

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
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NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 10002 COLUMBIA AVE MUNSTER, IN 46321
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R 000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: March 12 & 13, 2015</p> <p>Facility number: 010937 Provider number: 010937 AIM number: NA</p> <p>Survey team: Lara Richards, RN, TC Yolanda Love, RN</p> <p>Census bed type: Residential: 65 Total: 65</p> <p>Census payor type: Other: 65 Total: 65</p> <p>Sample: 8</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on March 17, 2015, by Janelyn Kulik, RN.</p>	R 000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R 092 Bldg. 00	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to ensure an attempted fire and disaster drill was held in conjunction with the local fire department every six months. This had the potential to affect the 65 residents who resided in the facility.</p> <p>Finding includes:</p> <p>Review of the Fire Drill log on 3/13/15 at</p>	R 092	<p>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</p>	04/12/2015			

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	<p>9:45 a.m., indicated the local Fire Department was called to the facility on 2/24/14 for a fire drill. There were fire drills held on 8/21/14, 9/11/14, 10/29/14, 11/28/14 and 12/16/14. There was no documentation to indicate if the local fire department participated in the drill.</p> <p>Interview with the Maintenance Supervisor on 3/13/15 at 10:00 a.m., indicated he contacted the local fire department but he didn't document their response.</p>				<p>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.</p> <p>R092 The facility failed to ensure an attempted fire and disaster drill was held in conjunction with the local fire department every six months.</p> <p>Corrective action taken for residents found to have been affected by the deficient practice: The facility scheduled a fire and disaster drill in conjunction with the local fire department. This drill is scheduled for Monday, March 30th, 2015.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents residing at Assisted Living at Hartsfield Village have the potential to be affected.</p> <p>To ensure that proper practices continue: The facility Maintenance director will be in-service in relation to documenting the response and participation of the local fire department in fire and disaster drills. The Maintenance director will ensure an attempted fire and</p>		

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			<p>disaster drill be held in conjunction with the local fire department every six months.</p> <p>The Maintenance Director/designee will initiate a monitoring tool and will conduct audits of each fire and disaster drill for six months to ensure compliance with this plan of correction. The audit tool will identify if the drill was held in conjunction with the local fire department. After six months, the QAA Committee will review all audit tools and will determine if the facility has achieved compliance with practices at which time the monitoring will cease. If the QAA Committee determines that compliance has not been achieved, the monitoring tool will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved compliance and has ensured the deficient practice will not recur.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p>Completion Date: April 12, 2015</p>	

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R 154 Bldg. 00	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure all kitchen equipment was maintained in good repair related to the proper functioning of the dishwasher in the Main Kitchen. This had the potential to affect 65 of the 65 residents who resided in the facility. The facility also failed to maintain sanitary precautions when taking food temperatures for 1 of 2 kitchen areas. (The Memory Care Servery). This had the potential to affect 23 of the 23 residents who resided on the Memory Care unit.</p> <p>Findings include:</p> <p>1. On 3/13/15 at 10:40 a.m., the dishwashing process was observed. The dishwasher temperature gage recorded a prewash temperature of 139 degrees Fahrenheit, a wash temperature of 166 degrees Fahrenheit, and a final rinse temperature of 155 degrees Fahrenheit. At that time, an interview with the Dietary Manager indicated, during the final rinse cycle the temperature should have recorded 180 degrees Fahrenheit. A</p>	R 154	<p>This plan of correction represents thecenter's allegation of compliance. The following combined plan of correctionand allegation of compliance is not an admission to any of the allegeddeficiencies and is submitted at the request of the Indiana State Department ofHealth. Preparation and execution of this response and plan of correction doesnot constitute an admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. Theplan of correction is prepared and/or executed solely because it is required bythe provision of federal and state law.</p> <p>R154 The facilityfailed to ensure all kitchen equipment was maintained in good repair related tothe proper functioning of the dishwasher in the Main Kitchen.</p> <p>The facilityalso failed to maintain sanitary precautions when taking food temperatures forone kitchen area on the Memory Care Unit.</p>	04/12/2015

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	<p>test strip was then placed on a fork and rewashed, the test strip failed to indicate a temperature of 180 degrees.</p> <p>Review of the manufacturer's instruction manual indicated the final rinse temperature should have been 180 degrees Fahrenheit.</p> <p>2. On 3/13/15 at 12:28 p.m., an observation of the Memory Care meal preparation was observed. The Prep Cook was observed wiping the food temperature thermometer on his unclean white apron and placing it into the green beans. An interview with the Prep Cook at the time, indicated he should have used a clean paper towel or a Santi Wipe to clean the thermometer before placing it into the green beans.</p> <p>Interview with the Dietary Manager on 3/13/15 at 12:38 p.m., indicated the Prep Cook should have used a Santi Wipe before placing the thermometer into the green beans.</p>		<p>Corrective action taken for residents found to have been affected by the deficient practice: The dishwasher in the Main Kitchen was serviced on March 16, 2015 and remains in good working condition.</p> <p>The Prep Cook observed wiping the food temperature thermometer on his unclean apron was in-serviced on appropriate sanitation practices while taking food temperatures during meal preparation.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents residing at Assisted Living at Hartsfield Village have the potential to be affected.</p> <p>To ensure that proper practices continue: All dietary staff responsible for monitoring dishwasher temperatures will be in-serviced regarding proper monitoring and recording of dishwasher temperatures. The temperature of the dishwasher in the Main Kitchen will be monitored to make sure it is within normal limits and recorded on the temperature log 3x/day by the Dietary Manager/designee.</p> <p>The Dietary Manager/designee will initiate a monitoring tool and will</p>	

