STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00395132, IN00395647, and IN00403122. Complaint IN00395132 - No deficiencies related to the allegations are cited. Complaint IN00395647 - Federal/State deficiencies related to the allegations are cited at F690. Complaint IN00403122 - No deficiencies related to the allegations are cited. Survey dates: March 6, 7, 8, 9, 10, and 13, 2023 Facility number: 010758 Provider number: 155662 AIM number: 200229550 Census Bed Type: SNF/NF: 16 SNF: 84 Total: 100 Census Payor Type: Medicare: 86 Medicaid: 1 Other: 13 Total: 100 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/17/23.	F 0000	Rehabilitation Center at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 **This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Seydel	Administrator	04/03/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders and an assessment to self-administer their own medications for 2 of residents reviewed for self-administration of medication. (Residents 148 and 5) Findings include: 1. On 3/6/23 at 3:10 p.m., Resident 148 was observed in his room in bed. An Albuterol Sulfate inhaler was observed on his over bed table. Interview with the resident at that time, indicated it was his "emergency inhaler" and he must keep it at his bedside. There was also a jar of Vicks Vapo Rub on the table. The resident also indicated he had Melatonin (an herbal sleep aid) that he was taking and the facility didn't know he had it. On 3/8/23 at 9:58 a.m., the resident was in his room in bed. The Albuterol inhaler remained on the over bed table, as well as the Vicks Vapo Rub. There was also a bottle of Fluticasone nasal spray on the table. The resident indicated his wife brought it from home. The record for Resident 148 was reviewed on 3/9/23 at 2:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertensive chronic kidney disease, and orthopedic aftercare following surgical amputation. The Admission Minimum Data Set (MDS)	F 0554	**F554** The resident has the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. The facility failed to ensure patients had Physician's Orders and an assessment to self-administer medications for two patients reviewed for self-administration of medication. (Residents 148 and 5) **Corrective action taken for residents found to have been affected by the deficient practice:** The over the counter medications for Residents 148 and 5 were removed from bedside when identified during the survey. Both short-term patients have since discharged home. Nursing staff conducted a sweep of the facility to ensure there were no other medications inappropriately stored at patients' bedsides. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected.	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 2/27/23, was still in process. Physician's Orders, dated 2/20/23, indicated the resident was to receive an Albuterol Sulfate HFA aerosol inhaler 90 micrograms (mcg)/actuation, 2 puffs every 4 hours as needed (prn) for wheezing and Flonase Allergy relief spray 50 mcg, 2 sprays to each nare daily. There was no order for the medications to be left at the bedside for self-administration. There was also no Physician's Order for the Vicks Vapo Rub or Melatonin. There was no self-administration of medication assessment completed. Interview with the Director of Nursing on 3/10/23 at 2:00 p.m., indicated the resident's medications should not have been left at the bedside. 2. Interview with Resident 5 on 3/6/23 at 11:52 a.m., indicated he administered his inhalers himself daily and used the albuterol inhaler as needed for asthma attacks. He indicated he kept the inhalers in his room all of the time and administered them himself. Two inhalers were noted on the bedside table at that time. On 3/08/23 at 11:16 a.m., an inhaler was noted laying in Resident 5's bed. Resident 5's record was reviewed on 3/8/23 at 10:38 a.m. Diagnoses included, but were not limited to, pneumonia, chronic obstructive pulmonary disease (COPD), and asthma. The Admission Minimum Data Set (MDS) assessment, dated 2/10/23, indicated the resident was cognitively intact for daily decision making.		**To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nursing staff regarding medications being stored at bedside, with a focus on over the counter medications the patient/resident may have brought from home. If the staff member observes medication being stored at bedside they are to bring that to the attention of a nurse. If the patient is determined to be cognitively impaired or otherwise unsafe to self-administer medications, the nurse will then remove the medication and discuss with the Physician and patient/family as needed. If the patient is alert and desires to participate in their medication administration, the nurse will initiate a self-administration of medication assessment and obtain a Physician's Order for self-administration of medication for that patient. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations of patient/resident rooms 3x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 30 audits will be conducted to monitor compliance and/or identify trends to review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Care Plan, dated 2/6/23, indicated the resident was at risk for respiratory distress related to a diagnosis of COPD. Interventions included, but were not limited to, administer medications as ordered. A Physician's Order, dated 2/6/23, indicated albuterol sulfate aerosol inhaler 90 micrograms/actuation, 2 puffs four times a day. A Physician's Order, dated 2/6/23, indicated Trelegy Ellipta 100-62.5-25 micrograms 1 inhalation once a day. There was no order for self-administration of medications. There was no assessment for self-administration of medications. Interview with the Director of Nursing on 3/10/23 at 1:49 p.m., indicated a self-administration of medication assessment was not completed and he did not have orders to self-administer medications. 3.1-11(a)		with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31, 2023	
F 0636 SS=E Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on record review and interview, the facility failed to ensure the Admission Minimum Data Set (MDS) assessment was completed within 14 days of admission for 6 of 24 MDS assessments reviewed. (Residents 148, 206, 37, 198, 195, & 12) Findings include: 1. The record for Resident 148 was reviewed on 3/9/23 at 2:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertensive chronic kidney disease, and orthopedic aftercare following surgical amputation. The resident was admitted to the facility on 2/20/23. The Admission Minimum Data Set (MDS) assessment, dated 2/27/23, was still in process. Sections B, E, G, GG, H, I, L, N, O, and P had not been completed.	F 0636	**F636** The facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified…within 14 calendar days of admission. The facility failed to ensure the Admission MDS assessment was completed within 14 days of admission for 6 of 24 MDS assessments reviewed. (Residents 148, 206, 37, 198, 195, 12) **Corrective action taken for residents found to have been affected by the deficient practice:** **Identification of other residents having the potential to be**	04/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with the MDS Coordinator on 3/8/23 at 3:20 p.m., indicated she was aware the MDS assessments were late. 2. The record for Resident 206 was reviewed on 3/9/23 at 8:21 a.m. The resident was admitted to the facility on 2/24/23. Diagnoses included, but were not limited to fracture of the right humerus, Alzheimer's disease, and acute respiratory failure with hypoxia. The Admission Minimum Data Set (MDS) assessment, dated 3/3/23, indicated it was still in progress. The MDS was still not completed on 3/13/23. 