	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155818	A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING COMPLETE 02/21/202			ETED
	ROVIDER OR SUPPLIER STONE HEALTH C			STREET ADDRESS, CITY, STATE, ZIP COD 3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404			
(X4) ID PREFIX TAG	· ·		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 0000	0000						
Bldg. 00	Licensure Survey. T Investigation of Cor included a State Res Complaint IN00401 deficiencies related Survey dates: Febru 2023 Facility number: 01 Provider number: 1: AIM number: 2012 Census Bed Type: SNF/NF: 1 SNF: 33 NF: 19 Residential: 52 Total: 105 Census Payor Type: Medicare: 19 Medicaid: 18 Other: 16 Total: 53 These deficiencies r accordance with 410	reflect State Findings cited in	F 00	000	Plan of Correction FOR HEARTHSTONE HEALTH CAMPUS F000 INITIAL COMMENTS Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the alleged or conclusions set for the Statement of Deficiencies Plan of Correction is prepared executed solely because it is required by the position of Fe and State Law. The Plan of Correction is submitted to rest to the allegation of noncomplicited during the Complaint Suconducted February 21, 2023 Please accept this Plan of Correction as the provider's credible allegation of complianas of March 14, 2023. The provider is in substantial compliance.	ement facts th on . The d and deral pond ance urvey nce povider view	
F 0554 SS=D Bldg. 00	§483.10(c)(7) The	nin Meds-Clinically Approp right to self-administer interdisciplinary team, as					