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			<p>conduct random auditsof dishwasher temperatures 3x/week for 4 weeks to ensure compliance with thisplan of correction. After 4 weeks, the QAA Committee will review all audittools and will determine if the facility has achieved at least 90% compliancewith practices at which time the monitoring will cease. If the QAA Committeedetermines that less than 90% compliance has been achieved, the monitoring toolwill continue for another 4 week period and will again be reviewed by the QAACommittee. This practice will continue until the facility has achieved at least90% compliance and has ensured the deficient practice will not recur.</p> <p>All dietary staff that are responsible for meal preparation will be in-serviced regardingappropriate sanitation practices to follow while taking food temperaturesduring meal preparation.</p> <p>The DietaryManager/designee will initiate a monitoring tool and will conduct random auditsof food temperature monitoring during meal preparation 3x/week for 4 weeks toensure compliance with this plan of correction. After 4 weeks, the QAACommittee will review all audit tools and will determine if the facility hasachieved at least 90% compliance with practices at which time the monitoringwill cease. If the</p>	

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R 241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure medications were discontinued as ordered for 1 of 7 records reviewed in the sample of 8. (Resident #5) Finding includes:</p>			R 241	<p>QAA Committee determines that less than 90% compliance has been achieved, the monitoring tool will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p>Completion Date: April 12, 2015</p> <p>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</p>		04/12/2015

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	<p>The record for Resident #5 was reviewed on 3/12/15 at 10:25 a.m. The resident's diagnoses included, but were not limited to, Vitamin D deficiency and anemia.</p> <p>A Physician's order dated 1/27/15, indicated the resident's Ferrous Sulfate (an iron supplement) 325 milligrams (mg) by mouth daily was to be discontinued.</p> <p>An entry in the Nursing progress notes dated 1/27/15 at 12:30 p.m., indicated the resident had been seen by the doctor and orders were received to discontinue her Ferrous Sulfate.</p> <p>The February 2015 Medication Administration Record (MAR) was reviewed. The resident received the Ferrous Sulfate for the entire month.</p> <p>The March 2015 MAR, indicated the resident received the Ferrous Sulfate 3/1-3/7/15. After 3/7/15, the medication was being held due to an upcoming outpatient procedure.</p> <p>Interview with LPN #1 on 3/13/15 at 9:30 a.m., indicated the resident's Ferrous Sulfate had been discontinued and the resident should not have received the medication after 1/27/15.</p>		<p>Indiana State Department of Health. Preparation and execution of this response and plan of correction doesnot constitute an admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. Theplan of correction is prepared and/or executed solely because it is required bythe provision of federal and state law.</p> <p>R241 The facilityfailed to ensure medications (Ferrous Sulfate) were discontinued as ordered forone record reviewed (Resident #5).</p> <p>Corrective action taken for residents foundto have been affected by the deficient practice: The FerrousSulfate prescribed for Resident #5 was discontinued on March 12, 2015.</p> <p>Identification of other residents havingthe potential to be affected by the same deficient practice: Allresidents residing at Assisted Living at Hartsfield Village who are prescribedmedication have the potential to be affected.</p> <p>To ensure that proper practices continue: All nurseswill be in-serviced on proper follow up related to Physician Orders, with afocus on orders related to medication</p>	

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R 354	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance		<p>changes.</p> <p>The Administrator/designee will initiate a monitoring tool and will conduct random audits of Physician Orders related to medication changes for 5 residents per day 3x/week for 4 weeks to ensure compliance with this plan of correction. After 4 weeks, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tool will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p>Completion Date: April 12, 2015</p>	