3. The record for Resident 37 was reviewed on 3/8/23 at 10:01 a.m. . The resident was admitted to the facility on 2/8/23. Diagnoses included, but were not limited to, adult failure to thrive, protein calorie malnutrition, respiratory failure, COPD, heart failure, and dependence on supplemental oxygen. The Admission Minimum Data Set (MDS) assessment, dated 2/15/23, indicated the resident was not cognitively intact. The assessment was signed by the RN Coordinator as being completed on 2/24/23. 4. The record for Resident 198 was reviewed on 3/8/23 at 12:25 p.m. The resident was admitted to the facility on 2/16/23. Diagnoses included but were not limited to, hip replacement. The Admission Minimum Data Set (MDS) assessment, dated 2/23/23, indicated it was still in process and not completed. The RN Coordinator signed the MDS as being completed on 3/10/23. 5. The record for Resident 195 was reviewed on		**affected by the same deficient practice:** All residents requiring an admission MDS assessment have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing and Administrator provided re-education to the Lead MDS Coordinator regarding the importance of timely admission MDS assessments. An audit to determine the status of every MDS assessment for all patients and residents in house from March 1, 2023 to date was completed by Polaris Group on April 2, 2023. The facility Administration is aware of the need for more assistance in our MDS department in order maintain timely admission assessments for all patients and residents. Currently, the facility employs two full time MDS coordinators. Employment 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 FTE for a medical coder to support the MDS department. Additionally, the facility finalized a contract with Polaris group for full time MDS support for the term of one year (12 months) on March 14, 2023. This contract was initiated prior to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3/8/23 at 10:50 a.m. The resident was admitted to the facility on 2/17/23. Diagnoses included, but were not limited to, anemia, heart failure, type 2 diabetes, fracture of the right femur, and history of falls. The Admission Minimum Data Set (MDS) assessment, dated 2/24/23, indicated it was still in process. The MDS should have been completed by 3/10/23. Interview with the MDS Coordinator on 3/8/23 at 3:18 p.m., indicated she was aware the Admission MDS assessments were late. Interview with the Administrator on 3/8/23 at 3:30 p.m., indicated she was aware the MDS assessments were late and not completed. There was an ad for another MDS Coordinator on several job sites, however they had no applicants as of yet. 6. Resident 12's record was reviewed on 3/8/23 at 3:06 p.m. The Admission Minimum Data Set (MDS) assessment, dated 2/16/23, was still in process. Interview with the MDS Coordinator on 3/8/23 at 3:18 p.m., indicated she was aware the Admission MDS assessments were late. 3.1-31(d)(1)		the start of survey and was discussed with the survey team, among other interventions the facility Administration had in place prior to March 2023, to support the MDS team. As of March 28, 2023, the full time MDS contract support is in place at the facility. The Administrator, Director of Nursing and MDS coordinator now meet weekly with the contracted MDS support to review the status of all MDS assessments to ensure admission assessments are completed timely. Any identified issues or trends will be presented monthly at the facility's QAA Committee. The systemic plan will be continuing to meet weekly with identified IDT members and the contracted MDS support group in order to review a status of all 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 discussed and implemented as needed. **Completion Date:** April 2, 2023	
F 0638 SS=D	483.20(c) Qrtly Assessment at Least Every 3 Months			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	§483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment timely for 1 of 24 residents whose MDS assessments were reviewed. (Resident 17) Finding includes: The record for Resident 17 was reviewed on 3/8/23 at 10:34 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 2/2/23, was in process. The Quarterly assessment was not signed as completed by the MDS Coordinator until 3/9/23. The previous Quarterly MDS assessment, was dated 11/2/22. Interview with the MDS Coordinator on 3/8/23 at 3:18 p.m., indicated she was aware the Quarterly assessments were late. 3.1-31(d)(3)	F 0638	**F638** The facility must assess a resident using the quarterly review instrument not less frequently than once every three months. The facility failed to complete a Quarterly MDS assessment timely for 1 of 24 residents whose MDS assessments were reviewed. (Resident 17) **Corrective action taken for residents found to have been affected by the deficient practice:** The Quarterly MDS assessment for Resident 17 was signed as complete on 3/9/2023. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents requiring a quarterly MDS assessment have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing and Administrator provided re-education to the Lead MDS Coordinator regarding the importance of timely quarterly MDS assessments. The	03/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			consultant MDS group and Lead MDS Coordinator audited all long term care residents to ensure that every resident is up to date with the required quarterly MDS assessment. At this time, all long term care residents are up to date 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. Currently, the facility employs two full time MDS coordinators. Employment 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 FTE for a medical coder to support the MDS department. Additionally, the facility finalized a contract with Polaris group for full time MDS support for the term of one year (12 months) on March 14, 2023. This contract was initiated prior to the start of survey and was discussed with the survey team, among other interventions the facility Administration had in place prior to March 2023, to support the MDS team. As of March 28, 2023, the full time MDS contract support is in place at the facility. The Administrator, Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Nursing and MDS coordinator now meet weekly with the contracted MDS support to review the status of all MDS assessments to ensure assessments are completed timely. Any identified issues or trends will be presented monthly at the facility's QAA Committee. The systemic plan will be continuing to meet weekly with identified IDT members and the contracted MDS support group in order to review a status of all 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 discussed and implemented as needed. **Completion Date:** March 28, 2023	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to anticoagulant medication for 1 of 24 MDS assessments reviewed. (Resident 37)	F 0641	**A tag – F641** **3.1-31(i)** The assessment must accurately reflect the resident's status. The facility failed to ensure the MDS comprehensive assessment was	03/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding includes: The record for Resident 37 was reviewed on 3/8/23 at 10:01 a.m. . The resident was admitted to the facility on 2/8/23. Diagnoses included, but were not limited to, adult failure to thrive, protein calorie malnutrition, respiratory failure, COPD, heart failure, and dependence on supplemental oxygen. The Admission Minimum Data Set (MDS) assessment, dated 2/15/23, indicated the resident was not cognitively intact and in the last 7 days she received an anticoagulant medication 3 times. Physician's Orders, dated 2/10/23, indicated clopidogrel (Plavix, an antiplatelet medication) 75 milligrams (mg) daily Interview with the MDS Coordinator on 3/8/23 at 3:18 p.m., indicated the clopidogrel was coded incorrectly. 