STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
		155818	B. WI	B. WING			01/14/2025	
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIE	R			ORTH LINTEL DRIVE			
	STONE HEALTH (CAMPLIC			MINGTON, IN 47404			
HEARTH	STONE REALTH (DAIVIFUS		BLOON	MINGTON, IN 47404			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0000								
Bldg. 00								
	This visit was for a	Recertification and State	F 00	00	Preparation or execution of thi	S		
	Licensure Survey.	This visit included the			plan of correction does not			
	Investigation of Co	omplaint IN00449577. This visit			constitute admission or agreer	nent		
	included the State I	Residential Licensure Survey.			of provider of the truth of the fa	acts		
					alleged or conclusions set fort	h on		
		9577 - No deficiencies related to			the Statement of Deficiencies.	The		
	the allegations are	cited.			Plan of Correction is prepared	and		
					executed solely because it is			
	Survey dates: Janua	ary 7, 8, 9, 10, 13 and 14, 2025			required it is required by the			
					position of Federal and State I	₋aw.		
	Facility number: 012974				The Plan of Correction is			
	Provider number: 1	55818			submitted to respond to the			
	AIM number: 2012	247830			allegation of noncompliance ci	ted		
					during the Annual Survey			
	Census Bed Type:				conducted January 14, 2025			
	SNF: 32				Please accept this Plan of			
	SNF/NF: 23				Correction as the provider's			
	Residential: 54				credible allegation of complian	ice		
	Total: 109				as of January 30, 2025. The			
					provider respectfully requests	desk		
	Census Payor Type	e:			review with paper compliance	to		
	Medicare: 12				be considered in establishing	that		
	Medicaid: 16				the provider is in substantial			
	Other: 27				compliance.			
	Total: 55							
	These deficiencies	reflect State Findings cited in						
	accordance with 41	0 IAC 16.2-3.1.						
	Quality review con	npleted January 17, 2025.						
F 0623	483.15(c)(3)-(6)(8							
SS=D	Notice Requireme							
Bldg. 00	Transfer/Discharg							
		and record review, the facility	F 06	23	F 623		01/30/2025	
		written notification required			It is the practice of Hearthston			
	for a transfer and d	ischarge was provided to the			provide a notice of transfer an	d		
			<u> </u>					

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

(X6) DATE

TITLE

Todd Nowacki **Executive Director** 01/30/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

Event ID: BBHT11 Facility ID: 012974 If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SU	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u> COMI			ED
155818		B. W	B. WING 01/14/2025			025	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ORTH LINTEL DRIVE		
HEARTH	STONE HEALTH C	CAMPUS			MINGTON, IN 47404		
	T		1		, T	ı	975)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE C	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ident representative for 1 of 2	+	TAG	discharge to residents.	+	DATE
		for hospitalization. (Resident			What corrective actions will	ha	
	262)	ioi nospitanzation. (Resident			taken for those residents wh		
	202)				have been found to have been		
	Findings include:				affected by the deficient	711	
	i mamgs merade.				practice?		
	On 1/12/25 at 9:44	a.m., Resident 262's clinical			Resident #262 was provided a	<u> </u>	
		d. The diagnoses included, but			copy of the notice of transfer a		
		urinary tract infection,			discharge from the previous		
		tis due to Clostridium difficile			discharge.		
		a person experiences repeated			How other residents having	the	
	•	nation in the intestines caused			potential to be affected by the		
	_	stridium difficile), and stage 3			same deficient practice will I		
	chronic kidney dise	ase.			identified and what corrective		
					action will be taken?		
	A progress note, da	ted 1/3/25 at 10:13 a.m.,			-Like residents are those who	will	
	indicated the reside	nt was sent to the hospital for			be transferred from Hearthsto	ne.	
		on and lethargy. The clinical			The notice will be sent with the	е	
		nentation of written			resident and a copy sent to th	е	
		ransfer and discharge forms			resident representative. This		
	_	e resident and the resident			notification will be documente		
	representative.				the progress note and verified	-	
		1/10/07			DHS or designee at the time of	of the	
		on 1/13/25 at 10:48 a.m.,			transfer.		
		sultant 1 indicated the notice of			-Licensed nursing staff have b		
		ge would be documented in			in-serviced on the need to ser		
		No documentation of the			copy of the notice of transfer a		
		ge notices were found in the			discharge with the resident an send a copy to the resident	iu	
	progress notes.				representative and document	it in	
	During an interview	on 1/13/25 at 2:54 p.m.,			the health record.	1. 111	
	_	sultant 2 indicated the clinical			What measures will be put in	nto	
		mentation the notice of transfer			place or what systemic		
		provided to the resident and			changes will be made to		
	the resident's repres				ensure that the deficient		
					practice does not reoccur?		
	On 1/13/25 at 2:54	p.m., Clinical Nurse Consultant			DHS and/or designee will aud	it l	
		ity policy, "Guidelines for			discharges for the notice of		
	_	arge (including AMA),"			transfer and discharge weekly	/ x 4	
	reviewed on 12/17/24, and indicated this was the				weeks then every other week		

