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	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hearthstone Health Campus	3043 North Lintel Drive Bloomington, IN 47404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 35318 Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and the resident representative for 3 of 4 residents reviewed for hospitalization and discharge. (Resident 39, Resident 63, Resident 64) Findings include: 1. On 2/29/24 at 12:00 p.m., Resident 39's clinical record was reviewed. The diagnoses included, but were not limited to, sepsis and acute respiratory failure. Resident 39's progress notes indicated the resident was sent to the hospital on 2/2/24, 1/7/24, 11/4/23 and 12/5/23. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. 2. On 2/29/24 at 12:15 p.m., Resident 63's clinical record was reviewed. The diagnosis included, but was not limited to, acquired absence of right leg below knee. Resident 63's progress notes indicated the resident was sent to the hospital on 12/8/23. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. 3. On 2/29/24 at 12:45 p.m., Resident 64's clinical record was reviewed. The diagnoses included, but were not limited to, dislocation of left shoulder joint and respiratory failure. Resident 64's progress notes indicated the resident was sent to the hospital on 12/13/23. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. During an interview on 3/4/24 at 1:59 p.m., Administrator 2 indicated there had been no documentation of the Notice of Transfer or Discharge forms having been provided to the resident and the resident representative for Resident 39, Resident 63, and Resident 64. (continued on next page)

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.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/24 at 1:28 p.m., Administrator 2 provided the facility policy, Bed Hold Notification, with an approval date of 9/24/18, and indicated this was the policy currently being used by the facility. A review of the policy did not indicate sending a Notice of Transfer and Discharge form with the resident and resident representative when the resident was transferred to the hospital. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 35318 Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 2 of 4 residents reviewed for hospitalization . (Resident 39, Resident 64) Findings include: 1. On 2/29/24 at 12:00 p.m., Resident 39's clinical record was reviewed. The diagnoses included, but were not limited to, sepsis and acute respiratory failure. Resident 39's progress notes indicated the resident was sent to the hospital on 2/2/24, 1/7/24, 11/4/23 and 12/5/23. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative. 2. On 2/29/24 at 12:45 p.m., Resident 64's clinical record was reviewed. The diagnoses included, but were not limited to, dislocation of left shoulder joint and respiratory failure. Resident 64's progress notes indicated the resident was sent to the hospital on 12/13/23. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative. During an interview on 3/4/24 at 1:59 p.m., Administrator 2 indicated there had been no documentation of the facility's bed-hold policy having been provided to the resident or the resident representative for Resident 39 and Resident 64. On 3/5/24 at 1:28 p.m., Administrator 2 provided the facility policy, Bed Hold Notification, with an approved date of 9/24/18, and indicated this was the policy currently being used by the facility. A review of the policy indicated, . OVERVIEW: . Before a nursing facility transfers a resident or a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies the duration of the state bed hold policy . 3.1-12(a)(25) 3.1-12(a)(26)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34848 Based on interview and record review, the facility failed to include the participation of the resident and the resident's representative in the development of a resident's care plan for 1 of 1 resident reviewed for care planning conferences. (Resident 8) Findings include: During a family interview on 2/28/24 at 12:31 p.m., Resident 8's family representative indicated they had not been invited to participate in any care planning conferences. On 3/4/24 at 10:36 a.m., Resident 8's clinical record was reviewed. The diagnoses included, but were not limited to, toxic encephalopathy (a disturbance of brain function. It causes confusion, memory loss and coma in severe cases), atrial fibrillation (an irregular and fast heart beat), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), mild cognitive impairment, and chronic kidney disease. A Quarterly Minimum Data Set (MDS) assessment, dated 12/22/23 indicated the resident had moderately impaired cognition. An Admission Resident First Meeting (care plan meeting), dated 9/26/23, indicated the resident's representative was not involved in the care plan conference. A review of the resident's clinical