STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155818	A. BUILDING 00 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEARTHSTONE HEALTH CAMPUS	3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00449577. This visit included the State Residential Licensure Survey. Complaint IN00449577 - No deficiencies related to the allegations are cited. Survey dates: January 7, 8, 9, 10, 13 and 14, 2025 Facility number: 012974 Provider number: 155818 AIM number: 201247830 Census Bed Type: SNF: 32 SNF/NF: 23 Residential: 54 Total: 109 Census Payor Type: Medicare: 12 Medicaid: 16 Other: 27 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 17, 2025.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted January 14, 2025 Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 30, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the	F 0623	F 623 It is the practice of Hearthstone to provide a notice of transfer and	01/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd Nowacki	Executive Director	01/30/2025

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	resident and the resident representative for 1 of 2 residents reviewed for hospitalization. (Resident 262) Findings include: On 1/12/25 at 9:44 a.m., Resident 262's clinical record was reviewed. The diagnoses included, but were not limited to, urinary tract infection, recurrent enterocolitis due to Clostridium difficile (a condition where a person experiences repeated episodes of inflammation in the intestines caused by the bacteria Clostridium difficile), and stage 3 chronic kidney disease. A progress note, dated 1/3/25 at 10:13 a.m., indicated the resident was sent to the hospital for low oxygen saturation and lethargy. The clinical record lacked documentation of written notification of the transfer and discharge forms were provided to the resident and the resident representative. During an interview on 1/13/25 at 10:48 a.m., Clinical Nurse Consultant 1 indicated the notice of transfer and discharge would be documented in the progress notes. No documentation of the transfer and discharge notices were found in the progress notes. During an interview on 1/13/25 at 2:54 p.m., Clinical Nurse Consultant 2 indicated the clinical record lacked documentation the notice of transfer and discharge was provided to the resident and the resident's representative. On 1/13/25 at 2:54 p.m., Clinical Nurse Consultant 1 provided the facility policy, "Guidelines for Transfer and Discharge (including AMA)," reviewed on 12/17/24, and indicated this was the		discharge to residents. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** Resident #262 was provided a copy of the notice of transfer and discharge from the previous discharge. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** -Like residents are those who will be transferred from Hearthstone. The notice will be sent with the resident and a copy sent to the resident representative. This notification will be documented in the progress note and verified by DHS or designee at the time of the transfer. -Licensed nursing staff have been in-serviced on the need to send a copy of the notice of transfer and discharge with the resident and send a copy to the resident representative and document it in the health record. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** DHS and/or designee will audit discharges for the notice of transfer and discharge weekly x 4 weeks then every other week x 2	

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	policy currently being used. A review of the policy indicated, "... a. Notify the resident in writing, and if known, a family member or legal representative ... of the transfer or discharge ..." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)		months then monthly x 3 months. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** DHS/designee will be responsible with monitoring compliance of the notice of transfer and discharge 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 facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **Date to be completed** 1/30/2025	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 1 of 2 residents reviewed for hospitalization. (Resident 262) Findings include: On 1/12/25 at 9:44 a.m., Resident 262's clinical record was reviewed. The diagnoses included, but	F 0625	F 625 It is the practice of Hearthstone to provide a notice of bed hold policy and return to residents and their resident representative. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** Resident #262 was provided a copy from previous discharge.	01/30/2025

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	were not limited to, urinary tract infection, recurrent enterocolitis due to Clostridium difficile (a condition where a person experiences repeated episodes of inflammation in the intestines caused by the bacteria Clostridium difficile), and stage 3 chronic kidney disease. A progress note, dated 1/3/25 at 10:13 a.m., indicated the resident was sent to the hospital for low oxygen saturation and lethargy. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative. During an interview on 1/13/25 at 10:48 a.m., Clinical Nurse Consultant 1 indicated the notice of the bed hold policy would be documented in the progress notes. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative During an interview on 1/13/25 at 2:54 p.m., Clinical Nurse Consultant 2 indicated the clinical record lacked documentation of the bed hold policy being provided to the resident and the resident's representative. On 1/13/25 at 2:54 p.m., Clinical Nurse Consultant 1 provided the facility policy, "Guidelines for Transfer and Discharge (including AMA)," reviewed on 12/17/24, and indicated this was the policy currently being used. A review of the policy indicated, "... 5. Notice of Bed-Hold Policy and Readmission ... b. Before the facility transfers a resident to a hospital ... staff member should provide written information to the resident and a family member or legal representative of the		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** -Like residents are those who will be transferred from Hearthstone. The notice will be with the resident and a copy sent to the resident representative. This notification will be documented in the progress note and verified by DHS or designee at the time of the transfer. -Licensed nursing staff have been in-serviced on the need send a copy of the bed hold policy with the resident and send a copy to the resident representative and document in health record. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** DHS and/or designee will audit discharges for the bed hold policy weekly x 4 weeks then every other week x 2 months then monthly x 3 months. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** DHS/designee will be responsible with monitoring compliance of the bed hold policy procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the	

