STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REHABILITATION CENTER AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DR MUNSTER, IN 46321

(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 Complaints IN00434235 & IN00435793. Complaint IN00434235 - Federal/State deficiencies related to the allegations are cited at F585. Complaint IN00435793 - No deficiencies related to the allegations are cited. Survey dates: May 28, 29, 30, 31 and June 3, 2024. Facility number: 010758 Provider number: 155662 AIM number: Census Bed Type: SNF/NF: 75 SNF: 19 Total: 94 Census Payor Type: Medicare: 79 Medicaid: 1 Other: 12 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review complated on 6/7/24.	F 0000	***This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.***	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified			

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

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	existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and	F 0550	A facility must treat each resident	06/21/2024

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	interview, the facility failed to ensure each resident's dignity was maintained related to uncovered foley (urinary) catheter bags with urine being seen from the hallway for 1 of 1 residents reviewed for dignity. (Resident 73) Finding includes: During random observations on 5/28/24 at 2:52 p.m. and 4:10 p.m., Resident 73 was observed in bed. At those times, his indwelling foley catheter bag was uncovered and hanging on the side of the bed. The urine in the bag could be seen from the hallway. On 5/29/24 at 8:20 a.m., 1:00 p.m., and 3:00 p.m., the resident's foley catheter bag was uncovered and the urine in the bag could be seen from the hallway. On 5/30/24 at 9:34 a.m., and 3:00 p.m., the resident's foley catheter bag was uncovered and the urine in the bag could be seen from the hallway. The record for Resident 73 was reviewed on 5/29/24 at 2:30 p.m. Diagnoses included, but were not limited to, sepsis, high blood pressure, atrial fibrillation, benign prostatic hyperplasia (an enlarged prostate), chronic kidney disease, acute cystitis, and Urinary Tract Infection (UTI). The 3/23/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling foley catheter. A Care Plan, dated 12/17/23, indicated the resident had potential complications related to an urinary indwelling catheter.		with respect and dignity. The facility failed to ensure each resident's dignity was maintained related to uncovered foley (urinary) catheter bags with urine being seen from the hallway for 1 of 1 resident reviewed for dignity. (Resident 73) **Corrective action taken for residents found to have been affected by the deficient practice:** A dignity bag was immediately provided for Resident 73. No other patients were found to be affected. **Identification of other residents having the potential to be affected by the same deficient practice:** All patients with an indwelling urinary catheter have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nursing staff regarding the standards of care for patients with an indwelling urinary catheter. Education will reinforce the expectation to cover the drainage bag with a dignity bag for privacy at all times. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations of patients	

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	Physician's Orders, dated 2/12/24, indicated foley catheter 16 French for urinary retention. During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing (ADON) 1 indicated the foley catheter bag should have been covered in a dignity bag. The current 1/1/24 "Standards of Care for the Resident with an Indwelling Urinary Catheter" policy provided by the Administrator on 5/31/24 at 2:25 p.m., indicated the drainage bag was to be covered with a dignity bag. 3.1-3(t)		2x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 12 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next three months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** June 21, 2024	

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F 0554 SS=E 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 defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure a self-medication administration assessment was completed for residents with medications at the bedside, for 4 of 4 random observations. (Residents 6, 73, 88, and 82) Findings include: 1. During random observations on 5/28/24 at 3:50 p.m., 5/29/24 at 8:20 a.m., 1:00 p.m., and 3:00 p.m., and on 5/30/24 at 9:32 a.m., Resident 6 was observed in her room. At those times there was a Breo hand held inhaler, antibiotic ointment cream, and healing ointment cream observed on the window sill. The record for Resident 6 was reviewed on 5/29/24 at 1:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes, COPD, heart disease, high blood pressure, anxiety and depression. The 4/26/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no self-administration of medication assessment located in the clinical record. The Physician Order Summary for the month of 5/2024 indicated there were no orders for the Breo inhaler or the antibiotic creams. There were no orders for the resident to self-administer her own medication or the healing cream.	F 0554	The resident has the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. The facility failed to ensure a self-medication administration assessment was completed for residents with medications at the bedside for 4 of 4 random observations. (Residents 6, 73, 88 and 82) **Corrective action taken for residents found to have been affected by the deficient practice:** The over the counter medications for Residents 6, 73, 88 and 82 were removed from bedside when identified during the survey. Nursing staff conducted a sweep of the facility to ensure there were no other medications inappropriately stored at patients' bedsides. **Identification of other residents having the potential to be affected by the same deficient practice:** All patients have the potential to be affected. **To ensure that proper practices**	06/21/2024