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

(X6) DATE

TITLE

Kimberly Bales Clinical Support RN 03/08/2023

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) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155818	B. WI	NG		02/21/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			IORTH LINTEL DRIVE		
HEARTH	ISTONE HEALTH C	CAMPLIS			MINGTON, IN 47404		
1167 (1111		, tivii 00	1	BLOOK			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		21(b)(2)(ii), has determined					
	that this practice i	s clinically appropriate.					
			F 05	554	F554 Resident Self-Admin		03/14/2023
		on, interview, and record			Meds-Clinically Appropriate		
		failed to ensure a self					
		nedications assessment was			1. Resident #41 was affected.	No	
	_	1 residents observed with			adverse effects noted. The		
	medications stored	at the bedside. (Resident 41)			medications were removed from		
					the resident's room and dispo	sed	
	Findings include:				of.		
	0.0/16/00 + 0.45				2. All residents have the poter		
	On 2/16/23 at 9:45 a.m., Registered Nurse (RN) 2				to be affected. Nurses and QN	ЛA´S	
	was observed to administer Resident 41 her medications for the morning. Upon entering the				educated on medication		
					administration.		
		on cups were observed on the			3. As a measure of ongoing		
		medication cup contained 1 medication cup contained 2			compliance, the DHS or desig	nee	
	tablets.	medication cup contained 2			will audit medication passes	4	
	tablets.				during rounding to ensure that medications are administered		
	During on interview	v on 2/16/23 at 9:46 a.m., RN 2			stored according to policy. Au		
	_	eation in the medication cup by			to consist of three residents	uit	
		um chloride (supplement) from			weekly x4 weeks, then every	other	
	_	the other two medications			week x2 months, then monthly		
	-	ticoagulant medication) and a			months.	y	
	- '	one to aid in sleep) from the			4. As a quality measure, the D)HS	
		did not know why the			or designee will review any	10	
	_	till on the bedside table and			findings and corrective action	at	
		as in atrial fibrillation (an			least quarterly and ongoing ur		
		and needed the eliquis.			campus achieves one hundre		
		1			percent compliance in the can		
	During an interview	v on 2/16/23 at 9:47 a.m.,			Quality Assurance Performan	-	
	_	ed she was unsure why the			Improvement meetings. The p		
		till on her bedside table. She			will be reviewed and updated		
		liquis and didn't know why she			warranted.		
		edication the night before.					
	wash t given the medication the hight before.						
	Resident 41's clinic	al record was reviewed on					
	2/16/23 at 10:00 a.1	m. The diagnoses included, but					
		, chronic atrial fibrillation and					
	hypokelemia.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155818		l í	JILDING	nstruction <u>00</u>	(X3) DATE (COMPL 02/21 /	ETED	
	PROVIDER OR SUPPLIEF			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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		orders, dated 2/17/23, indicated cations included, but were not					
	tablet once a day	e 20 meq (milliequivalents) 1 igrams) 1 tablet twice a day tablet at bedtime.					
	Record on 2/20/23 indicated the potass	dication Administration at 11:00 a.m., for Resident 41 sium chloride, eliquis, and ninistered as ordered on					
	Clinical Corporate	on 2/16/23 at 10:18 a.m., the Nurse indicated Resident 41 did medications and the not have been left on the					
	provided the facility General Guidelines and indicated it was used by the facility indicated, " 17. T.	30 a.m., the Administrator y's policy, "Preparation and " with a revised date of 11/2018, s the policy currently being A review of the policy he resident is always observed to ensure that the dose was 1"					
	3.1-11(a)						
F 0558 SS=D Bldg. 00	services in the factorion of accommodation of the services in the factorion of the services are services.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/21/2023 155818 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404 HEARTHSTONE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE endanger the health or safety of the resident or other residents. Based on observation, interview, and record F 0558 F558 Reasonable Accommodation 03/14/2023 review, the facility failed to ensure a resident was of Needs/Preferences provided a side rails for bed mobility for 1 of 1 1. Resident #44 was affected. No resident reviewed for accommodation of needs. (Resident 44) adverse effects noted. Bed rails were placed on the bed and used Finding includes: appropriately. 2. All residents have the potential During an interview on 2/15/23 at 9:52 a.m., to be affected. A 100% bed rail Resident 44 indicated she wished she had side audit was conducted with rails to help her get up out of bed. She did not assessments completed and know why she was not allowed to have side rails added to medical record as as they would greatly help her bed mobility. No appropriate. Nurses were side rails were observed to the resident's bed. educated on the bed rail policy. 3. As a measure of ongoing During an interview on 2/16/23 at 10:03 a.m., the compliance, the DHS or designee resident continued to ask about getting side rails. will perform bed rail audits to No side rails were observed to the resident's bed. ensure placement on 3 residents weekly x4 weeks, then every other On 2/16/23 at 11:26 a.m., Resident 44's clinical week x2 months, then monthly x3 record was reviewed. The diagnoses included, but months. were not limited to, Charcot's joint of left knee (a 4. As a quality measure, the DHS destructive joint disorder initiated by trauma or designee will review any knee), Parkinson's disease, morbid (severe) findings and corrective action at obesity, fibromyalgia (a disorder characterized by least quarterly and ongoing until widespread musculoskeletal pain accompanied by campus achieves one hundred fatigue, sleep, memory and mood issues), restless percent compliance in the campus leg syndrome, osteoarthritis, pain, tremor, and Quality Assurance Performance edema (swelling). Improvement meetings. The plan will be reviewed and updated as An Admission Minimum Data Set (MDS) warranted. assessment, dated 1/27/23, indicated the resident was cognitively intact, required extensive assistance of one staff member with bed mobility, and had lower extremity impairment on one side. A Bed Rail Evaluation, dated 1/30/23 at 3:12 p.m., indicated the resident had appropriate safety

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AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155818	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/21/2023
	PROVIDER OR SUPPLIE		3043 1	CADDRESS, CITY, STATE, ZIP COD NORTH LINTEL DRIVE MINGTON, IN 47404	
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	actively initiate and for safe bed mobili demonstrate the up to reposition self as	emonstrated the ability to I assist with the use of bed rail ty and transfer, and could per body strength and mobility way from the bed rail as rs were to be applied.			
	On 2/17/23 at 11:36 a.m., side rails were observed on the resident's bed. During an interview on 2/20/23 at 10:00 a.m., the Clinical Nurse Consultant indicated the side rails were not applied due to the resident being confused. The resident's clinical record lacked documentation of confusion between 1/30/23 and 2/9/23, which was when she was sent to the hospital for confusion and critically low potassium of 2.6 millimoles per liter (mmol/L) (normal range is 3.6 to 5.2 mmol/L.)				
	Consultant provide Rights Guidelines,' indicated it was the review of the policy have a right to t. to have input into the	p.m., the Corporate Nurse d the facility policy, "Resident revised on May 11, 2017, and policy currently being used. A y indicated, " 2. Our residents Be consulted and encouraged heir care plan which guides livered to the resident"			
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service nutrition, groomin hygiene; Based on observati	ed for Dependent Residents esident who is unable to s of daily living receives the es to maintain good g, and personal and oral on, interview, and record failed to ensure residents who	F 0677	F677 ADL Care Provided for Dependent Res	03/11/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155818	B. W	ING		02/21/	/2023
							
