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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Health Campus	3100 Shawnee Drive South 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive assessment of a resident within 14 calendar days after admission to the facility for 1 of 1 residents reviewed for assessments. (Resident 59)Findings include:On 9/17/25 at 10:27 a.m., Resident 59's clinical record was reviewed. The diagnoses included, but were not limited to, chronic kidney disease, COPD (chronic obstructive disease), and chronic respiratory failure. The resident was admitted on [DATE]. A 9/4/25 admission Minimum Data Set (MDS) assessment was completed on 9/14/25. This was 4 days after day 14. During an interview on 9/17/25 at 11:36 a.m., the Corporate Nurse Consultant indicated the MDS assessment was completed late. During an interview on 9/18/25 at 12:56 p.m., the Director of Health Services indicated the facility lacked a policy for completing MDS assessments, and the staff followed the Resident Assessment Instrument (RAI) manual. On 9/19/25 at 10:02 a.m., a review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument, dated 10/1/24, indicated, . admission Assessment . The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 . 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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a PASARR (preadmission screening and resident review) was completed when a new mental health diagnosis was added for 1 of 5 residents reviewed for unnecessary medications. (Resident 7)Findings include:On 9/17/25 at 11:30 a.m., Resident 7's clinical record was reviewed. The diagnoses included, but were not limited to, new diagnosis on 4/12/25 of schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder), dementia (loss of memory, language, problem-solving and other thinking abilities), brief psychotic disorder (mental health condition characterized by sudden, short-lived psychotic symptoms, that last for at least one day but less than one month), major depressive disorder, and anxiety disorder.A PASARR Level I screen, dated 10/2/23, indicated the resident's mental health conditions were major depressive disorder, without psychotic features and anxiety disorder, it did not include schizoaffective disorder as a mental health diagnosis. The Level I screen indicated a PASARR Level II evaluation was not required at this time. The Level I screen indicated, .If a status change occurred or other information suggested a potential serious mental illness, then an updated Level I must be submitted to report the change to reevaluate the need for a PASARR Level II behavioral health evaluation.During an interview with the Director of Health Services (DHS), on 9/18/25 11:27 a.m., she indicated the clinical record lacked an updated PASARR Level II, for a new diagnosis of schizoaffective disorder on 4/12/25.During an interview with the DHS, on 9/18/25 at 12:56 p.m., she indicated the facility did not have a PASARR Level II policy. She indicated they follow the RAI (Resident Assessment Instrument) manual.A review of the RAI 3.0 User's Manual Version 1.19.1, October 2024, indicated the following: .If a Significant Change in Status Assessment occurs for an individual known or suspected to have a mental illness, intellectual disability, or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act.3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide supporting documentation for a new diagnosis of schizoaffective disorder for 1 of 5 residents reviewed for unnecessary medication. (Resident 7)Findings include: On 9/15/25 at 11:34 a.m., Resident 7 was observed to be ambulating with a walker in the hallway. On 9/15/25 at 2:13 p.m., Resident 7 was observed to be sitting on her bed looking at books.On 9/17/25 at 10:26 a.m., Resident 7 was observed to be ambulating with a walker in the hallway.On 9/17/25 at 11:30 a.m., Resident 7's clinical record was reviewed. The diagnoses included, but were not limited to, dementia with psychotic disturbance, schizoaffective disorder, major depression, and anxiety.Resident 7's admission date was 12/1/23. A PASARR Level One (assessment to determine if the resident has a serious mental illness) indicated the following:- On 9/5/23, indicated the current mental health diagnoses were major depression and depression.- On 10/2/23, indicated the current mental health diagnoses were major depression, anxiety, and depression.The admission paperwork, dated 12/1/23, lacked documentation of a diagnosis of schizoaffective disorder.The psychiatric hospital Discharge Medication Reconciliation, dated 4/14/24, indicated discharge medications of lithium carbonate 450 milligrams (mg) every day at 6:00 p.m. for mood disorder and Seroquel 25 mg three times a day for bipolar disorder. The discharge diagnoses lacked documentation of a diagnosis of schizoaffective disorder.A progress note, dated 4/11/25 at 6:34 a.m., indicated past medical history of schizoaffective disorder.During an interview on 9/17/25 at 1:20 p.m., the Corporate Nurse Consultant presented Resident 7's progress notes and indicated they had no supporting documentation for diagnosing schizoaffective disorder prior to 4/11/25. During an interview on 9/17/25 at 3:06 p.m., the Director of Health Services (DHS) indicated they did not have a policy for supporting documentation for a new diagnosis of schizoaffective disorder. 3.1-35(g)(1)