record indicated no other care plan meetings took place between 9/26/23 and 3/6/24. During an interview on 3/6/24 at 2:45 p.m. the Clinical Nurse Consultant indicated the resident did not have a quarterly care plan conference after admission because the facility did not have a Social Services Director when her care plan conference would have been due. On 3/6/24 at 3:25 p.m., the Administrator provided the facility policy, Resident First Meeting Guidelines, revised 4/25/22, and indicated the policy was currently being used by the facility. A review of the policy indicated, PURPOSE To facilitate communication and participation regarding the resident's plan of care, medical condition and care need between the resident, family, and family representative and care givers . 3. Subsequent meetings . should be conducted minimally quarterly . 6. Director of Social Services or designee should send invitations to the resident and/or representative notifying them of the date and time of the conference as far in advance as possible . 18. Resident/ Resident Representative to e-sign completed Resident First Observation if present . 19. If the resident or representative is unable to attend . a copy of the Meeting discussion may be communicated with them . 3.1-35(c)(2)(C)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38312 Based on observation, interview, and record review, the facility failed to ensure a resident admitted to the facility without pressure-related skin impairment did not develop a pressure injury for 1 of 2 residents reviewed for pressure injuries. This deficient practice resulted in Resident 5 developing a facility acquired Stage 3 pressure ulcer on the left buttock. Findings include: During a continuous observation on 2/28/24 at 10:27 a.m. through 11:36 a.m., Resident 5 was observed sitting in wheelchair in her room. Resident 5's room was observed to have a urine odor. On 2/28/24 at 11:36 a.m., Certified Nursing Assistant (CNA) 1 was observed to enter Resident 5's room. CNA 1 placed Resident 5's sock on her foot; covered Resident 5's lap with a blanket; and assisted Resident 5 to the dining room for lunch. CNA 1 did not offer to assist Resident 5 to the bathroom or to reposition her prior to going to the dining room. During a continuous observation on 2/28/24 from 11:44 a.m. through 12:36 p.m., Resident 5 was observed to be in the dining room eating lunch. On 2/28/24 at 12:36 p.m., Resident 5's family member was observed to assist Resident 5 back to her room. On 2/28/24 from 12:42 p.m. until 12:57 p.m., Resident 5's family member was with Resident 5 in her room. At that time, Resident 5's family member indicated Resident 5 had a decline since receiving a left arm fracture after a fall. The family member indicated Resident 5 had developed a pressure ulcer to her buttock. When she or other family members visit Resident 5, the resident would be incontinent of urine and her room had an urine odor. On 2/28/24 at 12:57 p.m., Resident 5 was observed to be assisted to bed by CNA 1. During a continuous observation on 3/1/24 from 9:44 a.m. through 11:44 a.m., Resident 5 was observed sitting in a wheelchair in her room. Resident 5's room was observed to have a urine odor. On 3/1/24 at 10:49 a.m., CNA 2 was observed to offer Resident 5 a baby doll. CNA 2 did not offer to assist Resident 5 to the bathroom or to assist in repositioning her. On 3/1/24 at 11:00 a.m., Resident 5's clinical record was reviewed. The diagnoses included, but were not limited to, Stage 3 (full thickness tissue loss) pressure ulcer to left hip, weakness, left humerus (a bone in the upper arm) fracture, pain, and congested heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 11/17/23, indicated Resident 5 had severe cognitive impairment; no upper and lower extremity impairment; required maximal assistance with toileting, sit to stand; required moderate assistance with rolling left and right in bed, sitting to lying position; was always incontinent of urine and bowel movements; and was at risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Significant Change MDS assessment, dated 1/29/24, indicated Resident 5 had severe cognitive impairment; no upper and lower extremity impairment; required maximal assistance with toileting, roll left and right in bed, sit to stand, and sitting to lying position; was always incontinent of urine and bowel movements; and was at risk for skin breakdown. The care plan, dated 2/22/19 and current through 6/12/24, indicated Resident 5 was at risk for skin breakdown. The interventions were to avoid shearing skin during positioning, turning, and transferring; encourage and assist to turn and reposition for comfort as needed; keep linens clean and dry; keep resident clean and dry as possible. The care plan, dated 2/22/19 and current through 6/12/24, indicated Resident 5 had the potential for decline in activities of daily living (ADLs). Her interventions