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					ORTH LINTEL DRIVE		
HEARTH	ISTONE HEALTH (CAMPUS		BLOOM	AINGTON, IN 47404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	/ (DATE
	were unable to carr	y out activities of daily living					
	(ADLs) received th	ne necessary services to			1. Residents 4 and 47 were		
	maintain good groo	oming and personal hygiene for			affected. Resident shower		
	2 of 5 residents reviewed for choices. (Resident				preferences were completed,		
	47, Resident 4)				residents given showers. All		
					resident preferences for show	ver	
	Findings include:				days reviewed with residents	with	
					no changes needed.		
	-	iew on 2/15/23 at 10:00 a.m.,			2. All residents have the pote	ntial	
		ted she was supposed to get			to be affected. Nursing staff		
	showers each Tues	day and Thursday, however,			educated on following resider	nt	
	she had 1 shower since she had been admitted.				preferences for showers and		
					completion of shower		
		3 a.m., Resident 47's clinical			documentation.		
		ed. The diagnoses included, but			3. As a measure of ongoing		
		, Raynaud's syndrome (a			compliance, the DHS or design	gnee	
		es the blood vessels in the			will perform audits to ensure		
		ow, restricting blood flow),			showers are given and		
		drome (a rare blood vessel			documented on 5 residents		
	-	breathing trouble, face pain			weekly x4 weeks, then every		
	_	nny nose), motor and sensory			week x2 months, then month	ly x3	
		lition that affects the nerves			months.		
	_	or spinal cord), congestive			4. As a quality measure, the l	DHS	
		, difficulty in walking,			or designee will review any		
		et, and weakness. The resident			findings and corrective action		
	was admitted on 1/	20/23.			least quarterly and ongoing u		
					campus achieves one hundre		
		nimum Data Set (MDS)			percent compliance in the car	-	
		1/27/23, indicated the resident			Quality Assurance Performar		
		act, required extensive			Improvement meetings. The	•	
		f member with personal			will be reviewed and updated	as	
		pper extremity limitation on			warranted.		
		ower extremity limitation on					
	both sides.						
	The resident's clini	cal record indicated the					
		ed only 1 shower on 1/26/23.					
	1351dont had receiv						
	A Resident Profile	had no documentation when					
		pposed to be showered.					

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 02/21/2023		
	OVIDER 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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	5/14/23, indicated the for decline in ADLs Raynaud's syndrome ung involvement, Canxiety, depression, disease process. No necluded in her care shower/bathing school and the staff decline in the staff	on 2/20/23 at 10:30 a.m., the onsultant indicated the facility ower documentation for the ff must have missed giving on 2/20/23 at 10:45 a.m., the indicated the resident had not rs until 2/17/22, and she d more than what she had g an interview on 2/14/23 at 4 indicated she had not been ers twice a week. Her shower and Friday. m., Resident 4's clinical record diagnoses included, but were estive heart failure,				

