CENTERSTOR	MEDICARE & MEDIC					MB NO. 0936-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155662	B. WING		03/13/2023	
		.0002			00/1	
NAME OF P	ROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD		
I	, IDDIT OR BOTT BILL	-	503 O	TIS R BOWEN DR		
REHABIL	ITATION CENTER	AT HARTSFIELD VILLAGE	MUNS	TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DDOVIDED/A DV AV OF GOTTES	ION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE	DATE
F 0000						
. 5555						
Bldg. 00						
Biag. 00	This visit was for a	Recertification and State	F 0000	Rehabilitation Center at H	artefiald	
	Licensure Survey. This visit included the Investigation of Complaints IN00395132,		1 0000		artsiiciu	
				Village		
			1	503 Otis Bowen Drive		
	IN00395647, and I	NUU4U3122.		Munster, Indiana 46321		
	Complaint INI00205	5132 - No deficiencies related to		This plan of correction		
	•			This plan of correction		
	the allegations are c	med.		represents the center's	TL .	
	G 1 : DI0020	C47 E 1 1/G . 1 C		allegation of compliance.		
	•	5647 - Federal/State deficiencies		following combined plan		
	related to the allega	tions are cited at F690.		correction and allegation		
	S 11 . TT00.40			compliance is not an adn	nission	
	-	3122 - No deficiencies related to		to any of the alleged		
	the allegations are o	eited.		deficiencies and is subm		
				the request of the Indiana	a State	
	Survey dates: Marc	ch 6, 7, 8, 9, 10, and 13, 2023		Department of Health.		
				Preparation and execution	n of	
	Facility number: 0	10758		this response and plan o		
	Provider number: 1	155662		correction does not cons	titute	
	AIM number: 2002	229550		an admission or agreeme	ent by	
				the provider of the truth	of the	
	Census Bed Type:			facts alleged or conclusion	ons set	
	SNF/NF: 16			forth in the statement of		
	SNF: 84			deficiencies. The plan of		
	Total: 100			correction is prepared an	ıd/or	
				executed solely because		
	Census Payor Type	:		required by the provision		
	Medicare: 86			federal and state law.		
	Medicaid: 1					
	Other: 13					
	Total: 100					
	10181. 100					
	These deficiencies	reflect State Findings cited in				
	accordance with 41	ē				
	accordance with 41	U IAC 10.2-3.1.				
	Quality parison s	unlated on 2/17/22				
1	Quality review com	ipicica on 3/1//23.	- 1			1

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

Susan Seydel Administrator 04/03/2023

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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VG7Q11 Facility ID: 010758 If continuation sheet Page 1 of 51

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				ETED	
		155662	B. Wl	NG	_	03/13/	2023	
NAME OF P	DOMINED OF STIRRITER			STREET A	ADDRESS, CITY, STATE, ZIP COD	-		
NAME OF P	PROVIDER OR SUPPLIER	•		503 OTIS R BOWEN DR				
REHABIL	ITATION CENTER	AT HARTSFIELD VILLAGE		MUNST	ΓER, IN 46321			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION		
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0554 SS=D	483.10(c)(7)	sin Mada Clinically Ammun						
SS=D Bldg. 00		nin Meds-Clinically Approp						
Blug. 00		right to self-administer interdisciplinary team, as						
		1(b)(2)(ii), has determined						
		s clinically appropriate.						
		on, record review, and	F 05	554	F554		03/31/2023	
		ty failed to ensure residents	1 0.	JT	The resident has the right to		03/31/2023	
		lers and an assessment to			self-administer medications if	the		
		r own medications for 2 of			interdisciplinary team has			
		for self-administration of			determined that this practice is	S		
	medication. (Residents 148 and 5)				clinically appropriate. The faci			
					failed to ensure patients had			
	Findings include:				Physician's Orders and an			
					assessment to self-administer			
		0 p.m., Resident 148 was			medications for two patients			
	observed in his roor	n in bed. An Albuterol Sulfate			reviewed for self-administratio	n of		
		ed on his over bed table.			medication. (Residents 148 ar	nd 5)		
		resident at that time, indicated						
	_	cy inhaler" and he must keep it			Corrective action taken for			
		re was also a jar of Vicks Vapo			residents found to have been	า		
		The resident also indicated he			affected by the deficient			
		nerbal sleep aid) that he was			practice:			
	taking and the facili	ty didn't know he had it.			The over the counter medicati	ons		
	On 2/9/22 -4 0:59	me the medident receive his way.			for Residents 148 and 5 were			
		m., the resident was in his room rol inhaler remained on the			removed from bedside when	oth		
		rell as the Vicks Vapo Rub.			identified during the survey. B			
	· ·	ttle of Fluticasone nasal spray			short-term patients have since discharged home. Nursing sta			
		esident indicated his wife			conducted a sweep of the faci			
	brought it from hon				to ensure there were no other	-		
					medications inappropriately st			
	The record for Resid	dent 148 was reviewed on			at patients' bedsides.			
		Diagnoses included, but were			at patients seasings.			
	not limited to, type				Identification of other reside	nts		
		c kidney disease, and			having the potential to be			
	orthopedic aftercare	-			affected by the same deficien	nt		
	amputation.	2 2			practice:			
	-				All residents have the potentia	al to		
	The Admission Mir	nimum Data Set (MDS)			be affected.			

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLI	ETED
		155662	B. W	B. WING 03/13/2023			2023
				_			
NAME OF F	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
					IS R BOWEN DR		
REHABIL	LITATION CENTER	R AT HARTSFIELD VILLAGE		MUNST	ΓER, IN 46321		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	assessment, dated 2	2/27/23, was still in process.					
					To ensure that proper practic	ces	
	Physician's Orders,	dated 2/20/23, indicated the			continue:		
	resident was to rece	eive an Albuterol Sulfate HFA			The Director of Nursing/Design	nee	
	aerosol inhaler 90 r	micrograms (mcg)/actuation, 2			will re-educate nursing staff		
	puffs every 4 hours	as needed (prn) for wheezing			regarding medications being		
		y relief spray 50 mcg, 2 sprays			stored at bedside, with a focus	s on	
	to each nare daily.	There was no order for the			over the counter medications		
	medications to be le	eft at the bedside for			patient/resident may have bro	ught	
	self-administration.				from home. If the staff membe	-	
					observes medication being sto		
	There was also no Physician's Order for the Vicks				at bedside they are to bring th		
	Vapo Rub or Melatonin.				the attention of a nurse. If the		
	_				patient is determined to be		
	There was no self-a	administration of medication			cognitively impaired or otherw	ise	
	assessment comple	ted.			unsafe to self-administer		
	•				medications, the nurse will the	n I	
	Interview with the	Director of Nursing on 3/10/23			remove the medication and		
		ted the resident's medications			discuss with the Physician and	₁	
	_	en left at the bedside. 2.			patient/family as needed. If the		
	Interview with Resi	ident 5 on 3/6/23 at 11:52 a.m.,			patient is alert and desires to		
		istered his inhalers himself			participate in their medication		
	daily and used the a	albuterol inhaler as needed for			administration, the nurse will		
					-		
		-					
					-		
	On 3/08/23 at 11:10	6 a.m., an inhaler was noted					
					The Director of Nursing/Design	nee	
	, , ,				1		
	Resident 5's record	was reviewed on 3/8/23 at			-		
	_				_		
	_					klv	
	_				1 -	,	
	r announcing anotable	(2), and assume					
	The Admission Mi	nimum Data Set (MDS)			• · · · · · · · · · · · · · · · · · · ·		
					· · · · · · · · · · · · · · · · · · ·		
						,, <u> </u>	
	, as cognitively into	act for daily accision making.			-		
	asthma attacks. He in his room all of th himself. Two inhald table at that time. On 3/08/23 at 11:10 laying in Resident 5's record 10:38 a.m. Diagnos limited to, pneumon pulmonary disease The Admission Min assessment, dated 2	indicated he kept the inhalers he time and administered them ers were noted on the bedside 6 a.m., an inhaler was noted			initiate a self-administration of medication assessment and obtain a Physician's Order for self-administration of medicati for that patient. The Director of Nursing/Desig will initiate and complete a monitoring tool and conduct random observations of patient/resident rooms 3x/wee for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 30 audits will be conducted to monitor complian and/or identify trends to review	on nee kly	

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 3 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					COMPLETED	
		155662	B. W	ING		03/13/2023		
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DROLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	C .			IS R BOWEN DR			
REHABIL	ITATION CENTER	AT HARTSFIELD VILLAGE		MUNST	ΓER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLE	TION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATI	3	
	· ·	2/6/23, indicated the resident			with the facility's QAA Commit			
	_	iratory distress related to a			After the fourth week, the QAA			
	_	. Interventions included, but			Committee will review all audi			
	ordered.	, administer medications as			tools and will determine if the			
	ordered.				facility has achieved 100%			
	A Dhygiaian's Orda	r dated 2/6/22 indicated			compliance with practices at			
	albuterol sulfate aei	r, dated 2/6/23, indicated			which time the monitoring will			
		on, 2 puffs four times a day.			cease. If the QAA Committee),		
	micrograms/actuation	on, 2 puris four times a day.			determines that less than 100			
	A Dhygiaian's Orda	r dated 2/6/22 indicated			compliance has been achieve the monitoring tools will continue.			
	A Physician's Order, dated 2/6/23, indicated				_			
	Trelegy Ellipta 100-62.5-25 micrograms 1 inhalation				for another four week period a will again be reviewed by the			
	once a day.				Committee. This practice will			
	There was no order	for self-administration of			continue until the facility has			
	medications.	for seir-administration of			achieved at 100% compliance			
	medications.				The systemic plan will be	•		
	There was no assess	sment for self-administration			randomly initiating all audit too	ale		
	of medications.	sinent for sen duministration			again monthly throughout the			
					6 months, to ensure this defici			
	Interview with the I	Director of Nursing on 3/10/23			practice will not recur.			
		ted a self-administration of			praesiee wiii net recai:			
	_	nent was not completed and he			Quality Assurance Plan to			
	did not have orders	•			monitor compliance with this	,		
	medications.				Plan of Correction:			
					Identified concerns shall be			
	3.1-11(a)				reviewed by the facility's QAA			
					Committee. Findings from all			
					tools will continue to be review			
					monthly for the next 6 months			
					Recommendations for further			
					corrective action will be discus	sed		
					and implemented as needed.			
					Completion Date: March 31,			
					2023			
F 0636	483.20(b)(1)(2)(i)((iii)						
SS=E		uu) ssessments & Timing						
Bldg. 00	§483.20 Resident							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00			COMPLETED	
		155662	B. W	ING		03/13/	2023	
NAME OF I	PROVIDER OR SUPPLIER	· }	_		ADDRESS, CITY, STATE, ZIP COD			
					IS R BOWEN DR			
REHABII	LITATION CENTER	AT HARTSFIELD VILLAGE		MUNST	ER, IN 46321			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF			(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		conduct initially and						
	1 '	nprehensive, accurate,						
		oducible assessment of						
	each resident's fu	пспопаг сараску.						
	§483.20(b) Comp	rehensive Assessments						
	- , ,	sident Assessment						
	Instrument. A fac	ility must make a						
	comprehensive as	ssessment of a resident's						
	_	goals, life history and						
	I -	g the resident assessment						
	` ′	specified by CMS. The						
		include at least the						
	following:							
	1 ' '	nd demographic information						
	(ii) Customary rou							
	(iii) Cognitive patt							
	(iv) Communication	on.						
	(v) Vision.							
	(vi) Mood and beh							
	(vii) Psychologica							
		ctioning and structural						
	problems. (ix) Continence.							
	` '	osis and health conditions.						
	(xi) Dental and nu							
	(xii) Skin Conditio							
	(xiii) Activity pursu							
	(xiv) Medications.							
		ments and procedures.						
	(xvi) Discharge pl	-						
	` '	ion of summary information						
	` '	itional assessment						
		care areas triggered by the						
	I -	Minimum Data Set (MDS).						
	(xviii) Documenta	tion of participation in						
	' '	assessment process must						
	include direct obs	ervation and communication						
	with the resident,	as well as communication						
		nonlicensed direct care						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023				
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP COD 503 OTIS R BOWEN DR MUNSTER, IN 46321					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	timeframes prescr chapter, a facility comprehensive as accordance with the paragraphs (b)(2) section. The time §413.343(b) of this CAHs. (i) Within 14 calent excluding readmissignificant change or mental conditions section, "readmissignificant change or mental conditions section, "readmissignificant change or mental conditions section, "readmissifacility following a hospitalization or failed to ensure the (MDS) assessment of admission for 6 control of admission for 6 control of the findings include: 1. The record for Resident in the record for Resident	en required. Subject to the fibed in §413.343(b) of this must conduct a seessment of a resident in the timeframes specified in (i) through (iii) of this frames prescribed in schapter do not apply to dar days after admission, asions in which there is note in the resident's physical in. (For purposes of this sion" means a return to the temporary absence for therapeutic leave.) Indee every 12 months. Friew and interview, the facility Admission Minimum Data Set was completed within 14 days of 24 MDS assessments atts 148, 206, 37, 198, 195, & 12) desident 148 was reviewed on Diagnoses included, but were 2 diabetes mellitus, c kidney disease, and	F 0636	F636 The facility must conduct a comprehensive assessment of resident in accordance with the timeframes specifiedwithin calendar days of admission. If facility failed to ensure the Admission MDS assessment completed within 14 days of admission for 6 of 24 MDS assessments reviewed. (Residents 148, 206, 37, 198, 12) Corrective action taken for residents found to have bee affected by the deficient practice: Identification of other reside having the potential to be	ne 14 The was 195,			