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	bed-hold and admission policies ... " 3.1-12(a)(25) 3.1-12(a)(26)		Executive Director. If a threshold of 100% is not achieved, an action plan will be developed, and ongoing monitoring will occur. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **Date to be completed** 1/30/2025	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure a resident had a physician's order for oxygen therapy for 1 of 1 resident reviewed for respiratory care. (Resident 260) Findings include: On 1/8/25 at 10:18 a.m., Resident 260 was observed to be resting in bed with oxygen on at 3.5 liters (L) per nasal cannula (a device to administer additional oxygen through your nose) (NC). At that time, Resident 260 indicated she was on oxygen at 3.5 L. On 1/9/25 at 3:10 p.m., Resident 260 was observed to be resting in bed with oxygen on at 3.5 L. On 1/10/25 at 9:52 a.m., Resident 260 was observed to be resting in bed with oxygen on at 3.5 L.	F 0695	F 695 It is the practice of Hearthstone to obtain physician's orders for administration of oxygen. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** A physician order for oxygen was obtained for resident #260. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** -All residents currently receiving oxygen had their charts reviewed for physician orders for oxygen. -Licensed nursing staff have been in-serviced on the need to obtain a	01/30/2025

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	On 1/13/25 at 11:12 a.m., LPN 1 indicated Resident 260 was on oxygen at 3.5 L. On 1/13/25 11:28 a.m., Resident 260's clinical record was reviewed. The diagnoses included, but were not limited to, pneumonia, pulmonary disease, and chronic respiratory failure. The Admission Observation and Data Collection, dated 12/27/24 at 8:16 a.m., indicated Resident 260 utilized a high concentration of continuous oxygen. The baseline care plan goal was oxygen per Medical Doctor (MD) order. The Progress Notes indicated the following: - On 12/27/24 at 8:17 a.m., Resident 260 was on 4 L of oxygen per NC. - On 1/9/25 at 6:26 a.m., Resident 260 utilized oxygen. - On 1/13/25 at 6:18 a.m., Resident 260 utilized oxygen. The care plan, dated 1/9/25, indicated Resident 260 was at risk for cardiovascular distress related to diagnosis of hypertension. The intervention was to administer oxygen per order. The Physician Orders, dated 1/13/25, lacked documentation of a physician order for oxygen. On 1/13/25 at 11:00 a.m., the Corporate Nurse indicated a resident would need a physician order for oxygen. Resident 260's physician orders lacked documentation of a physician order for oxygen. On 1/13/25 at 11:45 a.m., the Corporate Nurse		physician order for oxygen. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** DHS and/or designee will audit residents with oxygen to ensure physician orders are present weekly x 4 weeks, then every other week x 2 months then monthly x 3 months. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** DHS/designee will be responsible with monitoring residents with oxygen for physician orders 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 facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **Date to be completed** 1/30/2025	

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	provided the facility's policy, "Administration of Oxygen," dated 12/13/24, and indicated it was the policy currently being used by the facility. A review of the policy indicated..."1. Verify physician's order for the procedure..." 3.1-47(a)(6)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to ensure a room was free from a urine odor for 3 of 6 days during the survey period. (Room 220) Findings include: On the following dates and times a strong urine odor was observed in Room 220: - On 1/8/25 at 10:19 a.m.; - On 1/8/25 at 11:46 a.m.; - On 1/8/25 at 2:46 p.m.; - On 1/9/25 at 9:21 a.m.; - On 1/9/25 at 11:53 a.m.; - On 1/9/25 at 2:29 p.m.; - On 1/10/25 at 9:41 a.m. During an interview on 1/9/25 at 12:28 p.m., a family member of a resident who currently resided in Room 220, indicated the room often had a smell of urine. During at interview on 1/13/25 at 10:03 a.m., the Corporate Nurse indicated she believed the smell of urine was in the carpet. They had switched out the mattresses, wheelchair cushions, and had been cleaning the carpets once a week to keep the smell of urine down.	F 0921	F 921 It is the practice of Hearthstone to provide a sanitary environment. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** The carpets in 220 were shampooed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** -Rooms were inspected for odors and corrections were made as needed. -Staff have been in-serviced on the need to alert housekeeping on the need to shampoo carpets that present with an odor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** The ED will conduct room odor audits weekly x 4 weeks, then	01/30/2025

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	On 1/14/25 at 12:02 p.m., the Administrator provided the policy, "Your Rights and Protections as a Nursing Home Resident", undated, and indicated it was the policy currently being used by the facility. A review of the policy did not mention the right to be free from odors ..." The Administrator indicated the facility did not have a policy related to the room environment. 3.1-19(f)		every other week x 2 months then 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 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 facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **Date to be completed** 1/30/2025	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00449577. Complaint IN00449577 - No deficiencies related to the allegations are cited. Survey dates: January 7, 8, 9, 10, 13 and 14, 2025 Facility number: 012974	R 0000		

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	Residential Census: 54 Hearthstone Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.			