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				NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155818	B. W	ING		02/21/	/2023
	PROVIDER OR SUPPLIER			3043 NO	ADDRESS, CITY, STATE, ZIP COD ORTH LINTEL DRIVE IINGTON, IN 47404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI ANI OF CORRECTIONI		(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 APPROPRI	ΔTF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Tuesday and Friday	7.					
	Category Report, daindicated Resident 4 staff for bathing. Shand 2/17/23. The reshowers on 2/7/23 (2/14/23 (Tuesday). During an interview Resident Care Assis Resident Care Assis Resident 4 was depeter showers days with the showers days with	ADL [activities of daily living] ated 2/1/23 through 2/20/23 4 was totally dependent on the received a shower on 2/3/23 port lacked documentation of Tuesday), 2/10/23 (Friday), or 2/17/23 10:08 a.m., Certified stant (CRCA) 2 indicated the endent on staff for bathing. Were Tuesday and Friday. 2 on 2/20/23 at 10:43 a.m., sultant indicated Resident 4 from 2/1/23 through 2/20/23. 2 p.m., the Corporate Nurse of the facility policy, "Resident revised on May 11, 2017, and policy currently being used. A resident, " 2. Our residents are consulted and encouraged their care plan which guides livered to the resident" 3 p.m., the Executive Director to thave a bathing or ADL					
	= 51 50(a)(5)						
F 0684	483.25						
SS=D Bldg. 00	Quality of Care	of care					
Diug. 00	§ 483.25 Quality of	or care a fundamental principle that					
		ment and care provided to					
	facility residents.						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155818	B. Wl	ING	_	02/21	/2023	
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	C			ORTH LINTEL DRIVE			
HEARTH	ISTONE HEALTH C	CAMPUS		BLOOM	MINGTON, IN 47404			
(X4) ID		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)	TE	COMPLETION	
TAG	i e	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
	· ·	ssessment of a resident, the						
	_	re that residents receive e in accordance with						
	l '	dards of practice, the erson-centered care plan,						
	and the residents'							
		on, interview, and record	F 06	584	F 684 Quality of Care		03/14/2023	
		failed to ensure skin conditions	1.00	JUT	. oo i gaanty of oare		03/17/2023	
		of 5 residents reviewed for skin			1. Residents 17 and 3 were			
	conditions. A skin t				affected. Both resident skin			
		ntified with physician treatment			assessments completed with	no		
		ound dressings were not			findings, orders updated as			
		, interventions to prevent skin			warranted.			
	tears were not implemented. (Resident 3, Resident				2. All residents have the poter	ntial		
	17)				to be affected. Nursing staff			
					educated on the Bruise, Rash	,		
	Findings include:				Lesion, Skin Tear and Lacerat	tion		
					policy.			
		:40 p.m., Resident 17 was			3. As a measure of ongoing			
		da chair (a wheelchairs which			compliance, the DHS or desig	nee		
		caregivers to provide optimal			will perform skin event audits			
		s on the client and the			during morning clinical care			
		eft upper arm was an island			meeting on 3 residents to ens			
	-	1. On the resident's right			proper interventions, prevention	on		
		the elbow was an island			and treatments are in place,			
	dressing, dated 2/11	l.			weekly x4 weeks, then every			
	On 2/16/22 at 1:05	p.m., Resident 17's clinical			week x2 months, then monthly	/ X3		
		d. The diagnoses included, but			months.	LIC.		
		, peripheral vascular disease			4. As a quality measure, the D or designee will review any	סחט		
	· ·	etive pulmonary disease.			findings and corrective action	at		
	and emonic obstruc	Are pullionary disease.			least quarterly and ongoing ur			
	A nursing progress	note, dated 1/19/23 at 2:05			campus achieves one hundred			
		resident sustained a skin tear to			percent compliance in the can			
		rior (back) arm while turning in			Quality Assurance Performance			
		as cleansed with wound			Improvement meetings. The p			
		, approximated with steri			will be reviewed and updated			
		by an island dressing.			warranted.			
	A physician's order	, dated 1/19/23 and open						