3.1-31(i)		accurately completed related to anticoagulant medication for 1 of 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 37 in February 2023. This MDS assessment was corrected on March 29, 2023. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents taking Plavix have the potential to be affected. **To ensure that proper practices 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. Currently, the facility staffs two full time MDS coordinators. Employment ads for a third full time MDS position have been posted on various job sites since spring 2022. In 2022, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			facility also opened and filled a full time FTE for a medical coder to support the MDS department. Additionally, the facility finalized a contract with Polaris group for full time MDS support for the term of one year (12 months) on March 14, 2023. This contract had been pending during the time of survey and was discussed with the survey team among other interventions in place. As of March 28, 2023, the full time MDS contract support is in place at the facility. As part of this contracted support, Polaris group has the ability to continually audit the facility's MDS assessments (5-7% each month) for accuracy in coding. The Administrator, Director of Nursing and Lead MDS coordinator will review monthly the MDS consultant group report to ensure assessments are completed accurately. Any identified issues or trends will be presented monthly at the facility's QAA Committee. The systemic plan will be to continue this monthly review for accuracy through our contracted support which is in place for a term of at least one year (twelve months), until March 2024. **Quality Assurance Plan to**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			monitor compliance with this Plan of Correction: Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 28, 2023	
F 0642 SS=A Bldg. 00	483.20(h)-(j) Coordination/Certification of Assessment §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure the RN Coordinator had signed the Minimum Data Set (MDS) assessments for completion for 2 of 24 MDS assessments reviewed. (Residents 15 and 12) Findings include: 1. The closed record for Resident 15 was reviewed on 3/13/23 at 10:12 a.m. The resident was admitted to the facility on 9/19/22 and discharged home with a return not anticipated on 9/30/22. The Discharge Return not Anticipated Minimum Data Set (MDS) assessment, dated 9/30/22, indicated it was still in process. Interview with the Administrator on 3/13/23 at 10:30 p.m., indicated she was aware the MDS assessment had not completed or submitted timely due to needing another MDS Coordinator. 2. Resident 12's record was reviewed on 3/8/23 at 3:06 p.m. The Discharge - Return Anticipated MDS assessment, dated 2/18/23, was still in progress. The MDS Coordinator had not signed the assessment. Interview with the Administrator on 3/13/23 at 10:30 p.m., indicated she was aware the MDS assessment had not completed or submitted timely due to needing another MDS Coordinator.	F 0642	**A tag – F642** **3.1-31(h)** A registered nurse must sign and certify that the assessment is complete. The facility failed to ensure the RN coordinator had signed the MDS assessments for completion for 2 of 24 MDS assessments reviewed (Residents 15 and 12) **Corrective action taken for residents found to have been affected by the deficient practice:** The assessments in question for Residents 15 and 12 were signed by the MDS coordinator during the time the surveyors were on site. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing re-educated the Lead MDS Coordinator related to the required RN signature for certification of completion of the MDS.	04/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 and residents. Currently, the facility staffs two full time MDS coordinators. Employment 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 FTE for a medical coder to support the MDS department. Additionally, the facility finalized a contract with Polaris group for full time MDS support for the term of one year (12 months) on March 14, 2023. This contract had been pending during the time of survey and was discussed with the survey team among other interventions in place. As of March 28, 2023, the full time MDS contract support is in place at the facility. An audit to determine the status of every MDS assessment for all patients and residents in house from March 1, 2023 to date was completed by Polaris Group on April 2, 2023. The Administrator, Director of Nursing and Lead MDS coordinator now meet weekly with the MDS consultant group to review the status of all MDS assessments to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			assessments are completed and certified timely. Any identified issues or trends will be presented monthly at the facility's QAA Committee. The systemic plan will be continuing to meet weekly with identified IDT members and the contracted MDS support group in order to review a status of all 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 discussed and implemented as needed. **Completion Date:** April 2, 2023	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents were provided assistance with activities of daily living (ADLs) related to shaving for 1 of 6 residents reviewed for ADLs. (Resident 247) Finding includes: On 3/6/23 at 2:39 p.m., Resident 247 was observed sitting in her wheelchair in her room. There was	F 0677	**F677** The facility must ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene. The facility failed to ensure grooming assistance was provided for one patient who was observed with a facial hair on her	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facial hair noted along her chin. On 3/8/23 at 11:08 a.m., Resident 247 was observed sitting in her wheelchair in her room. There was facial hair noted along her chin. Resident 247's record was reviewed on 3/8/23 at 2:52 p.m. The resident was admitted on 3/2/23. Diagnoses included, but were not limited to, fracture of nasal bones, syncope and collapse, and hypothyroidism. The Admission Minimum Data Set (MDS) assessment indicated it was still in progress. A Nurses' Note, dated 3/3/23 at 1:07 p.m., indicated the resident was able to make needs known and required extensive assistance with ADL care. The Shower Day Skin Audit, dated 3/7/23, indicated the resident received a bed bath. There was no documentation of facial shaving offered to the resident. Interview with the Administrator and the Director of Nursing on 3/10/23 at 9:52 a.m., indicated they had no further information to provide. 3.1-38(a)(3)(D)		chin. (Resident 247) **Corrective action taken for residents found to have been affected by the deficient practice:** The facial hair was removed from this patient's chin. (Resident 247) **Identification of other residents having the potential to be affected by the same deficient practice:** All patients who are dependent on staff for assistance with grooming have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate the CNA staff regarding providing assistance with facial grooming and other personal hygiene as needed for patients. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations of patients 3x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 30 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31, 2023	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 5 residents reviewed for skin conditions (non-pressure related). (Resident 148) Finding includes: On 3/6/23 at 3:10 p.m., Resident 148 was observed in his room in bed. The resident had a reddish/purple discoloration to both of his hands. On 3/8/23 at 9:58 a.m., the resident was observed in his room in bed. The resident had a pink foam dressing to his left forearm as well as a large area of reddish/purple discoloration to the forearm. The discoloration to the resident's hands also remained. The record for Resident 148 was reviewed on 3/9/23 at 2:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertensive chronic kidney disease, and orthopedic aftercare following surgical amputation. The Admission Minimum Data Set (MDS) assessment, dated 2/27/23, was still in process. A Care Plan, dated 2/20/23, indicated the resident was at risk for complications associated with Xarelto (an anticoagulant) therapy. Interventions included, but were not limited to, observe skin with each encounter for bruising and skin tears.	F 0684	**F684** The facility must ensure that residents receive treatment and care in accordance with professional standards of practice. The facility failed to monitor and assess bruises for 1 of 5 residents reviewed for skin conditions. (Resident 148) **Corrective action taken for residents found to have been affected by the deficient practice:** Resident 148 was admitted with the bruising identified and has since discharged home from the facility. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents with bruises have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate all nursing staff regarding identification of bruises upon admission, with a focus on obtaining physician orders for bruise monitoring at the time of identification. The facility's policy	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician's Orders, dated 2/20/23, indicated the resident was to receive Xarelto 20 milligrams (mg) daily and the bruising to the resident's bilateral arms was to be monitored every shift. The Treatment Administration Record (TAR) for the dates of February 20 through March 10, 2023, indicated the bruising had not been monitored each shift 2/20-3/6/23. Interview with the Director of Nursing on 3/10/23 at 1:00 p.m., indicated documentation related to monitoring the bruising to the bilateral arms was not started until 3/7/23. 3.1-37(a)		is to conduct a full weekly skin assessment for all patients and residents in house, and this practice will continue. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random audits 3x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 30 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31, 2023	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure preventative measures were in place related to offloading a resident's foot to prevent further pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. (Resident 195) Finding includes: Interview with Resident 195 and a previous caregiver for the resident on 3/6/23 at 3:03 p.m., indicated she had an open sore on her heel. The	F 0686	**F686** A resident with pressure ulcers receives necessary treatment to prevent new ulcers from developing. The facility failed to ensure preventative measures were in place related to offloading a patient's foot to prevent further pressure ulcers for 1 of 3 patients reviewed for pressure ulcers. (Resident 195)	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	caregiver indicated her foot was never offloaded and was always laying directly on the bed. The resident was currently observed sitting in a wheelchair and her right leg/foot was propped up on the leg rest with a pillow underneath. On 3/7/23 at 9:40 a.m. the resident was observed lying in bed and her right foot was laying directly on the mattress. It was not offloaded. On 3/9/23 at 8:02 a.m., until 10:05 a.m., the resident was observed lying in bed and her right foot was laying directly on the mattress. It was not offloaded. At 10:35 a.m., both Wound Nurses were observed during the pressure ulcer treatment. The resident's right heel was observed with a large black Deep Tissue Injury (DTI). There was no drainage noted. The record for Resident 195 was reviewed on 3/8/23 at 10:50 a.m. The resident was admitted to the facility on 2/17/23. Diagnoses included, but were not limited to, anemia, heart failure, type 2 diabetes, fracture of the right femur, and history of falls. The Admission Minimum Data Set (MDS) assessment, dated 2/24/23, indicated it was still in process. A Care Plan, dated 2/18/23, indicated the resident was admitted with a DTI to the right heel. Physician's Orders, dated 2/19/23, indicated Venelex ointment apply a thin layer to the right heel after cleansing with normal saline and pat dry daily and prn. The Wound Information Assessments indicated on 2/18/23, the right heel DTI measured 4.5		**Corrective action taken for residents found to have been affected by the deficient practice:** Resident 195's right heel was offloaded upon identification of this issue. Staff have ensured that Resident 195's heel continues to be offloaded when in bed; this pressure ulcer was present upon admission and has been steadily improving since the time of admission. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents having preventative treatments in place for pressure ulcers have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate all nursing staff regarding adhering to physician orders related to preventative measures in place for patients with pressure ulcers, such as off-loading heels when in bed. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations of patients with orders for preventative treatments related to pressure ulcers 3x/weekly for four weeks to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	centimeters (cm) by 4.5 cm and was dark purple in color. The most recent measurement on 3/7/23, indicated the DTI remained dark purple in color and was hard to touch. The ulcer remained closed and measured 4.5 cm by 4.5 cm. Interview with both Wound Nurses on 3/89/23 at 10:45 a.m., indicated the right heel should be offloaded at all times while in bed. The foot should not be directly laying on the bed. The current 1/1/22 "Skin Prevention Plan" policy, provided by the Administrator on 3/10/23 at 10:04 a.m., indicated interventions included, but were not limited to, suspend heels with pillows under the calf or use off-loading devices and recheck frequently. 3.1-40(a)(2)		ensure compliance with this plan of correction. Each week a minimum of 9 observations will be conducted to ensure compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Completion Date: March 31, 2023	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	function as possible. Based on record review and interview, the facility failed to monitor a resident's urine output after an indwelling foley catheter was removed to prevent reoccurrence for 1 of 3 residents reviewed for bowel and bladder incontinence. (Resident B) Finding includes: The closed record for Resident B was reviewed on 3/9/23 at 3:14 p.m. The resident was admitted to the facility on 10/19/22. Diagnoses included, but were not limited to, urinary tract infection, chronic kidney disease, and hydronephrosis (the swelling of one or both kidneys). The Admission Minimum Data Set (MDS) assessment, dated 11/4/22, indicated the resident was moderately impaired for decision making. The resident was an extensive assist with a 2 person physical assist for bed mobility and toilet use. She had an indwelling foley catheter. Nurses' Notes, dated 10/19/22 at 7:34 a.m., indicated the resident arrived to the facility around 6:35 p.m. The resident was admitted to the facility for therapy following hospitalization for a fall at home resulting in a right femur fracture. The resident had a foley catheter, 18 French with a 10 cubic centimeters (cc) bulb in place that was due to be removed on 10/21/22. Nurses' Notes, dated 10/21/22 at 6:26 a.m., indicated at 5:14 a.m., the foley catheter was removed. Nurses' Notes, dated 10/21/22 at 12:50 p.m., indicated the foley catheter was removed this morning and the resident had been voiding without difficulty. The resident denied pain or	F 0690	**F690** The facility must ensure that a resident receives services and assistance to prevent catheterization and restore continence to the extent possible. The facility failed to monitor a resident's urine output after an indwelling Foley catheter was removed to prevent reoccurrence for 1 of 3 residents reviewed for bowel and bladder incontinence. (Resident B) **Corrective action taken for residents found to have been affected by the deficient practice:** Resident B was a short term patient admitted to this facility with an indwelling Foley catheter present. Resident B has since discharged home and is no longer a patient at this facility. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents with indwelling Foley catheters have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate the nursing staff regarding patient monitoring and documentation requirements post	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	discomfort to the abdomen. Nurses' Notes, dated 10/21/22 at 7:52 p.m., indicated the resident had complaints of generalized pain but not to the abdomen. The resident continued to void without difficulty. There was no documentation in Nursing Progress Notes on 10/23, 10/24, 10/25, 10/26, and 10/27/22 of the resident being incontinent or continent of urine or even voiding without difficulty after the indwelling foley catheter was removed. The urine output log indicated nothing was documented on 10/19, 10/20, 10/21, 10/23, 10/24, 10/25, 10/27, and 10/28/22. On 10/22/22 at 3:09 a.m., a large amount of urine output was recorded and on 10/26/22 at 8:22 a.m., a large amount of urine output was recorded. Nurses' Notes, dated 10/28/22 at 8:25 p.m., indicated during a wound assessment, the Wound Nurse noted the resident had foul smelling urine. The Nurse Practitioner (NP) was notified and orders were obtained for an urinalysis and culture. Nurses' Notes, dated 10/28/22 at 10:02 p.m., indicated the resident urinated in the bed pan, however, it was contaminated with bowel movement. The resident was straight cathed for the urine specimen. Urine started coming out and reached 1400 cc before it was stopped by the nurse. The Physician was notified and orders were received to anchor an indwelling foley catheter for urinary retention. The urine output log indicated the following: - 10/29/22 large amount of urine. - 10/30/22 large amount of urine.		Foley catheter removal. Education will focus on the type and duration of monitoring and associated documentation expected in the patient's medical record following removal of a Foley catheter. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct an audit of all patients who have had indwelling Foley catheter removed 1x/weekly for four weeks to ensure compliance with this plan of correction. Each week, audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 10/31/22 850 cc of urine - 11/1/22 large amount of urine. - 11/2/22 1000 cc of urine at 2:02 p.m. and a large amount at 8:17 p.m. - 11/3/22 700 cc of urine - 11/5/22 a large amount of urine. There was no documentation of any urine output on 11/4, 11/6 or 11/7/22. Physician's Orders, dated 11/2/22, indicated Cephalexin (an antibiotic) 500 milligrams (mg) 1 tab every 6 hours for a Urinary Tract Infection. Nurses' Notes, dated 11/7/22 at 2:09 p.m., indicated the resident had increased confusion and increased complaints of pain. This afternoon the writer was informed by the CNA the resident had no urine output for the shift. After the writer was informed about the urine, the therapist notified the writer the resident was not herself, and after they attempted to sit the resident to the side of the bed she turned pale. The resident was having labored breathing, and had complaints of abdomen pain. The resident was sent out 911 to the hospital. The resident returned to the facility on 11/15/22. An NP (Nurse Practitioner) Progress Note, dated 11/16/22 at 10:17 p.m. indicated the patient was sent to the hospital on 11/7/22 with a chief complaint of shortness of breath and tachycardia. Supplemental oxygen was applied at 4 liters via nasal cannula. A Cat Scan (CT) of the abdomen/pelvis showed severely distended bladder with bilateral hydronephrosis. Interview with the Director of Nursing on 3/10/23 at 1:30 p.m., indicated urine output for foley		**Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	catheters did not need to be documented. There was documentation the resident was voiding without difficulty on 10/21/22 after the catheter was removed and the resident did urinate on 10/28/22 as the urine was foul smelling. The facility has no policy for intake and output documentation in general and for indwelling foley catheters. This Federal tag relates to Complaint IN00395647. 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure the meal consumption logs were completed for a resident with a history of weight	F 0692	**F692** The facility must ensure that residents receive assistance with	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	loss for 1 of 1 residents reviewed for nutrition. (Resident 37) Finding includes: The record for Resident 37 was reviewed on 3/8/23 at 10:01 a.m. . The resident was admitted to the facility on 2/8/23. Diagnoses included, but were not limited to, adult failure to thrive, protein calorie malnutrition, respiratory failure, COPD, heart failure, and dependence on supplemental oxygen. The Admission Minimum Data Set (MDS) assessment, dated 2/15/23, indicated the resident was not cognitively intact and needed supervision with set up assistance with eating. The resident had no oral problems, weighed 108 pounds, and was receiving a therapeutic diet. A Care Plan, dated 2/16/23, indicated the resident may need supervision to eat and drink at times. The approaches were to monitor and record intake of food/fluids. A Care Plan, dated 2/9/23, indicated the resident received a regular with no added salt diet. The approaches were to monitor intake, weight, and labs. An RD's (Registered Dietitian) assessment, dated 2/8/23, indicated the resident weighed 108 pounds at the time of admission. The resident had a Body Mass Index of 19.8 and a score of a 5 (meaning malnourished) on the Nestle Nutrition MNA (mini nutritional assessment). Recommend addition of mighty shakes twice a day with lunch and dinner. Physician's Orders, dated 2/9/23, indicated mighty shakes for lunch and dinner and weekly weight		nutrition and hydration. The facility failed to ensure the meal consumption logs were consistently completed for a patient with a history of weight loss for 1 of 1 residents reviewed for nutrition. (Resident 37) **Corrective action taken for residents found to have been affected by the deficient practice:** Resident 37 admitted to the facility for a short term stay with a diagnosis of failure to thrive. Her admission weight was 108 pounds. She discharged home from the facility five weeks later weighing 107 pounds. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate the CNA staff regarding completion of meal consumption tracking in the patient medical record after each meal. Education will focus on consistent completion of meal consumption tracking after each meal for all patients and residents, particularly those at risk for weight loss.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	times 4 weeks. The weekly weights were 108 pounds on 2/14/23, 100 pounds on 2/22/23, 101 pounds on 3/1/23 and 107 pounds on 3/7/23. The meal consumption log indicated breakfast was not recorded on 2/11-2/13, 2/21, 2/23-2/27, 3/1, 3/4, 3/6, and 3/7/23. Lunch was not recorded on 2/11-2/13, 2/20, 2/21, 2/23-2/28, 3/1, 3/4. 