07 p.m. noted Resident 11's room with missing paint alongside the wall behind the headboard. An observation conducted on 3/18/24 at 12:19 p.m. noted Resident 28's room with missing paint alongside the wall behind the headboard. An environmental tour was conducted on 3/21/24 at 3:44 p.m. with the Maintenance Director and Housekeeping Supervisor. Resident 40, Resident 18, Resident 44, and Resident 283's room were noted with the same observations of missing paint, headboard, and cove base. The Maintenance Director indicated that it has been on ongoing issue with getting the walls repaired. He just repaired 5 walls on the Moving Forward Unit and when he returned the following week there were 2 rooms, previously repaired, noted with the same issues again. It appeared the nursing staff had been pushing the bed or recliner towards the wall and causing the missing paint along the walls. The Maintenance Director indicated they have implemented a training program for the staff regarding the beds going alongside the walls but it's a work in progress. He was waiting for approval to conduct such repairs due to only having a limited amount of work to conduct monthly. They have a system to where the nursing staff and housekeeping can input work orders if they were to see any environmental concerns. The work orders go to the Maintenance Director. 3.1-19(f)(5)