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		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLI	
		155818	B. WI	NG		02/21/	2023
	PROVIDER OR SUPPLIER			3043 NO	ADDRESS, CITY, STATE, ZIP COD ORTH LINTEL DRIVE IINGTON, IN 47404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		island dressing covering the					
	steri-strips on the sl	kin wound on the resident's					
		to be changed once daily, with					
	-	ange as needed when the					
	dressing becomes d	islodged or soiled.					
	The treatment of	nictration record in diseased					
		nistration record indicated enting the dressing was					
		5, 2/12/23, 2/13/23, 2/14/23, and					
	2/15/23.	, ,					
	The clinical record	lacked documentation					
	indicating the resident had a skin wound to the right arm and lacked physician orders to treat the						
	wound on the right	arm.					
	During an interview	v on 2/16/23 at 12:44 p.m.,					
	-	le (CNA) 2 indicated the					
		agile skin. The CNA was did					
		injuries had occurred but					
		ad skin tears to the left and					
	right arms with ban	dages on them dated 2/11.					
	_	v on 2/16/23 at 3:38 p.m.,					
	•	RN) 2 indicated he changed the					
	_	ident's left and right arm skin ted, and the island dressing					
	· ·	daily as ordered and as needed					
		ame soiled or dislodged. The					
	~	et been changed this current					
	date (2/16/23).	<i>6</i>					
	•						
	-	v on 2/17/23 at 2:40 PM, the					
	•	for indicated the clinical record					
		entation of a skin tear and					
		Resident 17's right forearm. 2.					
		ion on 2/15/23 at 9:57 a.m.,					
		erved to be sitting in her bom. She was observed to have					
		ing on her right lower leg. The					
	a minic gauze aress	ing on not right to well log. The	1			1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155818	B. W	ING		02/21/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ORTH LINTEL DRIVE		
HEARTH	ISTONE HEALTH C	CAMPUS			IINGTON, IN 47404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	ace wraps were not	observed to be on her lower					
	legs.						
	.	2/16/22 + 10 10					
		ion on 2/16/23 at 10:19 a.m.,					
		erved to be sitting in her white gauze dressing on her					
		raps were not observed to be					
	on her lower legs.	raps were not observed to be					
	on nor tower legs.						
	During an observati	ion on 2/20/23 10:22 a.m.,					
	_	erved to be sitting in her					
	wheelchair with a w	white dressing on her back of					
	her right leg. The ac	ce wraps were not observed to					
	be on her lower leg	s.					
	0.00/17/02 + 11 1	D 11 (21 11 1 1					
		16 a.m., Resident 3's clinical					
		d. The diagnoses included, but atrial fibrillation (abnormal					
		t failure, and weakness.					
	licart mytimi), near	t failure, and weakness.					
	The Skin Integrity I	Events, dated 1/8/23 at 9:35					
		ident 3 had a skin tear and					
	hematoma on her le	eft lower leg from being					
	transferred from be-	d to wheelchair. Resident 3					
	kicked her leg out a	and connected with the arm of					
	the wheelchair.						
	The Intendicain!:	Trans (IDT) note dated					
		ry Team (IDT) note, dated indicated Resident 3 obtained a					
		ft lower leg while transferring.					
		d documentation of					
		vent further skin tears.					
	The Skin Integrity Events, dated 1/20/23 at 1:38						
		ident 3 had a skin tear on the					
	back of her right leg	<u>5</u> .					
	The Interdiscipling	ry Team (IDT) note, dated					
	-	m., indicated Resident 3 had a					
		k of her right leg. It appeared					
	Skin tear on the bac	is of not fight log. It appeared					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155818		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/21/2023		
	PROVIDER OR SUPPLIER	<u> </u>	3043	T ADDRESS, CITY, STATE, ZIP COD NORTH LINTEL DRIVE DMINGTON, IN 47404	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE
	she "bumped it." The documentation of its skin tears.	ne IDT note lacked nterventions to prevent further			
	The Physician Order Report, dated 2/20/23, indicated remove ace wraps every evening, initiated 10/27/20. The Treatment Administration Record, dated 2/1/23 through 2/20/23, lacked documentation of Resident 3 refusing ace wraps to lower legs. The Progress Notes, dated 2/2/23 through 2/20/23, lacked documentation of Resident 3 refusing ace wraps to lower legs. During an interview on 2/17/23 at 10:05 a.m., Certified Resident Care Assistant (CRCA) 2 indicated Resident 3's skin was "paper" thin and had a skin tear to her right lower leg. During an interview on 2/20/23 at 10:44 a.m., the Minimum Data Set (MDS) Nurse indicated Resident 3 had fragile skin and should have had interventions in place to prevent skin tears.				
	Consultant provided Rash, Lesion, Skin Guidelines" dated 1 the policy currently review of the policy	d a.m., the Clinical Nurse d the facility's policy, "Bruise, tear, Laceration Assessment 2/31/22, and indicated this was being used by the facility. A v lacked documentation of the to prevent skin tears.			
	3.1-37(a)				
F 0690 SS=D Bldg. 00	§483.25(e) Incont	continence, Catheter, UTI inence. e facility must ensure that			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GBD411 Facility ID: 012974

