STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155818	A. BUILDING -- B. WING	01/29/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/29/25 Facility Number: 012974 Provider Number: 155818 AIM Number: 201247830 At this Emergency Preparedness survey, Hearthstone Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 64 certified beds. At the time of the survey, the census was 62. Quality Review conducted on 01/30/25	E 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 Life Safety Survey conducted January 29, 2025 Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 6, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Life Safety Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/29/25 Facility Number: 012974 Provider Number: 155818 AIM Number: 201247830	K 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd Nowacki	Executive Director	02/07/2025

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	At this Life Safety Code survey, Hearthstone Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detection in all resident sleeping rooms. The facility has a capacity of 64 and had a census of 62 at the time of this visit. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review conducted on 01/30/25		position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Survey conducted January 29, 2025 Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 6, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Based on observation and interview, the facility failed to ensure 1 of 1 separation fire doors would limit the spread of fire and restrict the movement of smoke. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect 25 residents.	K 0131	K131 It is the practice of Hearthstone to have barrier doors close and latch. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** The barrier doors outside 305 were adjusted and close and latch. **How other residents having the potential to be affected by the**	02/06/2025

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	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 double set of barrier doors near Resident Room 305 did not close and latch. This condition would not limit the spread of smoke from one side of the fire barrier to the other. The DPO acknowledged these barrier doors did not close completely and latch stating that they would need to be lubricated. 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)		**same deficient practice will be identified and what corrective action will be taken?** -All other barrier doors were checked. They all closed and latched. -Plant Operations staff have been in-serviced on the need to have barrier doors close and latch. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Director of Plant Operations and/or designee will audit barrier doors 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?** Director of Plant Operations /designee will be responsible with monitoring barrier doors 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.	

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			Date to be completed 2/6/2025	
K 0321 SS=E Bldg. 01	NFPA 101 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 0321	K321 It is the practice of Hearthstone to have closures on doors where combustible material is stored. **What corrective actions will be taken for those residents who 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 on doors where combustible materials are stored. - Plant Operations staff have been in-serviced on the need to have closures on doors where combustible materials are stored. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Director of Plant Operations and/or designee will audit rooms where combustible materials are stored for closures weekly x 4 weeks then every other week x 2 months	02/06/2025

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			then monthly x 3 months. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** Director of Plant Operations and/or designee will be responsible with monitoring rooms where combustible materials are stored for closures 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** 2/6/2025	
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 1 of over 20 resident rooms was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect 1 resident. Findings include: Based on observations during the facility tour and interview with the Director of Plant Operations	K 0753	K753 It is the practice of Hearthstone to not have wick burning candles. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** The candle was removed from room 107 and given to family for removal. The family was also	02/06/2025

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	(DPO) on 01/29/25 between 12:45 p.m. and 2:50 p.m., resident room 107 contained a wick burning candle with 3 wicks. The DPO stated that no one had noticed the candle and he suspected it had not been there long. 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)		educated on not bringing candles into campus. **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 rooms were checked and no other candles were found. -Staff have been in-serviced on the need to remove candles from rooms and return to families for removal. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Director of Plant Operations and/or designee will audit resident rooms for candles 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?** Director of Plant Operations and/or designee will be responsible with monitoring resident's rooms 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	

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			needed for sustaining substantial compliance for no less than 6 months. **Date to be completed** 2/6/2025	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was provided with a sign indicating that transferring is occurring. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(3) states, the area is posted with signs indicating that transfilling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect residents, staff and visitors while in the same smoke compartment as the oxygen 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 oxygen storage/transfer room had oxygen containers and oxygen cylinders. The door to this room lacked a sign indicating that smoking in the immediate area is not permitted. This was acknowledged by the DPO at the time of observation stating that recent renovations had removed most of the signs and that a resident enjoyed collecting the signage which was temporarily placed on the railing. This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the DPO present.	K 0927	K927 It is the practice of Hearthstone to have no smoking signage in immediate area of oxygen room. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** A no smoking sign was placed on the door to the oxygen storage room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** -The campus does not have any other oxygen rooms. -Plant Operations staff have been in-serviced on the need to have no smoking signs in the immediate area of the oxygen storage room. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Director of Plant Operations and/or designee will conduct oxygen	02/06/2025

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	3.1-19(b)		room signage audits 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?** Director of Plant Operations and/or designee will be responsible with monitoring the no smoking sign in the immediate area of the oxygen 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% 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** 2/6/2025	