PRINTED:	01/26/2022
FORM API	PROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDIC	CAID SERVICES				ORM APPROVED MB NO. 0938-039
	VT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155662	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 01/03/2022	
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COI	D	
REHABIL	LITATION CENTER	R AT HARTSFIELD VILLAGE		TIS R BOWEN DR STER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE PROPRIATE	COMPLETION
TAG F 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE		DATE
1 0000						
Bldg. 00	Control Survey.	a COVID-19 Focused Infection	F 0000			
	Survey date: Janua Facility number: 0	•				
	Provider number: AIM number: 200	155662				
	Census Bed Type: SNF/NF: 18					
	SNF: 64 Total: 82					
	Census Payor Type Medicare: 72 Medicaid: 1 Other: 9 Total: 82	2:				
	This deficiency ref accordance with 4	lects State Findings cited in 10 IAC 16.2-3.1.				
	Quality review cor	npleted on 1/10/22.				
F 0880 SS=E Bldg. 00	infection preventi designed to provi comfortable envir the development	ion & Control				
	§483.80(a) Infect program.	ion prevention and control				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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.

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155662		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		CO	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 01/03/2022		
	PROVIDER OR SUPPLIE	R AT HARTSFIELD VILLAGE		503 OTI	ADDRESS, CITY, STATE, ZIP CO IS R BOWEN DR 'ER, IN 46321	D	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	PI	ID REFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	ULD BE	(X5) COMPLETIC
TAG	REGULATORY C	PR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NOTRAL	DATE
	prevention and c must include, at elements:	establish an infection ontrol program (IPCP) that a minimum, the following system for preventing,					
	identifying, repor controlling infecti diseases for all re visitors, and othe services under a	ing, investigating, and ons and communicable esidents, staff, volunteers, r individuals providing contractual arrangement					
	conducted accor following accepte	acility assessment ding to §483.70(e) and ad national standards;					
	and procedures to include, but are r (i) A system of su identify possible infections before persons in the fa	urveillance designed to communicable diseases or they can spread to other cility;					
	communicable di be reported; (iii) Standard and	whom possible incidents of sease or infections should I transmission-based e followed to prevent spread					
	for a resident; ind (A) The type and depending upon organism involve	w isolation should be used cluding but not limited to: duration of the isolation, the infectious agent or d, and it that the isolation should be					
	the least restriction under the circum (v) The circumstar must prohibit em communicable di	ve possible for the resident stances. ances under which the facility					

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155662	A. BUILDING B. WING		
			503 (	ET ADDRESS, CITY, STATE, ZIP COD DTIS R BOWEN DR STER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETIC
	155662         PROVIDER OR SUPPLIER         ITATION CENTER AT HARTSFIELD VILLAGE         SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION         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.         §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 guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to a CNA wearing a cloth face mask from the start of her shift while taking care of residents who were in Transmission Based Precautions (TBP). This had the potential to affect all residents residing on the first floor.         Finding includes:       During a random observation on 1/3/22 at 10:00 a.m., CNA 1 was observed wearing a cloth face mask over her mouth and nose. She was walking around the first floor. During that time, every room but 1 was in TBP.         Interview with CNA 1 on 1/3/22 at 10:14 a.m., indicated she arrived to work at 6:00 a.m., and		F 0880	F880 The facility must establish a maintain an infection preve and control program design provide a safe, sanitary and comfortable environment a help prevent the development transmission of communica diseases and infections. The facility failed to ensure infe- control guidelines were in pre- related to one staff member was observed wearing a clu- mask on the first floor when patients were in transmission based precautions. Corrective action taken for residents found to have b affected by the deficient	ntion ned to d nd to ent and able ne ction olace r who oth face re on