If continuation sheet Page 12 of 20

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155818 NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS SIMMARY STATEMENT OF DEPICITING BLOOMINGTON, IN 47404 (V4) ID SIMMARY STATEMENT OF DEPICITING BLOOMINGTON, IN 47404 (V4) ID SIMMARY STATEMENT OF DEPICITING BLOOMINGTON, IN 47404 (V5) ID SIMMARY STATEMENT OF DEPICITING BLOOMINGTON, IN 47404 (V5) IN TESTED AND IN COMPLETION OF SUPPLIED BY PULL TAG RECULATION OF LIGHENITY IN ORIGINATION OF SUPPLIED BY PULL TAG RECULATION OF LIGHENITY IN ORIGINATION TO THE CHICALTON OF A LIGHENITY IN ORIGINATION OF SUPPLIES IN ORIGINATION OR SUPPLIES IN ORIGINATION OF SUPPLIES IN ORIGINATION OF SUPPLIES IN ORIGINATION OR SUPPLIES IN ORE	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
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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. building <u>00</u>			COMPLETED	
		155818	B. W	B. WING		02/21/2023	
				_			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					ORTH LINTEL DRIVE		
HEARTH	STONE HEALTH C	CAMPUS		BLOOMINGTON, 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Findings include:				were needed, catheter orders		
					obtained and placed in medica	al	
	On 2/16/23 at 10:51	l a.m., Resident 1 was observed			record.		
	to be awake in his b	ed while the urinary catheter			2. All like residents have the		
	drainage bag sat on	the floor.			potential to be affected. A 100	%	
					audit was completed for all		
	On 2/16/23 at 2:57	p.m., Resident 1 was observed			residents with catheters. Nursi	ing	
		ecliner while the urinary			staff educated on Urinary Cath	-	
	drainage bag sat on	the floor.			policy and placement.		
					3. As a measure of ongoing		
	Resident 1's clinica	l record was reviewed on			compliance, the DHS or desig	nee	
	2/16/23 at 10:43 a.r	n. The diagnoses included, but			will perform catheter order aud	dits	
	were not limited to,	chronic kidney disease and			during morning clinical care		
	retention of urine.				meeting on 3 residents weekly	/ x4	
					weeks, then every other week	x2	
	Current physician of	orders, dated 2/17/23, lacked			months, then monthly x3 mont	hs.	
	documentation of a	n order for the urinary catheter			As a measure of ongoing		
	and indicated Resid	lent 1 was taking cipro (an			compliance, the DHS or desig	nee	
	antibiotic) 500 mg	(milligrams) twice a day for a			will complete random catheter		
	urinary tract infecti	on (UTI). The start date of the			placement observations to ens	sure	
	cipro was 2/13/23.				proper catheter bag placemen	t, 3	
					residents weekly x4 weeks, the	en	
	A care plan, initiate	ed on 2/13/23, and current			every other week x2 months, t	hen	
	through target date	5/13/23, for Resident 1			monthly x3 months.		
	indicated, " Probl	em: Bowel and Bladder.			4. As a quality measure, the D	HS	
	Resident uses a sup	rapubic catheter or F/C for dx			or designee will review any		
		ary retention Goal: Resident			findings and corrective action	at	
		lverse effects from catheter use.			least quarterly and ongoing ur	ntil	
	Approach: lab work	c completed per physician			campus achieves one hundred	t	
		place to prevent residents			percent compliance in the cam	npus	
		pulling out [sic], maintain a			Quality Assurance Performand	ce	
	closed system with urinary bag below the residents bladder and cover, observe for any signs of complication such as UTI observe tubing and avoid any obstructions, please record resident urinary output, provide assist with				Improvement meetings. The p	lan	
					will be reviewed and updated	as	
					warranted.		
		nange Foley catheter per					
	physician orders'	'					
	During an interview	v on 2/17/23 at 10:27 a.m.,	1				

