

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155818 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/10/2016 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>HEARTHSTONE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3043 NORTH LINTEL DRIVE<br>BLOOMINGTON, IN 47404 |
|---|---|

| (X4) ID PREFIX TAG     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE |
|------------------------|---|---------------|--|----------------------|
| K 0000<br><br>Bldg. 01 | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/10/16</p> <p>Facility Number: 012974<br/>Provider Number: 155818<br/>AIM Number: 201247830</p> <p>At this Life Safety Code survey, Hearthstone Health Campus was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, in all living areas and has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 64 and had a census of 47 at the time of this</p> | K 0000        | The submission of this plan of correction does not indicate an admission by Hearthstone Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to our residents of Hearthstone Health Campus. This facility recognizes 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 comprehensive health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance of this facility. We respectfully request from the Department paper compliance. It is thus submitted as a matter of statute only. All corrections have been submitted to this POC. |                      |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

|   |   |   |   |   |  |   |  |
|---|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155818 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____                              |  | X3) DATE SURVEY COMPLETED<br><br>08/10/2016 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>HEARTHSTONE HEALTH CAMPUS |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3043 NORTH LINTEL DRIVE<br>BLOOMINGTON, IN 47404 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE  |  |   |  |
| K 0021<br>SS=E<br>Bldg. 01                                    | <p>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 08/11/16 - DA</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and</p> <p>(b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and</p> <p>(c) The automatic sprinkler system, if installed<br/>18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.<br/>Based on observation and interview, the</p> | K 0021  | The storeroom door was  | 09/10/2016  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155818 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/10/2016 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>HEARTHSTONE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3043 NORTH LINTEL DRIVE<br>BLOOMINGTON, IN 47404 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
|                    | <p>facility failed to ensure doors to 1 of 21 hazardous areas such as such as combustibile storage rooms greater than 100 square feet in size were self closing. Doors to hazardous areas are kept in the closed position unless held open by a releasing device complying with 7.2.1.8.2. This deficient practice could affect 8 residents, staff and visitors in the vicinity of the Storage Room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 1:20 p.m. on 08/10/16, the corridor door to the Storage Room was propped in the fully open position with a wedge placed under the door on the floor. The Storage Room measured greater than 100 square feet in size and was being used to store combustibile boxes and supplies on shelving throughout the room. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned hazardous area door did not self close because it was propped in the fully open position with a device which would not automatically release the door to self close.</p> <p>3.1-19(b)</p> |               | <p>immediately closed and the staff was educated to not prop open a door to a hazardous area where the enclosure is self closing. A release device that automatically closes the door upon activation of the fire alarm system will be installed by 9-10-16. The DPO or designee will provide an in-service to the staff regarding the Life Safety Code that requires doors to a hazardous area to have an enclosure that is self-closing and kept in the closed position, unless held open by a release device will be completed by 9-2-16. The DPO or designee will audit the storeroom door to ensure that it is closed 2 times per week for 4 weeks and then once a month for three months.</p> |                      |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155818 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/10/2016 |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>HEARTHSTONE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3043 NORTH LINTEL DRIVE<br>BLOOMINGTON, IN 47404 |
|---|---|

| (X4) ID PREFIX TAG         | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE |
|----------------------------|--|---------------|--|----------------------|
| K 0147<br>SS=E<br>Bldg. 01 | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 11 residents, staff and visitors in the vicinity of Room 107.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 1:20 p.m. on 08/10/16, a microwave oven was plugged into a power strip on the floor in Room 107. An extension cord for a lamp was also plugged into the power strip. Based</p> | K 0147        | <p>Immediate intervention was to remove the extension cord and unplug the microwave from the power strip. The DPO will audit all rooms by 8-26-16 to ensure compliance with Life Safety Code regarding the use of extension cords or power strips. The DPO or designee will inspect rooms monthly for any improper use of extension cords and power strips. Results of these inspections will be recorded and the results will be presented at the monthly Campus Quality Assurance meeting to determine the need to modify the frequency of these inspections. The DPO or designee will provide an in-service to the staff on the requirements of the Life Safety Code in regards to the use of extension cords and power strips to be completed by 9-2-16.</p> | 09/02/2016           |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155818 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>08/10/2016 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>HEARTHSTONE HEALTH CAMPUS |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3043 NORTH LINTEL DRIVE<br>BLOOMINGTON, IN 47404                       |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
|   | on interview at the time of observation, the Director of Plant Operations acknowledged extension cords including power strips were used as a substitute for fixed wiring in Room 107.<br><br>3.1-19(b) |   |   |                      |   |