DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING -- B. WING	04/04/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/04/23 Facility Number: 010758 Provider Number: 155662 AIM Number: 200229550 At this Emergency Preparedness survey, Rehabilitation Center At Hartsfield Village, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 112 certified beds. At the time of the survey, the census was 100. Quality Review completed on 04/11/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/04/23 Facility Number: 010758 Provider Number: 155662 AIM Number: 200229550 At this Life Safety Code survey, Rehabilitation	K 0000		

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

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 01 B. WING	04/04/2023

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
	Center at Hartsfield Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies. The facility is a two story building with a one story section and a partial basement. The one story section is Type II (000) construction and the two story building is of Type II (111) construction. Because the one story and two sections of the building are not separated by two hour rated construction, the building is considered one building of Type II (000) construction. The building is fully sprinklered with supervised smoke detectors on all levels including in corridors, in resident rooms, and in areas open to the corridor. The building is protected by a 400 kW diesel powered emergency generator The facility has the capacity for 112 and had a census of 100 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 04/11/23			
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 01 B. WING	04/04/2023

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
	through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 1. Based on observation and interview, the facility failed to ensure 5 of 7 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects all residents in the facility. Findings include: Based on an observation during a tour of the facility with the Maintenance Director and Maintenance Technician #1 on 04/04/23 between 12:40 p.m. and 2:25 p.m., in all resident halls Personal Protective Equipment (PPE) carts were in use but were not equipped with wheels allowing the carts to be move out of the halls during an emergency. The PPE carts were observed by rooms, A102, A202, A204, B209, B204, B213, C102, C202, C205, C208 and D206. Based on an interview at the time of observations, the Maintenance Technician #1 acknowledged the aforementioned PPE carts were not equipped with wheels.	K 0211	**K211** Corridors are maintained free of all obstructions; wheeled carts are permitted. PPE carts were observed in corridors without wheels. One corridor (service hallway) was not continuously maintained free of obstruction and was observed with the following items: a recliner, a chair and three dressers. **Corrective action taken:** All PPE carts in house were checked and the facility replaced all carts that did not have wheels in place. The recliner, chair and three dressers were removed from the service hall immediately at the time of surveyor observation. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents and the staff working in the service hall could potentially be affected. **To ensure that this deficient practice will not recur:** The central supply clerk was in-serviced regarding inspection of PPE carts to ensure they have wheels in place. Carts without wheels will be replaced immediately.	04/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 01 B. WING	04/04/2023

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 finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician #1 during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 8 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects approximately 10 staff in the service hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director and Maintenance Technician #1 on 04/04/23 between 12:40 p.m. and 2:25 p.m., a recliner, a dining chair and three dressers were located in the service corridor. Based on an interview at the time of observations, the Maintenance Technician #1 acknowledged the storage in the service corridor and would get them moved. At the time of observation the furniture was moved. Findings were discussed with the Maintenance Director, Maintenance Technician #1, and Administrator at exit conference. 3.1-19(b)		Maintenance staff was in-serviced regarding the requirement for maintaining the service hall free from obstruction. The Director of Maintenance will monitor the corridors during daily building rounds to ensure compliance with this plan of correction. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed. **REQUEST FOR IDR:** **The facility contends the following:** 1. The items in the service corridor at the time of the survey were as follows: one recliner, one sitting chair, three "dressers": (nightstand, dresser and wardrobe). 2. These items were NOT being stored in the service corridor. They had temporarily been moved out of a patient room during the time of observation/building tour as part of preparation for a new admission.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 01 B. WING	04/04/2023

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. Large furniture items are routinely moved out of patient rooms temporarily in order to thoroughly clean and/or replace flooring as needed and to paint/touch up paint as needed prior to a new admission. b. These furniture items are then brought back into the patient room immediately upon completion of the project within a timeframe of 2-4 hours. 3. The means of egress are not blocked during this process. The facility respectfully requests that this observation under K211 be removed and that the scope/severity of this citation be reduced accordingly.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72			
	Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA	K 0345	**K345** A fire alarm system is tested and maintained in accordance with an approved program. The facility failed to maintain 1 of 1 fire alarm	04/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 01 B. WING	04/04/2023

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
	70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Maintenance Assistant #1 on 04/04/23 between 10:45 a.m. and 12:38 p.m., no documentation for a smoke detector sensitivity test was available for review. Based on interview at the time of record review, the Maintenance Technician #1 was able to contact the alarm company for a report and stated a smoke detector sensitivity test was conducted in 2021, but no documentation could be produced to support the smoke detector sensitivity test was conducted within the past two years at the time of the survey. This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician #1 at the exit conference. 3.1-19(b)		systems; no documentation could be provided regarding a smoke detector sensitivity test within the past two year timeframe. **Corrective action taken:** The facility contacted TrueAlarm during the survey to request documentation. TrueAlarm was unable to provide the report during the time of survey. The facility contacted this vendor and the smoke alarm sensitivity test was completed on Friday April 14, 2023. The system will continue to be tested every two years as required and the facility will maintain documentation of required testing. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents could potentially be affected. **To ensure that this deficient practice will not recur:** A smoke alarm sensitivity test will be conducted every other year within the two year timeframe. Maintenance Staff will maintain these records. The Director of Maintenance created a tracking form to document and monitor this required testing in order ensure compliance with this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 01 B. WING	04/04/2023

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
			Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing review of all fire alarm reporting logs/records by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 01 B. WING	04/04/2023

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
	applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 14 resident room corridor doors on the second floor B-hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect residents and staff near room B211. Findings include: Based on observation with the Maintenance Director, Maintenance Technician #1, and Administrator on 04/04/23 between 12:40 p.m. and 2:25 p.m., the corridor door to resident room B211 did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and agreed the door did not latch into the frame.	K 0363	**K363** The facility failed to ensure room corridor doors were provided with a means suitable for keeping the door closed and would resist the passage of smoke. The corridor door for 1 of 14 rooms (room B211) did not latch into the frame when tested. **Corrective action taken:** A fire metal shim was installed on the bottom hinge of the door for room B211. The door was then tested and latched properly into the frame. **Identification of other residents having the potential to be affected by the same deficient**	04/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 01 B. WING	04/04/2023

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 finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician #1 during the exit conference. 3.1-19(b)		**practice:** Residents and staff in/near room B211 could be affected. **To ensure that this deficient practice will not recur:** The Maintenance Director checked the entire facility and did not note any other doors that did not latch into the frame. The Maintenance Director will continue to monitor all doors to ensure they latch properly through daily rounds and routine maintenance of the facility. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed.	