PRINTED: 02/11/2025

	T OF HEALTH AND HU R MEDICARE & MEDIC						IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155818		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/29/2025	
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIE				3043 N	ADDRESS, CITY, STATE, ZIP COD ORTH LINTEL DRIVE MINGTON, IN 47404		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42 Survey Date: 01/29 Facility Number: 01/29 Facility Number: 201 At this Emergency Hearthstone Health compliance with Engliance with Engliance Provided 483.73 The facility has 64 the survey, the censure of the survey in the survey	2/25 2/25 2/2974 2/25 2/2974 2/25 2/27830 Preparedness survey, Campus was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of	E 00	000	Preparation or execution of the plan of correction does not constitute admission or agreed of provider of the truth of the falleged or conclusions set fort the Statement of Deficiencies. Plan of Correction is prepared executed solely because it is required it is required by the position of Federal and State of The Plan of Correction is submitted to respond to the allegation of noncompliance of during the Life Safety Survey conducted January 29, 2025 Please accept this Plan of Correction as the provider's credible allegation of compliar as of February 6, 2025. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance.	ment acts h on The and Law. ited desk to	
K 0000							
Bldg. 01	Survey was conduc		K 0	000	Preparation or execution of thi plan of correction does not constitute admission or agreed of provider of the truth of the falleged or conclusions set fort the Statement of Deficiencies. Plan of Correction is prepared	ment acts h on The	