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CRS FOR MEDICARE & MEDICAID SERVICES         ATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         D PLAN OF CORRECTION       IDENTIFICATION NUMBER         155662		(X2) MULTIPLE CO A. BUILDING B. WING	DINSTRUCTION D 00	OMB NO. 0938-039 [X3] DATE SURVEY COMPLETED 01/03/2022	
		503 OT	TIS R BOWEN DR		
(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
EFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIONthere were no N95 face masks available for her to wear, so she put on her cloth face mask. She was unaware she could not wear the cloth face mask while taking care of the residents. She indicated she had entered the TBP rooms while wearing her cloth face mask.Interview with LPN 1 on 1/3/22 at 10:25 a.m., indicated she arrived at work at 7:00 a.m. and there were plenty of N95 face masks available and face shields to use. She was unaware CNA 1 was wearing a cloth face mask and entering TBP rooms.Interview with the first floor ADON (Assistant Director of Nursing) on 1/3/22 at 10:30 a.m., indicated all staff were to use their N95 face mask 1 time and throw it away at end of their shift. The N95 face masks were readily available at the nurses' station, the front desk or in the education room. All staff working on the first floor were required to wear a N95 face mask and face shield during the entire shift. She was unaware CNA 1 was wearing a cloth face mask and face shield during the entire shift. She was unaware CNA 1 was wearing a cloth face mask and face shield during the entire shift. She was unaware CNA 1 was wearing a cloth face mask.		TAG	DEFICIENCY) practice: The facility provided 1:1 education to the staff member identified. Education was also provided to staff to ensure a thorough understanding of how and where properly DON/DOFF PPE, as we as the location(s) where addition PPE is readily available throughout the facility. Additional instructional signage related to PPE accessibility was placed throughout patient care areas a well as the reception / screening area. Identification of other resident having the potential to be affected by the same deficient practice: All patients on the 1st Floor had the potential to be affected. To ensure that proper practices continue:	DATE DATE DATE DATE DATE DATE	
1/3/22 at 3:40 p.m. care of 14 resident	., indicated CNA 1 was taking s, all were in TBP except for 1		Infection Preventionist re-educa facility staff regarding requirements for PPE based on	ited	
Department of Hea Guidance in Long- indicated "Direct a (Healthcare Profes procedure mask fo N95 respirator mas units and with any	alth COVID-19 Infection Control term Care Facilities" policy and indirect care HCP sional) should wear a medical r the duration of their shifts. sk should be worn in COVID-19 resident who is symptomatic or		utilized for each patient care zor (green, yellow, red) as well as the proper practice to DON/DOFF PPE. Education also focused on the location(s) where additional PPE is readily available throughout the facility. The education provided strongly	ne he	
	LITATION CENTER SUMMARY (EACH DEFICIE) REGULATORY O there were no N95 wear, so she put or unaware she could while taking care of she had entered the cloth face mask. Interview with LPI indicated she arrivy were plenty of N92 shields to use. She wearing a cloth face rooms. Interview with the Director of Nursin indicated all staff vol required to wear a during the entire sh was wearing a clot Follow up intervie 1/3/22 at 3:40 p.m care of 14 resident resident who was i The current and up Department of Hea Guidance in Long- indicated "Direct and (Healthcare Profess procedure mask foo N95 respirator mast units and with any in TBP (red or yell	PROVIDER OR SUPPLIER LITATION CENTER AT HARTSFIELD VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION there were no N95 face masks available for her to wear, so she put on her cloth face mask. 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The N95 face masks were readily available at the nurses' station, the front desk or in the education room. All staff working on the first floor were required to wear a N95 face mask. Follow up interview with the first floor ADON on 1/3/22 at 3:40 p.m., indicated CNA 1 was taking care of 14 residents, all were in TBP except for 1 resident who was in the green zone. The current and updated 11/22/21 "Indiana Department of Health COVID-19 Infection Control Guidance in Long-term Care Facilities" policy indicated "Direct and indirect care HCP (Healthcare Professional) should wear a medical procedure mask for the duration of their shifts. N95 respirator mask should be worn in COVID-19 units and with any resident who is symptomatic or in TBP (red or yellow zone) awaiting testing.	PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP COD 503 OTIS R BOWEN DR MUNSTER, IN 46321         ITATION CENTER AT HARTSFIELD VILLAGE       UD WUNSTER, IN 46321         SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST ER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION       D PROVIDER PLANOF CORRECTION TAG         Wars as she put on her cloth face mask. while taking care of the residents. She indicated she had entered the TBP rooms while wearing her cloth face mask.       D Practice: The facility provided 1: 1 deucat to the staff member identified. Education was also provided to staff to ensure a thorough understanding of how and wher properly DON/DOFF PPE, as as the location(s) where addition process mer readily available and face shields to use. She was unaware CNA 1 was wearing a cloth face mask.         Interview with the first floor ADON (Assistant Director of Nursing) on 1/3/22 at 10:30 a.m., indicated all staff work to use their N95 face masks and face shield during the enter shift. She was unaware CNA 1 was wearing a cloth face mask.         Follow up interview with the first floor ADON on 1/3/22 at 3:40 p.m., indicated CNA 1 was taking care of 14 residents, all were in TBP except for 1 resident who was in the green zone.       Identification of other resident having the potential to be affected by the same deficient practice: The Director of Nursing and face infaction Preventionist re-educa facility staff regarding requirements for PPE based on transmission based precautions toroniscie and indirect care HCP (Healthcare Professional) should wear a medical proced me mask for the duration of their shifts. N95 respirator mask should be worn in COVID-19 units and with any resident who is symptomatic or in TBP (red or yellow zone) awaiting testing.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9YWZ11 Facility ID: 010758

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155662 B. WING 01/03/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 503 OTIS R BOWEN DR REHABILITATION CENTER AT HARTSFIELD VILLAGE MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE conserved and only a single mask should be worn safe patient care. Signage by HCP each shift. N95 mask may only be remains in place facility wide to removed (doffed) five times before it should be identify PPE requirements, discarded. Masks should be changed when location of additional PPE and visibly soiled or wet. When possible, by supply proper practice to DON/DOFF and lower transmission in the facility, mask use PPF. can return to conventional usage and NIOSH-approved N95 respirators." The Director of Nursing/Designee will initiate a monitoring tool to 3.1-18(b) document daily observations of staff to ensure that appropriate PPE is being utilized correctly. Visual rounds will be conducted in patient care areas throughout the facility to ensure compliance with this Plan of Correction. Audits will be conducted for six weeks and will be reviewed by the Administrator and/or Infection Preventionist in order to identify trends to discuss with the facility's QAA Committee After successful completion of the six week monitoring period, the QAA Committee will review all audit tools to 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 six week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systemic plan is to randomly

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9YWZ11

Facility ID: 010758

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OMB NO. 0938-039

PARTMENT	OF HEALTH AND HUN	MAN SERVICES			FORM APPROVED
NTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 01/03/2022	
	ROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	503 OT	ADDRESS, CITY, STATE, ZIP COD TIS R BOWEN DR TER, IN 46321	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
				initiate the audit tool monthly the next six months to ensure deficient practice will not recu	e this
				Quality Assurance Plan to monitor compliance with th Plan of Correction: Identified concerns shall be	
				reviewed by the facility's QAA Committee. Findings from all tools will continue to be revie monthly by the QAA Committ for the next six months.	audit wed tee
				Recommendations for further corrective action will be discu and implemented as needed.	issed

**9YWZ11** Facility ID: **010758** 

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