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet

Page 6 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î í	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLE		
		155662	B. W	TNG		03/13/2023
NAME OF E	PROVIDER OR SUPPLIER	· ?	-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-
					TIS R BOWEN DR	
REHABIL	LITATION CENTER	AT HARTSFIELD VILLAGE		MUNS	TER, IN 46321	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	DATE
		MDS Coordinator on 3/8/23 at			affected by the same deficie	nt
		I she was aware the MDS			practice:	
		ate. 2. The record for Resident			All residents requiring an	
		on 3/9/23 at 8:21 a.m. The			admission MDS assessment	have
	resident was admitt	ed to the facility on 2/24/23.			the potential to be affected.	
	Diagnoses included	l, but were not limited to			To ensure that proper practi	ces
	_	humerus, Alzheimer's disease,			continue:	
	_	ry failure with hypoxia.			The Director of Nursing and	
					Administrator provided	
	The Admission Mir	nimum Data Set (MDS)			re-education to the Lead MDS	8
	assessment, dated 3	3/3/23, indicated it was still in			Coordinator regarding the	
	progress. The MDS was still not completed on				importance of timely admission	on l
	3/13/23.	•			MDS assessments. An audit t	
					determine the status of every	MDS
	3. The record for R	Resident 37 was reviewed on			assessment for all patients ar	
	3/8/23 at 10:01 a.m	The resident was admitted to			residents in house from Marc	l l
	the facility on 2/8/2	3. Diagnoses included, but			2023 to date was completed by	ру
	were not limited to,	, adult failure to thrive, protein			Polaris Group on April 2, 2023	3.
	calorie malnutrition	n, respiratory failure, COPD,				
	heart failure, and de	ependence on supplemental			The facility Administration is	
	oxygen.				aware of the need for more	
					assistance in our MDS	
		nimum Data Set (MDS)			department in order maintain	
		2/15/23, indicated the resident			timely admission assessment	s for
		intact. The assessment was			all patients and residents.	
		Coordinator as being completed			Currently, the facility employs	two
	on 2/24/23.				full time MDS coordinators.	
					Employment ads for a third fu	
		esident 198 was reviewed on			time MDS position have been	
		. The resident was admitted to			posted on various job sites si	nce
		23. Diagnoses included but			spring 2022. In 2022, the facil	-
	were not limited to,	hip replacement.			also opened and filled a full ti	
					FTE for a medical coder to su	pport
		nimum Data Set (MDS)			the MDS department. Addition	nally,
		2/23/23, indicated it was still in			the facility finalized a contract	with
	1 ~	npleted. The RN Coordinator			Polaris group for full time MD	
	signed the MDS as	being completed on 3/10/23.			support for the term of one ye	ar
					(12 months) on March 14, 202	23.
	5. The record for Ro	esident 195 was reviewed on			This contract was initiated pri-	or to

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING DO DO DO DO DO DO DO D	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HARTSFIELD VILLAGE STREET ADDRESS, CITY, STATE, ZIP COD 503 OTIS R BOWEN DR MUNSTER, IN 46321	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HARTSFIELD VILLAGE 503 OTIS R BOWEN DR MUNSTER, IN 46321	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HARTSFIELD VILLAGE 503 OTIS R BOWEN DR MUNSTER, IN 46321	
REHABILITATION CENTER AT HARTSFIELD VILLAGE MUNSTER, IN 46321	
(VA) ID CHARADY CTATEMENT OF DEFICIENCIE ID	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)	
The vibration of conduction)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE	ΓΙΟΝ
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
3/8/23 at 10:50 a.m. The resident was admitted to the start of survey and was	
the facility on 2/17/23. Diagnoses included, but discussed with the survey team,	
were not limited to, anemia, heart failure, type 2 among other interventions the	
diabetes, fracture of the right femur, and history of facility Administration had in place	
falls. prior to March 2023, to support the	
MDS team. As of March 28, 2023,	
The Admission Minimum Data Set (MDS) the full time MDS contract support	
assessment, dated 2/24/23, indicated it was still in is in place at the facility.	
process. The MDS should have been completed	
by 3/10/23. The Administrator, Director of	
Nursing and MDS coordinator now	
Interview with the MDS Coordinator on 3/8/23 at meet weekly with the contracted	
3:18 p.m., indicated she was aware the Admission MDS support to review the status	
MDS assessments were late. of all MDS assessments to ensure	
admission assessments are	
Interview with the Administrator on 3/8/23 at 3:30 completed timely. Any identified	
p.m., indicated she was aware the MDS issues or trends will be presented	
assessments were late and not completed. There monthly at the facility's QAA	
was an ad for another MDS Coordinator on Committee. The systemic plan will	
several job sites, however they had no applicants be continuing to meet weekly with	
as of yet. 6. Resident 12's record was reviewed on identified IDT members and the	
3/8/23 at 3:06 p.m. contracted MDS support group in	
order to review a status of all MDS	
The Admission Minimum Data Set (MDS) assessments.	
assessment, dated 2/16/23, was still in process.	
Quality Assurance Plan to	
Interview with the MDS Coordinator on 3/8/23 at monitor compliance with this	
3:18 p.m., indicated she was aware the Admission Plan of Correction:	
MDS assessments were late. Identified concerns shall be	
reviewed by the facility's QAA	
3.1-31(d)(1) Committee monthly or more	
frequently as needed.	
Recommendations for further	
corrective action will be discussed	
and implemented as needed.	
and implemented de needed.	
Completion Date: April 2, 2023	
Completion Butt. 7 pm 2, 2020	
F 0638 483.20(c)	
SS=D Qrtly Assessment at Least Every 3 Months	

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 8 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>			ETED	
		155662	B. W	B. WING			03/13/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	L.			IS R BOWEN DR			
REHABIL	ITATION CENTER	AT HARTSFIELD VILLAGE		1	ΓER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
Bldg. 00	- ',	erly Review Assessment						
	-	ess a resident using the						
		strument specified by the						
		ed by CMS not less						
		ce every 3 months.						
		view and interview, the facility	F 0	638	F638		03/28/2023	
		Quarterly Minimum Data Set			The facility must assess a			
		timely for 1 of 24 residents			resident using the quarterly re			
		ments were reviewed.			instrument not less frequently			
	(Resident 17)				once every three months. The	;		
					facility failed to complete a			
	Finding includes:				Quarterly MDS assessment tir	•		
					for 1 of 24 residents whose M	DS		
	The record for Resident 17 was reviewed on 3/8/23				assessments were reviewed.			
		noses included, but were not			(Resident 17)			
		abetes mellitus and dementia						
	without behavior dis	sturbance.			Corrective action taken for			
		D			residents found to have been	n		
		mum Data Set (MDS)			affected by the deficient			
		/2/23, was in process. The			practice:			
	•	nt was not signed as			The Quarterly MDS assessme			
	completed by the M	IDS Coordinator until 3/9/23.			for Resident 17 was signed as	3		
	Th	- I- MDC			complete on 3/9/2023.			
	dated 11/2/22.	erly MDS assessment, was			Identification of attended	4		
	ualeu 11/2/22.				Identification of other reside	IIIS		
	Intervious with the N	MDS Coordinator on 3/8/23 at			having the potential to be	nt		
		I she was aware the Quarterly			affected by the same deficient practice:	III.		
	assessments were la				All residents requiring a quarte	orly		
	assessments were la				MDS assessment have the	>11y		
	3.1-31(d)(3)				potential to be affected.			
	(-)(-)				potoniai to be anestea.			
					To ensure that proper practic	ces		
					continue:			
					The Director of Nursing and			
					Administrator provided			
					re-education to the Lead MDS	;		
					Coordinator regarding the			
					importance of timely quarterly			
					MDS assessments. The			
	1		1		İ		Ī	

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 9 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2023			
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD S R BOWEN DR		
REHABIL	ITATION CENTER	AT HARTSFIELD VILLAGE			ER, IN 46321		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	·				consultant MDS group and Let MDS Coordinator audited all lot term care residents to ensure every resident is up to date with the required quarterly MDS assessment. At this time, all lot term care residents are up to with required quarterly assessments. The facility Administration is aware of the need for more assistance in our MDS department in order maintain timely assessments for all patients and residents. Currenthe facility employs two full time MDS coordinators. Employme ads for a third full time MDS position have been posted on various job sites since spring 2022. In 2022, the facility also opened and filled a full time For a medical coder to support MDS department. Additionally facility finalized a contract with Polaris group for full time MDS support for the term of one year (12 months) on March 14, 202 This contract was initiated prior the start of survey and was discussed with the survey tear among other interventions the	ad ong that th ing date the the the the the the the the the t	
					facility Administration had in please of the full time MDS contract support to march 28, 20 the full time MDS contract support in place at the facility.	t the 023,	
					is in place at the facility.		

