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	02/21/2023

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 IN00401201. This visit included a State Residential Licensure Survey. 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 Provider number: 155818 AIM number: 201247830 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 reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 27, 2023.	F 0000	**Plan of Correction FOR HEARTHSTONE HEALTH CAMPUS** **F000 INITIAL COMMENTS** 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 by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted February 21, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 14, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self administration of medications assessment was completed for 1 of 1 residents observed with medications stored at the bedside. (Resident 41) Findings include: On 2/16/23 at 9:45 a.m., Registered Nurse (RN) 2 was observed to administer Resident 41 her medications for the morning. Upon entering the room, two medication cups were observed on the bedside table. One medication cup contained 1 tablet and the other medication cup contained 2 tablets. During an interview on 2/16/23 at 9:46 a.m., RN 2 indicated the medication in the medication cup by itself was a potassium chloride (supplement) from the day before and the other two medications were an eliquis (anticoagulant medication) and a melatonin (a hormone to aid in sleep) from the night before. RN 2 did not know why the medications were still on the bedside table and that Resident 41 was in atrial fibrillation (an irregular heart rate) and needed the eliquis. During an interview on 2/16/23 at 9:47 a.m., Resident 41 indicated she was unsure why the medications were still on her bedside table. She really needed the eliquis and didn't know why she wasn't given the medication the night before. Resident 41's clinical record was reviewed on 2/16/23 at 10:00 a.m. The diagnoses included, but were not limited to, chronic atrial fibrillation and hypokelemia.	F 0554	F554 Resident Self-Admin Meds-Clinically Appropriate 1. Resident #41 was affected. No adverse effects noted. The medications were removed from the resident's room and disposed of. 2. All residents have the potential to be affected. Nurses and QMA's educated on medication administration. 3. As a measure of ongoing compliance, the DHS or designee will audit medication passes during rounding to ensure that medications are administered and stored according to policy. Audit to consist of three residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	03/14/2023

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	Current physician orders, dated 2/17/23, indicated Resident 41's medications included, but were not limited to: - potassium chloride 20 meq (milliequivalents) 1 tablet once a day - eliquis 5 mg (milligrams) 1 tablet twice a day - melatonin 3 mg 1 tablet at bedtime. A review of the Medication Administration Record on 2/20/23 at 11:00 a.m., for Resident 41 indicated the potassium chloride, eliquis, and melatonin were administered as ordered on 2/15/23. During an interview on 2/16/23 at 10:18 a.m., the Clinical Corporate Nurse indicated Resident 41 did not self administer medications and the medications should not have been left on the bedside table. On 2/20/2023 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, "... 17. The resident is always observed after administration to ensure that the dose was completely ingested ..." 3.1-11(a)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would			

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	endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure a resident was provided a side rails for bed mobility for 1 of 1 resident reviewed for accommodation of needs. (Resident 44) Finding includes: During an interview on 2/15/23 at 9:52 a.m., Resident 44 indicated she wished she had side rails to help her get up out of bed. She did not know why she was not allowed to have side rails as they would greatly help her bed mobility. No side rails were observed to the resident's bed. During an interview on 2/16/23 at 10:03 a.m., the resident continued to ask about getting side rails. No side rails were observed to the resident's bed. On 2/16/23 at 11:26 a.m., Resident 44's clinical record was reviewed. The diagnoses included, but were not limited to, Charcot's joint of left knee (a destructive joint disorder initiated by trauma knee), Parkinson's disease, morbid (severe) obesity, fibromyalgia (a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues), restless leg syndrome, osteoarthritis, pain, tremor, and edema (swelling). An Admission Minimum Data Set (MDS) 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	F 0558	F558 Reasonable Accommodation of Needs/Preferences 1. Resident #44 was affected. No adverse effects noted. Bed rails were placed on the bed and used appropriately. 2. All residents have the potential to be affected. A 100% bed rail audit was conducted with assessments completed and added to medical record as appropriate. Nurses were educated on the bed rail policy. 3. As a measure of ongoing compliance, the DHS or designee will perform bed rail audits to ensure placement on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	03/14/2023