3/5, 3/6, and 3/7/23 and dinner was not recorded on 2/9-2/13, 2/18, 2/20-2/22, 2/24-2/28, 3/2, 3/3, 3/5, and 3/7/23. Interview with the Director of Nursing on 3/10/23 at 10:00 a.m., indicated food consumption should be completed after every meal. 3.1-46(a)(1)		The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct audits of meal consumption tracking for all meals 5x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 30 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31, 2023	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was changed as per Physician's Orders and facility policy for 2 of 3 residents reviewed for oxygen therapy. (Residents 37 and 206) Findings include: 1. On 3/6/23 at 2:25 p.m., 3/7 at 10:11 a.m., and 3/8 at 9:45 a.m., Resident 37 was observed sitting in a wheelchair in her room. At those times, the oxygen tubing and humidification bottle was dated 2/20/23. The resident indicated she wore oxygen at night time. On 3/9/23 at 8:03 a.m., the resident was observed in bed with her eyes closed. At that time she was wearing oxygen at 2 liters per minute via nasal	F 0695	**F695** The facility must ensure that residents who need respiratory care are provided such care in accordance with professional standards of practice. The facility failed to ensure oxygen tubing was changed as per Physician Orders and facility policy for 2 of 3 residents reviewed for oxygen therapy. (Residents 37 and 206) **Corrective action taken for residents found to have been affected by the deficient practice:** The oxygen tubing for both Residents 37 and 206 was	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cannula. The record for Resident 37 was reviewed on 3/8/23 at 10:01 a.m. . The resident was admitted to the facility on 2/8/23. Diagnoses included, but were not limited to, adult failure to thrive, protein calorie malnutrition, respiratory failure, COPD, heart failure, and dependence on supplemental oxygen. The Admission Minimum Data Set (MDS) assessment, dated 2/15/23, indicated the resident was not cognitively intact and received oxygen while a resident. A Care Plan, dated 2/9/23, indicated the resident was at risk for respiratory distress related to the diagnosis of COPD. The approach was to change oxygen tubing weekly. Physician's Orders, dated 2/8/23, indicated change oxygen tubing and humidifier bottle every week. Physician's Orders, dated 2/23/23, indicated oxygen 2 liters per nasal cannula continuously at bed time and prn. The Treatment Administration Record (TAR) for 2/2023 indicated the oxygen tubing was signed out as being completed on 2/19, 2/26, and 3/5/23. Oxygen therapy was signed out as being administered at 9:00 p.m., 2/23-3/6/23. Interview with the Respiratory Therapist on 3/9/23 at 10:45 a.m., indicated the oxygen tubing was to be changed every week. She changed the resident's oxygen tubing today as it was dated 2/20/23. Interview with the Director of Nursing on 3/10/23		replaced and dated immediately upon identification. Both are short term patients who have since discharged home from the facility. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents who require the use of oxygen have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate the Respiratory Therapist regarding the facility's policy for changing/dating oxygen tubing at least once weekly and/or when soiled. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations of patients who utilize oxygen 3x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 15 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at 1:30 p.m., indicated the oxygen tubing was to be changed weekly. 2. On 3/6/23 at 3:30 p.m., 3/7 at 9:45 a.m., 3/8 at 10:19 a.m. and 2:15 p.m., and on 3/9/23 at 7:48 a.m., the oxygen tubing and humidification bottle was dated 2/27/23 for Resident 206. The record for Resident 206 was reviewed on 3/9/23 at 8:21 a.m. The resident was admitted to the facility on 2/24/23. Diagnoses included, but were not limited to fracture of the right humerus, Alzheimer's disease, and acute respiratory failure with hypoxia. The Admission Minimum Data Set (MDS) assessment, dated 3/3/23 was still in progress. There was no Care Plan for oxygen therapy. Physician's Orders, dated 2/24/23, indicated change oxygen tubing and humidifier bottle every week. Physician's Orders, dated 2/24/23, indicated oxygen at 4 liters nasal cannula continuously 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,		determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided by the Administrator on 3/10/23 at 9:54 a.m. indicated cannula and tubing should be changed weekly or more frequently if grossly soiled or becomes contaminated. 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to manage medications appropriately related to medications not administered as ordered by the physician and the side effects of opioid medication not monitored for 2 of 5 residents reviewed for unnecessary medication. (Residents 191 and 206)	F 0757	**F757** Each resident's drug regimen must be free from unnecessary drugs. The facility failed to manage medications appropriately related to medications not administered as ordered by the	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. During an interview with Resident 191 on 3/6/23 at 3:51 p.m., he indicated he goes to dialysis on Tuesdays, Thursdays, and Saturdays. He indicated his chair time was 7:00 a.m. The record for Resident 191 was reviewed on 3/9/23 at 1:55 p.m. The resident was admitted on 2/28/23. Diagnoses included, but were not limited to, absence of toes, type 2 diabetes, diabetic neuropathy, end stage renal disease, hypertensive chronic kidney disease, anemia, and dependence on renal dialysis. The Admission Minimum Data Set (MDS) assessment was still in process. Physician's Orders, dated 2/28/23, indicated Clopidogrel 75 milligrams (mg) daily at 9 a.m. and Carvedilol 25 mg 1 tablet twice a day 9:00 a.m. and 9:00 p.m. The 3/2023 Medication Administration Record (MAR) indicated the resident missed the 9:00 a.m. dose of both medications on 3/2, 3/4, and 3/7/23 (dialysis days) Interview with the Director of Nursing on 3/10/23 at 1:30 p.m., indicated she called dialysis and they would like those medications held on dialysis days. There was no order to hold the medications prior to today. 2. The record for Resident 206 was reviewed on 3/9/23 at 8:21 a.m. The resident was admitted to the facility on 2/24/23. Diagnoses included, but were not limited to,		physician and the side effects of opioid medication not monitored for 2 of 5 residents reviewed for unnecessary medication. (Residents 191 and 206) **Corrective action taken for residents found to have been affected by the deficient practice:** Resident 191 was noted to miss a 9am dose of medication on dialysis days. The Director of Nursing clarified with Dialysis and the attending Physician that medication is to be held on dialysis days. The order was updated on 3/10/2023. Resident 206 was a short term patient who has since discharged home from the facility. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nurses regarding the importance of following physician orders accurately, to include medication orders. The Assistant Directors of Nursing for each nursing unit review MARs each morning to ensure medications from the day before	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fracture of the right humerus, Alzheimer's disease, and acute respiratory failure with hypoxia. The Admission Minimum Data Set (MDS) assessment, dated 3/3/23 was still in progress. A Care Plan, dated 2/24/23, indicated the resident had the potential for constipation related to decreased mobility and medication side effects. The goal was for the resident to have a bowel movement 1 time every 3 days. The approaches were to document all bowel movements in point of care and administer stool softeners per orders. A Care Plan, dated 2/24/23, indicated the resident had potential for pain related to right humerus fracture. The approaches were to administer medications as needed and report adverse side effects. Physician's Orders, dated 2/24/23, indicated Hydrocodone (a narcotic pain medication) 5-325 milligrams (mg) every 6 hours PRN (as needed) and Docusate Sodium (a stool softener) 100 mg twice a day PRN. Physician's Orders, dated 2/28/23, indicated Hydrocodone 5-325 mg daily at 9 a.m. The Medication Administration Record (MAR) for 2/2023 indicated the resident received a PRN Hydrocodone 5-325 mg tablet on 2/26/23 at 4:20 p.m. and on 2/27/23 at 8:21 p.m. The Docusate tablet PRN was not signed out as being administered 2/24-2/28/23. The 3/2023 MAR, indicated the PRN Hydrocodone 5-325 mg was signed out as being administered on 3/1/23 at 7:22 p.m. and on 3/4/23 at 5:32 p.m. The routine dose of Hydrocodone was		were administered as ordered. Additionally, a new facility practice was implemented related to the use of narcotic pain medication. Moving forward, nursing staff will work with providers to ensure stool softeners are routinely scheduled for all patients receiving narcotic pain medication. The Director of Nursing/Designee will provide education to nursing staff related to this new practice. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random audits of patients receiving narcotic pain medication weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 10 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	signed out as being administered 3/1-3/7/23 at 9:00 a.m. The PRN Docusate was not signed out as being administered on 3/1/23. Nurses' Notes, dated 3/3/23 at 4:19 p.m., indicated the resident had complaints of constipation that morning and was observed trying to dig bowel movement (bm) from her rectum. The NP was notified and gave new orders for Lactulose 30 cubic centimeters (cc) daily as needed as well as Bisacodyl suppository daily as needed. The bowel movement log indicated the only documented bowel movements from the time the resident was admitted until 3/9/23 were on 3/1 and 3/3/23 which indicated the resident had a large bm. "None" was recorded on 3/6 and 3/9/23. There were no other bowel movements documented in the log or Nursing Progress Notes. Interview with the Director of Nursing on 3/10/23 at 1:45 p.m., indicated she had interviewed some CNAs and they told her the resident had a bowel movement on 3/6 and 3/8/23 in the evening. She was going to inservice Nursing staff to ensure stool softeners were routinely scheduled for residents receiving narcotic pain medication. 3.1-48(a)(6)		The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31, 2023	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure there was an indication for the use and interventions were attempted prior to administering an as needed (PRN) anti-anxiety medication for 2 of 5 residents reviewed for unnecessary medications. (Residents 148 and 206) Findings include: 1. The record for Resident 148 was reviewed on 3/9/23 at 2:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertensive chronic kidney disease, and orthopedic aftercare following surgical amputation. The Admission Minimum Data Set (MDS) assessment, dated 2/27/23, was still in process. A Physician's Order, dated 2/28/23, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) three times a day as needed (PRN) for anxiety. The March 2023 Medication Administration Record (MAR) indicated the resident received the prn Xanax on 3/2 at 10:01 a.m. and 8:36 p.m., 3/3 at 9:21 p.m., 3/4 at 8:22 p.m., and 3/6/23 at 5:03 a.m. and 8:55 p.m. The PRN reason was coded as "O" other. There was no documentation in the nursing progress notes or elsewhere of why the medication was given. Interview with the Director of Nursing on 3/13/23 at 11:20 a.m., indicated documentation should have been completed indicating why the PRN Xanax was given. 2. The record for Resident 206 was reviewed on 3/9/23 at 8:21 a.m. The resident	F 0758	**F758** The facility must ensure that residents who use psychotropic drugs receive behavioral interventions in an effort to discontinue these drugs. The facility failed to ensure interventions were attempted prior to administering PRN anti-anxiety medication for 2 of 5 residents reviewed for unnecessary medications. (Residents 148 and 206) **Corrective action taken for residents found to have been affected by the deficient practice:** Residents 148 and 206 were both admitted to the facility for short-term rehabilitation with orders for PRN anti-anxiety medication and have both since discharged home. **Identification of other residents having the potential to be affected by the same deficient practice:** All other residents with orders for psychotropic medications have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate all nurses regarding the need to offer and attempt appropriate behavioral	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was admitted to the facility on 2/24/23. Diagnoses included, but were not limited to fracture of the right humerus, Alzheimer's disease, and acute respiratory failure with hypoxia. The Admission Minimum Data Set (MDS) assessment, dated 3/3/23 was still in progress. A Care Plan, dated 2/24/23, indicated the resident was at risk for having changes in her mood. The resident was prescribed Alprazolam (an anti-anxiety medication) and Risperidone (an antipsychotic medication) Physician's Orders, dated 2/24/23, indicated Alprazolam 0.25 milligrams (mg) twice a day PRN. The medication was discontinued on 3/7/23. Physician's Orders, dated 3/7/23, indicated Alprazolam 0.25 mg twice a day PRN. The Medication Administration Record (MAR) for the month of 2/2023 indicated, on 2/27/23 at 4:08 p.m., the resident received the Alprazolam for the reason of "other." The 3/2023 MAR indicated the resident received the Alprazolam on 3/4/23 at 5:32 for a behavior issue. There was no documentation in Nursing Progress Notes on 2/27 or 3/4/23 of any interventions tried prior to the administration of the PRN anti-anxiety medication. Interview with the Director of Nursing on 3/10/23 at 1:45 p.m., indicated there was no documentation of what was tried prior to the administration of the Alprazolam.		interventions prior to administering PRN anti-anxiety medications. These behavioral intervention attempts, as well as the success of the outcome, must be documented in the patient's medical record. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random audits of patient charts with orders for PRN anti-anxiety medications 1x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 10 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-48(a)(4)		**Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31, 2023	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 failed to ensure medications were labeled for 2 of 4 medication carts observed. (A-100 & D-200 carts) Findings include: 1. On 3/10/23 at 12:24 p.m., the A-100 Cart was reviewed with RN 1. There was a stack of Lidocaine 5% patches in a drawer unlabeled. The nurse was unable to find the original label/box. She indicated the box did not fit in the drawer so they had torn off a section of the box that contained the label which indicated whose patches they were. The label section of the box was not found in the cart. 2. On 3/13/23 at 9:55 a.m., the D-200 Cart was reviewed with Agency LPN 1. A bottle of fleet suppositories and a bottle of Tylenol 650 milligrams were in the cart drawer with no labels on either of the bottles. Agency LPN 1 indicated each bottle should have a label with the patient name and the order on them. Interview with the Director of Nursing on 3/13/23 at 10:19 a.m., indicated she had no further information to provide. 