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	During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing 1 indicated there were no residents on the unit who were able to self-administer their own medications. 2. During random observations on 5/28/24 at 10:30 a.m., 11:47 a.m., 2:52 p.m., and 4:10 p.m., there was a bottle of Nystatin powder observed on Resident 73's night stand. The record for Resident 73 was reviewed on 5/29/24 at 2:30 p.m. Diagnoses included, but were not limited to, sepsis, high blood pressure, atrial fibrillation, benign prostatic hyperplasia (an enlarged prostate), chronic kidney disease, acute cystitis, and Urinary Tract Infection (UTI). The 3/23/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no self-administration of medication assessment located in the clinical record. Physician's Orders, dated 4/19/24, indicated Nystatin powder 100,000 unit/gram 1 application topical to scrotum for yeast twice a day upon rising and before bed. There was no Physician's Order to self-administer his own medications or to leave the medication at the bedside. During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing 1 indicated there were no residents on the unit who were able to self-administer their own medications. The Nystatin powder was not supposed to be left in the resident's room.		**continue:** The Director of Nursing/Designee will re-educate nursing staff regarding facility policy for self-administration of medications. If medications are observed at bedside and the patient is determined to be cognitively impaired or otherwise unsafe to self-administer medications, the nurse will remove the medication and discuss with the Physician and patient/family as needed. If the patient is alert and desires to participate in their medication administration, the nurse will initiate a self-administration of medication assessment and obtain the appropriate Physician's Order. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations of patient/resident rooms 2x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 20 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee	

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	3. During random observations on 5/28/24 at 10:36 a.m., 11:47 a.m., 2:55 p.m., and 4:10 p.m., 5/29/24 at 8:20 a.m., 1:00 p.m., and 3:00 p.m., and 5/30/24 at 9:35 a.m., there was bottle of Nystatin powder on Resident 88's dresser. The record for Resident 88 was reviewed on 5/30/24 at 9:40 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, and anxiety disorder. The 3/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. There was no self-administration of medication assessment located in the clinical record. Physician's Orders, dated 5/13/24, indicated Nystatin powder 100,000 unit/gram apply to abdominal folds twice a day. There was no Physician's Order to self-administer her own medications or to leave the medication at the bedside. During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing 1 indicated there were no residents on the unit who were able to self-administer their own medications. The Nystatin powder was not supposed to be left in the resident's room. 4. On 5/28/24 at 10:45 a.m., there were 3 containers of glucose tablets on the resident's night stand next to the bed. The resident indicated she would take them at night if her blood sugar dropped. On 5/28/24 at 11:50 a.m., glucose tablets were observed in the same place on the resident's		determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next three months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed.	

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	nightstand. On 5/29/24 at 1:00 p.m. and 3:00 p.m., the resident was observed in her room, glucose tablets remained on the nightstand. On 5/29/24 at 1:37 p.m., the resident was not in her room, the 3 containers of glucose tablets were on the resident's nightstand. On 5/31/24 at 8:30 a.m., the resident's systane eye drops were not available in the medication cart. The resident indicated the eye drops were in her room but she couldn't give them to herself. The bottle of eye drops was observed on the window ledge. There was no medication label on the bottle and there was no box for the medication in the room. LPN 2 removed the eye drops from the resident's room and indicated she would order a new bottle from the pharmacy The record for Resident 82 was reviewed on 5/29/24 at 1:00 p.m. The diagnoses included, but were not limited to, diabetes, depression, weakness, Alzheimer's disease, thyroid disorder, and anemia. The Admission Minimum Data Set (MDS) assessment, dated 4/20/24, indicated the resident was cognitively intact for daily decision making. The resident received insulin 7 of 7 days for the last look back period. A Care Plan, dated 4/14/24, indicated the resident had the potential for hypo/hyperglycemia due to diabetes. A Physician's Order, dated 4/13/23, indicated to administer a 4-gram glucose chewable tablet as needed for a blood sugar less than 60 with			

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	symptoms of hypoglycemia. A Physician's Order, dated 4/13/23, indicated to administer Systane eye drops once a day in both eyes. There was no self-medication administration assessment. There was no Physician order to self-administer medications. During an interview on 5/30/24 at 1:15 p.m., ADON 1 indicated there were no residents on the unit who were able to self-administer their own medications. There was no additional information provided. 3.1-11			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.			

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	§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing			

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	written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the			