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet

Page 10 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155662	A. BUILDING B. WING	00 00	COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	503 OT	ADDRESS, CITY, STATE, ZIP COD TIS R BOWEN DR FER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE	
				Nursing and MDS coordinator meet weekly with the contractor MDS support to review the state of all MDS assessments to en assessments are completed timely. Any identified issues of trends will be presented montract the facility's QAA Committe. The systemic plan will be continuing to meet weekly with identified IDT members and the contracted MDS support group order to review a status of all I assessments. 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 discuss and implemented as needed. Completion Date: March 28, 2023	ed ttus sure - nlly e. n e o in MDS
F 0641 SS=A Bldg. 00		ssments acy of Assessments. nust accurately reflect the			
	failed to ensure the comprehensive asse completed related to	Minimum Data Set (MDS) ssment was accurately anticoagulant medication for ments reviewed. (Resident 37)	F 0641	A tag – F641 3.1-31(i) The assessment must accurate reflect the resident's status. The facility failed to ensure the MD comprehensive assessment was a session of the facility failed to ensure the MD comprehensive assessment was a session of the facility failed to ensure the MD comprehensive assessment was a session of the facility failed to ensure the facility fai	ne S

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet

Page 11 of 51

	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 03/13/2023			2023	
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP COD 503 OTIS R BOWEN DR MUNSTER, IN 46321				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID I				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
	Finding includes:				accurately completed related t	to	
	at 10:01 a.m The facility on 2/8/23. It not limited to, adult calorie malnutrition heart failure, and do oxygen. The Admission Mir assessment, dated 2 was not cognitively	dent 37 was reviewed on 3/8/23 resident was admitted to the Diagnoses included, but were failure to thrive, protein, respiratory failure, COPD, ependence on supplemental minum Data Set (MDS) /15/23, indicated the resident intact and in the last 7 days coagulant medication 3 times.			anticoagulant medication for 1 24 MDS assessments reviewed (Resident 37) Corrective action taken for residents found to have been affected by the deficient practice: The assessment was submitted and transmitted for Resident 3 February 2023. This MDS assessment was corrected on March 29, 2023.	n n ed 37 in	
	Physician's Orders, clopidogrel (Plavix, milligrams (mg) dai	dated 2/10/23, indicated an antiplatelet medication) 75			Identification of other reside having the potential to be affected by the same deficien practice: All residents taking Plavix hav	nt	
	3:18 p.m., indicated incorrectly. 3.1-31(i)	the clopidogrel was coded			To ensure that proper practic continue: The Director of Nursing re-educated the Lead MDS Coordinator related to proper coding of Plavix. The facility Administration is aware of the need for more assistance in our MDS department in order maintain accurate assessments for all patients and residents. Currenthe facility staffs two full time M coordinators. Employment ads a third full time MDS position been posted on various job sit since spring 2022. In 2022, the	ntly, MDS s for nave es	

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 12 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155662	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	ROVIDER OR SUPPLIE	R AT HARTSFIELD VILLAGE	503 O	ADDRESS, CITY, STATE, ZIP COL FIS R BOWEN DR TER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION DATE
				facility also opened and fitme FTE for a medical consupport the MDS departry. Additionally, the facility fit contract with Polaris grout time MDS support for the one year (12 months) on 14, 2023. This contract his pending during the time of and was discussed with the survey team among othe interventions in place. As 28, 2023, the full time MI contract support is in place facility. As part of this consupport, Polaris group has ability to continually audit facility's MDS assessment each month) for accuracy coding. The Administrator, Direct Nursing and Lead MDS coordinator will review mind MDS consultant group refersure assessments are completed accurately. An identified issues or trends presented monthly at the QAA Committee. The sysplan will be to continue the monthly review for accurately our contracted so which is in place for a ter least one year (twelve monthly March 2024. Quality Assurance Plan	oder to ment. inalized a up for full e term of March had been of survey the er s of March DS ce at the intracted has the t the ints (5-7% by in tor of honthly the eport to his acy upport rm of at onths),

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 13 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BU		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	503 O	ADDRESS, CITY, STATE, ZIP COD TIS R BOWEN DR STER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 0642 SS=A Bldg. 00	§483.20(h) Coordi A registered nurse coordinate each a appropriate partici professionals. §483.20(i) Certifice §483.20(i)(1) A regard certify that the completed. §483.20(i)(2) Each a portion of the ascertify the accurace assessment. §483.20(j) Penalty §483.20(j)(1)Under an individual who (i) Certifies a mater a resident assessment; (ii) Causes another	e must conduct or ssessment with the pation of health ation. gistered nurse must sign assessment is individual who completes sessment must sign and by of that portion of the for Falsification. If Medicare and Medicaid, willfully and knowingly-brial and false statement in ment is subject to a civil not more than \$1,000 for		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 discutand implemented as needed. Completion Date: March 28, 2023	A ussed

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 14 of 51

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	LETED	
		155662	B. W	B. WING 03/13/2023			/2023	
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD				
REHABILITATION CENTER AT HARTSFIELD VILLAGE				TER, IN 46321				
KEHADIL	TIATION CENTER	AT HARTSFIELD VILLAGE		MONS	1EK, IN 40321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	assessment is sul	bject to a civil money						
	penalty or not mo	re than \$5,000 for each						
	assessment.							
	, . ,	ical disagreement does not						
		rial and false statement.						
		view and interview, the facility	F 00	542	A tag – F642		04/02/2023	
		RN Coordinator had signed			3.1-31(h)			
		Set (MDS) assessments for			A registered nurse must sign a	and		
		24 MDS assessments			certify that the assessment is			
	reviewed. (Residen	ts 15 and 12)			complete. The facility failed to			
				ensure the RN coordinator				
	Findings include:				signed the MDS assessments	for		
					completion for 2 of 24 MDS			
		rd for Resident 15 was			assessments reviewed (Resid	ents		
		3 at 10:12 a.m. The resident was			15 and 12)			
		lity on 9/19/22 and discharged						
	home with a return	not anticipated on 9/30/22.			Corrective action taken for			
					residents found to have been	า		
	_	arn not Anticipated Minimum			affected by the deficient			
		sessment, dated 9/30/22,			practice:	_		
	indicated it was stil	I in process.			The assessments in question			
	T	A 1			Residents 15 and 12 were sig			
		Administrator on 3/13/23 at			by the MDS coordinator during the			
	_	ed she was aware the MDS			time the surveyors were on sit	e.		
		completed or submitted				4		
	1	ng another MDS Coordinator.			Identification of other reside	nts		
		ord was reviewed on 3/8/23 at			having the potential to be	-4		
	3:06 p.m.				affected by the same deficien	π		
	The Discharge De	turn Anticipated MDS			practice:	l to		
	_	1/18/23, was still in progress.			All residents have the potential be affected.	11 10		
		ator had not signed the			be allected.			
	assessment.	nor had not signed the			To ensure that proper practic	206		
	ussessment.				continue:	- 		
	Interview with the	Administrator on 3/13/23 at			The Director of Nursing			
		ed she was aware the MDS			re-educated the Lead MDS			
	_	completed or submitted			Coordinator related to the requ	iired		
		ng another MDS Coordinator.			RN signature for certification of			
	anner, ade to needi	and another tribe coordinator.			completion of the MDS.	· ·		
	1		1		L SOUTH OF THE INDO.		1	

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155662	A. BUILDING B. WING	00	COMPLETED 03/13/2023
	PROVIDER 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 REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-31(h)			The facility Administration is aware of the need for more assistance in our MDS department in order maintain timely certification of assessments for all patients a residents. Currently, the facilit staffs two full time MDS coordinators. Employment ads a third full time MDS position been posted on various job sit since spring 2022. In 2022, the facility also opened and filled at time FTE for a medical coder support the MDS department. Additionally, the facility finalize contract with Polaris group for time MDS support for the term one year (12 months) on March 14, 2023. This contract had be pending during the time of sur and was discussed with the survey team among other interventions in place. As of M 28, 2023, the full time MDS contract support is in place at facility. An audit to determine status of every MDS assessm for all patients and residents in house from March 1, 2023 to was completed by Polaris Groon April 2, 2023. The Administrator, Director of Nursing and Lead MDS coordinator now meet weekly the MDS consultant group to review the status of all MDS assessments to ensure	s for nave es e a full to ed a full a of ch een vey arch the ent ent a date up

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

Event ID:

VG7Q11

Facility ID: 010758

If continuation sheet

Page 16 of 51

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
	155662 B. WING			03/13/	/2023		
				_			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DELLABII	ITATION OFNITED	AT 114 DTOE!ELD \			IS R BOWEN DR		
KEHABIL	ITATION CENTER	AT HARTSFIELD VILLAGE		MUNSI	ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					assessments are completed a	nd	
					certified timely. Any identified		
					issues or trends will be preser	nted	
					monthly at the facility's QAA		
					Committee. The systemic plar	ı will	
					be continuing to meet weekly	with	
					identified IDT members and th	ie	
					contracted MDS support group	o in	
					order to review a status of all I	MDS	
					assessments.		
					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 discus	sed	
					and implemented as needed.		
					Completion Date: April 2, 202	:3	
E 0077	400.04//0)						
F 0677	483.24(a)(2)	16 5 1 15 11 1					
SS=D		ed for Dependent Residents					
Bldg. 00	- ' ' ' '	esident who is unable to					
		of daily living receives the					
	-	es to maintain good					
		g, and personal and oral					
	hygiene;	on, record review, and	EA	(77	F677		02/21/2022
		ty failed to ensure dependent	F 06	3//	The facility must ensure a resi	dent	03/31/2023
		ided assistance with activities			who is unable to carry out	ueni	
	•	Ls) related to shaving for 1 of 6			activities of daily living receive	s the	
		for ADLs. (Resident 247)			necessary services to maintain		
	1331donies 10 viewed	(Resident 217)			good grooming and personal	•	
	Finding includes:				hygiene. The facility failed to		
	1 manig morados.				ensure grooming assistance w	uas	
	On 3/6/23 at 2:39 n	.m., Resident 247 was observed			provided for one patient who v		
		chair in her room. There was			observed with a facial hair on		

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

Event ID:

