STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING -- B. WING	07/01/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/01/24 Facility Number: 010758 Provider Number: 155662 AIM Number: 200229550 At this Emergency Preparedness survey, Rehabilitation Center At Hartsfield Village, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 112 certified beds. At the time of the survey, the census was 104. Quality Review completed on 07/08/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/01/24 Facility Number: 010758 Provider Number: 155662 AIM Number: 200229550 At this Life Safety Code survey, Rehabilitation	K 0000	Rehabilitation Center at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 **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**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Seydel	Administrator	07/31/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Center at Hartsfield Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies. The facility is a two story building with a one story section and a partial basement. The one story section is Type II (000) construction and the two story building is of Type II (111) construction. Because the one story and two sections of the building are not separated by two hour rated construction, the building is considered one building of Type II (000) construction. The building is fully sprinklered with supervised smoke detectors on all levels including in corridors, in resident rooms, and in areas open to the corridor. The building is protected by a 400 kW diesel powered emergency generator The facility has the capacity for 112 and had a census of 104 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/08/24		**deficiencies and is submitted at the request of the Indiana State 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.**	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT			

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	LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			

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	ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 4 of 6 stairwell door delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect approximately all residents, staff and visitors. Findings include: Based on observation during tour of the facility with the Environmental Service Director, Administrator and Maintenance Technician #1 on 07/01/24 between 12:29 p.m. and 2:14 p.m., the facility had approximately three stairwells marked and used as emergency exits. Four of the six stairwell doors were magnetically locked and	K 0222	**K222** The facility failed to ensure the means of egress through 4 of 6 stairwell door delayed egress locks had a durable sign stating “PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS”. **Corrective action taken:** All stairwell doors with delayed egress locks now have signage on the egress side of the door indicating to “PUSH UNTIL ALARM SOUNDS. DOOR WILL OPEN IN 15 SECONDS”. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents, staff and visitors have the potential to be affected.	07/12/2024

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	could be unlocked with the fire alarm system or with the swipe of a keycard. When the door was pushed on, a delayed egress function would initiate and unlock within 15 seconds. The doors did not have signage indicating of the emergency function on the egress side of the door. Upon further investigation, on the opposite side of the door, a sign that was posted that indicated the door needed to be pulled on to open in 15 seconds. Based on interview at the time of observation, the Administrator agreed that no signage had been posted on the egress side of the door and further acknowledged that no one would be able to identify of the function due to no signage. The finding was discussed with the Environmental Services Director and Administrator at exit conference. 3.1-19(b)		**To ensure that this deficient practice will not recur:** Signage was installed on the egress side of all stairwell doors with delayed egress locks. The Maintenance Director / Designee will monitor exit doors during daily building rounds to ensure continued compliance with this plan of correction. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed.	
K 0325 SS=D Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage			

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	cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485			
	Based on observation and interview, the facility failed to ensure 1 of 1 alcohol-based hand sanitizer dispensers in the beauty salon were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect approximately 3 residents and staff. Findings include: Based on observation with the Environmental Services Director, Administrator and Maintenance Technician #1 on 07/01/24 between 12:29 p.m. and 2:44 p.m., an alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical outlet in the beauty salon. Based on	K 0325	**K325** An alcohol based hand sanitizer dispenser was installed on the wall directly above an electrical outlet in the beauty salon. **Corrective action taken:** As stated in the 2567, the dispenser was removed and this was corrected during the survey. **Identification of other residents having the potential to be affected by the same deficient practice:** Residents or staff utilizing that hand sanitizer dispenser have the potential to be affected. **To ensure that this deficient practice will not recur:** The Maintenance Director rounded the facility to ensure all hand sanitizer dispensers were installed	07/01/2024

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	interview at the time of observation, the Director of Environmental Services Director and Maintenance Technician #1 agreed that the dispenser was installed above an outlet. The dispenser was removed by the end of the survey. The finding was reviewed with the Administrator and Environmental Service Director during the exit conference. 3.1-19(b)		correctly, ie: not above an electrical outlet. This was identified to be an isolated issue with nothing further noted. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed.	