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	grievance decision. Based on record review and interview, the facility failed to thoroughly investigate and resolve grievances in writing from a resident's family member for 1 of 1 resident reviewed for grievances. (Resident B) Finding includes: During an interview with Resident B and her husband on 5/28/24 at 2:57 p.m., they indicated he had a care plan meeting with staff to ensure the staff got his wife dressed and out of bed daily. He indicated the staff left the resident in her room and in the bed several times. Resident B's husband had filed a grievance with the administrator and had not received anything from the staff regarding his complaint. The husband indicated he had requested grievance information and had requested meeting several times to talk about his concerns. The resident's husband also indicated he felt the administrator had avoided responding to him regarding his concerns for his wife's care. The record for Resident B was reviewed on 5/28/24 at 10:00 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, weakness, dysphagia, oral phase, other lack of coordination, other speech and language deficits following cerebral infarction, unspecified protein-calorie malnutrition, dysphagia following other cerebrovascular disease, morbid (severe) obesity due to excess calories, type 2 diabetes mellitus without complications, hypothyroidism, unspecified, depression, unspecified. The Admission Minimum Data Set (MDS) assessment, dated 4/29/24, indicated the resident	F 0585	The facility failed to thoroughly investigate and resolve grievances in writing from a resident's family member for 1 of 1 resident reviewed for grievances. (Resident B) **Corrective action taken for residents found to have been affected by the deficient practice:** Resident B was a short term patient now discharged from the facility. **Identification of other residents having the potential to be affected by the same deficient practice:** No other patients were identified to be affected. **To ensure that proper practices continue:** The current facility process is to provide a copy of the grievance/grievance resolution to a patient and/or family member *upon request*. Facility Administration revised the grievance tracking process to include a tracking log. The tracking log has a column to document *if* and *when* a copy of the grievance/grievance resolution is requested by the patient/family. This tracking log will be used by the facility Administrator as part of the grievance tracking process to ensure compliance with this plan	06/21/2024

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REHABILITATION CENTER AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DR MUNSTER, IN 46321

(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
	was cognitively intact. Informal notes for resident B, received from the Administrator on 5/31/24 when asked for grievances, indicated the following: 5/6/24: Resident B's husband complained that his wife was in her wheelchair for one hour and spent 23 hours in the bed. He also complained that his wife did not attend the activities because she was in the bed. He stated the CNA told him that she could not transfer his wife unless she was agreeable to the care or transfer. The resident indicated he felt his wife was being kept in bed to make her too tired to attend activities. He also felt the staff did not communicate between shifts. There was no documentation of an investigation, summary, decision of confirmed or not confirmed, corrective action, or date a written decision was issued. 5/8/24: the resident's husband believed the staff continually changed the plan for the resident. Resident B's husband indicated that he wanted more showers for his wife instead of bed baths. The Director of Rehab discussed the involvement of therapy in shower sessions and continually communicated changes to nursing. 5/15/24: a care plan meeting was conducted. Resident B's husband was pleased with the therapy involvement in showers. 5/17/24: Resident B's husband was visibly upset and indicated the CNA's knew nothing about the orders for his wife. The staff attempted to calm Resident B's husband down and were unsuccessful. 5/20/24: Resident B's husband was visibly upset		of correction. The Administrator/designee will initiate and complete a monitoring tool weekly for four weeks to ensure compliance with this plan of correction. Each week, all grievance forms submitted will be reviewed to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next three months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further	

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	and waiting in the lobby for staff. Resident B's husband indicated the CNA's told him his wife was not scheduled for a shower for that day. Staff confirmed that Resident B's shower days were Monday and Thursday. The staff followed up with Resident B and her husband, and Resident B received her shower for 5/20/24. 5/24/24: Resident B's husband was waiting in the lobby for staff to arrive. Resident B's husband told staff he felt the staff was not listening to him. He began being disruptive and using aggressive language. Security asked Resident B's husband to leave the building until he felt calm enough to visit. 5/27/24: Resident B's husband informed the staff of a concern from Resident B, which related to a dining area attendant. Staff indicated they spoke to Resident B, and Resident B was not familiar with the concern. Staff reassured the resident that they were available if Resident B had any concerns. 5/28/24: the ADON told the Administrator that Resident B expressed to her that she might like to limit visits from her husband. Facility staff offered to help facilitate a conversation with Resident B and her husband. Resident B declined and indicated she would talk to her husband. The administrator reached out to the ombudsman for further support. A message was left and follow up plans were indicated. 5/30/24: the administrator checked in with Resident B and she indicated she was comfortable and had no concerns at this time. The staff indicated that they would continue to monitor the resident.		corrective action will be discussed and implemented as needed. **Completion Date:** June 21, 2024	

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	There was no documentation to indicate written follow up from the facility was provided to Resident B and/or Resident B's representative regarding the concerns and/or grievances filed. During an interview on 5/31/24 at 4:10 p.m. with the Administrator, she indicated she allowed the staff to have full autonomy when it came to handling the concerns of their residents. She did not keep a grievance log and did not track grievances, she allowed the staff to handle the resolutions for the residents. During an interview on 6/3/24 at 4:20 p.m. with the Administrator, she indicated Resident B's husband did tell her his concerns, he also emailed his concerns to her, and expressed his desire to schedule a meeting to discuss his concerns. A Policy titled, "Grievance Policy", provided by the Administrator on 6/3/234 at 3:30 p.m., indicated "... The facility has named the Administrator or his/her designee as the Grievance Official. The Grievance Official shall oversee the grievance process, receiving, and tracking grievances through to their conclusions. In addition, the Grievance Official shall: Provide written outcomes to the resident/residents representative if requested..." This Federal tag relates to Complaint IN00434235. 3.1-7(a)(2) 3.1-7(a)(3)(b)			
F 0684 SS=E 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			