VG7Q11

Facility ID: 010758

If continuation sheet

Page 17 of 51

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	03/13/2023	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER 503 OTIS R BOWEN DR		
REHABILITATION CENTER AT HARTSFIELD VILLAGE MUNSTER, IN 46321		
REHABILITATION CENTER AT HARTSFIELD VILLAGE WONSTER, IN 40321		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
facial hair noted along her chin. chin. (Resident 247)		
On 3/8/23 at 11:08 a.m., Resident 247 was Corrective action taken for		
observed sitting in her wheelchair in her room. residents found to have bee	n	
There was facial hair noted along her chin. affected by the deficient		
practice:		
Resident 247's record was reviewed on 3/8/23 at The facial hair was removed f		
2:52 p.m. The resident was admitted on 3/2/23. this patient's chin. (Resident 2	247)	
Diagnoses included, but were not limited to,		
fracture of nasal bones, syncope and collapse, Identification of other reside	ents	
and hypothyroidism. having the potential to be		
affected by the same deficie	nt	
The Admission Minimum Data Set (MDS) practice:		
assessment indicated it was still in progress. All patients who are dependent		
staff for assistance with groor	-	
A Nurses' Note, dated 3/3/23 at 1:07 p.m., have the potential to be affect	ted.	
indicated the resident was able to make needs		
known and required extensive assistance with To ensure that proper practi	ces	
ADL care. continue:		
The Director of Nursing/Desig	nee	
The Shower Day Skin Audit, dated 3/7/23, will re-educate the CNA staff		
indicated the resident received a bed bath. regarding providing assistance received a bed bath.		
with facial grooming and othe		
There was no documentation of facial shaving personal hygiene as needed to	for	
offered to the resident. patients.		
Interview with the Administrator and the Director		
Interview with the Administrator and the Director of Nursing on 3/10/23 at 9:52 a.m., indicated they will initiate and complete a	Jilee	
	will initiate and complete a	
	nto	
random observations of paties 3.1-38(a)(3)(D) 3x/weekly for four weeks to express to express the second of the control of the		
3.1-38(a)(3)(D) 3x/weekly for four weeks to ell compliance with this plan of	iioui¢	
correction. Each week, a		
minimum of 30 audits will be		
conducted to monitor complia	ince	
and/or identify trends to revie		
with the facility's QAA Commi		
After the fourth week, the QA		
Committee will review all audi		
tools and will determine if the		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155662	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	ROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	503 O	ADDRESS, CITY, STATE, ZIP COD TIS R BOWEN DR STER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	(X5) COMPLETION DATE
				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 conting for another four week period a will again be reviewed by the Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit to again monthly throughout the 6 months, to ensure this deficing 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 tools will continue to be review monthly for the next 6 months. Recommendations for further corrective action will be discuand implemented as needed. Completion Date: March 31, 2023	% ed, nue and QAA e. ols next ient s audit wed i.
F 0684 SS=D Bldg. 00	applies to all treat facility residents.	a fundamental principle that ment and care provided to			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 03/13/2023 155662 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 F 0684 F684 03/31/2023 interview, the facility failed to ensure areas of The facility must ensure that bruising were assessed and monitored for 1 of 5 residents receive treatment and residents reviewed for skin conditions care in accordance with (non-pressure related). (Resident 148) professional standards of practice. The facility failed to monitor and Finding includes: assess bruises for 1 of 5 residents reviewed for skin conditions. On 3/6/23 at 3:10 p.m., Resident 148 was observed (Resident 148) in his room in bed. The resident had a reddish/purple discoloration to both of his hands. Corrective action taken for residents found to have been On 3/8/23 at 9:58 a.m., the resident was observed affected by the deficient in his room in bed. The resident had a pink foam practice: dressing to his left forearm as well as a large area Resident 148 was admitted with of reddish/purple discoloration to the forearm. the bruising identified and has The discoloration to the resident's hands also since discharged home from the remained. facility. The record for Resident 148 was reviewed on Identification of other residents 3/9/23 at 2:01 p.m. Diagnoses included, but were having the potential to be not limited to, type 2 diabetes mellitus, affected by the same deficient hypertensive chronic kidney disease, and practice: orthopedic aftercare following surgical All residents with bruises have the amputation. potential to be affected. The Admission Minimum Data Set (MDS) To ensure that proper practices assessment, dated 2/27/23, was still in process. continue: The Director of Nursing/Designee A Care Plan, dated 2/20/23, indicated the resident will re-educate all nursing staff was at risk for complications associated with regarding identification of bruises Xarelto (an anticoagulant) therapy. Interventions upon admission, with a focus on included, but were not limited to, observe skin obtaining physician orders for with each encounter for bruising and skin tears. bruise monitoring at the time of

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

Event ID:

VG7Q11

Facility ID: 010758

If continuation sheet

identification. The facility's policy

Page 20 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155662	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIEF	AT HARTSFIELD VILLAGE	503 OT	ADDRESS, CITY, STATE, ZIP COD FIS R BOWEN DR TER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION DATE
	resident was to recedaily and the bruisin arms was to be more. The Treatment Adn the dates of Februar indicated the bruisin each shift 2/20-3/6/	ninistration Record (TAR) for ry 20 through March 10, 2023, ng had not been monitored		is to conduct a full weekly assessment for all patients residents in house, and thi practice will continue. The Director of Nursing/De will initiate and complete a monitoring tool and conduct random audits 3x/weekly for weeks to ensure compliant this plan of correction. Each a minimum of 30 audits will	esignee ct or four ce with ch week,
	-	sing to the bilateral arms was		a minimum of 30 audits will conducted to monitor compand/or identify trends to rewith the facility's QAA Com After the fourth week, the Committee will review all a tools and will determine if the facility has achieved 100% compliance with practices which time the monitoring cease. If the QAA Committee determines that less than compliance has been achieved the monitoring tools will confor another four week period will again be reviewed by the Committee. This practice where continue until the facility has achieved at 100% compliance at 100% compliance with again monthly throughout the facility has achieved at 100% compliance with again monthly throughout the facility has achieved at 100% compliance will not recur. Quality Assurance Plan to monitor compliance with Plan of Correction: Identified concerns shall be	poliance view nmittee. QAA audit the at will tee 100% eved, ntinue od and he QAA vill as nce. t tools the next eficient

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet

Page 21 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		A. BUILDING 00 COMPLETED B. WING 03/13/2023				
	ROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	503 OT	ADDRESS, CITY, STATE, ZIP COD TIS R BOWEN DR FER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				reviewed by the facility's QAA Committee. Findings from all a tools will continue to be review monthly for the next 6 months. Recommendations for further corrective action will be discus and implemented as needed. Completion Date: March 31, 2023	ved	
F 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin In §483.25(b)(1) Pres Based on the com a resident, the faci (i) A resident recei professional stand pressure ulcers an pressure ulcers un condition demonst unavoidable; and (ii) A resident with necessary treatme with professional spromote healing, pnew ulcers from de Based on observatio interview, the facilit measures were in pl resident's foot to prefor 1 of 3 residents in (Resident 195) Finding includes: Interview with Residence in the resident in the resident in the resident includes:	prehensive assessment of lity must ensure that- ves care, consistent with ards of practice, to prevent d does not develop less the individual's clinical rates that they were pressure ulcers receives and services, consistent trandards of practice, to prevent infection and prevent	F 0686	F686 A resident with pressure ulcerreceives necessary treatment prevent new ulcers from developing. The facility failed tensure preventative measures were in place related to offload a patient's foot to prevent furth pressure ulcers for 1 of 3 patiereviewed for pressure ulcers. (Resident 195)	to o sing ner	

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet

Page 22 of 51

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155662	B. W	ING		03/13/2023	
		<u> </u>	1	OTREET	ADDRESS CITY STATE TO SOF	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DELIABILITATION OFNITED AT LIABTORIE DAY LAGE				IS R BOWEN DR			
KEHABIL	LITATION CENTER	AT HARTSFIELD VILLAGE		MUNSI	ΓER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	caregiver indicated	her foot was never offloaded			Corrective action taken for		
	and was always lay	ing directly on the bed. The			residents found to have been	n	
	resident was curren	tly observed sitting in a			affected by the deficient		
	wheelchair and her	right leg/foot was propped up			practice:		
	on the leg rest with	a pillow underneath.			Resident 195's right heel was		
					offloaded upon identification of	f this	
	On 3/7/23 at 9:40 a	.m. the resident was observed			issue. Staff have ensured that		
	lying in bed and her	r right foot was laying directly			Resident 195's heel continues	s to	
	on the mattress. It v	vas not offloaded.			be offloaded when in bed; this	;	
					pressure ulcer was present up	on	
	On 3/9/23 at 8:02 a	.m., until 10:05 a.m., the resident			admission and has been stead	dily	
	was observed lying	in bed and her right foot was			improving since the time of		
	laying directly on the	he mattress. It was not			admission.		
	offloaded. At 10:35	a.m., both Wound Nurses					
	were observed duri	ng the pressure ulcer			Identification of other reside	nts	
		dent's right heel was observed	having the potential to be				
	_	Deep Tissue Injury (DTI). There			affected by the same deficien	nt	
	was no drainage no	ted.			practice:		
					All residents having preventat	ive	
		dent 195 was reviewed on			treatments in place for pressu	re	
		. The resident was admitted to			ulcers have the potential to be)	
		23. Diagnoses included, but			affected.		
		anemia, heart failure, type 2					
		f the right femur, and history of			To ensure that proper practic	ces	
	falls.				continue:		
					The Director of Nursing/Desig		
		nimum Data Set (MDS)			will re-educate all nursing staf		
		2/24/23, indicated it was still in			regarding adhering to physician		
	process.				orders related to preventative		
		0/10/00			measures in place for patients	3	
		2/18/23, indicated the resident			with pressure ulcers, such as		
	was admitted with a	a DTI to the right heel.			off-loading heels when in bed.		
	Dhyaiaiant- Ond	datad 2/10/22 indi			The Discrete of Normalis of D		
		dated 2/19/23, indicated			The Director of Nursing/Desig	nee	
		apply a thin layer to the right			will initiate and complete a		
	· ·	with normal saline and pat dry			monitoring tool and conduct	.4.	
	daily and prn.				random observations of patier	าเร	
	T1- 337 1 T C	-4: A			with orders for preventative		
		ation Assessments indicated			treatments related to pressure		
	on 2/18/23, the righ	t heel DTI measured 4.5	1		ulcers 3x/weekly for four week	s to	I

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155662	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	503 O	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 . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	color. The most receindicated the DTI reand was hard to tou and measured 4.5 colors and measured 4.5 colors are indicated offloaded at all time should not be direct. The current 1/1/22 provided by the Ada.m., indicated internot limited to, suspense.	ent measurement on 3/7/23, comained dark purple in color ch. The ulcer remained closed on by 4.5 cm. Wound Nurses on 3/89/23 at d the right heel should be so while in bed. The foot ly laying on the bed. Skin Prevention Plan" policy, ministrator on 3/10/23 at 10:04 eventions included, but were end heels with pillows under bading devices and recheck		ensure compliance with this pof correction. Each week a minimum of 9 observations we conducted to ensure compliant and/or identify trends to review with the facility's QAA Command After the fourth week, the QA Committee will review all aud 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 until the facility has achieved at 100% compliance. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit to again monthly throughout the 6 months, to ensure this deficience will not recur.	ill be nce w ittee. A it 0% ed, nue and QAA e. ols next
				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 tools will continue to be review monthly for the next 6 months Recommendations for further corrective action will be discurant implemented as needed.	audit wed s. ssed

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 24 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155662	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIEF	AT HARTSFIELD VILLAGE	503 OT	ADDRESS, CITY, STATE, ZIP COD FIS R BOWEN DR TER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE
				Completion Date: March 3 2023	31,
F 0690 SS=D Bldg. 00	§483.25(e) (1) The resident who is composed on admissional assistance to main or her clinical contract continence is §483.25(e)(2)For incontinence, base comprehensive as ensure that— (i) A resident who an indwelling cath unless the resident demonstrates that necessary; (ii) A resident who indwelling cathete one is assessed for as soon as possible clinical condition of catheterization is (iii) A resident who receives appropriate to prevent urinary restore continence. §483.25(e)(3) For incontinence, base comprehensive as ensure that a residual condition catheterization is (iii) A resident who receives appropriate to prevent urinary restore continence.	e facility must ensure that ontinent of bladder and on receives services and nain continence unless his dition is or becomes such not possible to maintain. a resident with urinary ed on the resident's essessment, the facility must enters the facility without leter is not catheterized in the catheterization was on enters the facility with an error subsequently receives for removal of the catheter ole unless the resident's demonstrates that			