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	awareness, could demonstrated the ability to actively initiate and assist with the use of bed rail for safe bed mobility and transfer, and could demonstrate the upper body strength and mobility to reposition self away from the bed rail as needed. Enabler bars 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.) On 2/21/23 at 1:11 p.m., the Corporate Nurse Consultant provided the facility policy, "Resident Rights Guidelines," revised on May 11, 2017, and indicated it was the policy currently being used. A review of the policy indicated, "... 2. Our residents have a right to ... t. Be consulted and encouraged to have input into their care plan which guides theservices [sic] delivered to the resident ..." 3.1-3(v)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure residents who	F 0677	----------F677 ADL Care Provided for Dependent Residents	03/14/2023

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	were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 2 of 5 residents reviewed for choices. (Resident 47, Resident 4) Findings include: 1. During an interview on 2/15/23 at 10:00 a.m., Resident 47 indicated she was supposed to get showers each Tuesday and Thursday, however, she had 1 shower since she had been admitted. On 2/16/23 at 10:33 a.m., Resident 47's clinical record was reviewed. The diagnoses included, but were not limited to, Raynaud's syndrome (a condition that causes the blood vessels in the extremities to narrow, restricting blood flow), Churg-Strauss syndrome (a rare blood vessel disease may cause breathing trouble, face pain and a persistent runny nose), motor and sensory neuropathy (a condition that affects the nerves outside your brain or spinal cord), congestive heart failure (CHF), difficulty in walking, unsteadiness on feet, and weakness. The resident was admitted on 1/20/23. An Admission Minimum Data Set (MDS) assessment, dated 1/27/23, indicated the resident was cognitively intact, required extensive assistance of 1 staff member with personal hygiene, and had upper extremity limitation on one side and had lower extremity limitation on both sides. The resident's clinical record indicated the resident had received only 1 shower on 1/26/23. A Resident Profile had no documentation when the resident was supposed to be showered.		1. Residents 4 and 47 were affected. Resident shower preferences were completed, residents given showers. All resident preferences for shower days reviewed with residents with no changes needed. 2. All residents have the potential to be affected. Nursing staff educated on following resident preferences for showers and completion of shower documentation. 3. As a measure of ongoing compliance, the DHS or designee will perform audits to ensure showers are given and documented on 5 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	A care plan, dated 2/14/23 with a target date of 5/14/23, indicated the resident had the potential for decline in ADLs related to heart disease, Raynaud's syndrome, Churg-Strauss disease with lung involvement, CHF, HTN (hypertension), anxiety, depression, GERD, and advanced age and disease process. No specific intervention was included in her care plan in regard to shower/bathing schedule. During an interview on 2/20/23 at 10:30 a.m., the Corporate Nurse Consultant indicated the facility did not have any shower documentation for the resident and the staff must have missed giving them. During an interview on 2/20/23 at 10:45 a.m., the Executive Director indicated the resident had not received any showers until 2/17/22, and she should have received more than what she had been given.2. During an interview on 2/14/23 at 2:38 p.m., Resident 4 indicated she had not been receiving her showers twice a week. Her shower days were Tuesday and Friday. On 2/17/23 11:03 a.m., Resident 4's clinical record was reviewed. The diagnoses included, but were not limited to, congestive heart failure, osteoarthritis, and muscle weakness. The Annual MDS assessment, dated 12/30/22, indicated Resident 4 had moderate impaired cognition; was very important to choose between a tub bath, shower, bed bath, or sponge bath; and was totally dependent on 2 or more staff for bathing. The care plan, dated 4/12/22 and current through 6/3/23, indicated Resident 4's shower days were			