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	facility residents. Based on the 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, record review, and interview, the facility failed to ensure areas of bruising and skin tears were assessed and monitored for 4 of 6 residents reviewed for skin conditions non-pressure related. (Residents 26, 60, 168, and 6) Findings include: 1. On 5/29/24 at 9:45 a.m., Resident 26 was observed in her room in bed. An area of reddish purple discoloration was observed on top of the resident's right hand and in between her ring and middle finger. During an interview at that time, the resident indicated she hit her hand on the door frame. The record for Resident 26 was reviewed on 5/29/24 at 3:56 p.m. Diagnoses included, but were not limited to, Guillain-Barre syndrome and history of falling. The Admission Minimum Data Set (MDS) assessment, dated 5/8/24, indicated the resident had short and long term memory problems and was dependent on staff for transfers. The 5/2024 Physician's Order Summary (POS) indicated there was no order to monitor the bruising. The resident was to have weekly skin assessments on Wednesday. There was no documentation in the nursing	F 0684	The facility must ensure that residents receive treatment and care in accordance with professional standards of practice. The facility failed to ensure areas of bruising and skin tears were assessed and monitored for 4 of 6 residents reviewed for skin conditions non-pressure related. (Residents 26, 60, 168 and 6) **Corrective action taken for residents found to have been affected by the deficient practice:** All identified areas of bruising and skin tears identified for Residents 26, 60, 168 and 6 were addressed at the time of identification during survey. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents with bruises and/or skin tears have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nursing staff	06/21/2024

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	progress notes nor on the 5/2024 Medication Administration Record (MAR) related to the discoloration. The weekly skin assessment was signed out as being completed on 5/8, 5/15, 5/22, and 5/29/24 on the 5/2024 MAR. There were special instructions to complete a head to toe assessment and document and measure any bruises or skin tears noted. There was no documentation related to the bruising. During an interview on 5/30/24 at 2:45 p.m., Assistant Director of Nursing (ADON) 1 indicated bruises should have been documented when they were observed. A Physician's Order, dated 5/31/24, indicated to monitor the bruise to the right and left third metacarpophalangeal joint until resolved every shift. 2. On 5/29/24 at 9:43 a.m., Resident 60 was observed in her room seated in her chair. A light purple discoloration was observed on the top of her right hand. The record for Resident 60 was reviewed on 5/29/24 at 1:34 p.m. Diagnoses included, but were not limited to, atrial fibrillation (irregular heartbeat) and hypertensive heart disease with heart failure. The Admission Minimum Data Set (MDS) assessment, dated 5/10/24, indicated the resident was cognitively intact. She needed partial to moderate assistance for transfers. The 5/2024 Physician's Order Summary (POS) indicated there was no order to monitor the bruising.		regarding facility procedure as it relates to the identification, monitoring and documentation related to bruising and/or skin tears. Current facility practice is to conduct a skin assessment on all patients at the time of admission and weekly thereafter. Bruising and/or skin tears shall be documented on when they are observed and monitored until resolved. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random audits 2x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 20 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools	

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	There was no documentation in the nursing progress notes nor on the 5/2024 Medication Administration Record (MAR) related to the discoloration. During an interview on 5/30/24 at 2:45 p.m., Assistant Director of Nursing (ADON) 1 indicated bruises should have been documented when they were observed. A Physician's Order, dated 5/30/24, indicated to monitor the bruise to the right hand until resolved every shift Nurses' Notes, dated 5/31/24 at 8:37 a.m., indicated the resident had bruising to the right hand, light purple in color and no pain was noted with tactile stimulation. The resident's family stated the bruise was from a previous IV insertion. 3. On 5/29/24 at 9:36 a.m., Resident 168 was observed in his room seated in a high back wheelchair. The resident was observed with multiple areas of reddish/purple discoloration to his bilateral arms and a dressing was in place to his left upper arm. The record for Resident 168 was reviewed on 5/29/24 at 2:18 p.m. Diagnoses included, but were not limited to, Parkinson's disease, atrial fibrillation (irregular heartbeat), and anemia. The 5 day Minimum Data Set (MDS) assessment, dated 5/21/24, indicated the resident was cognitively intact and required partial to moderate assistance with transfers. A Care Plan, dated 5/14/24, indicated the resident was at risk for complications associated with		again monthly throughout the next three months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** June 21, 2024	

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	aspirin and antiplatelet therapy. Interventions included, but were not limited to, observe skin with each encounter for bruising and skin tears. The Admission assessment dated, 5/14/24, indicated the resident had bruises to the left upper arm, left antecubital, left lower arm, left wrist, left hand, right upper arm, right antecubital, front of neck, right side of neck, right elbow, right wrist, and right hand A Physician's Order, dated 5/20/24, indicated the resident was to have weekly skin assessments on Mondays. The 5/2024 Physician's Order Summary (POS), indicated there was no order to monitor the bruising and there was no order for the dressing to the left upper arm. There was no documentation in the nursing progress notes nor on the 5/2024 Medication Administration Record (MAR) related to the discoloration. During an interview on 5/30/24 at 2:45 p.m., Assistant Director of Nursing (ADON) 1 indicated bruises should have been documented when they were observed. A Physician's Order, dated 5/30/24, indicated the resident's left arm was to be cleansed with normal saline, pat dry, and apply foam dressing every Monday, Wednesday, and Friday and as needed (PRN). A Physician's Order, dated 5/30/24, indicated to monitor the bruises to the resident's left forearm every shift until resolved.			