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Event ID:

BBHT11 Facility ID: 012974

If continuation sheet Page 2 of 9

ľ		X1) PROVIDER/SUPPLIER/CLIA	r í	PLE CONSTRUCTION NG 00	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155818	A. BUILDIN B. WING	COMPLETED 01/14/2025		
		133010			01/14/2023	
NAME OF F	ROVIDER OR SUPPLIER	1		REET ADDRESS, CITY, STATE, ZIP COD 43 NORTH LINTEL DRIVE		
HEARTH	STONE HEALTH C	CAMPUS		OOMINGTON, IN 47404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE APPROPR		
TAG		ng used. A review of the	TA	9	DATE	
		a. Notify the resident in		months then monthly x 3 mo How the corrective action v		
		vn, a family member or legal		be monitored to ensure the		
	-	the transfer or discharge"		deficient practice does not		
				reoccur?		
	3.1-12(a)(6)(A)(i)			DHS/designee will be respor		
	3.1-12(a)(6)(A)(iii)			with monitoring compliance of		
				notice of transfer and discha	_	
				procedure for 6 months. The results of these audits will be		
				reviewed by the QA committee		
				overseen by the Executive		
				Director. If a threshold of 100)% is	
				not achieved, an action plan	will	
				be developed, and ongoing		
				monitoring will occur. The fa	-	
				through the QAPI program, v		
				review, update, and make che to the POC as needed for	anges	
				sustaining substantial compl	iance	
				for no less than 6 months.		
				Date to be completed 1/30/2025		
				170072020		
F 0625 SS=D	483.15(d)(1)(2) Notice of Bed Hole	d Policy Before/Upon Trnsfr				
Bldg. 00	Based on interview	and record review, the facility	F 0625	F 625	01/30/2025	
		notification of the bed-hold	F 0023	It is the practice of Hearthsto		
		a resident who transferred to		provide a notice of bed hold		
		ovided in writing to the		and return to residents and t	•	
		ent representative for 1 of 2		resident representative.		
		for hospitalization. (Resident		What corrective actions wil		
	262)			taken for those residents w		
	Findings include:			have been found to have be	en	
	rmanigs include:			affected by the deficient practice?		
	On 1/12/25 at 9:44	a.m., Resident 262's clinical		Resident #262 was provided	a	
		d. The diagnoses included, but		copy from previous discharge		

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Event ID:

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If continuation sheet Page 3 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> C		COMPLI	COMPLETED	
		155818	B. WING 01/14/2025			2025	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	2					
	ICTONE LIEALTH C	SAMDLIC			ORTH LINTEL DRIVE		
HEARTH	ISTONE HEALTH C	AMPUS		BLOOM	MINGTON, IN 47404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were not limited to,	urinary tract infection,			How other residents having	he	
	recurrent enterocoli	tis due to Clostridium difficile			potential to be affected by th		
	(a condition where	a person experiences repeated			same deficient practice will b	e	
	episodes of inflamn	nation in the intestines caused			identified and what correctiv	e	
	by the bacteria Clos	stridium difficile), and stage 3			action will be taken?		
	chronic kidney dise	ase.			-Like residents are those who	will	
					be transferred from Hearthsto	ne.	
	A progress note, da	ted 1/3/25 at 10:13 a.m.,			The notice will be with the resi	dent	
	indicated the reside	nt was sent to the hospital for			and a copy sent to the residen	t	
	low oxygen saturati	on and lethargy. The clinical			representative. This notificatio	n will	
	record lacked docus	mentation of written			be documented in the progres	s	
	notification which s	specified the facility's bed-hold			note and verified by DHS or		
	policy having been	provided to the resident or the			designee at the time of the		
	resident representat	ive.			transfer.		
					-Licensed nursing staff have b	een	
	During an interview	v on 1/13/25 at 10:48 a.m.,			in-serviced on the need send	a	
	Clinical Nurse Cons	sultant 1 indicated the notice of			copy of the bed hold policy wit	h	
	the bed hold policy	would be documented in the			the resident and send a copy	io	
	progress notes. The	clinical record lacked			the resident representative an	d	
	documentation of w	ritten notification which			document in health record.		
	specified the facility	y's bed-hold policy having			What measures will be put in	to	
	been provided to the	e resident or the resident			place or what systemic		
	representative				changes will be made to		
					ensure that the deficient		
	During an interview	v on 1/13/25 at 2:54 p.m.,			practice does not reoccur?		
		sultant 2 indicated the clinical			DHS and/or designee will aud	it	
		mentation of the bed hold			discharges for the bed hold po	licy	
	policy being provid	ed to the resident and the			weekly x 4 weeks then every of	other	
	resident's representa	ative.			week x 2 months then monthly	/ x 3	
					months.		
		p.m., Clinical Nurse Consultant		How the corrective action will			
	_	ity policy, "Guidelines for			be monitored to ensure the		
		arge (including AMA),"			deficient practice does not		
		24, and indicated this was the			reoccur?		
		ng used. A review of the			DHS/designee will be respons		
		. 5. Notice of Bed-Hold Policy			with monitoring compliance of		
		b. Before the facility transfers			bed hold policy procedure for	6	
	_	ital staff member should			months. The results of these		
	_	ormation to the resident and a			audits will be reviewed by the	QA	
	family member or legal representative of the				committee overseen by the		