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	Tuesday and Friday. The Point of Care ADL [activities of daily living] Category Report, dated 2/1/23 through 2/20/23 indicated Resident 4 was totally dependent on staff for bathing. She received a shower on 2/3/23 and 2/17/23. The report lacked documentation of showers on 2/7/23 (Tuesday), 2/10/23 (Friday), or 2/14/23 (Tuesday). During an interview on 2/17/23 10:08 a.m., Certified Resident Care Assistant (CRCA) 2 indicated Resident 4 was dependent on staff for bathing. Her showers days were Tuesday and Friday. During an interview on 2/20/23 at 10:43 a.m., Clinical Nurse Consultant indicated Resident 4 only had 2 showers from 2/1/23 through 2/20/23. On 2/21/23 at 1:11 p.m., the Corporate Nurse Consultant provided the facility policy, "Resident Rights Guidelines," revised on May 11, 2017, and indicated it was the policy currently being used. A review of the policy indicated, "... 2. Our residents have a right to ... t. Be consulted and encouraged to have input into their care plan which guides theservices [sic] delivered to the resident ..." On 2/21/23 at 1:04 p.m., the Executive Director indicated they did not have a bathing or ADL policy. 31-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure skin conditions were treated for 2 of 5 residents reviewed for skin conditions. A skin tear wound was not documented as identified with physician treatment orders, skin tear wound dressings were not changed as ordered, interventions to prevent skin tears were not implemented. (Resident 3, Resident 17) Findings include: 1. On 2/16/23 at 12:40 p.m., Resident 17 was observed in her broda chair (a wheelchairs which makes it easier for caregivers to provide optimal care with less stress on the client and the caregiver). On her left upper arm was an island dressing, dated 2/11. On the resident's right forearm, just below the elbow was an island dressing, dated 2/11. On 2/16/23 at 1:05 p.m., Resident 17's clinical record was reviewed. The diagnoses included, but were not limited to, peripheral vascular disease and chronic obstructive pulmonary disease. A nursing progress note, dated 1/19/23 at 2:05 a.m., indicated the resident sustained a skin tear to her left upper posterior (back) arm while turning in bed. The wound was cleansed with wound cleanser, patted dry, approximated with steri strips, and covered by an island dressing. A physician's order, dated 1/19/23 and open	F 0684	F 684 Quality of Care 1. Residents 17 and 3 were affected. Both resident skin assessments completed with no findings, orders updated as warranted. 2. All residents have the potential to be affected. Nursing staff educated on the Bruise, Rash, Lesion, Skin Tear and Laceration policy. 3. As a measure of ongoing compliance, the DHS or designee will perform skin event audits during morning clinical care meeting on 3 residents to ensure proper interventions, prevention and treatments are in place, weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	03/14/2023

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	ended indicated the island dressing covering the steri-strips on the skin wound on the resident's left upper arm was to be changed once daily, with special orders to change as needed when the dressing becomes dislodged or soiled. The treatment administration record indicated staff initials documenting the dressing was changed on 2/11/23, 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 on 2/16/23 at 12:44 p.m., Certified Nurse Aide (CNA) 2 indicated the resident had very fragile skin. The CNA was did not know when the injuries had occurred but knew the resident had skin tears to the left and right arms with bandages on them dated 2/11. During an interview on 2/16/23 at 3:38 p.m., Registered Nurse (RN) 2 indicated he changed the dressings on the resident's left and right arm skin tears on 2/11, as dated, and the island dressing was to be changed daily as ordered and as needed if the dressings became soiled or dislodged. The dressings had not yet been changed this current date (2/16/23). During an interview on 2/17/23 at 2:40 PM, the facility Administrator indicated the clinical record was lacking documentation of a skin tear and treatment order to Resident 17's right forearm. 2. During an observation on 2/15/23 at 9:57 a.m., Resident 3 was observed to be sitting in her wheelchair in her room. She was observed to have a white gauze dressing on her right lower leg. The			