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

Provider Number: 155818

AIM Number: 201247830

(X6) DATE

executed solely because it is

required it is required by the

TITLE

Todd Nowacki **Executive Director** 02/07/2025

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COMPL		ETED					
		155818	B. WI	NG	01/2		2025	
				STREET A	ADDRESS CITY STATE ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3043 NORTH LINTEL DRIVE				
HEVDTH	STONE HEALTH C	AMDUS			IINGTON, IN 47404			
HEARTH	STONE HEALTH C	AMF03		BLOOM	IIING I OIN, IIN 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)	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE	
					position of Federal and State L	₋aw.		
	At this Life Safety (Code survey, Hearthstone			The Plan of Correction is			
	Health Campus was	found not in compliance with			submitted to respond to the			
	Requirements for Pa	-			allegation of noncompliance ci	ted		
	-	, 42 CFR Subpart 483.90(a),			during the Life Safety Survey			
		re and the 2012 edition of the			conducted January 29, 2025			
		etion Association (NFPA) 101,			Please accept this Plan of			
		SC), Chapter 19, Existing			Correction as the provider's			
	• `	ancies and 410 IAC 16.2.			credible allegation of complian	ce		
	Treatin Cure Occupi	ancies and 110 II to 10.2.			as of February 6, 2025. The	00		
	This one story facili	ity was determined to be of			provider respectfully requests	dock		
		ruction and fully sprinkled. The			review with paper compliance			
	* *	arm system with smoke			be considered in establishing t			
	•	ridors, spaces open to the			_	ııaı		
		wired smoke detection in all			the provider is in substantial			
					compliance.			
		oms. The facility has a						
		nad a census of 62 at the time						
	of this visit.							
	A 11 1 41	.1 . 1						
		residents have customary						
	_	ed and all areas providing						
	facility services wer	re sprinkled.						
	Quality Review con	ducted on 01/30/25						
14.04.04	NEDA 404							
K 0131	NFPA 101							
SS=E	Multiple Occupand	cies						
Bldg. 01		11						
		on and interview, the facility	K 0	131	K131		02/06/2025	
		1 separation fire doors would			It is the practice of Hearthston			
	_	ire and restrict the movement			have barrier doors close and la			
		1.1.3 requires all health care			What corrective actions will I			
		tained and operated to			taken for those residents who	0		
		oility of a fire emergency			have been found to have bee	n		
		ation of the occupants. LSC			affected by the deficient			
	_	opening in a fire barrier shall			practice?			
	•	t the spread of fire and restrict			The barrier doors outside 305	were		
	the movement of sn	noke from one side of the fire			adjusted and close and latch.			
	barrier to the other.	This deficient practice could			How other residents having t	he		
	affect 25 residents.				potential to be affected by the			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155818	B. WING 01/29/2025			2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ORTH LINTEL DRIVE		
HEARTHSTONE HEALTH CAMPUS					MINGTON, IN 47404		
HEARTH				DLOON			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					same deficient practice will I	be	
	Findings include:				identified and what corrective	re	
					action will be taken?		
		ons during the facility tour and			-All other barrier doors were		
		Director of Plant Operations			checked. They all closed and		
	, ,	between 12:45 p.m. and 2:50			latched.		
	•	t of barrier doors near Resident			-Plant Operations staff have b		
		close and latch. This condition			in-serviced on the need to have	⁄e	
		spread of smoke from one side			barrier doors close and latch.		
		the other. The DPO			What measures will be put in	nto	
		e barrier doors did not close			place or what systemic		
		ch stating that they would need			changes will be made to		
	to be lubricated.				ensure that the deficient		
					practice does not reoccur?		
	_	cknowledged by the DPO at the			Director of Plant Operations a		
	-	nd again at the exit conference			designee will audit barrier doc		
	with the DPO prese	ent.			weekly x 4 weeks then every		
	21.10(1)				week x 2 months then monthly	y x 3	
	3.1-19(b)				months.		
					How the corrective action wi	(11	
					be monitored to ensure the		
					deficient practice does not		
					reoccur?		
					Director of Plant Operations	with	
					/designee will be responsible	WILLI	
					monitoring barrier doors for 6 months. The results of these		
						\circ	
					audits will be reviewed by the committee overseen by the	QA.	
					Executive Director. If a thresh	old	
					of 100% is not achieved, an a		
					plan will be developed, and	5.1011	
					ongoing monitoring will occur.		
					The facility through the QAPI		
					program, will review, update,	and	
					make changes to the POC as		
					needed for sustaining substar		
					compliance for no less than 6		
					months.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155818	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/29/2025	
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		<u> </u>	3043 N	ADDRESS, CITY, STATE, ZIP COD IORTH LINTEL DRIVE MINGTON, IN 47404	<u>!</u>		
(X4) ID PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	Date to be completed 2/6/2025		DATE
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure					
	Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 2 staff in the work room. Findings include: Based on observations during the facility tour and interview with the Director of Plant Operations (DPO) on 01/29/25 between 12:45 p.m. and 2:50 p.m., the Work Room, greater than 50 square feet contained a number of combustible items, such as, paper, and several cardboard boxes. The corridor door to this office did not self-close and latch into the door frame. This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the DPO present. 3.1-19(b)		K 03	321	It is the practice of Hearthston have closures on doors where combustible material is stored What corrective actions will taken for those residents where have been found to have been affected by the deficient practice? A closure was added to the workroom door. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? -An audit of the campus was completed to verify closures of doors where combustible materials are stored. - Plant Operations staff have be in-serviced on the need to have closures on doors where combustible materials are stored. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Director of Plant Operations a designee will audit rooms where combustible materials are stored for closures weekly x 4 weeks then every other week x 2 more affected.	the ne been we red. nto	02/06/2025

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DEPARTMENT CENTERS FOI	FORM APPROVED OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155818		(X2) MULTIPLE O A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/29/2025		
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD		
HEARTH	ISTONE HEALTH C	AMPUS		MINGTON, IN 47404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
				then monthly x 3 months. How the corrective action will be monitored to ensure the deficient practice does not reoccur? Director of Plant Operations a designee will be responsible will be responsible will be monitoring rooms where combustible materials are sto for closures for 6 months. The results of these audits will be reviewed by the QA committe overseen by the Executive Director. If a threshold of 100 not achieved, an action plan will be developed, and ongoing monitoring will occur. The fathrough the QAPI program, will review, update, and make charton the POC as needed for sustaining substantial compliation for no less than 6 months. Date to be completed 2/6/2025	and/or with red e % is will cility ill anges	
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Deco	orations				
٠	failed to ensure 1 or maintained in accor 19.7.5.6 prohibits c	on and interview, the facility fover 20 resident rooms was dance with 19.7.5.6. LSC ombustible decorations unless et. This deficient practice ent.	K 0753	K753 It is the practice of Hearthstor not have wick burning candles What corrective actions will taken for those residents whave been found to have been affected by the deficient practice?	s. be 10	02/06/2025