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 25 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COM		COMPLETE	ED
		155662	B. W	B. WING 03/13/2023			23
		<u> </u>		CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD TIS R BOWEN DR		
DEUVDII	ITATION CENTED	AT HARTSFIELD VILLAGE			TER, IN 46321		
NETABIL	- ITATION CENTER	AT HANTSFIELD VILLAGE	_	INIOINS			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	function as possib						
		view and interview, the facility	F 00	590	F690		3/31/2023
		resident's urine output after an			The facility must ensure that a		
		theter was removed to prevent			resident receives services and	t l	
		of 3 residents reviewed for			assistance to prevent		
	bowel and bladder	incontinence. (Resident B)			catheterization and restore		
					continence to the extent possi	ble.	
	Finding includes:				The facility failed to monitor a		
					resident's urine output after ar	า	
		or Resident B was reviewed on			indwelling Foley catheter was		
	_	The resident was admitted to			removed to prevent reoccurre		
	· ·	9/22. Diagnoses included, but			for 1 of 3 residents reviewed f		
		urinary tract infection, chronic			bowel and bladder incontinend	ce.	
		hydronephrosis (the swelling			(Resident B)		
	of one or both kidn	eys).					
					Corrective action taken for		
		nimum Data Set (MDS)			residents found to have been	n	
		1/4/22, indicated the resident			affected by the deficient		
		paired for decision making. The			practice:		
		ensive assist with a 2 person			Resident B was a short term		
		bed mobility and toilet use. She			patient admitted to this facility		
	had an indwelling f	oley catheter.			with an indwelling Foley cathe		
	37 137 . 1 .	1.10/10/20 7.24			present. Resident B has since		
		d 10/19/22 at 7:34 a.m.,			discharged home and is no lo	nger	
		nt arrived to the facility			a patient at this facility.		
	_	he resident was admitted to the			Identification 6 th		
		following hospitalization for a			Identification of other reside	nts	
		ng in a right femur fracture. The			having the potential to be		
	-	catheter, 18 French with a 10 cc) bulb in place that was due			affected by the same deficient	nt	
	to be removed on 1	-			practice:	olov	
	to be removed on 1	U/ ∠ 1/ ∠∠.			All residents with indwelling Fo	-	
	Nurses! Notes data	d 10/21/22 at 6:26 a.m.,			catheters have the potential to affected.	n ne	
		m., the foley catheter was			anecteu.		
	removed.	in., the foley catheter was			To oncure that proper process		
	Tellioved.				To ensure that proper practic continue:	Les	
	Nurses! Notes data	d 10/21/22 at 12:50 p.m.,				200	
		catheter was removed this			The Director of Nursing/Desig		
					will re-educate the nursing sta		
	_	sident had been voiding			regarding patient monitoring a		
	without difficulty.	The resident denied pain or	1		documentation requirements p	JUSL I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		155662	B. WING 03/13/2023			/2023	
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			IS R BOWEN DR		
BEHVBII	ITATION CENTED	AT HARTSFIELD VILLAGE			TER, IN 46321		
NEHADIL	TIATION CENTER	AAT HANTOITELD VILLAGE		IVIUIVOI	LIX, IIV 4002 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	discomfort to the al	odomen.			Foley catheter removal. Educa	ation	
					will focus on the type and dura	ation	
		d 10/21/22 at 7:52 p.m.,			of monitoring and associated		
		ent had complaints of			documentation expected in the	е	
		t not to the abdomen. The			patient's medical record follow	/ing	
	resident continued t	to void without difficulty.			removal of a Foley catheter.		
		mentation in Nursing Progress			The Director of Nursing/Desig	nee	
	· ·	/24, 10/25, 10/26, and 10/27/22			will initiate and complete a		
		g incontinent or continent of			monitoring tool and conduct a	n	
		ng without difficulty after the			audit of all patients who have	had	
	indwelling foley ca	theter was removed.			indwelling Foley catheter remo	oved	
					1x/weekly for four weeks to er	nsure	
		g indicated nothing was			compliance with this plan of		
		19, 10/20, 10/21, 10/23, 10/24,			correction. Each week, audits will		
	10/25, 10/27, and 1	0/28/22.			be conducted to monitor		
					compliance and/or identify tre	nds	
		9 a.m., a large amount of urine			to review with the facility's QA	A	
	-	d and on 10/26/22 at 8:22 a.m.,			Committee. After the fourth we	eek,	
	a large amount of u	rine output was recorded.			the QAA Committee will review		
					audit tools and will determine	if the	
		d 10/28/22 at 8:25 p.m.,		facility has achieved 100%			
		wound assessment, the Wound			compliance with practices at		
		ident had foul smelling urine.			which time the monitoring will		
		oner (NP) was notified and			cease. If the QAA Committee		
	orders were obtaine	ed for an urinalysis and culture.			determines that less than 100		
					compliance has been achieve		
		d 10/28/22 at 10:02 p.m.,			the monitoring tools will contin		
		ent urinated in the bed pan,			for another four week period a		
		ntaminated with bowel			will again be reviewed by the	QAA	
		ident was straight cathed for			Committee. This practice will		
	•	Urine started coming out and			continue until the facility has		
		fore it was stopped by the			achieved at 100% compliance		
		an was notified and orders were			The systemic plan will be		
		an indwelling foley catheter for			randomly initiating all audit too		
	urinary retention.				again monthly throughout the		
					6 months, to ensure this defici	ent	
		g indicated the following:			practice will not recur.		
	- 10/29/22 large am						
	- 10/30/22 large am	nount of urine.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			ETED
155662		B. WI	NG		03/13/	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			IS R BOWEN DR		
REHARII	ITATION CENTER	AT HARTSFIELD VILLAGE			ER, IN 46321		
I VELIADIL	- TATION CENTER	ANT HARTOI ILLD VILLAGE	_	MONST	LIX, IIV 7002 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- 10/31/22 850 cc o				Quality Assurance Plan to		
	- 11/1/22 large amo				monitor compliance with this	S	
		f urine at 2:02 p.m. and a large			Plan of Correction:		
	amount at 8:17 p.m				Identified concerns shall be		
	- 11/3/22 700 cc of				reviewed by the facility's QAA		
	- 11/5/22 a large ar	nount of urine.			Committee. Findings from all		
					tools will continue to be review		
		mentation of any urine output			monthly for the next 6 months	-	
	on 11/4, 11/6 or 11/	r//22.			Recommendations for further	_	
	n	1 . 111/0/00			corrective action will be discus	ssed	
		dated 11/2/22, indicated			and implemented as needed.		
		biotic) 500 milligrams (mg) 1 tab					
	every 6 hours for a	Urinary Tract Infection.			Completion Date: March 31,		
	37 137 . 1 .	1.1.1/7/22 2.00			2023		
		d 11/7/22 at 2:09 p.m.,					
		nt had increased confusion					
		plaints of pain. This afternoon					
		med by the CNA the resident					
	_	for the shift. After the writer					
		t the urine, the therapist					
		he resident was not herself,					
	-	npted to sit the resident to the					
		turned pale. The resident was					
		athing, and had complaints of resident was sent out 911 to					
	^	resident was sent out 911 to					
	the hospital.						
	The resident return	ed to the facility on 11/15/22.					
	An NP (Nurse Proc	titioner) Progress Note, dated					
	,	.m. indicated the patient was					
	•	on 11/7/22 with a chief					
	^	ess of breath and tachycardia.					
	_	en was applied at 4 liters via					
	nasal cannula. A Ca						
		owed severely distended					
	bladder with bilater						
	oracide with onater	ar nyaronepinosis.					
	Interview with the l	Director of Nursing on 3/10/23					
		ted urine output for foley					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	î í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155662	B. WI	ILDING NG	00	COMPL 03/13/	
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE		503 OT	ADDRESS, CITY, STATE, ZIP COD IS R BOWEN DR ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	was documentation without difficulty or was removed and th 10/28/22 as the urin facility has no polic	the resident was voiding in 10/21/22 after the catheter are resident did urinate on the was foul smelling. The y for intake and output eneral and for indwelling foley					
	This Federal tag rela	ates to Complaint IN00395647.					
	3.1-41(a)(2)						
F 0692 SS=D Bldg. 00	§483.25(g) Assiste (Includes naso-ga tubes, both percut gastrostomy and p jejunostomy, and	n Status Maintenance ed nutrition and hydration. stric and gastrostomy aneous endoscopic percutaneous endoscopic enteral fluids). Based on a hensive assessment, the e that a resident-					
	usual body weight range and electrol	ritional status, such as or desirable body weight yte balance, unless the condition demonstrates sible or resident					
	, ,	ffered sufficient fluid intake hydration and health;					
	when there is a nu health care provid Based on record rev failed to ensure the	ffered a therapeutic diet atritional problem and the er orders a therapeutic diet. Friew and interview, the facility meal consumption logs were dent with a history of weight	F 06	592	F692 The facility must ensure that residents receive assistance	with	03/31/2023

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

Event ID: VG7Q11 Facility ID: 010758

If continuation sheet Page 29 of 51

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED	
		155662	B. W	NG		03/13/	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
REHARII	ITATION CENTER	AT HARTSFIELD VILLAGE			TER, IN 46321		
INCLIADID	- TATION CENTER	TANTOTILLD VILLAGE	_	MONSI	LIN, IN TOOL I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ents reviewed for nutrition.			nutrition and hydration. The fa	cility	
	(Resident 37)				failed to ensure the meal		
	F				consumption logs were		
	Finding includes:				consistently completed for a		
	TI ICD	1 4 27 1 2 /9/22			patient with a history of weigh		
		dent 37 was reviewed on 3/8/23			loss for 1 of 1 residents review	vea	
		resident was admitted to the Diagnoses included, but were			for nutrition. (Resident 37)		
	_	t failure to thrive, protein			Corrective action taken for		
		, respiratory failure, COPD,			residents found to have been	_	
		ependence on supplemental			affected by the deficient	11	
	oxygen.	ependence on supprementar			practice:		
	oxygen.				Resident 37 admitted to the		
	The Admission Mir	nimum Data Set (MDS)			facility for a short term stay wi	th a	
		/15/23, indicated the resident			diagnosis of failure to thrive.		
	was not cognitively				admission weight was 108	101	
		t up assistance with eating.			pounds. She discharged home	A	
	_	o oral problems, weighed 108			from the facility five weeks late		
		ceiving a therapeutic diet.			weighing 107 pounds.		
	•						
	A Care Plan, dated	2/16/23, indicated the resident			Identification of other reside	nts	
	may need supervisi	on to eat and drink at times.			having the potential to be		
	The approaches we	re to monitor and record intake			affected by the same deficie	nt	
	of food/fluids.				practice:		
					All residents have the potentia	al to	
		2/9/23, indicated the resident			be affected.		
	received a regular v	vith no added salt diet. The					
		monitor intake, weight, and			To ensure that proper practi	ces	
	labs.				continue:		
					The Director of Nursing/Desig	nee	
		d Dietitian) assessment, dated			will re-educate the CNA staff		
		e resident weighed 108 pounds			regarding completion of meal		
		ssion. The resident had a Body			consumption tracking in the		
		and a score of a 5 (meaning			patient medical record after ea	ach	
	· ·	ne Nestle Nutrition MNA (mini			meal. Education will focus on		
		ent). Recommend addition of			consistent completion of meal		
	mighty shakes twice	e a day with lunch and dinner.			consumption tracking after ea		
	Dhysiciant- O-1	data d 2/0/22 in dia-4-1:-1.4			meal for all patients and resid		
		dated 2/9/23, indicated mighty			particularly those at risk for we	eignt	
shakes for lunch and dinner and weekly weight		1		loss.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	503 O	ADDRESS, CITY, STATE, ZIP COD ΓIS R BOWEN DR TER, IN 46321	
	SUMMARY: (EACH DEFICIEN REGULATORY OR times 4 weeks. The weekly weights 100 pounds on 2/22 107 pounds on 3/7/2 The meal consumpt was not recorded or 3/4, 3/6, and 3/7/23 2/11-2/13, 2/20, 2/2 and 3/7/23 and dinn 2/9-2/13, 2/18, 2/20 and 3/7/23. Interview with the I	AT HARTSFIELD VILLAGE STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION S were 108 pounds on 2/14/23, /23, 101 pounds on 3/1/23 and 23. ion log indicated breakfast in 2/11-2/13, 2/21, 2/23-2/27, 3/1, . Lunch was not recorded on 1, 2/23-2/28, 3/1, 3/4. 3/5, 3/6, her was not recorded on 1-2/22, 2/24-2/28, 3/2, 3/3, 3/5, Director of Nursing on 3/10/23 ated food consumption should	503 O	ΓIS R BOWEN DR	gnee audits g for veeks is k, a ance ew nittee. AA dit e 0% ed, inue and e QAA
				Quality Assurance Plan to monitor compliance with th Plan of Correction: Identified concerns shall be reviewed by the facility's QA. Committee. Findings from all	A