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	A Physician's Order, dated 5/31/24, indicated to monitor the scattered bruising to the resident's right forearm every shift until resolved. 4. During random observations on 5/28/24 at 4:00 p.m. and on 5/29/24 at 8:20 a.m., Resident 6 was observed in bed. At those times a bandaid was noted to her left forearm with no date on it. Dried blood could be seen underneath the bandage. On 5/29/24 at 1:00 p.m. and 3:00 p.m., the resident was sitting up in her wheelchair beside the bed in her room. The bandaid was no longer there and a skin tear was observed to the left arm. The skin was rolled back and was bloody. On 5/30/24 at 9:32 a.m., the resident was observed sitting up in the wheelchair in her room. At that time, a clean bandaid was observed over the skin tear. The record for Resident 6 was reviewed on 5/29/24 at 1:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes, COPD, heart disease, high blood pressure, anxiety and depression. The 4/26/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 4/7/24, indicated the resident was at risk for skin breakdown. The approaches were to notify the nurse and physician of any skin changes and observe the skin with a.m. and p.m. care. There was no documentation in the nursing progress notes regarding any skin tear to the left forearm. During an interview on 5/30/24 at 1:15 p.m.,			

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	Assistant Director of Nursing 1 indicated she was unaware the resident had a skin tear on her left arm. There should have been an assessment of the area and physician's orders to treat and monitor the area. During an interview on 5/30/24 at 2:00 p.m., the Hospice Nurse indicated the resident had a scab on that arm when she was first admitted, she told the staff to leave it open to air. She was unaware the area had reopened. Nursing Progress Notes, dated 5/30/24 at 2:11 p.m., indicated a new skin tear was noted on the left forearm that measured 2 centimeters (cm) by 1.6 cm. Nursing Progress Notes, dated 5/30/24 at 2:34 p.m., indicated the Nurse Practitioner was notified of the new skin tear and orders to cleanse with normal saline and apply an adaptive bandage was ordered. During an interview on 5/30/24 at 3:00 p.m., RN 1 indicated she had been taking care of the resident today and was unaware she had a skin tear to the left arm. She was not given any information when she came on shift from the night nurse. She measured the skin tear, notified the doctor, family and received an order to treat. 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 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his			

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	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, record review, and interview, the facility failed to ensure foley (urinary) catheter bags and tubing were kept off the floor, for 2 of 2 residents reviewed for catheters. (Residents 73 and 93) Findings include: 1. During random observations on 5/28/24 at 10:30 a.m. and 11:47 a.m., Resident 73 was observed	F 0690	A resident who is incontinent of bladder receives appropriate treatment and services. The facility failed to ensure foley (urinary) catheter bags and tubing were kept off the floor, for 2 of 2 residents reviewed for catheters. (Residents 73 and 93) **Corrective action taken for**	06/21/2024

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	sitting in a wheelchair. At those times, his indwelling foley catheter bag was observed on the floor under the wheelchair. The catheter tubing was above his waist. On 5/29/24 at 3:00 p.m., and on 5/30/24 at 3:00 p.m., the resident was observed in bed. At those times, the foley catheter bag was touching the floor. On 6/3/24 8:50 a.m., the resident was observed sitting in the wheelchair in his room eating breakfast. At that time, the foley catheter bag was in a dignity bag under the wheelchair, however, the tubing was dragging on the floor. The record for Resident 73 was reviewed on 5/29/24 at 2:30 p.m. Diagnoses included, but were not limited to, sepsis, high blood pressure, atrial fibrillation, benign prostatic hyperplasia (an enlarged prostate), chronic kidney disease, acute cystitis, and Urinary Tract Infection (UTI). The 3/23/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling foley catheter. A Care Plan, dated 12/17/23, indicated the resident had potential complications related to an urinary indwelling catheter. The approaches were to maintain the catheter bag and tubing below the bladder level. Physician's Orders, dated 2/12/24, indicated foley catheter 16 French for urinary retention. Physician's Orders, dated 4/16/24, indicated give Macrobid (an antibiotic) 100 milligrams (mg) daily for chronic UTI.		**residents found to have been affected by the deficient practice:** The catheter tubing was immediately removed from the floor and disinfected for both Residents 73 and 93. Resident 93 is a short term patient who has since discharged home from the facility. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents with indwelling Foley catheters have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nursing staff regarding the standards of care for patients with an indwelling urinary catheter. Education will reinforce the expectation of ensuring catheter bags and tubing are not touching the floor at any time. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations of patients 2x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 12 audits will be conducted to monitor compliance and/or identify trends to review	