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	ace wraps were not observed to be on her lower legs. During an observation on 2/16/23 at 10:19 a.m., Resident 3 was observed to be sitting in her wheelchair with a white gauze dressing on her right leg. The ace wraps were not observed to be on her lower legs. During an observation on 2/20/23 10:22 a.m., Resident 3 was observed to be sitting in her wheelchair with a white dressing on her back of her right leg. The ace wraps were not observed to be on her lower legs. On 02/17/23 at 11:16 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), heart failure, and weakness. The Skin Integrity Events, dated 1/8/23 at 9:35 a.m., indicated Resident 3 had a skin tear and hematoma on her left lower leg from being transferred from bed to wheelchair. Resident 3 kicked her leg out and connected with the arm of the wheelchair. The Interdisciplinary Team (IDT) note, dated 1/9/23 at 9:41 a.m., indicated Resident 3 obtained a hematoma to her left lower leg while transferring. The IDT note lacked documentation of interventions to prevent further skin tears. The Skin Integrity Events, dated 1/20/23 at 1:38 p.m., indicated Resident 3 had a skin tear on the back of her right leg. The Interdisciplinary Team (IDT) note, dated 1/23/23 at 10:21 a.m., indicated Resident 3 had a skin tear on the back of her right leg. It appeared			

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	she "bumped it." The IDT note lacked documentation of interventions to prevent further skin tears. 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. On 2/20/23 at 11:30 a.m., the Clinical Nurse Consultant provided the facility's policy, "Bruise, Rash, Lesion, Skin tear, Laceration Assessment Guidelines" dated 12/31/22, and indicated this was the policy currently being used by the facility. A review of the policy lacked documentation of interventions in place to prevent skin tears. 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to provide care for urinary catheters for 1 of 1 residents reviewed for urinary catheter use. Urinary catheter drainage bag was positioned on the floor and no orders for the urinary catheter were obtained. (Resident 1)	F 0690	F 690 Bowel/Bladder Incontinence, Catheter, UTI 1. Resident 1 was affected. Catheter bag was noted to be on floor, catheter bag was removed from the floor. Catheter orders	03/14/2023

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	Findings include: On 2/16/23 at 10:51 a.m., Resident 1 was observed to be awake in his bed while the urinary catheter drainage bag sat on the floor. On 2/16/23 at 2:57 p.m., Resident 1 was observed to be awake in his recliner while the urinary drainage bag sat on the floor. Resident 1's clinical record was reviewed on 2/16/23 at 10:43 a.m. The diagnoses included, but were not limited to, chronic kidney disease and retention of urine. Current physician orders, dated 2/17/23, lacked documentation of an order for the urinary catheter and indicated Resident 1 was taking cipro (an antibiotic) 500 mg (milligrams) twice a day for a urinary tract infection (UTI). The start date of the cipro was 2/13/23. A care plan, initiated on 2/13/23, and current through target date 5/13/23, for Resident 1 indicated, "... Problem: Bowel and Bladder. Resident uses a suprapubic catheter or F/C for dx [diagnoses] of urinary retention ... Goal: Resident will be free from adverse effects from catheter use. Approach: lab work completed per physician orders, leg strap in place to prevent residents catheter from being pulling out [sic], maintain a 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 catheter care and change Foley catheter per physician orders ..." During an interview on 2/17/23 at 10:27 a.m.,		were needed, catheter orders obtained and placed in medical record. 2. All like residents have the potential to be affected. A 100% audit was completed for all residents with catheters. Nursing staff educated on Urinary Catheter policy and placement. 3. As a measure of ongoing compliance, the DHS or designee will perform catheter order audits during morning clinical care meeting on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. As a measure of ongoing compliance, the DHS or designee will complete random catheter placement observations to ensure proper catheter bag placement, 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	Certified Resident Care Assistant (CRCA) 1 indicated the urinary catheter tubing and bag should never be on the floor. During an interview on 2/20/23 at 10:11 a.m., the Administrator indicated there was no order for the urinary catheter but they had entered it in with today's date (2/20/23). On 2/20/23 at 9:30 a.m., the Administrator provided the facility's policy, "Urinary Catheter Care", dated 12/31/22, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Overview: To prevent infection of the resident's urinary tract ... 11. Be sure the catheter tubing and drainage bag are kept off the floor ..." The policy did not mention obtaining a physician order for the F/C. 3.1-41(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring the resident's condition during treatments, and failed to have ongoing communication and collaboration with the dialysis facility for 1 of 1 resident reviewed for dialysis services. (Resident 111) Findings include:	F 0698	F 698 Dialysis 1. Resident 111 was affected. Resident was assessed with no adverse reactions noted. 2. All like residents have the potential to be affected. A 100% audit was completed on all residents with dialysis. Nurses were educated on guidelines for	03/14/2023