3.1-25(j)	F 0761	**F761** Drugs used in the facility must be labeled in accordance with the currently accepted professional principles. The facility failed to ensure medications were labeled for 2 of 4 medication carts observed. **Corrective action taken for residents found to have been affected by the deficient practice:** The medications (lidocaine 5% patches, fleet suppositories, Tylenol) were removed from the medication carts and disposed of properly. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nurses regarding proper medication storage, to include the requirement that all medications must have a label with patient name and the order. If	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			a medication is observed in their cart without a label, the nurse is to inform their charge nurse or ADON who will either appropriately label or properly dispose of the medication. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct audits of all medication carts 1x/weekly for four weeks to ensure compliance with this plan of correction. Each week, every medication cart in the facility will be checked to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at 100% compliance. The systemic plan will be randomly initiating all audit tools again monthly throughout the next 6 months, to ensure this deficient practice will not recur. **Quality Assurance Plan to**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			monitor compliance with this Plan of Correction: Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31, 2023	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to ensuring multi-use equipment was disinfected after resident use for random observations for infection control. (Residents 198 and 52) Findings include: 1. During a random observation on 3/6/23 at 2:12 p.m., Agency LPN 1 was observed checking Resident 198's blood pressure with a wrist cuff. After obtaining the blood pressure reading, the LPN put the wrist cuff back into a pouch that was around her waist and left the room. She walked out to her medication cart and proceeded to prepare and pour medications for another resident. She did not sanitize the blood pressure cuff. Interview with Agency LPN 1 at 2:17 p.m., indicated she had forgotten to clean the wrist blood pressure cuff after she used it for the resident. 2. During a random observation on 3/6/23 at 2:37 p.m., CNA 1 was observed checking Resident 52's vital signs with a multi-use blood pressure machine and cuff on wheels. After completing the resident's vital signs check, he pushed the machine towards the medication cart and plugged it into the wall. He did not sanitize or clean the machine after he was finished.	F 0880	**F880 – Directed Plan of Correction** The facility staff, to include the Administrator, Director of Nursing/Infection Preventionist, Director of Clinical Services and Manager of Clinical Services consulted with Alicia Snedecor for the development of this Directed Plan of Correction. Ms. Snedecor is Board Certified in Infection Control and serves as the Infection Control Coordinator at St. Mary's Medical Center. Consultation included areview of the findings from the March 13, 2023 Annual Survey related to F880 as well as the facility's proposed response and plan for correction. The facility's Infection Prevention and Control Assessment Response (ICAR) Tool was presented. **A. Specific/Immediate: Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct:** All blood pressure cuffs were immediately disinfected facility wide. Education with return demonstration was provided to all	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/9/23 at 7:49 a.m., Agency LPN 2 was observed checking vital signs for a resident in the hallway. She checked the resident's blood pressure using a multi-use machine on wheels. After finishing with the resident's vital signs check, she placed all of the equipment back in the basket and documented the information in the computer and went onto the next resident. She did not sanitize the machine. Interview with Agency LPN 2 on 3/9/23 at 8:30 a.m., indicated she was aware the machine was to be sanitized after each resident. Interview with the Director of Nursing on 3/13/23 at 10:00 a.m., indicated multi-use blood pressure cuffs should be cleaned after resident contact. The current 1/1/21, "Reusable Medical Equipment" policy, provided by the DON on 3/13/23 at 10:20 a.m., indicated all reusable medical equipment should be cleaned and disinfected when visibly soiled and between patient use. 3.1-18(b)		nursing staff to ensure a thorough understanding of the requirement to disinfect multi-use medical equipment with EPA appropriate cleaner (Sani-Cloth Plus) after patient use. Education focused on both the method by which to properly clean/disinfect equipment as well as the location(s) where the appropriate cleaning supplies are readily available throughout the facility. Education reviewed the following: types of medical equipment to be used in the facility, EPA wipes/solutions to be used to properly disinfect multi-use equipment, and the location of these cleaning products (and back up supply) throughout the facility. These products will now be stored on the vitals carts for immediate use. **B. Systemic:** A Root Cause Analysis (RCA) was conducted by members of the QAA Committee to include the facility Administrator, Director of Nursing/Infection Preventionist, Director of Clinical Services and Manager of Clinical Services in conjunction with Alicia Snedecor. The RCA is included for review. Facility staff listed above also reviewed the LTC Infection Prevention and Control Assessment Tool to ensure it is an accurate reflection of the facility. A copy of this assessment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			is included for review. **C. Training:** After the completion of the RCA and facility Infection Control Assessment, education was developed and presented to all facility staff in 1:1 education with demonstration and return demonstration. Staff were educated on requirements for cleaning and disinfection of multi-use medical equipment after patient use. Education focused on the EPA appropriate cleaner to use (Sani-Cloth Plus) and involved a demonstration with return demonstration to ensure correct cleaning methods are used. Education also instructed staff on where to located the appropriate cleaning supplies (and back up supply) for multi-use equipment throughout the facility as needed. **D. Monitoring:** The Director of Nursing/Designee will initiate a monitoring tool to document daily observations of staff to ensure that multi-use medical equipment is properly disinfected between each patient use. Visual rounds will be conducted in patient care areas throughout the facility to ensure compliance with this Plan of Correction. Audits will be conducted for six weeks and will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			be reviewed by the Administrator and/or Infection Preventionist in order to identify trends to discuss with the facility's QAA Committee. **E. Quality Assurance and Performance Improvement:** After successful completion of the six week monitoring period, the QAA Committee will review all audit tools to determine if the facility has achieved 100% compliance with practices, at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another six week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systemic plan is to randomly initiate the audit tool monthly over the next six months to ensure this deficient practice will not recur. Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly by the QAA Committee for the next six months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** March 31,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			2023	