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	During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing (ADON) 1 the foley catheter bag and/or tubing should not have been on the floor. 2. On 5/28/24 at 1:30 p.m., Resident 93 was sitting in his wheelchair in front of the nurse's station. The resident had a Foley catheter and the tubing was observed on the floor. On 5/28/24 at 2:29 p.m., Resident 93 was observed in the same place. He was watching television by the nurse's station. The Foley catheter tubing remained on the floor. On 5/28/24 at 3:00 p.m., Resident 93 was observed sitting in his wheelchair in front of the television in the common area. The catheter tubing was observed on the floor. The record for Resident 93 was reviewed on 5/29/24 at 3:47 p.m. The diagnoses included, but were not limited to, anemia, hypertension (high blood pressure), urinary retention, arthritis, dementia, anxiety, and depression. The resident was dependent with toileting hygiene. The resident had an indwelling catheter. The Admission Minimum Data Set (MDS) Assessment, dated 4/12/24, indicated the resident was not cognitively intact for daily decision making. A Care Plan, dated 5/15/24, indicated the resident had a potential for complications related to a urinary indwelling catheter. A Physician's Order, dated 5/15/24, had indicated to insert a Foley catheter related to urinary retention. During an interview on 5/31/24 at 10:50 a.m.,		with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next three months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** June 21, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REHABILITATION CENTER AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DR MUNSTER, IN 46321

(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
	ADON 2 indicated the indwelling foley catheter tubing should not have been on the floor. A policy titled, "Standards of Care for the Resident with an Indwelling Catheter," was provided as current by the Administrator on 5/31/24 at 2:25 p.m. The policy indicated, "...Secure the catheter to the patients thigh using a securement device. Hang the collection bag below the level of the bladder to prevent urine reflux to the bladder. To maintain free urinary flow the catheter drainage tube is to be free of kinks..." 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 1 of 1 resident reviewed for oxygen. (Resident 60) Finding includes: On 5/28/24 at 1:58 p.m. and 4:05 p.m., Resident 60 was observed in her room. She had oxygen per nasal cannula in use. The resident's oxygen concentrator was set at 3 1/2 liters.	F 0695	The facility must ensure that residents who need respiratory care are provided such care in accordance with professional standards of practice. The facility failed to ensure oxygen was at the correct flow rate for 1 of 1 residents reviewed for oxygen. (Resident 60) **Corrective action taken for residents found to have been**	06/21/2024

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	On 5/29/24 at 9:42 a.m. and 1:21 p.m., the resident was again observed in her room with oxygen by the way of a nasal cannula in use. The resident's oxygen concentrator was set at 3 1/2 liters. On 5/30/24 at 9:40 a.m., the resident was observed in her room. Oxygen per nasal cannula was in use and the oxygen concentrator was set at 3 1/2 liters. The record for Resident 60 was reviewed on 5/29/24 at 1:34 p.m. Diagnoses included, but were not limited to, pneumonia, emphysema, and congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 5/10/24, indicated the resident was cognitively intact and received oxygen therapy. A Care Plan, dated 5/3/24, indicated the resident required the use of oxygen therapy due to emphysema, congestive heart failure, chronic obstructive pulmonary disease, respiratory failure, pneumonia, and asthma. Interventions included, but were not limited to, oxygen as ordered. A Physician's Order, dated 5/3/24, indicated the resident was to receive oxygen at 4 liters per minute per nasal cannula continuously every shift. During an interview on 5/30/24 at 2:45 p.m., Assistant Director of Nursing (ADON) 1 indicated she would check the resident's oxygen concentrator. 3.1-47(a)(6)		**affected by the deficient practice:** The concentrator for Resident 60 was set at the physician ordered flow rate at the time of identification during the survey. No other residents were found to be affected. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents who require the use of oxygen have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nursing staff and reinforce the importance of following Physician orders for oxygen therapy with a focus on accurately setting the oxygen concentrator flow rate. The Respiratory Therapist/Designee will initiate and complete a monitoring tool and conduct random observations of patients who utilize oxygen 3x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 9 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA	

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			Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next three months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** June 21, 2024	
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-			

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	§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 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 record review and interview, the facility failed to ensure blood pressure medication was not administered outside of the physician-ordered parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 88) Finding includes: The record for Resident 88 was reviewed on 5/30/24 at 9:40 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, and anxiety disorder. The 3/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. Physician's Orders, dated 4/1/24, indicated Verapamil (a medication used to treat chest pain and lower the blood pressure) 120 milligrams (mg) give 60 mg twice a day and hold if the systolic	F 0757	Each resident's drug regimen must be free from unnecessary drugs. The facility failed to ensure blood pressure medication was not administered outside of the physician-ordered parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 88) **Corrective action taken for residents found to have been affected by the deficient practice:** The Medication Administration Record for May and June 2024 for Resident 88 was reviewed by NP/MD with no new orders. **Identification of other residents having the potential to be**	06/21/2024

