STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155818	A. Building B. Wing	01/14/2025

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. 34848 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 1 of 2 residents reviewed for hospitalization . (Resident 262) Findings include: On 1/12/25 at 9:44 a.m., Resident 262's clinical record was reviewed. The diagnoses included, but were not limited to, urinary tract infection, recurrent enterocolitis due to Clostridium difficile (a condition where a person experiences repeated episodes of inflammation in the intestines caused by the bacteria Clostridium difficile), and stage 3 chronic kidney disease. A progress note, dated 1/3/25 at 10:13 a.m., indicated the resident was sent to the hospital for low oxygen saturation and lethargy. The clinical record lacked documentation of written notification of the transfer and discharge forms were provided to the resident and the resident representative. During an interview on 1/13/25 at 10:48 a.m., Clinical Nurse Consultant 1 indicated the notice of transfer and discharge would be documented in the progress notes. No documentation of the transfer and discharge notices were found in the progress notes. During an interview on 1/13/25 at 2:54 p.m., Clinical Nurse Consultant 2 indicated the clinical record lacked documentation the notice of transfer and discharge was provided to the resident and the resident's representative. On 1/13/25 at 2:54 p.m., Clinical Nurse Consultant 1 provided the facility policy, Guidelines for Transfer and Discharge (including AMA), reviewed on 12/17/24, and indicated this was the policy currently being used. A review of the policy indicated, . a. Notify the resident in writing, and if known, a family member or legal representative . of the transfer or discharge . 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)

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 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. 34848 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 1 of 2 residents reviewed for hospitalization . (Resident 262) Findings include: On 1/12/25 at 9:44 a.m., Resident 262's clinical record was reviewed. The diagnoses included, but were not limited to, urinary tract infection, recurrent enterocolitis due to Clostridium difficile (a condition where a person experiences repeated episodes of inflammation in the intestines caused by the bacteria Clostridium difficile), and stage 3 chronic kidney disease. A progress note, dated 1/3/25 at 10:13 a.m., indicated the resident was sent to the hospital for low oxygen saturation and lethargy. 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 1/13/25 at 10:48 a.m., Clinical Nurse Consultant 1 indicated the notice of the bed hold policy would be documented in the progress notes. 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 1/13/25 at 2:54 p.m., Clinical Nurse Consultant 2 indicated the clinical record lacked documentation of the bed hold policy being provided to the resident and the resident's representative. On 1/13/25 at 2:54 p.m., Clinical Nurse Consultant 1 provided the facility policy, Guidelines for Transfer and Discharge (including AMA), reviewed on 12/17/24, and indicated this was the policy currently being used. A review of the policy indicated, . 5. Notice of Bed-Hold Policy and Readmission . b. Before the facility transfers a resident to a hospital . staff member should provide written information to the resident and a family member or legal representative of the bed-hold and admission policies . 3.1-12(a)(25) 3.1-12(a)(26)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 38312 Based on observation, interview, and record review, the facility failed to ensure a resident had a physician's order for oxygen therapy for 1 of 1 resident reviewed for respiratory care. (Resident 260) Findings include: On 1/8/25 at 10:18 a.m., Resident 260 was observed to be resting in bed with oxygen on at 3.5 liters (L) per nasal cannula (a device to administer additional oxygen through your nose) (NC). At that time, Resident 260 indicated she was on oxygen at 3.5 L. On 1/9/25 at 3:10 p.m., Resident 260 was observed to be resting in bed with oxygen on at 3.5 L. On 1/10/25 at 9:52 a.m., Resident 260 was observed to be resting in bed with oxygen on at 3.5 L. On 1/13/25 at 11:12 a.m., LPN 1 indicated Resident 260 was on oxygen at 3.5 L. On 1/13/25 11:28 a.m., Resident 260's clinical record was reviewed. The diagnoses included, but were not limited to, pneumonia, pulmonary disease, and chronic respiratory failure. The Admission Observation and Data Collection, dated 12/27/24 at 8:16 a.m., indicated Resident 260 utilized a high concentration of continuous oxygen. The baseline care plan goal was oxygen per Medical Doctor (MD) order. The Progress Notes indicated the following: - On 12/27/24 at 8:17 a.m., Resident 260 was on 4 L of oxygen per NC. - On 1/9/25 at 6:26 a.m., Resident 260 utilized oxygen. - On 1/13/25 at 6:18 a.m., Resident 260 utilized oxygen. The care plan, dated 1/9/25, indicated Resident 260 was at risk for cardiovascular distress related to diagnosis of hypertension. The intervention was to administer oxygen per order. The Physician Orders, dated 1/13/25, lacked documentation of a physician order for oxygen. On 1/13/25 at 11:00 a.m., the Corporate Nurse indicated a resident would need a physician order for oxygen. Resident 260's physician orders lacked documentation of a physician order for oxygen. On 1/13/25 at 11:45 a.m., the Corporate Nurse provided the facility's policy, Administration of Oxygen, dated 12/13/24, and indicated it was the policy currently being used by the facility. A review of the policy indicated . 1. Verify physician's order for the procedure . 3.1-47(a)(6)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 35318 Based on observation, interview, and record review, the facility failed to ensure a room was free from a urine odor for 3 of 6 days during the survey period. (room [ROOM NUMBER]) Findings include: On the following dates and times a strong urine odor was observed in room [ROOM NUMBER]: - On 1/8/25 at 10:19 a.m.; - On 1/8/25 at 11:46 a.m.; - On 1/8/25 at 2:46 p.m.; - On 1/9/25 at 9:21 a.m.; - On 1/9/25 at 11:53 a.m.; - On 1/9/25 at 2:29 p.m.; - On 1/10/25 at 9:41 a.m. During an interview on 1/9/25 at 12:28 p.m., a family member of a resident who currently resided in room [ROOM NUMBER], indicated the room often had a smell of urine. During at interview on 1/13/25 at 10:03 a.m., the Corporate Nurse indicated she believed the smell of urine was in the carpet. They had switched out the mattresses, wheelchair cushions, and had been cleaning the carpets once a week to keep the smell of urine down. On 1/14/25 at 12:02 p.m., the Administrator provided the policy, Your Rights and Protections as a Nursing Home Resident, undated, and indicated it was the policy currently being used by the facility. A review of the policy did not mention the right to be free from odors . The Administrator indicated the facility did not have a policy related to the room environment. 3.1-19(f)