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Based on observations during the facility tour and

interview with the Director of Plant Operations

BBHT21

Facility ID: 012974

The candle was removed from

removal. The family was also

room 107 and given to family for

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED	
155818		B. WING	01/29/2025			
			CTREE	CADDREGG CITY CTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP COD		
LIEADTI	IOTONE LIEALTILO	NAMBUIO		NORTH LINTEL DRIVE		
HEARTH	ISTONE HEALTH (CAMPUS	BLOO	MINGTON, IN 47404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S DI AN OF CODDECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	(DPO) on 01/29/25	between 12:45 p.m. and 2:50		educated on not bringing cand	dles	
	p.m., resident room	107 contained a wick burning		into campus.		
	candle with 3 wicks	s. The DPO stated that no one		How other residents having	the	
	had noticed the can	dle and he suspected it had		potential to be affected by the		
	not been there long			same deficient practice will		
				identified and what corrective		
	This finding was ac	knowledged by the DPO at the		action will be taken?		
	_	nd again at the exit conference		-All rooms were checked and	no	
	with the DPO prese	_		other candles were found.		
	•			-Staff have been in-serviced of	on the	
	3.1-19(b)			need to remove candles from		
				rooms and return to families for	or	
				removal.		
				What measures will be put in	nto	
				place or what systemic		
				changes will be made to		
				ensure that the deficient		
				practice does not reoccur?		
				Director of Plant Operations a	nd/or	
				designee will audit resident ro		
				for candles weekly x 4 weeks		
				then every other week x 2 mo		
				then monthly x 3 months.		
				How the corrective action wi	II	
				be monitored to ensure the		
				deficient practice does not		
				reoccur?		
				Director of Plant Operations a	nd/or	
				designee will be responsible v	vith	
				monitoring resident's rooms f	or 6	
				months. The results of these		
				audits will be reviewed by the	QA	
				committee overseen by the		
				Executive Director. If a thresh	old	
				of 100% is not achieved, an a	ction	
				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		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
155818		155818	B. WI	NG		01/29/2025	
	ROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	needed for sustaining substaicompliance for no less than 6 months. Date to be completed 2/6/2025		DATE
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment -	Transfilling Cylinders					
Diag. 01	failed to ensure 1 o location was provide transferring is occur as ferring is occur. Facilities Code, 20 states, the area is per that transfilling is of the immediate area practice could affect while in the same soxygen room. Findings include: Based on observation interview with the 10 (DPO) on 01/29/25 p.m., the oxygen stroxygen containers adoor to this room lass moking in the imm. This was acknowle observation stating removed most of the enjoyed collecting temporarily placed.	cknowledged by the DPO at the nd again at the exit conference	K 09	927	It is the practice of Hearthstor have no smoking signage in immediate area of oxygen roo What corrective actions will taken for those residents whave been found to have be affected by the deficient practice? A no smoking sign was place the door to the oxygen storag room. How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken? -The campus does not have a other oxygen rooms. -Plant Operations staff have to in-serviced on the need to ha smoking signs in the immedia area of the oxygen storage roo What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Director of Plant Operations a designee will conduct oxygen	om. be no en d on ee the he be ve any been ve no ate bom. nto	02/06/2025

BBHT21

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

PRINTED: 02/11/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155818	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/29/2025		
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS			3043 NO	DDRESS, CITY, STATE, ZIP COD DRTH LINTEL DRIVE IINGTON, IN 47404			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	3.1-19(b)				room signage audits weekly x weeks, then every other week months then monthly x 3 mont How the corrective action will be monitored to ensure the deficient practice does not reoccur? Director of Plant Operations ar designee will be responsible w monitoring the no smoking signification to the immediate area of the oxyg storage room 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% not achieved, an action plan who developed, and ongoing monitoring will occur. The facil through the QAPI program, will review, update, and make charto the POC as needed for sustaining substantial compliant for no less than 6 months. Date to be completed 2/6/2025	x 2 hs. I I I I I I I I I I I I I	

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