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 _____	C 03/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00429626 and IN00429701. This visit was in conjunction with the Recertification and State Licensure Survey, State Residential Licensure Survey, and the Investigation of Complaints IN00429061, IN00428485, and IN00428342. Complaint IN00429626 - No deficiencies related to the allegations are cited. Complaint IN00429701 - No deficiencies related to the allegations are cited. Complaint IN00429061 - No deficiencies related to the allegations are cited. Complaint IN00428485 - No deficiencies related to the allegations are cited. Complaint IN00428342 - No deficiencies related to the allegations are cited. Survey dates: February 27, 28, 29, March, 1, 4, 5 and 6, 2024 Facility number: 012974 Provider number: 155818 AIM number: 201247830 Census Bed Type: SNF/NF: 23 SNF: 30 Residential: 41 Total: 94	F 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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 _____	C 03/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	Continued From page 1 Census Payor Type: Medicare: 17 Medicaid: 17 Other: 19 Total: 53 Hearthstone Health Campus was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00429626 and IN00429701. Quality review completed March 8, 2024.	F 000		