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Event ID:

BBHT11 Facility ID: 012974

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>00</u> COMPI			ETED	
155818		B. WING 01/14/2025			/2025		
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
F 0695 SS=D Bldg. 00	bed-hold and admis 3.1-12(a)(25) 3.1-12(a)(26) 483.25(i) Respiratory/Traches Suctioning Based on observation review, the facility is a physician's order for resident reviewed for 260) Findings include: On 1/8/25 at 10:18 a	eostomy Care and on, interview, and record failed to ensure a resident had for oxygen therapy for 1 of 1 or respiratory care. (Resident	PREFIX		Executive Director. If a threshold of 100% is not achieved, an adplan will be developed, and ongoing monitoring will occur. The facility through the QAPI program, will review, update, a make changes to the POC as needed for sustaining substant compliance for no less than 6 months. Date to be completed 1/30/2025 F 695 It is the practice of Hearthston obtain physician's orders for administration of oxygen. What corrective actions will taken for those residents whehave been found to have been affected by the deficient practice?	e to	01/30/2025
		ng in bed with oxygen on at			A physician order for oxygen v	vas	
		sal cannula (a device to all oxygen through your nose)			obtained for resident #260.	ho	
		Resident 260 indicated she was			How other residents having t potential to be affected by th		
	on oxygen at 3.5 L.				same deficient practice will b		
					identified and what corrective		
	-	.m., Resident 260 was observed			action will be taken?		
	to be resting in bed	with oxygen on at 3.5 L.			-All residents currently receiving	_	
		a.m., Resident 260 was ng in bed with oxygen on at			oxygen had their charts review for physician orders for oxyger -Licensed nursing staff have b in-serviced on the need to obta	n. een	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	COMPLETED	
155818		B. W	ING		01/14/	/2025		
			1	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ORTH LINTEL DRIVE			
HEARTH	STONE HEALTH C	CAMPUS			/INGTON, IN 47404			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE	
					physician order for oxygen.			
	On 1/13/25 at 11:12	2 a.m., LPN 1 indicated Resident			What measures will be put ir	nto		
	260 was on oxygen	at 3.5 L.			place or what systemic			
					changes will be made to			
	On 1/13/25 11:28 a	.m., Resident 260's clinical			ensure that the deficient			
	record was reviewe	d. The diagnoses included, but			practice does not reoccur?			
	were not limited to,	, pneumonia, pulmonary			DHS and/or designee will aud	it		
	disease, and chronic	c respiratory failure.			residents with oxygen to ensu	re		
					physician orders are present			
		servation and Data Collection,			weekly x 4 weeks, then every			
		:16 a.m., indicated Resident 260			other week x 2 months then			
		centration of continuous			monthly x 3 months.			
		ne care plan goal was oxygen			How the corrective action wi	II		
	per Medical Doctor	(MD) order.			be monitored to ensure the			
					deficient practice does not			
	The Progress Notes	s indicated the following:			reoccur?			
					DHS/designee will be respons			
		17 a.m., Resident 260 was on 4 L			with monitoring residents with			
	of oxygen per NC.				oxygen for physician orders for	or 6		
					months. The results of these			
		a.m., Resident 260 utilized			audits will be reviewed by the	QA		
	oxygen.				committee overseen by the			
	- 4/40/0 .				Executive Director. If a thresh			
		8 a.m., Resident 260 utilized			of 100% is not achieved, an a	ction		
	oxygen.				plan will be developed, and			
	TO 1 1 1	11/0/05 : 1: . 1D : 1 .			ongoing monitoring will occur.			
	•	d 1/9/25, indicated Resident			The facility through the QAPI	d		
		cardiovascular distress related			program, will review, update, and			
		ertension. The intervention			make changes to the POC as			
	was to administer o	oxygen per order.			needed for sustaining substar	ıuaı		
	The Dhysisian O.1	ove dated 1/12/25 leaked			compliance for no less than 6			
	· ·	ers, dated 1/13/25, lacked physician order for oxygen.			months.			
	documentation of a	physician order for oxygen.			Date to be completed 1/30/2025			
	On 1/13/25 at 11:00	0 a.m., the Corporate Nurse						
		would need a physician order						
		nt 260's physician orders lacked						
		physician order for oxygen.						
	On 1/13/25 at 11:44	5 a.m., the Corporate Nurse						
	1 On 1/13/23 at 11.4.	a.m., the Corporate Nuise	1		l .		I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155818		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2025		
	ROVIDER OR SUPPLIER		3043 N	ADDRESS, CITY, STATE, ZIP COD IORTH LINTEL DRIVE MINGTON, IN 47404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0921	Oxygen," dated 12/ policy currently bei	y's policy, "Administration of 13/24, and indicated it was the ng used by the facility. A indicated"1. Verify r the procedure"			
SS=D Bldg. 00	Safe/Functional/Safe/Functiona	anitary/Comfortable Environ on, interview, and record failed to ensure a room was free	F 0921	F 921	01/30/2025
	-	or 3 of 6 days during the survey		It is the practice of Hearthstone provide a sanitary environment What corrective actions will taken for those residents who	t. De
	Findings include:			have been found to have bee affected by the deficient	n
	On the following da odor was observed in	ates and times a strong urine in Room 220:		practice? The carpets in 220 were	
	- On 1/8/25 at 10:19			shampooed.	
	- On 1/8/25 at 11:46			How other residents having t	he
	- On 1/8/25 at 2:46	p.m.;		potential to be affected by the	e
	- On 1/9/25 at 9:21	a.m.;		same deficient practice will b	е
	- On 1/9/25 at 11:53			identified and what corrective	e
	- On 1/9/25 at 2:29	•		action will be taken?	
	- On 1/10/25 at 9:41	I a.m.		-Rooms were inspected for odd	
	During an interview	on 1/9/25 at 12:28 p.m., a		and corrections were made as needed.	
	_	resident who currently resided		-Staff have been in-serviced or	n the
		ated the room often had a smell		need to alert housekeeping on	
	of urine.			need to shampoo carpets that	
				present with an odor.	
	_	on 1/13/25 at 10:03 a.m., the		What measures will be put in	to
	•	dicated she believed the smell		place or what systemic	
		carpet. They had switched out		changes will be made to	
	· ·	elchair cushions, and had		ensure that the deficient	
	smell of urine down	arpets once a week to keep the		practice does not reoccur?	.
	sinen of urine down	1.		The ED will conduct room odor audits weekly x 4 weeks, then	
ı			1	addito Woonly A T Woons, HIGH	I