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	blood pressure (top number) was under 140. The 4/2024 Medication Administration Record (MAR) indicated the Verapamil 60 mg was administered on the following dates with a blood pressure outside of the ordered parameters: 4/4 at 9:00 p.m. blood pressure of 139/79 4/6 at 9:00 p.m. blood pressure of 122/73 4/7 at 9:00 a.m. blood pressure of 133/74 4/8 at 9:00 a.m. blood pressure of 136/84 4/8 at 9:00 p.m. blood pressure of 130/80 4/9 at 9:00 p.m. blood pressure of 127/89 4/10 at 9:00 a.m. blood pressure of 126/70 4/10 at 9:00 p.m. blood pressure of 122/80 4/11 at 9:00 a.m. blood pressure of 135/81 4/11 at 9:00 p.m. blood pressure of 133/71 4/12 at 9:00 a.m. blood pressure of 122/82 4/12 at 9:00 p.m. blood pressure of 131/79 4/16 at 9:00 p.m. blood pressure of 132/72 4/17 at 9:00 a.m. blood pressure of 130/72 4/20 at 9:00 p.m. blood pressure of 138/83 4/22 at 9:00 p.m. blood pressure of 137/89 4/25 at 9:00 p.m. blood pressure of 131/71 4/26 at 9:00 p.m. blood pressure of 124/79 4/27 at 9:00 a.m. blood pressure of 122/79 4/29 at 9:00 p.m. blood pressure of 133/81 4/30 at 9:00 p.m. blood pressure of 114/83 The 5/2024 MAR indicated the Verapamil 60 mg was administered on the following dates with a blood pressure outside of the ordered parameters: 5/2 at 9:00 p.m. blood pressure of 127/80 5/3 at 9:00 a.m. blood pressure of 128/79 5/5 at 9:00 p.m. blood pressure of 120/70 5/15 at 9:00 p.m. blood pressure of 129/79 5/17 at 9:00 p.m. blood pressure of 113/71 5/20 at 9:00 p.m. blood pressure of 130/77 5/24 at 9:00 a.m. blood pressure of 130/78 During an interview on 5/31/24 at 10:32 a.m.,		**affected by the same deficient practice:** All residents with medication orders with specified parameters have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nurses regarding the importance of following physician orders as written, with a focus on identifying and adhering to set medication parameters that dictate the administration of a particular medication. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random audits of patients receiving medication with parameters (ie: blood pressure medication) weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 8 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue	

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	Assistant Director of Nursing 1 indicated nursing staff should have followed the physician's orders for the administration of the Verapamil. 3.1-48(a)(3)		for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next three months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** June 21, 2024	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on			

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	each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.			

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	§483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to dialysis day, dialysis chair time, and dialysis pick up time, for 1 of 1 resident reviewed for dialysis. (Resident 268) Finding include: 1. The record for Resident 268 was reviewed on 5/28/24 at 1:15 p.m. Diagnoses included, but were not limited to, fracture of nasal bones, subsequent encounter for fracture with routine healing, end stage renal disease, retention of urine, unspecified, dependence on renal dialysis, benign prostatic hyperplasia with lower urinary tract symptoms. The Admission Minimum Data Set (MDS) assessment, dated 5/22/24, was incomplete and in process. The resident was admitted on 5/22/24. A Physician's Order, dated 5/22/24, indicated the resident was to receive hemodialysis at [name of] Dialysis Center, on Monday, Wednesday, and Friday. The resident's dialysis pick up time was	F 0842	The facility must maintain medical records on each resident that are accurately documented. The facility failed to maintain clinical records that were complete and accurately documented related to dialysis day, dialysis chair time and dialysis pick up time for 1 of 1 residents reviewed for dialysis. (Resident 268) **Corrective action taken for residents found to have been affected by the deficient practice:** The physician's order for Resident 268 reflected the dialysis chair time/day assigned at the time of recent admission. The chair time/day had since been changed and were updated timely in the dialysis communication logs, which is the primary method of communication for this type of appointment. The physician's order was updated at the time of	06/21/2024

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	ordered for 3:00 p.m. The resident's dialysis chair time was ordered for 4:00 p.m. A Progress Note, dated 5/29/24, indicated the resident received dialysis services on Tuesday, Thursday, and Saturday. The progress notes and the resident's dialysis communication book indicated the resident's dialysis pick up time was signed out at 12:00 p.m., and the resident's dialysis chair time was signed out at 1:00 p.m. During an interview on 5/31/24 at 2:31 p.m. with Assistant Director of Nursing (ADON) 1, she indicated the resident's dialysis order has not been updated and she would correct the order. 3.1-50(a)(2)		identification during survey. **Identification of other residents having the potential to be affected by the same deficient practice:** All other residents with orders for dialysis have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate all nurses regarding the need to maintain accurate clinical records, with a focus on ensuring physician orders for appointments (such as dialysis) are complete and accurate. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct audits of patients with orders for dialysis treatment 1x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 6 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved,	