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 31 of 51

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		A. BUILDING	00	COMPLETED 03/13/2023		
		B. WING	· · · · · · · · · · · · · · · · · · ·			
	Г	AT HARTSFIELD VILLAGE STATEMENT OF DEFICIENCIE	503 OT	ADDRESS, CITY, STATE, ZIP COD FIS R BOWEN DR TER, IN 46321	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
				tools will continue to be review monthly for the next 6 months Recommendations for further corrective action will be discus and implemented as needed. Completion Date: March 31, 2023		
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must e needs respiratory tracheostomy care is provided such o professional stand comprehensive pe the residents' goa 483.65 of this sub	e and tracheal suctioning, eare, consistent with lards of practice, the erson-centered care plan, ls and preferences, and part.				
	interview, the facilit tubing was changed facility policy for 2 oxygen therapy. (Refindings include: 1. On 3/6/23 at 2:25 at 9:45 a.m., Reside wheelchair in her rooxygen tubing and dated 2/20/23. The oxygen at night tim On 3/9/23 at 8:03 a	on, record review, and ty failed to ensure oxygen as per Physician's Orders and of 3 residents reviewed for esidents 37 and 206) 5 p.m., 3/7 at 10:11 a.m., and 3/8 ont 37 was observed sitting in a form. At those times, the humidification bottle was resident indicated she wore e. m., the resident was observed as closed. At that time she was	F 0695	The facility must ensure that residents who need respirator care are provided such care in accordance with professional standards of practice. The fact failed to ensure oxygen tubing changed as per Physician Ordand facility policy for 2 of 3 residents reviewed for oxygen therapy. (Residents 37 and 20 Corrective action taken for residents found to have been affected by the deficient practice: The oxygen tubing for both	ility I was ders	

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

wearing oxygen at 2 liters per minute via nasal

Event ID:

VG7Q11

Facility ID: 010758

Residents 37 and 206 was

If continuation sheet

Page 32 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/13/2023 155662 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE cannula. replaced and dated immediately upon identification. Both are short The record for Resident 37 was reviewed on 3/8/23 term patients who have since at 10:01 a.m. . The resident was admitted to the discharged home from the facility. facility on 2/8/23. Diagnoses included, but were not limited to, adult failure to thrive, protein Identification of other residents calorie malnutrition, respiratory failure, COPD, having the potential to be heart failure, and dependence on supplemental affected by the same deficient oxygen. practice: All residents who require the use The Admission Minimum Data Set (MDS) of oxygen have the potential to be assessment, dated 2/15/23, indicated the resident affected. was not cognitively intact and received oxygen while a resident. To ensure that proper practices continue: A Care Plan, dated 2/9/23, indicated the resident The Director of Nursing/Designee was at risk for respiratory distress related to the will re-educate the Respiratory diagnosis of COPD. The approach was to change Therapist regarding the facility's oxygen tubing weekly. policy for changing/dating oxygen tubing at least once weekly and/or Physician's Orders, dated 2/8/23, indicated change when soiled. oxygen tubing and humidifier bottle every week. The Director of Nursing/Designee Physician's Orders, dated 2/23/23, indicated will initiate and complete a oxygen 2 liters per nasal cannula continuously at monitoring tool and conduct bed time and prn. random observations of patients who utilize oxygen 3x/weekly for The Treatment Administration Record (TAR) for four weeks to ensure compliance with this plan of correction. Each 2/2023 indicated the oxygen tubing was signed out as being completed on 2/19, 2/26, and 3/5/23. week, a minimum of 15 audits will Oxygen therapy was signed out as being be conducted to monitor administered at 9:00 p.m., 2/23-3/6/23. compliance and/or identify trends to review with the facility's QAA Interview with the Respiratory Therapist on 3/9/23 Committee. After the fourth week. at 10:45 a.m., indicated the oxygen tubing was to the QAA Committee will review all be changed every week. She changed the audit tools and will determine if the resident's oxygen tubing today as it was dated facility has achieved 100% 2/20/23. compliance with practices at which time the monitoring will Interview with the Director of Nursing on 3/10/23 cease. If the QAA Committee

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

Event ID:

VG7Q11

Facility ID: 010758

If continuation sheet

Page 33 of 51

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662 NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HARTSFIELD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL A. BUILDING 00 STREET ADDRESS, CITY, STATE, ZIP COD 503 OTIS R BOWEN DR MUNSTER, IN 46321 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HARTSFIELD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MIJST RE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HARTSFIELD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MILET BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HARTSFIELD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MILET BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)	
REHABILITATION CENTER AT HARTSFIELD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (BACH DEFICIENCY MILIST RE PRECEDED BY FILL I PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION) (EACH DEFICIENCY MILIST RE PRECEDED BY FILL I PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MIJST BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)	
PREFIX (FACH DEFICIENCY MIST BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION	
	ON
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
at 1:30 p.m., indicated the oxygen tubing was to be determines that less than 100%	
changed weekly. compliance has been achieved,	
the monitoring tools will continue	
2. On 3/6/23 at 3:30 p.m., 3/7 at 9:45 a.m., 3/8 at for another four week period and	
10:19 a.m. and 2:15 p.m., and on 3/9/23 at 7:48 a.m., will again be reviewed by the QAA	
the oxygen tubing and humidification bottle was Committee. This practice will	
dated 2/27/23 for Resident 206.	
achieved at 100% compliance.	
The record for Resident 206 was reviewed on The systemic plan will be	
3/9/23 at 8:21 a.m. The resident was admitted to randomly initiating all audit tools	
the facility on 2/24/23. again monthly throughout the next	
6 months, to ensure this deficient	
Diagnoses included, but were not limited to practice will not recur.	
fracture of the right humerus, Alzheimer's disease,	
and acute respiratory failure with hypoxia. Quality Assurance Plan to	
monitor compliance with this	
The Admission Minimum Data Set (MDS) Plan of Correction:	
assessment, dated 3/3/23 was still in progress. Identified concerns shall be	
reviewed by the facility's QAA There was no Care Plan for oxygen therapy. Committee. Findings from all audit	
There was no Care Plan for oxygen therapy. Committee. Findings from all audit tools will continue to be reviewed	
Physician's Orders, dated 2/24/23, indicated monthly for the next 6 months.	
change oxygen tubing and humidifier bottle every Recommendations for further	
week.	
and implemented as needed.	
Physician's Orders, dated 2/24/23, indicated Completion Date: March 31,	
oxygen at 4 liters nasal cannula continuously 2023	
every shift. The order was discontinued on 3/6/23	
and a new order dated 3/6/23 for oxygen at 2 liters	
prn was obtained.	
The Treatment Administration Record (TAR) for	
3/2023, indicated the oxygen tubing was signed	
out as being changed on 3/5/23.	
Interview with the Respiratory Therapist on 3/9/23	
at 10:45 a.m., indicated the oxygen tubing was to	
be changed every week.	
The current 1/1/22 "Oxygen Therapy" policy,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	503 OT	ADDRESS, CITY, STATE, ZIP COD TIS R BOWEN DR TER, IN 46321	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG	provided by the Ada	ministrator on 3/10/23 at 9:54 ula and tubing should be more frequently if grossly ontaminated.	TAG	DA KILIKUT	DATE
F 0757 SS=D Bldg. 00	Drugs §483.45(d) Unnec Each resident's dr	Free from Unnecessary ressary Drugs-General. regimen must be free drugs. An unnecessary rhen used-			
	§483.45(d)(1) In e duplicate drug the	xcessive dose (including rapy); or			
	§483.45(d)(2) For	excessive duration; or			
	§483.45(d)(3) With or	hout adequate monitoring;			
	§483.45(d)(4) With for its use; or	hout adequate indications			
	consequences wh	ne presence of adverse ich indicate the dose d or discontinued; or			
	reasons stated in (5) of this section. Based on record rev failed to manage me to medications not a physician and the si medication not mon	view and interview, the facility edications appropriately related administered as ordered by the	F 0757	F757 Each resident's drug regimen must be free from unnecessary drugs. The facility failed to manage medications appropria related to medications not administered as ordered by the	tely

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 35 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLET			
		155662	B. WI	ING		03/13/2023	
NAME OF T	DROWNED OF CURPLIES			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	C.		503 OT	TS R BOWEN DR		
REHABIL	ITATION CENTER	AT HARTSFIELD VILLAGE		MUNST	TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE	
					physician and the side effects		
	Findings include:				opioid medication not monitor		
		11 P 11 101 0/6/00			for 2 of 5 residents reviewed f	or	
	_	ew with Resident 191 on 3/6/23			unnecessary medication.		
		icated he goes to dialysis on			(Residents 191 and 206)		
		ys, and Saturdays. He			0		
	indicated his chair t	ime was /:00 a.m.			Corrective action taken for		
	TEI 10 FO	1 4 101			residents found to have bee	n	
		dent 191 was reviewed on			affected by the deficient		
	•	The resident was admitted on			practice:		
	_	included, but were not limited			Resident 191 was noted to mi	ss a	
		type 2 diabetes, diabetic			9am dose of medication on		
		ge renal disease, hypertensive			dialysis days. The Director of		
	1	ase, anemia, and dependence			Nursing clarified with Dialysis and		
	on renal dialysis.				the attending Physician that		
					medication is to be held on		
		nimum Data Set (MDS)			dialysis days. The order was		
	assessment was still	I in process.			updated on 3/10/2023. Reside		
	P1 1 1 0 1	1 . 10/20/20 : 1: 1			206 was a short term patient v		
	1 -	dated 2/28/23, indicated			has since discharged home fr	om	
		igrams (mg) daily at 9 a.m. and			the facility.		
		tablet twice a day 9:00 a.m. and					
	9:00 p.m.				Identification of other reside	nts	
	The 2/2022 Mar.11	tion Administration Decemb			having the potential to be		
		tion Administration Record			affected by the same deficie	πτ	
		e resident missed the 9:00 a.m.			practice:	-1 4a	
		ations on 3/2, 3/4, and 3/7/23			All residents have the potentia	II IO	
	(dialysis days)				be affected.		
	Interview with the I	Director of Nursing on 3/10/23			To ensure that proper practi	ces	
		ted she called dialysis and they			continue:		
	_	edications held on dialysis			The Director of Nursing/Desig	nee	
		order to hold the medications			will re-educate nurses regardi		
	prior to today.	vo note and moundations			the importance of following	a	
	Filer to toung.				physician orders accurately, to	,	
	2. The record for R	esident 206 was reviewed on			include medication orders. Th		
		The resident was admitted to			Assistant Directors of Nursing		
	the facility on 2/24/				each nursing unit review MAR		
					each morning to ensure		
	Diagnoses included	. but were not limited to.			medications from the day before	ore	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	LETED
		155662	B. W	ING		03/13/	/2023
		l .	1	STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			IS R BOWEN DR		
BEHVDII	ITATION CENTED	AT HARTSFIELD VILLAGE			TER, IN 46321		
NETABIL	TIATION CENTER	AT HANTSFIELD VILLAGE		IVIOINS	LIN, IIN 4002 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	humerus, Alzheimer's disease,			were administered as ordered		
	and acute respirator	y failure with hypoxia.			Additionally, a new facility pra		
					was implemented related to th		
		nimum Data Set (MDS)			use of narcotic pain medicatio		
	assessment, dated 3/3/23 was still in progress.				Moving forward, nursing staff		
					work with providers to ensure		
	A Care Plan, dated 2/24/23, indicated the resident had the potential for constipation related to				softeners are routinely schedu		
	-	-			for all patients receiving narco		
		and medication side effects.			pain medication. The Director		
		e resident to have a bowel			Nursing/Designee will provide		
	movement 1 time every 3 days. The approaches were to document all bowel movements in point of				education to nursing staff rela	tea	
		stool softeners per orders.			to this new practice.		
	care and administer	stool softeners per orders.			The Director of Nursing/Desig	noo	
	Δ Care Plan dated	2/24/23, indicated the resident			will initiate and complete a	lice	
		in related to right humerus			monitoring tool and conduct		
		aches were to administer			random audits of patients rece	aivina	
		led and report adverse side			narcotic pain medication week	-	
	effects.	aca ana report adverse side			for four weeks to ensure	ч	
	511551 51				compliance with this plan of		
	Physician's Orders.	dated 2/24/23, indicated			correction. Each week, a		
	-	rcotic pain medication) 5-325			minimum of 10 audits will be		
		ery 6 hours PRN (as needed)			conducted to monitor complian	nce	
		ım (a stool softener) 100 mg			and/or identify trends to review		
	twice a day PRN.	, , ,			with the facility's QAA Commit		
	-				After the fourth week, the QAA		
	Physician's Orders,	dated 2/28/23, indicated			Committee will review all audi		
	Hydrocodone 5-325	5 mg daily at 9 a.m.			tools and will determine if the		
					facility has achieved 100%		
	The Medication Ad	ministration Record (MAR) for			compliance with practices at		
	2/2023 indicated th	e resident received a PRN			which time the monitoring will		
		5 mg tablet on 2/26/23 at 4:20			cease. If the QAA Committee		
		3 at 8:21 p.m. The Docusate			determines that less than 100	%	
		signed out as being			compliance has been achieve		
	administered 2/24-2	2/28/23.			the monitoring tools will contin		
					for another four week period a		
	The 3/2023 MAR, i				will again be reviewed by the	QAA	
		5 mg was signed out as being			Committee. This practice will		
		/23 at 7:22 p.m. and on 3/4/23			continue until the facility has		
	lat 5:32 nm The ro	utine dose of Hydrocodone was	1		achieved at 100% compliance		I .