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 02/21/2023	
	PROVIDER 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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0698 SS=D Bldg. 00	Certified Resident C indicated the urinary should never be on During an interview Administrator indic urinary catheter but today's date (2/20/2 On 2/20/23 at 9:30 provided the facility Care", dated 12/31/policy currently bei review of the policy prevent infection of 11. Be sure the cath are kept off the floor mention obtaining a 3.1-41(a)(2) 483.25(I) Dialysis §483.25(I) Dialysis system consistent with propractice, the comp	Care Assistant (CRCA) 1 y catheter tubing and bag the floor. y on 2/20/23 at 10:11 a.m., the ated there was no order for the they had entered it in with 3). a.m., the Administrator y's policy, "Urinary Catheter 22, and indicated it was the ng used by the facility. A y indicated, " Overview: To the resident's urinary tract eter tubing and drainage bag r" The policy did not a physician order for the F/C.	TAG	DETICIENCY	DATE
	preferences. Based on interview failed to ensure ong oversight of the residialysis treatments, resident's condition to have ongoing con with the dialysis fac	and record review, the facility oing assessment and dent before, during and after including monitoring the during treatments, and failed munication and collaboration cility for 1 of 1 resident is services. (Resident 111)	F 0698	F 698 Dialysis 1. Resident 111 was affected. Resident was assessed with nadverse reactions noted. 2. All like residents have the potential to be affected. A 100 audit was completed on all residents with dialysis. Nurses	%
	Findings include:		1	were educated on guidelines f	or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155818		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/21/2023					
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS			3043 N	STREET ADDRESS, CITY, STATE, ZIP COD 3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRI DEFICIENCY) Dialysis policy.	(X5) COMPLETION DATE				
	record was reviewe were not limited to,	6 a.m., Resident 111's clinical d. The diagnoses included, but acute kidney failure, end stage ype 2 diabetes mellitus with iney disease.		3. As a measure of ongoing compliance, the DHS or design will perform dialysis audits dumorning clinical care meeting ensure dialysis assessment a completed for before during a	to rire				
	The resident had dialysis on 2/7/23, 2/9/23, and 2/11/23. The resident's dialysis communication documents indicated 3 out of 3 visits had no dialysis nurse communication notes. The clinical record lacked any documentation from the dialysis center to the facility.			after dialysis as well as ongoi dialysis facility communication Audits will be completed for 3 residents weekly x4 weeks, the every other week x2 months, monthly x3 months.	ng n. nen then				
	indicated she printe sheets and sends it did not know if the with any communic	on 2/17/23 at 11:16 a.m., LPN 1 d off the dialysis observation with the resident. The nurse resident returned to the facility ration from the dialysis center to communication binder for		4. As a quality measure, the I or designee will review any findings and corrective action least quarterly and ongoing u campus achieves one hundre percent compliance in the cal Quality Assurance Performan Improvement meetings. The percent control of the call the c	at ntil ed mpus nce olan				
	indicated the dialys	y on 2/17/23 at 11:30 a.m., RN 1 is center did not send back to the facility. They would if there was a change in the		will be reviewed and updated warranted.	as				
	Corporate Nurse Codid not have a commercident and they diback with the resident in condition. She in record lacked documents	on 2/17/23 at 12:29 p.m., the onsultant indicated the facility munication binder for the d not get information sent ent unless there was a change dicated the resident's clinical mentation in regard to her she would call the dialysis ocumentation.							
	· ·	p.m., the Corporate Nurse d a hemodialysis treatment							

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155818			UILDING	nstruction 00	(X3) DATE COMPL 02/21 /	ETED		
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404					
(X4) ID PREFIX TAG	(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	
	dialysis treatment for received once they a on this date. On 2/21/23 at 1:11 growth consultant provided	dicated pre/post vitals and for the resident. The facility asked dialysis center to send p.m., the Corporate Nurse d the facility policy, alysis," revised on May 11,						
	2016, and indicated being used. A review A report (may be we requested from the latter the campus regarding b. vital signs, c. med	I it was the policy currently w of the policy indicated, "4. rritten or verbal) shall be Dialysis Provider that will alert ng: a. Tolerance to procedure, dications administered d. other d necessary for the ongoing						
F 0757 SS=D Bldg. 00	Drugs §483.45(d) Unnec Each resident's dr	Free from Unnecessary cessary Drugs-General. rug regimen must be free drugs. An unnecessary when used-						
	duplicate drug the							
	. , , ,	excessive duration; or hout adequate monitoring;						
	§483.45(d)(4) With for its use; or	hout adequate indications						
	_ ,,,,	he presence of adverse nich indicate the dose						