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			the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. The systemic plan will be randomly initiating all audit tools again monthly throughout the next three months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** June 21, 2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing,			

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	identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place related to staff failing to sanitize hands in between glove changes for 1 of 1 glucometer use observed and staff failing to donn personal protective equipment (PPE) for a resident in contact precautions during a random infection control observation. (Residents 53 and 73) Findings include: 1. On 5/29/24 at 4:34 p.m., LPN 1 was preparing to complete a blood sugar check via glucometer for Resident 53. The LPN donned gloves and did not hand sanitize nor wash her hands prior. After obtaining the resident's blood sugar result, the LPN removed her gloves and donned a new pair of gloves, she did not hand sanitize in between glove changes. She proceeded to cleanse the glucometer with a germicidal wipe and she removed her gloves. Again, she did not use hand sanitizer. The LPN prepared the resident's medications and administered them. She sanitized her hands prior to leaving the resident's room.	F 0880	The facility failed to ensure infection control practices were in place related to staff failing to sanitize hands in between glove changes for 1 of 1 observations and staff failing to donn PPE for a resident in contact precautions. (Residents 53 and 73) **Corrective action taken for residents found to have been affected by the deficient practice:** **Identification of other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nursing staff on the Hand Hygiene and Transmission	06/21/2024

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	155662	A. BUILDING 00 B. WING	06/03/2024

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	During an interview on 6/3/24 at 9:47 a.m., Assistant Director of Nursing (ADON) 2, indicated the LPN should have hand sanitized prior to donning her gloves and in between glove changes. The facility "Hand Hygiene" policy was provided by the Administrator on 6/3/24 at 10:03 a.m. The policy indicated to decontaminate hands after glove removal and before medication administration. 2. During a random observation on 5/31/24 at 7:45 a.m., the Wound Nurse was observed standing over Resident 73 finishing a skin treatment. At that time, the Wound Nurse was wearing gloves on both hands. She did not have on an isolation gown. A sign posted on the wall outside of the resident's room indicated enteric/contact isolation: all staff must wash their hands with soap and water and don an isolation gown and gloves prior to entering the room. Another sign posted on the wall indicated enhanced barrier precautions (EBP): if contact was made, a gown and gloves was required prior to touching the resident. A 3 tiered container full of isolation gowns, gloves, and face masks was located right by the resident's room door. During an interview on 5/31/24 at 7:52 a.m., the Wound Nurse indicated she was aware she needed to wear an isolation gown when performing the wound treatment, however, she was "in a hurry this morning." The record for Resident 73 was reviewed on 5/29/24 at 2:30 p.m. Diagnoses included, but were not limited to, sepsis, high blood pressure, atrial fibrillation, benign prostatic hyperplasia (an enlarged prostate), chronic kidney disease, acute cystitis, and Urinary Tract Infection (UTI).		Based Precautions and reinforce expectations related to infection prevention and control measures. Education will review hand hygiene, with a focus on *when* sanitization shall be practiced (ie: after removing gloves and prior to administering medication). Education will reinforce proper PPE use as it relates to transmission based precautions in patient care scenarios. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations of patient care 2x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 12 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be	

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	The 3/23/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling foley catheter. Physician's Orders, dated 2/12/24, indicated foley catheter 16 French for urinary retention. Physician's Orders, dated 5/22/24, indicated to cleanse the head of the penis with soap and water and apply triad wound paste every shift. Nursing Progress Notes, dated 5/24/24 at 2:34 p.m., indicated the resident had 3 foul smelling and mucus filled stool. A new order was obtained to collect a stool specimen. Nursing Progress Notes, dated 5/26/24 at 1:30 p.m., indicated the doctor was notified the resident tested positive for C-Difficile toxin. Physician's Orders, dated 5/26/24, indicated contact/enteric isolation. During an interview on 5/31/25 at 10:50 a.m., Assistant Director of Nursing 1 indicated the Wound Nurse should have donned an isolation gown prior to completing the resident's treatment to his penis area. The current 1/1/23 "Prevention and Management of Multi-Drug Resistant Organisms" policy, provided by the Director of Nursing on 6/3/24 at 1:30 p.m., indicated enhanced barrier precautions applied to residents with urinary catheters and gowns and gloves were required for high contact care activity. Contact Precautions applied to residents with infected Multi Drug Resistant Organisms and presence of acute diarrhea.		randomly initiating all audit tools again monthly throughout the next three months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** June 21, 2024	

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	3.1-18(b)			