were to provide incontinent care after each incontinence episode. The care plan, dated 2/22/19 and current through 6/12/24, indicated Resident 5 had impairment with bed mobility, transfers, and toileting. She required extensive assistance with transfers, bed mobility, and toileting. The care plan, dated 2/22/19 and current through 6/12/24, indicated Resident 5 had episodes of incontinence. Her interventions were to offer and to assist with toileting as needed and/or per request and to provide incontinence care as needed. The care plan, dated 2/9/24 and current through 6/12/24, indicated Resident 5 had a pressure ulcer. The care plan lacked interventions to assist with repositioning or toileting resident. The care plan lacked any new interventions after Resident 5's decline in mobility from the left humerus fracture. The Quarterly Observation and Data Collection, dated 11/6/23 at 3:01 a.m., indicated Resident 5 was incontinent and the Braden Scale indicated she was at a moderate risk for skin breakdown. The clinical record lacked documentation of a Braden Scale Assessment after her fall with a left humerus fracture and her Significant Change MDS assessment. The Hospital Discharge Instructions, dated 1/21/24, indicated the diagnoses during Resident 5's emergency room visit were a fall and a left humeral fracture. The Progress Notes indicated the following: - On 1/22/24 at 2:16 a.m., Resident 5 returned the from emergency room . She had a left humeral fracture. - On 1/22/24 at 6:42 a.m., Resident 5 had a fall and was diagnosed with a left humerus fracture. The plan was for staff to assist with ADLs and mobility as needed. - On 1/22/24 at 11:09 a.m., the Interdisciplinary Team (IDT) note indicated Resident 5 had pain related to shoulder fracture. The note lacked any documentation of interventions for requiring more assistance since recent fall. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- On 2/8/24 at 6:21 p.m., Resident 5 had a chronic wound on her left ischium. The wound was closed and had reopened. - On 2/16/24 at 12:22 p.m., Resident 5 had a pressure ulcer to left buttock. The care plan was reviewed and updated as needed. The Treatment Administration History indicated the following: - On 1/25/24, the weekly skin assessment indicated an old impairment. - On 2/1/24, the weekly skin assessment indicated unchanged. - On 2/8/24, the weekly skin assessment indicated an old impairment. The Wound Management Report dated 7/27/23 at 12:10 p.m., indicated Resident 5 had a Stage 2 pressure ulcer healed to left hip on 9/25/23 at 10:34 a.m., . The Wound Management Detail Report indicated the following: - On 2/8/24 at 10:24 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 3.5 centimeters (cm) length (l) by (X) 2.5 cm width (w) with granulation tissue. - On 2/9/24 at 10:26 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 3.5 cm l X 2.5 cm w with granulation tissue. - On 2/16/24 at 10:26 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 3.5 cm l X 2.5 cm w with granulation tissue. - On 2/21/24 at 11:17 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 4 cm l X 3 cm w with granulation tissue. - On 2/28/24 at 9:10 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 4cm l X 3 w with granulation tissue. On 3/1/24 at 11:44 a.m., Licensed Practical Nurse (LPN) 1 offered to take Resident 5 to the dining room. LPN 5 did not offer to assist Resident 5 to the bathroom or to reposition her prior to going to the dining room. On 3/1/24 11:44 a.m. through 12:40 p.m., Resident was in the dining room eating lunch. On 3/1/24 at 12:40 p.m., Resident 5 was assisted back to her room from lunch. At that time LPN 1, administered Resident 5 her medication. LPN 1 did not assist Resident 5 to the bathroom or assist in repositioning her. During a continuous observation on 3/1/24 from 12:40 p.m. through 12:55 p.m., Resident 5 was observed sitting in a wheelchair in her room. During this observation, no staff offered to assist Resident 5 to the bathroom or to assist with repositioning her. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a continuous observation from 3/1/24 from 1:00 p.m. through 1:51 p.m., Resident 5 was observed sitting in a wheelchair in her room. During this observation, no staff offered to assist Resident 5 to the bathroom or to assist with repositioning her. On 3/1/24 at 1:55 p.m., the Corporate Nurse Consultant indicated the clinical record lacked any Braden Scale Assessment completed since 11/6/23. On 3/4/24 at 10:30 a.m., Resident 5 was observed to be lying in bed. The Corporate Nurse was observed to remove the dressing on Resident 5's left buttock. The pressure ulcer was the size of a half dollar with a red center and white tissue surrounding the area. The Corporate Nurse indicated Resident 5's pressure ulcer was observed on her left buttock. She indicated Resident 5 had a history of pressure ulcer to her left buttock. On 3/4/24 at 