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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. BUILDING <u>00</u>		COMPLETED	
		155818	B. WING 02/21/2023				/2023
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUDERS N. AN 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	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		.16	DATE
	should be reduced or discontinued; or						
	§483.45(d)(6) Any reasons stated in (5) of this section. Based on observation review, the facility was discontinued peresidents observed of administration. (Residents observed to administration.) (Residents observed to prefor Resident 41. RN medication cup the potassium chlorida meq (milliequivaler - venlafaxine (antid (milligrams) 1 table - acidophilus (a proformation of the potassium chlorida (milligrams) 1 table - acidophilus (a proformation of the potassium chlorida (an aller potassium) 20 mg 1 table torsemide (a diure potassium) 20 mg 1 table - torsemide (a diure potassium) 20 mg 1 table - torsemide (a diure potassium) 20 mg 1 table - torsemide (a diure potassium) 20 mg 1 table - torsemide (a diure potassium) 21 mg 1 table - torsemide (a diure potassium) 21 mg 1 table - torsemide (a diure potassium) 21 mg 1 table - torsemide (a diure potassium) 21 mg 1 table - torsemide (a diure potassium) 21 mg 1 table - torsemide (a diure potassium) 21 mg 1 table - torsemide (a diure potassium) 21 mg 1 table - torsemide (a diure potassium) 22 mg 1 table - torsemide (a diure potassium) 21 mg 1 table - torsemide (a diure potassium) 22 mg 1 table - torsemide (a diure potassium) 22 mg 1 table - torsemide (a diure potassium) 23 mg 1 table - torsemide (a diure potassium) 24 mg 1 table - torsemide (a diure potassium) 24 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 24 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure potassium) 25 mg 1 table - torsemide (a diure	combinations of the paragraphs (d)(1) through on, interview, and record failed to ensure a medication er physician's orders for 1 of 7 during medication sident 41) a.m., Registered Nurse (RN) 2 expare the morning medications 12 was observed to place in the following medications: e (potassium supplement) 20 ont) 1 tablet PO (by mouth) expressant medication) 37.5 mg of PO biotic supplement) 1 capsule regy medication) 10 mg 1 tablet od pressure medication) 50 mg 1 edication used to treat acid	FO	757	F 757 Drug Regimen is Free f Unnecessary Drugs 1. Resident 41 was affected. Nadverse reactions noted. Acidophilus was removed from medication cart. 2. All residents have the poter to be affected. Nurses and QNeducated on medication administration guidelines. 3. As a measure of ongoing compliance, the DHS or designed will perform medication cart at to ensure expired medications removed from cart. Audits will conducted weekly x4 weeks, the every other week x2 months, so monthly x3 months. 4. As a quality measure, the Dor designee will review any findings and corrective action least quarterly and ongoing uncampus achieves one hundred percent compliance in the can Quality Assurance Performance Improvement meetings. The pwill be reviewed and updated warranted.	n the ntial MA's nee udits are be hen then oHS at ntil d npus ce lan	03/14/2023

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

PRINTED: 03/24/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155818		r í	LDING	nstruction <u>00</u>	(X3) DATE S COMPLI 02/21/2	ETED		
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 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 PROVIDER'S PLAN OF (PREFIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI TAG DEFICIENCY		TE	(X5) COMPLETION DATE	
TAU	REGULATORY OR LSC IDENTIFYING INFORMATION Current physician orders, dated 2/17/23, indicated Resident 41's medications included, but were not limited to: - acidophilus 1 capsule once a day with a start date of 1/11/23, and a stop date of 2/10/23. During an interview on 2/20/23 at 2:01 p.m., the Clinical Corporate Nurse indicated Resident 41 did not have a current order for the acidophilus. On 2/20/23 at 9:30 a.m., the Administrator provided the facility's policy, "Preparation and General Guidelines" with a revised date of 11/2018, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " Medications are administered as prescribed in accordance with good nursing principal and practices" 3.1-48(a)(2)						DAIL	
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 IN00401201. Complaint IN00401201 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: February 14, 15, 16, 17, 20, and 21, 2023 Facility number: 012974 Residential Census: 52 Hearthstone Health Campus was found to be in		R 00	00	Plan of Correction FOR HEARTHSTONE HEALTH CAMPUS F000 INITIAL COMMENTS Preparation or execution of thi plan of correction does not constitute admission or agreet of provider of the truth of the fa alleged or conclusions set fort the Statement of Deficiencies. Plan of Correction is prepared executed solely because it is required by the position of Fec and State Law. The Plan of Correction is submitted to resp to the allegation of noncomplia	ment acts h on The l and deral		
		•			5p			

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

PRINTED: 03/24/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155818	r í	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 02/21 /	ETED
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE HEALTH CAMPUS			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	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG			DATE
	compliance with 41	0 IAC 16.2-5 in regard to the			cited during the Complaint Sur	vey	
	State Residential Li	censure Survey.			conducted February 21, 2023.		
	Quality review com	apleted February 27, 2023.			Please accept this Plan of Correction as the provider's credible allegation of complian as of March 14, 2023. The pro respectfully requests desk reviwith paper compliance to be considered in establishing that provider is in substantial compliance.	vider iew	

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