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLETED		
		155662	B. W	ING		03/13/	2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			IS R BOWEN DR			
REHARII	ITATION CENTER	R AT HARTSFIELD VILLAGE			TER, IN 46321			
INCHADI		TAT HARTOTIELD VILLAGE		WONO				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	,	g administered 3/1-3/7/23 at 9:00			The systemic plan will be			
	a.m. The PRN Docusate was not signed out as				randomly initiating all audit too			
	being administered	1 on 3/1/23.			again monthly throughout the next			
					6 months, to ensure this defici	s, to ensure this deficient		
		ed 3/3/23 at 4:19 p.m., indicated			practice will not recur.			
		emplaints of constipation that						
		observed trying to dig bowel			Quality Assurance Plan to			
		om her rectum. The NP was			monitor compliance with this	s		
		new orders for Lactulose 30			Plan of Correction:			
		(cc) daily as needed as well as			Identified concerns shall be			
	Bisacodyl supposi	tory daily as needed.			reviewed by the facility's QAA			
					Committee. Findings from all a			
		ent log indicated the only			tools will continue to be review			
		movements from the time the			monthly for the next 6 months			
		ted until 3/9/23 were on 3/1 and			Recommendations for further			
		ated the resident had a large bm.			corrective action will be discus	ssed		
	"None" was record	led on 3/6 and 3/9/23.			and implemented as needed.			
	Th	er bowel movements			Commission Boton Manch 24			
					Completion Date: March 31,			
	documented in the	log or Nursing Progress Notes.			2023			
	Interview with the	Director of Nursing on 3/10/23						
		ated she had interviewed some						
		d her the resident had a bowel						
		and 3/8/23 in the evening. She						
		vice Nursing staff to ensure						
		re routinely scheduled for						
		narcotic pain medication.						
		•						
	3.1-48(a)(6)							
F 0758	483.45(c)(3)(e)(1)-(5)						
SS=D	Free from Unnec	Psychotropic Meds/PRN						
Bldg. 00	Use							
	§483.45(e) Psych	notropic Drugs.						
	§483.45(c)(3) A p	osychotropic drug is any						
	drug that affects	brain activities associated						
	with mental proce	esses and behavior. These						
	drugs include, bu	t are not limited to, drugs in						
	the following cate	egories:						

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155662	l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPI 03/13	LETED
	PROVIDER OR SUPPLIE	R AT HARTSFIELD VILLAGE	-	503 OTI	DDRESS, CITY, STATE, ZIP COD S R BOWEN DR ER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(i) Anti-psychotic; (ii) Anti-depressal (iii) Anti-anxiety; a (iv) Hypnotic	nt;					
		rehensive assessment of a ty must ensure that					
	psychotropic drug unless the medica	sidents who have not used used used used are not given these drugs ation is necessary to treat a as diagnosed and e clinical record;					
	reductions, and b	ns receive gradual dose ehavioral interventions, ontraindicated, in an effort					
	psychotropic drug unless that medic a diagnosed spec	sidents do not receive ps pursuant to a PRN order eation is necessary to treat eific condition that is e clinical record; and					
	drugs are limited provided in §483. physician or presonant it is appropriate extended beyond	N orders for psychotropic to 14 days. Except as 45(e)(5), if the attending cribing practitioner believes ate for the PRN order to be 14 days, he or she should					
		tionale in the resident's nd indicate the duration for					
	drugs are limited renewed unless the	N orders for anti-psychotic to 14 days and cannot be ne attending physician or tioner evaluates the resident					

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 39 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED
		155662	B. W	ING		03/13/2023
NAME OF T	DROWNER OF CURPLYEE			STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	(503 OT	TS R BOWEN DR	
REHABIL	ITATION CENTER	AT HARTSFIELD VILLAGE		MUNST	ΓER, IN 46321	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)	DATE
		eness of that medication.	F 0/	750		02/21/2022
		view and interview, the facility	F 0'	/58	F758	03/31/2023
	failed to ensure there was an indication for the use and interventions were attempted prior to administering an as needed (PRN) anti-anxiety				The facility must ensure that	:-
					residents who use psychotrop	OIC
		5 residents reviewed for			drugs receive behavioral	
		ations. (Residents 148 and			interventions in an effort to	
	1	ations. (Residents 148 and			discontinue these drugs. The	
	206)				facility failed to ensure interventions were attempted	prior
	Findings include:				1	-
	rindings include.				to administering PRN anti-ana medication for 2 of 5 residents	-
The record for Resident 148 was reviewed on				reviewed for unnecessary		
	3/9/23 at 2:01 p.m. Diagnoses included, but were				medications. (Residents 148 a	and
	not limited to, type 2 diabetes mellitus,				206)	anu
		ic kidney disease, and			200)	
	orthopedic aftercare	-			Corrective action taken for	
	amputation.	c following surgical			residents found to have bee	n
	amputation.				affected by the deficient	··
	The Admission Mir	nimum Data Set (MDS)			practice:	
		/27/23, was still in process.			Residents 148 and 206 were	hoth
	ussessment, dated 2	727723, was still in process.			admitted to the facility for	botti
	A Physician's Order	r, dated 2/28/23, indicated the			short-term rehabilitation with	
	-	eive Xanax (an anti-anxiety			orders for PRN anti-anxiety	
		illigrams (mg) three times a day			medication and have both sing	ce
	as needed (PRN) fo				discharged home.	
		•] """	
	The March 2023 M	edication Administration			Identification of other reside	nts
	Record (MAR) indi	cated the resident received the			having the potential to be	
		t 10:01 a.m. and 8:36 p.m., 3/3 at			affected by the same deficie	nt
	9:21 p.m., 3/4 at 8:2	22 p.m., and 3/6/23 at 5:03 a.m.			practice:	
		PRN reason was coded as "O"			All other residents with orders	for
	other. There was no	o documentation in the			psychotropic medications hav	e the
	nursing progress no	tes or elsewhere of why the			potential to be affected.	
	medication was giv	en.				
					To ensure that proper practi	ces
	Interview with the I	Director of Nursing on 3/13/23			continue:	
	·	ated documentation should			The Director of Nursing/Desig	nee
	have been complete	ed indicating why the PRN			will re-educate all nurses rega	arding
	Xanax was given. 2	. The record for Resident 206			the need to offer and attempt	
	was reviewed on 3/	9/23 at 8:21 a.m. The resident			appropriate behavioral	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	ETED
		155662	B. W	'ING		03/13/2	2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			TIS R BOWEN DR		
RFHARII	ITATION CENTER	AT HARTSFIELD VILLAGE			TER, IN 46321		
					1	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	was admitted to the	facility on 2/24/23.			interventions prior to administe	~	
	D' ' 1 1 1				PRN anti-anxiety medications		
	_	, but were not limited to			These behavioral intervention	I	
	_	humerus, Alzheimer's disease,			attempts, as well as the succe	ess	
	and acute respirator	y failure with hypoxia.			of the outcome, must be		
	TEL 4 1 ' ' 35'				documented in the patient's		
		nimum Data Set (MDS)			medical record.		
	assessment, dated 3	/3/23 was still in progress.			T. D		
	AC DI 1.1	2/24/22 : 1: 4 1:1 : 1:1			The Director of Nursing/Desig	nee	
		2/24/23, indicated the resident			will initiate and complete a		
		ng changes in her mood. The			monitoring tool and conduct		
resident was prescribed Alprazolam (an				random audits of patient chart			
anti-anxiety medication) and Risperidone (an				with orders for PRN anti-anxie	-		
antipsychotic medication)				medications 1x/weekly for four			
		1 . 10/04/00 : 1: 1			weeks to ensure compliance v		
	-	dated 2/24/23, indicated			this plan of correction. Each w		
	_	illigrams (mg) twice a day PRN.			a minimum of 10 audits will be	I	
	The medication was	s discontinued on 3/7/23.			conducted to monitor complian		
	D1 '' 1 O 1	1 . 12/7/22 : 1: . 1			and/or identify trends to review		
	-	dated 3/7/23, indicated			with the facility's QAA Commit		
	Alprazolam 0.25 m	g twice a day PKN.			After the fourth week, the QAA	I	
	7F1 N. 1' 4' A.1	i i di Di 1 (MAD) C			Committee will review all audit	[
		ministration Record (MAR) for			tools and will determine if the		
		3 indicated, on 2/27/23 at 4:08			facility has achieved 100%		
	p.m., the resident re reason of "other."	eceived the Alprazolam for the			compliance with practices at		
	reason of "otner."				which time the monitoring will		
	The 2/2022 MAD :-	ndigated the regident received			cease. If the QAA Committee	_{0/}	
		ndicated the resident received			determines that less than 100	I	
		3/4/23 at 5:32 for a behavior			compliance has been achieve		
	issue.				the monitoring tools will contin		
	Thoromas as do	montation in Nursing Decompos			for another four week period a		
		mentation in Nursing Progress			will again be reviewed by the	WAA	
		4/23 of any interventions tried			Committee. This practice will		
	_	tration of the PRN anti-anxiety			continue until the facility has		
	medication.				achieved at 100% compliance		
	Intomious with the	Director of Nursing on 2/10/22			The systemic plan will be		
		Director of Nursing on 3/10/23			randomly initiating all audit too		
	_	ted there was no documentation			again monthly throughout the		
	_	rior to the administration of the			6 months, to ensure this defici	ent	
	Alprazolam.				practice will not recur.	J	