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Event ID:

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155818		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/14/2025			
	ROVIDER OR SUPPLIER STONE HEALTH C		STREET ADDRESS, CITY, STATE, ZIP COD 3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	provided the policy, as a Nursing Home indicated it was the by the facility. A re- mention the right to	p.m., the Administrator "Your Rights and Protections Resident", undated, and policy currently being used view of the policy did not be free from odors" The ated the facility did not have a room environment.		every other week x 2 months to monthly x 3 months. How the corrective action will be monitored to ensure the deficient practice does not reoccur? Executive Director/designee will be responsible with monitoring room odor for 6 months. The results of these audits will be reviewed by the QA committed overseen by the Executive Director. If a threshold of 100% not achieved, an action plan will be developed, and ongoing monitoring will occur. The facilithrough the QAPI program, will review, update, and make charto the POC as needed for sustaining substantial compliation for no less than 6 months. Date to be completed 1/30/2025	vill g e % is vill lity ll nges		
R 0000							
Bldg. 00	Survey. This visit is State Licensure Sur Complaint IN00449 Complaint IN00449 the allegations are consurvey dates: January	577 - No deficiencies related to ited. ry 7, 8, 9, 10, 13 and 14, 2025	R 0000				
	Facility number: 01	<i>4)</i> T					

State Form Event ID: BBHT11 Facility ID: 012974 If continuation sheet Page 8 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/31/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155818	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/14/2025	
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS				3043 N	ADDRESS, CITY, STATE, ZIP COD ORTH LINTEL DRIVE IINGTON, IN 47404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Residential Census:	Campus was found to be in 0 IAC 16.2-5 in regard to the					

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