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	On 2/15/23 at 11:16 a.m., Resident 111's clinical record was reviewed. The diagnoses included, but were not limited to, acute kidney failure, end stage renal disease, and type 2 diabetes mellitus with diabetic chronic kidney disease. 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. During an interview on 2/17/23 at 11:16 a.m., LPN 1 indicated she printed off the dialysis observation sheets and sends it with the resident. The nurse did not know if the resident returned to the facility with any communication from the dialysis center because there was no communication binder for dialysis. During an interview on 2/17/23 at 11:30 a.m., RN 1 indicated the dialysis center did not send back any communication to the facility. They would only call or update if there was a change in the resident's condition. During an interview on 2/17/23 at 12:29 p.m., the Corporate Nurse Consultant indicated the facility did not have a communication binder for the resident and they did not get information sent back with the resident unless there was a change in condition. She indicated the resident's clinical record lacked documentation in regard to her previous visits and she would call the dialysis center to get that documentation. On 2/17/23 at 2:00 p.m., the Corporate Nurse Consultant provided a hemodialysis treatment		Dialysis policy. 3. As a measure of ongoing compliance, the DHS or designee will perform dialysis audits during morning clinical care meeting to ensure dialysis assessment are completed for before during and after dialysis as well as ongoing dialysis facility communication. Audits will be completed for 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	document which indicated pre/post vitals and dialysis treatment for the resident. The facility received once they asked dialysis center to send on this date. On 2/21/23 at 1:11 p.m., the Corporate Nurse Consultant provided the facility policy, "Guidelines for Dialysis," revised on May 11, 2016, and indicated it was the policy currently being used. A review of the policy indicated, "...4. A report (may be written or verbal) shall be requested from the Dialysis Provider that will alert the campus regarding: a. Tolerance to procedure, b. vital signs, c. medications administered d. other information deemed necessary for the ongoing provision of care..." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose			

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	should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, interview, and record review, the facility failed to ensure a medication was discontinued per physician's orders for 1 of 7 residents observed during medication administration. (Resident 41) Findings include: On 2/16/23 at 9:30 a.m., Registered Nurse (RN) 2 was observed to prepare the morning medications for Resident 41. RN 2 was observed to place in the medication cup the following medications: - potassium chloride (potassium supplement) 20 meq (milliequivalent) 1 tablet PO (by mouth) - venlafaxine (antidepressant medication) 37.5 mg (milligrams) 1 tablet PO - acidophilus (a probiotic supplement) 1 capsule PO - loratadine (an allergy medication) 10 mg 1 tablet PO - metoprolol (a blood pressure medication) 50 mg 1 tablet PO - pantoprazole (a medication used to treat acid reflux) 20 mg 1 tablet PO - torsemide (a diuretic medication) 20 mg 1 tablet PO - eliquis (an anticoagulant medication) 5 mg 1 tablet PO Resident 41's clinical record was reviewed on 2/16/23 at 10:00 a.m. The diagnosis included, but was not limited to, gastric esophageal reflux disease.	F 0757	F 757 Drug Regimen is Free from Unnecessary Drugs 1. Resident 41 was affected. No adverse reactions noted. Acidophilus was removed from the medication cart. 2. All residents have the potential to be affected. Nurses and QMA's educated on medication administration guidelines. 3. As a measure of ongoing compliance, the DHS or designee will perform medication cart audits to ensure expired medications are removed from cart. Audits will be conducted weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	03/14/2023

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	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)			
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 0000	**Plan of Correction FOR HEARTHSTONE HEALTH CAMPUS** **F000 INITIAL COMMENTS** 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 by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance	

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	compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed February 27, 2023.		cited during the Complaint Survey conducted February 21, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 14, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	