10:33 a.m., LPN 2 indicated Resident 5 had a fall with a left arm fracture. Resident 5 required extensive assistance of 2 staff members with ADLs. She had a pressure ulcer to her left buttock. Her pressure ulcer interventions were a pressure relieving wheelchair cushion, a low-loss air mattress to her bed, and to turn and reposition every 2 hours while she is in the bed or chair. The facility had been working short-staffed. Some days it was difficult to get Resident 5 toileted and turned and repositioned. Some days it would be 4 hours before they could turn and reposition and toilet the residents. On 3/4/24 at 11:23 a.m., CNA 1 indicated Resident 5 had a fall with a fractured left arm and had a pressure ulcer to her left buttock. Resident 5's interventions were check and change and reposition every 2 hours and pressure relieving cushion in her wheelchair and bed. It had been challenging getting the residents checked, changed, and repositioned every 2 hours because they had been working short-staffed. On 3/5/24 at 10:18 a.m., the Corporate Nurse indicated the old impairments on the weekly skin assessments were not documented in the clinical record. On 3/5/24 at 2:04 p.m., Corporate Nurse Consultant indicated the last time Resident 5 had a pressure ulcer on left buttock was 7/27/23 and it was healed on 9/13/23. The pressure ulcer which healed on 9/25/23 at 10:34 a.m., was the same as left buttock. On 3/5/24 at 1:21 p.m., The Administrator provided the facility's policy, Guidelines for Pressure Prevention, dated 12/31/23, and indicated it was the policy being used by the facility. A review of the policy indicated, . Clean skin with premoistened wipes or periwash, rinse and dry thoroughly after incontinent episodes .Keep skin clean, dry and free of body wastes, perspiration, and wound drainage .Establish an individualized turning schedule if resident is immobile or compromised. Frequency of position change is individualized. Notify the nurse to document if the resident refuses turning intervention . On 3/5/24 at 1:21 p.m., The Administrator provided the facility's policy, Guidelines for General Wound and Skin Care, dated 12/31/23, and indicated it was the policy being used by the facility. A review of the policy indicated, .2. Turn/reposition residents who are immobile according to their care plan requirements .8. Provide incontinence care promptly . 3.1-40(a)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36912 Based on observation, interview, and record review, the facility failed to provide a sanitary environment for 4 of 7 days during the survey. Sit to stand lift foot platforms were not clean and resident rooms were not free from urine odor. (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER]) Findings include: 1. On the following dates and times, a sit to stand lift was observed between rooms [ROOM NUMBERS] with the foot platform containing food crumbs and debris: - On 2/28/24 at 11:37 a.m.; - On 3/1/24 at 1:21 p.m.; - On 3/4/24 at 10:45 a.m.; - On 3/5/24 at 9:15 a.m. On the following dates and times, a sit to stand lift was observed by room [ROOM NUMBER] with the foot platform containing food crumbs and debris: - On 2/28/24 at 11:55 a.m.; - On 3/1/24 at 1:28 p.m.; - On 3/4/24 at 10:55 a.m.; - On 3/5/24 at 9:20 a.m. On the following dates and times, a sit to stand lift between rooms [ROOM NUMBERS] was observed with the foot platform contain food crumbs and debris: - On 2/28/24 at 2:49 p.m.; - On 3/1/24 at 1:25 p.m.; - On 3/4/24 at 10:50 a.m.; - On 3/5/24 at 9:25 a.m. On the following dates and times, a sit to stand lift by room [ROOM NUMBER] was observed with the foot platform containing food crumbs and debris: - On 2/28/24 at 2:52 p.m.; (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 3/1/24 at 1:24 p.m.; - On 3/4/24 at 10:52 a.m.; - On 3/5/24 at 9:27 a.m. 2. On the following dates and times a strong urine odor was observed in room [ROOM NUMBER]: - On 2/28/24 at 2:50 p.m.; - On 3/1/24 at 1:26 p.m.; - On 3/4/24 at 10:51 a.m.; - On 3/5/24 at 9:26 a.m. On the following dates and times a strong urine odor was observed in room [ROOM NUMBER]: - On 2/28/24 at 2:53 p.m.; - On 3/1/24 at 1:25 p.m.; - On 3/4/24 at 10:53 a.m.; - On 3/5/24 at 9:28 a.m. On the following dates and times a strong urine odor was observed in room [ROOM NUMBER]: - On 2/28/24 at 2:53 p.m.; - On 3/1/24 at 1:25 p.m.; - On 3/4/24 at 10:53 a.m.; - On 3/5/24 at 9:28 a.m. During an interview on 3/5/24 at 10:17 a.m., the Executive Director indicated the sit to stand lift foot platforms were in need of cleaning, and rooms [ROOM NUMBER] each had an odor of urine. On 2/28/24 at 11:50 AM, the facility Executive Director provided the Resident Rights, dated 11/1/23 and indicated these were the resident rights currently used by the facility. A review of the Resident Rights indicated, .the resident has the right to a safe, clean, comfortable and homelike environment . 3.1-19(f)