

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155838	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Stonecroft Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 363 South Fieldstone Blvd Bloomington, IN 47403	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's choice of code status was documented accurately for 1 of 2 residents reviewed for advanced directives. (Resident 13)</p> <p>Finding includes:</p> <p>On [DATE] at 2:34 p.m., Resident 13's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, acute respiratory failure with hypoxia (condition where you don't have enough oxygen in the tissues in your body), and chronic kidney disease (condition where the kidneys are damaged and can't properly filter waste and fluid from the blood).</p> <p>An Out of Hospital Do Not Resuscitate declaration and order, a choice of treatment document, dated [DATE], was signed by the Resident's POA (power of attorney) and the resident's physician, the document indicated no CPR (cardiopulmonary resuscitation) to be performed.</p> <p>The CPR consent, dated [DATE], indicated to perform CPR while the resident was in the facility. The CPR consent was obtained by verbal phone consent of the Resident's POA and witnessed by two nurses on [DATE].</p> <p>A review of the physician orders indicated the following:</p> <p>On [DATE] Code Status: Full Code (all possible life-saving measures taken in the event of a medical emergency, such as cardiac or respiratory arrest, including CPR). The order was discontinued on [DATE].</p> <p>On [DATE]: Code Status: DNR (Do Not Resuscitate). The order was discontinued on [DATE].</p> <p>On [DATE]: Code Status: DNR. The order was discontinued on [DATE].</p> <p>On [DATE]: Code Status: DNR.</p> <p>A Social Service Comprehensive Note, dated [DATE], indicated the resident was a full code.</p> <p>A Social Service Comprehensive Note, dated [DATE], indicated the resident was a DNR.</p> <p>(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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Resident First Meeting Minutes Note, dated [DATE], indicated the Resident's code status remained a DNR.</p> <p>A Resident First Meeting Minutes Note, dated [DATE], indicated the Resident's code status remained a DNR.</p> <p>A Hospital History and Physical, dated [DATE], indicated the resident was a full code.</p> <p>No additional documentation was in the clinical record to reflect the change in advanced directive.</p> <p>During an interview with the DON (Director of Nursing) on [DATE] at 11:55 a.m., she indicated she was unsure why the advanced directive order was changed. The DON indicated there was no further documentation in the record that indicated a request from the POA to change the resident's advanced directive.</p> <p>On [DATE] at 11:45 a.m., the Administrator provided the facility's admission packet, dated [DATE]. The Administrator indicated this was the current admission packet used by the facility. The document indicated . Out of Hospital Do Not Resuscitate Declaration and Order .is used to state your wishes .The declaration may be canceled by you at any time by a signed and dated writing .or by communicated to health care providers at the scene the desire to cancel the order .</p> <p>On [DATE] at 1:08 p.m., the DON provided the Guidelines for DNR Order policy. The policy was dated, [DATE], the DON indicated this was a current policy used by the facility. The policy indicated, .2. A Do Not resuscitate Form shall be completed and signed .and placed in medical record .5. The interdisciplinary care planning team will review advance directives with the resident during quarterly Resident First Conference to determine if the resident wishes to make changes in such directives .</p> <p>3.1-4(f)(5)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 1 residents reviewed for Resident Assessment. (Resident 55)</p> <p>Findings includes:</p> <p>On 5/19/25 at 11:21 a.m., Resident 55's clinical record was reviewed. The diagnoses included, but were not limited to, lung cancer and lupus (disease when your body's immune system attacks your own organs and tissue).</p> <p>The progress notes, dated 4/18/25 at 3:01 p.m., indicated Resident 55 was discharged home with her husband.</p> <p>The discharge MDS assessment, dated 4/18/25, indicated Resident 55 was discharged to a short term general hospital.</p> <p>During an interview on 5/19/25 at 3:07 p.m., the Social Services Director (SSD) indicated Resident 55 was discharged home.</p> <p>During an interview on 5/20/25 at 10:52 a.m., the MDS nurse indicated Resident 55 was discharged home. The MDS was coded wrong.</p> <p>During an interview on 5/20/25 at 12:24 p.m., the MDS Consultant indicated they did not have a MDS coding policy. The facility followed the RAI (Resident Assessment Instrument) manual.</p> <p>3.1-31(d)</p>		