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 41 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155662	B. W	NG		03/13/	/2023
	ROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	•	503 OT	ADDRESS, CITY, STATE, ZIP COD IS R BOWEN DR ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0761 SS=D Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accinstructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In a Federal laws, the and biologicals in under proper temporation only author access to the keys §483.45(h)(2) The separately locked, compartments for	and Biologicals and of Drugs and Biologicals cals used in the facility accordance with currently conal principles, and include accessory and cautionary the expiration date when are of Drugs and Biologicals accordance with State and accility must store all drugs allocked compartments accordance controls, and accided personnel to have			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 a tools will continue to be review monthly for the next 6 months Recommendations for further corrective action will be discus and implemented as needed. Completion Date: March 31, 2023	audit ved	

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 42 of 51

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 03/13/2023 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 Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility F 0761 F761 03/31/2023 failed to ensure medications were labeled for 2 of 4 Drugs used in the facility must be medication carts observed. (A-100 & D-200 carts) labeled in accordance with the currently accepted professional Findings include: principles. The facility failed to ensure medications were labeled 1. On 3/10/23 at 12:24 p.m., the A-100 Cart was for 2 of 4 medication carts reviewed with RN 1. There was a stack of observed. Lidocaine 5% patches in a drawer unlabeled. The nurse was unable to find the original label/box. Corrective action taken for She indicated the box did not fit in the drawer so residents found to have been they had torn off a section of the box that affected by the deficient contained the label which indicated whose practice: patches they were. The label section of the box The medications (lidocaine 5% was not found in the cart. patches, fleet suppositories, Tylenol) were removed from the 2. On 3/13/23 at 9:55 a.m., the D-200 Cart was medication carts and disposed of reviewed with Agency LPN 1. A bottle of fleet properly. suppositories and a bottle of Tylenol 650 milligrams were in the cart drawer with no labels Identification of other residents on either of the bottles. Agency LPN 1 indicated having the potential to be each bottle should have a label with the patient affected by the same deficient name and the order on them. practice: All residents have the potential to Interview with the Director of Nursing on 3/13/23 be affected. at 10:19 a.m., indicated she had no further information to provide. To ensure that proper practices continue: 3.1-25(j)The Director of Nursing/Designee will re-educate nurses regarding proper medication storage, to include the requirement that all medications must have a label with patient name and the order. If

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/13/2023	
	ROVIDER OR SUPPLIE	R R AT HARTSFIELD VILLAGE	503 O	ADDRESS, CITY, STATE, ZIP COD FIS R BOWEN DR TER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				a medication is observed in the cart without a label, the nurse inform their charge nurse or A who will either appropriately last or properly dispose of the medication. The Director of Nursing/Design will initiate and complete a monitoring tool and conduct a of all medication carts 1x/wee for four weeks to ensure compliance with this plan of correction. Each week, every medication cart in the facility whose checked to monitor compliant and/or identify trends to review with the facility's QAA Committed 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 until the facility has achieved at 100% compliance. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit too again monthly throughout the 6 months, to ensure this deficing practice will not recur.	eir is to DON abel nee udits kly vill ance v ttee. A t % d, nue and QAA
				Quality Assurance Plan to	

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 44 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (00) COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155662	A. BU B. WI		00	COMPL 03/13/	
		100002	D. W	_		03/13/	ZUZJ
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
REHABIL	LITATION CENTER	AT HARTSFIELD VILLAGE			ER, IN 46321		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(1)(2)(4)(1)(1)(2)(4)(1)(1)(2)(4)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	on & Control Control stablish and maintain an an and control program le a safe, sanitary and comment and to help prevent and transmission of leases and infections. In prevention and control stablish an infection introl program (IPCP) that minimum, the following ystem for preventing, and ins and communicable isidents, staff, volunteers, individuals providing contractual arrangement		TAG	monitor compliance with this Plan of Correction: Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all a tools will continue to be review monthly for the next 6 months. Recommendations for further corrective action will be discuss and implemented as needed. Completion Date: March 31, 2023	audit /ed	DATE

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet Page 45 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 03/13/2023				
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	503 OTI	ADDRESS, CITY, STATE, ZIP COD IS R BOWEN DR ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	and procedures for include, but are not (i) A system of suridentify possible or infections before the persons in the fact (ii) When and to work communicable distinctions to be of infections; (iii) Standard and precautions to be of infections; (iv) When and how for a resident; include (A) The type and ordepending upon the organism involved (B) A requirement the least restrictive under the circums (v) The circumstant must prohibit emporommunicable distinctions from direct their food, if direct disease; and (vi) The hand hygical followed by staff in contact. §483.80(a)(4) A sylincidents identified and the corrective facility.	rveillance designed to ommunicable diseases or hey can spread to other illity; whom possible incidents of sease or infections should transmission-based followed to prevent spread visolation should be used uding but not limited to: duration of the isolation, he infectious agent or l, and that the isolation should be expossible for the resident trances. Incest under which the facility aloyees with a sease or infected skin to contact with residents or exponentially contact will transmit the ene procedures to be involved in direct resident system for recording differential under the facility's IPCP reactions taken by the				
	of infection.	. ,				

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet

Page 46 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155662	B. W	NG		03/13/	2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			IS R BOWEN DR		
DEHARII	ITATION CENTER	AT HARTSFIELD VILLAGE			TER, IN 46321		
KEHADII	LITATION CENTER	AT HARTSFIELD VILLAGE		MONST	IER, IN 4032 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	its IPCP and update necessary. Based on observation interview, the facility control guidelines were related to ensuring a disinfected after results observations for informand 52) Findings include: 1. During a random p.m., Agency LPN Resident 198's blook After obtaining the LPN put the wrist control around her waist an out to her medication prepare and pour more resident. She did not cuff. Interview with Age indicated she had for blood pressure cuffices indicated she had for blood pressure cuffices in the properties of the pr	anduct an annual review of ate their program, as on, record review, and ty failed to ensure infection were in place and implemented multi-use equipment was sident use for random fection control. (Residents 198) observation on 3/6/23 at 2:12 1 was observed checking depressure with a wrist cuff. blood pressure reading, the suff back into a pouch that was deleft the room. She walked on cart and proceeded to edications for another of sanitize the blood pressure. The program of the sanitize the blood pressure are the sanitize the blood pressure of the sanitize the blood pressure. The program of the sanitize the blood pressure are sanitize the second of the sanitize the second of the sanitize the second of the sanitize of the sanitize of clean the second of the sanitize of clean the sanitize of	F 08	380	F880 – Directed Plan of Correction The facility staff, to include the Administrator, Director of Nursing/Infection Preventionis Director of Clinical Services a Manager of Clinical Services consulted with Alicia Snedece the development of this Direct Plan of Correction. Ms. Snede is Board Certified in Infection Control and serves as the Infection Control Coordinator at St. Ma Medical Center. Consultation included areview of the finding from the March 13, 2023 Ann. Survey related to F880 as we the facility's proposed responsand plan for correction. The facility's Infection Prevention a Control Assessment Response (ICAR) Tool was presented. A. Specific/Immediate: Immediately implement specific plan for resident/residents/area/othe identified in the deficiency to correct: All blood pressure cuffs were immediately disinfected facility wide. Education with return demonstration was provided to	est, and or for ted eccor ection ry's ual II as se and se	03/31/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2023		
	ROVIDER OR SUPPLIER		503 C	T ADDRESS, CITY, STATE, ZIP COI DTIS R BOWEN DR	D	
REHABIL	ITATION CENTER	AT HARTSFIELD VILLAGE	MUN	STER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP	ULD BE PROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		.m., Agency LPN 2 was		nursing staff to ensure a	_	
	_	vital signs for a resident in the ed the resident's blood		understanding of the req		
	-	llti-use machine on wheels.		to disinfect multi-use me equipment with EPA app		
		the resident's vital signs		cleaner (Sani-Cloth Plus		
	_	Il of the equipment back in the		patient use. Education for	•	
	_	nted the information in the		both the method by which		
		onto the next resident. She did		properly clean/disinfect		
	not sanitize the mac	chine.		as well as the location(s		
				the appropriate cleaning	supplies	
Interview with Agency LPN 2 on 3/9/23 at 8:30			are readily available thro	ughout the		
a.m., indicated she was aware the machine was to			facility. Education review	ed the		
be sanitized after each resident.			following: types of medic	al		
				equipment to be used in		
	Interview with the Director of Nursing on 3/13/23			facility, EPA wipes/soluti		
		ated multi-use blood pressure		used to properly disinfed		
	cuffs should be clea	ned after resident contact.		multi-use equipment, an		
	TT 1/1/01	WD 11 36 11 1		location of these cleanin	•	
	The current 1/1/21,			products (and back up s		
		provided by the DON on n., indicated all reusable medical		throughout the facility. T		
		e cleaned and disinfected		products will now be stored vitals carts for immediate		
		and between patient use.		vitais carts for infinediate	e use.	
	-	and setween patient use.		B. Systemic:		
	3.1-18(b)			A Root Cause Analysis (RCA)	
				was conducted by memb	,	
				QAA Committee to inclu		
				facility Administrator, Dir		
				Nursing/Infection Prever		
				Director of Clinical Servi	ces and	1
				Manager of Clinical Serv		
				conjunction with Alicia S		
				The RCA is included for		
				Facility staff listed above		
				reviewed the LTC Infecti	on	
				Prevention and Control		
				Assessment Tool to ens		
				an accurate reflection of		
			I	facility. A copy of this as	sessment	1

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155662	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2023
	OF PROVIDER OR SUPPLIEF	AT HARTSFIELD VILLAGE	503 O	TADDRESS, CITY, STATE, ZIP COD TIS R BOWEN DR STER, IN 46321	
(X4) II PREFII TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				is included for review. C. Training: After the completion of the RC	CA CA
				and facility Infection Control Assessment, education was developed and presented to a facility staff in 1:1 education w demonstration and return demonstration. Staff were educated on requirements for cleaning and disinfection of multi-use medical equipment a patient use. Education focuse the EPA appropriate cleaner t use (Sani-Cloth Plus) and invo a demonstration with return demonstration to ensure corre cleaning methods are used. Education also instructed staff where to located the appropria cleaning supplies (and back u	after d on o olved ect f on ate p
				supply) for multi-use equipme throughout the facility as need D. Monitoring: The Director of Nursing/Desig will initiate a monitoring tool to document daily observations of staff to ensure that multi-use medical equipment is properly disinfected between each patifuse. Visual rounds will be conducted in patient care area throughout the facility to ensure compliance with this Plan of Correction. Audits will be conducted for six weeks and weeks	nee of ent as

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

Event ID:

VG7Q11 Facility ID: 010758

If continuation sheet

Page 49 of 51

PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2023				
	ROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP COD 503 OTIS R BOWEN DR MUNSTER, IN 46321					
REHABIL (X4) ID PREFIX TAG	SUMMARY S	AT HARTSFIELD VILLAGE STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION			ator in uss ttee. If the lee I			
			1	Tompicuon Date. Maron 31,	i			

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VG7Q11 Facility ID: 010758

If continuation sheet Page 50 of 51

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED	
		155662	B. WING		03/13/2023		
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 503 OTIS R BOWEN DR MUNSTER, IN 46321				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					2023	·	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VG7Q11 Facility ID: 010758 If continuation sheet Page 51 of 51