

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155727                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>07/14/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Stonebridge Health Campus                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3100 Shawnee Drive South<br>Bedford, IN 47421 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            |                                                 |
| F 0628<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to ensure the Notice of Transfer or Discharge and Bed hold Policy was provided to the residents or the resident's representative when transferred to the hospital for 2 of 4 residents reviewed for hospitalization. (Resident 11, Resident 68)</p> <p>Findings include:</p> <p>On 7/13/26 at 9:55 a.m., Resident 11's clinical record was reviewed. The diagnoses included, but were not limited to, stroke and anxiety.</p> <p>A progress note, dated 4/13/26 at 10:51 p.m., indicated Resident 11 fell while sitting in the wheelchair. Resident 11 was transferred to the emergency room for evaluation.</p> <p>The Notice of Transfer or Discharge lacked documentation of Resident 11's responsible party being notified of the Notice of Transfer or Discharge and the Bed Hold Policy.</p> <p>During an interview on 7/14/26 at 9:45 a.m., the Director of Health Services (DHS) indicated the clinical record lacked documentation of the family being provided the Notice of Transfer or Discharge and the Bed Hold Policy.</p> <p>2. On 7/9/26 at 11:00 a.m., Resident 68's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus, convulsions (rapid, involuntary muscle contractions), and chronic kidney disease (your kidneys are damaged and cannot filter blood properly).</p> <p>A review of the progress notes indicated the resident was transferred to the hospital on 5/23/26 and returned to the facility on 5/25/26.</p> <p>The clinical record lacked documentation that a written copy of the Notice of Transfer or Discharge and Bed Hold policy were provided to the resident and the resident representative.</p> <p>During an interview with the DHS (Director of Health Services) on 7/13/26 at 11:50 a.m., she indicated she could not find any documentation that the resident and/or the resident representative (continued on next page)</p> |                                                                                            |                                                 |

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

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| F 0628<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>were notified in writing.</p> <p>On 7/14/26 at 11:35 a.m., the Executive Director provided a policy labeled Guidelines for Transfer and discharge date d 12/8/25, she indicated this was a current policy used by the facility. A review of the policy indicated, .c. In cases of emergency transfers, the notice of the bed<sup>^</sup>hold policy under the State plan and the facility's bed<sup>^</sup>hold policy should be provided to the resident or resident's representative within 24 hours of the transfer. This may be sent with other papers accompanying the resident to the hospital. d. Social Service should review the documentation in CCM the following business day to assure written information was provided to the resident and a family member or legal representative of the bed<sup>^</sup>hold and admission policies. Notification of Bed<sup>^</sup>Hold Policy and readmission should be provided via certified mail in the event notification was not provided as part of the discharge process .</p> <p>410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(6)(A)(i)410 IAC 16.2-3.1-12(a)(6)(A)(ii)410 IAC 16.2-3.1-12(a)(6)(A)(iii)410 IAC 16.2-3.1-12(a)(25)(A)410 IAC 16.2-3.1-12(a)(25)(B)410 IAC 16.2-3.1-12(a)(26)</p> |                                                                                            |                                                 |