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	03/20/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00427268, IN00428897, IN00429002, and IN00429419. Complaint IN00427268 - Federal/State deficiencies related to the allegations are cited at F745. Complaint IN00428897 - No deficiencies related to the allegations are cited. Complaint IN00429002 - No deficiencies related to the allegations are cited. Complaint IN00429419 - Federal/State deficiencies related to the allegations are cited at F580. Survey dates: March 19 and 20, 2024 Facility number: 010758 Provider number: 155662 AIM number: 200229550 Census Bed Type: SNF/NF: 19 SNF: 77 Total: 96 Census Payor Type: Medicare: 62 Medicaid: 3 Other: 31 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/28/24.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Seydel	Administrator	04/12/2024

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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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident			

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	representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the resident's family was notified of a change in condition, for 1 of 3 residents reviewed for notification of change. (Resident H) Finding includes: The record for Resident H was reviewed on 3/19/24 at 4:25 p.m. Diagnoses included, but were not limited to, sepsis, chronic respiratory failure, atrial fibrillation, anemia, heart failure, cirrhosis of the liver, alcohol abuse, and chronic kidney disease. A Nurse's Note, dated 2/26/24 at 9:31 a.m., indicated the Nurse Practitioner (NP) was notified due to the resident not being easily aroused, and only able to verbalize some words but was very lethargic. The NP indicated she would be in to assess the patient. A Nurse Practitioner (NP) Progress Note, dated 2/16/24 at 11:03 a.m., indicated the patient was being evaluated for increased lethargy and dyspnea (shortness of breath). Nursing staff indicated the patient refused oral intake this morning, and his breathing appeared labored. Labs were repeated this morning and results were	F 0580	**F580** A facility must inform the resident representative(s) when there is a significant change in the resident's condition…or a decision to transfer the resident from the facility. The facility failed to ensure the patient's family was notified of a transfer to the hospital for one (1) of three (3) residents reviewed for notification of change. (Resident H) **Corrective action taken for residents found to have been affected by the deficient practice:** Resident H is a short term patient at the facility who has returned to the community. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents with a change in condition requiring transfer to a hospital have the potential to be	04/11/2024

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	pending. The patient was noted to awaken to verbal stimuli, however he had increased confusion, and respirations were tachypneic (rapid shallow breathing), but did not appear to be in distress. A Nurse's Note, dated 2/26/24 at 11:59 a.m., indicated the NP was made aware of the resident's hemoglobin of 6.9. A new order was obtained to check his Hemoglobin and Hematocrit stat (immediately). A Nurse's Note, dated 2/26/24 at 2:51 p.m., indicated the resident was being sent to the emergency room for altered mental status and acute kidney injury. A Nurses' Note, dated 2/27/24 at 12:43 a.m., indicated the resident was admitted to the hospital with the diagnoses of altered mental status, acute kidney injury, anemia, pneumonia, and hypotension. The Hospital Transfer Form, dated 2/26/24, indicated the time of transfer was 2:30 p.m., due to altered mental status. There was no documentation the resident's family was notified of the change of condition and the transfer to the hospital on 2/26/24. During an interview, on 3/20/24 at 9:15 a.m., the Assistant Director of Nursing indicated nursing staff were supposed to notify the resident's family at the time of the change in status. During an interview, on 3/20/24 at 12:00 p.m., the Director of Nursing indicated the resident's family was not notified of his change of condition and transfer to the hospital.		affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nurses. Nursing staff is to notify both the MD and family/responsible party as applicable in a timely manner should a patient or resident have a condition change requiring a transfer from the facility, ie: to the Emergency Room. All attempts to notify the responsible party shall be documented in the patient's medical record. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 10 observations 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	

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	This citation relates to Complaint IN00429419. 3.1-5(a)(2)		practice will continue until the facility has achieved 100% compliance. The systematic 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. Findings from all audit tools will continue to be reviewed monthly for the next three months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** April 11, 2024	
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide appropriate social services follow up, related to an outside allegation of exploitation and misappropriation for a resident by family and facility staff, for 1 of 3 residents reviewed for change of condition. (Resident B) Finding Includes: During a phone interview, on 3/20/24 at 11:13 a.m., the Adult Protective Services (APS) representative indicated she had contacted the	F 0745	**F745** The facility must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility failed to provide follow up related to an outside allegation of from Adult Protective Services regarding a concern from the community.	04/11/2024

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	assigned facility Social Worker (SW) regarding Resident B and left voice messages. Detailed voicemails were left for the SW on 1/24/24 at 12:16 p.m. and on 1/25 at 1:52 p.m. The SW called the APS representative back on 1/25/24 at 2:10 p.m. During that call, the APS representative discussed the reports of allegations, which included neglect and financial exploitation of Resident B. A psychiatric evaluation was recommended, APS jurisdiction was explained, and documentation for the current healthcare POA was requested. The facility's fax number was provided by the SW, and on 1/29/24 at 12:33 p.m., APS faxed a blank physician report to be completed and faxed back by the SW. The APS representative indicated they never received any further communication or documentation. The record for Resident B was reviewed on 3/19/24 at 1:18 p.m. Diagnoses included, but were not limited to, hemiplegia, hypertension (high blood pressure), asthma, dysarthria (difficulty speaking), aphasia (difficulty with comprehension), muscle weakness, protein calorie malnutrition and atrial fibrillation (abnormal heart rhythm). The 1/26/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was severely impaired with daily decision making. The resident had impairments in both upper and lower extremities, used a wheelchair and was dependent with oral hygiene, toileting hygiene, shower and bathing, upper and lower body dressing, and all transfers. Eating required substantial/maximum assistance. There was no Social Service documentation regarding exploitation and misappropriation allegations.		**Corrective action taken for residents found to have been affected by the deficient practice:** Resident B is a short term patient who was discharged at the time of survey. The social worker assigned to work with Resident B is no longer employed at the facility. **Identification of other residents having the potential to be affected by the same deficient practice:** Any patient or resident who is the subject of an outside investigation by a state agency (ie: Adult Protective Services) has the potential to be affected. No patients meet this description at this time. **To ensure that proper practices continue:** The Administrator will educate the Social Services department as it relates to their role in requests received from outside agencies, such as Adult Protective Services. Social Service staff is expected to provide timely response to requests from outside agencies, such as Adult Protective Services. If such a request is received, Social Service staff shall inform the facility Administrator and appropriate IDT members of the allegation(s) if needed in order to have appropriate services in place.	

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	There was no documentation of communication with the APS representative. During an interview on 3/19/24 at 3:03 p.m., the Administrator indicated there were no grievances for the last 3 months, and Administration empowers the unit managers to handle concerns as they come up. During an interview, on 3/20/24 at 10:15 a.m., the Social Service Director (SSD) indicated there was no documentation in Resident B's chart about a concern the resident was being financially exploited or neglected. There was also no documentation of communication with APS. The SW formerly assigned to Resident B no longer worked at the facility. During an interview, on 3/20/24 at 11:54 p.m., the Director of Nursing indicated she was unaware of the situation. This citation relates to Complaint IN00427268. 3.1-34(a)		Social Service staff shall document facility response to requests from outside agencies in the medical record. The Administrator will initiate a monitoring tool to review weekly with the Social Service team for four weeks to monitor compliance with this plan of correction. 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 100% compliance. The systematic plan will be to initiate this monitoring tool to track compliance with future complaints as they are received. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** April 11, 2024	

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