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Bldg. 00	<p>(g) A transfer form shall include the following:</p> <p>(1) Identification data.</p> <p>(2) Name of the transferring institution.</p> <p>(3) Name of the receiving institution and date of transfer.</p> <p>(4) Resident ' s personal property when transferred to an acute care facility.</p> <p>(5) Nurses ' notes relating to the resident ' s:</p> <p>(A) functional abilities and physical limitations;</p> <p>(B) nursing care;</p> <p>(C) medications;</p> <p>(D) treatment; and</p> <p>(E) current diet and condition on transfer.</p> <p>(6) Diagnosis.</p> <p>(7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on observation, record review, and interview, the facility failed to ensure all residents' clinical records were completely documented related to no diagnoses for the use of psychotropic medications and the failure to monitor a resident for bruising. (Resident #2)</p> <p>Finding includes:</p> <p>The record for Resident #2 was reviewed on 3/12/15 at 11:00 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, hypertension, and kidney disease.</p> <p>The Physician's Orders dated 3/2015, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25</p>	R 354	<p>This plan of correction represents thecenter's allegation of compliance. The following combined plan of correctionand allegation of compliance is not an admission to any of the allegeddeficiencies and is submitted at the request of the Indiana State Department ofHealth. Preparation and execution of this response and plan of correction doesnot constitute an admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. Theplan of correction is prepared and/or executed solely because it is required bythe provision of federal and state law.</p>	04/12/2015			

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	<p>milligrams (mg) by mouth every evening, and Seroquel (a mood disorder medication) 25 mg by mouth once daily. There was no evidence of documentation for the diagnosed use of the medications.</p> <p>Interview with the Unit Manager on 3/13/15 at 9:25 a.m., indicated the resident should have a diagnosis for the use of his ordered psychotropic medications.</p> <p>On 3/12/15 at 11:10 p.m., the resident was observed seated in the Memory Care dining room. There was a large purplish bruise noted to the top of his left hand.</p> <p>The Nursing Progress notes for Resident #2 were reviewed on 3/12/15 at 11:19 a.m. The resident was noted to have bruising to the top of his left hand measuring 3-4 inches in size. There was no evidence of documentation indicating the resident was being monitored for bruising. Interview with the Unit Manager at the time, indicated the resident should have been monitored for the bruising to his left hand for 72 hours.</p> <p>On 3/13/15 at 10:08 a.m., the Unit Manager measured the bruise. The bruising was 8.5 centimeters (cm) by 7 cm. An interview with the resident at the</p>		<p>R354</p> <p>The facility failed to ensure all residents' clinical records were completely documented related to no diagnoses for the use of psychotropic medications and the failure to monitor a resident for bruising (Resident #2)</p> <p>Corrective action taken for residents found to have been affected by the deficient practice:</p> <p>The clinical record for Resident #2 was reviewed by the attending physician and diagnoses appropriate for prescribed psychotropic medications were added.</p> <p>Resident #2 was assessed for bruising and subsequently monitored for 72 hours.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice:</p> <p>All residents residing at Assisted Living at Hartsfield Village have the potential to be affected.</p> <p>To ensure that proper practices continue:</p> <p>All nurses will be in-serviced on the practices related to following Physician Orders, with a focus on identification of appropriate diagnosis for prescribed psychotropic medications.</p> <p>All nursing staff will be in-serviced on practices related to identification</p>				

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	time indicated he was not aware of the cause for the bruising and further indicated, "It's not fatal, I'm ok." An observation at the time, also indicated a small bruise to his right hand located near his wrist. There was no evidence of documentation related to the bruising to the resident's right wrist. The Unit Manager was made aware. She then measured the bruise. The bruise to the resident's right wrist measured 1.5 cm x 1 cm, it was purplish in color.		and documented monitoring of resident bruises. The Administrator/designee will initiate a monitoring tool and will conduct random audits of Physician Orders related to prescribed psychotropic medications for 5 residents per day 3x/week for 4 weeks to ensure compliance with this plan of correction. After 4 weeks, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tool will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur. The Administrator/designee will initiate a monitoring tool and will conduct random audits of progress notes with documented bruising and 72 hour monitoring for 5 residents per day 3x/week for 4 weeks to ensure compliance with this plan of correction. After 4 weeks, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the	

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NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 10002 COLUMBIA AVE MUNSTER, IN 46321			
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R 407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure a system was	R 407	monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tool will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the 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. Recommendations for further corrective action will be discussed and implemented as needed. Completion Date: April 12, 2015 This plan of correction represents the center's allegation of	04/12/2015			

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	<p>in place to analyze patterns of known infectious symptoms. This had the potential to affect the 65 residents who resided in the facility.</p> <p>Finding includes:</p> <p>The monthly infection control logs were reviewed on 3/13/15 at 10:30 a.m. The October 2014 infection control log indicated there were eight urinary tract infections in the facility. There was no documentation to indicate where the infections were located within the facility.</p> <p>The monthly infection control log for the month of December 2014, indicated there were twenty cases of upper respiratory infections (URI). The outbreak was reported to the State Agency. The facility investigation did not include how many cases were on each unit.</p> <p>Continued review of the monthly infection control log, indicated a log had not been completed for the months of January and February 2015.</p> <p>Interview with the Administrator on 3/13/15 at 11:00 a.m., indicated the URI outbreak was investigated but not broken down by unit. She also indicated the monthly logs had not been completed for</p>		<p>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.</p> <p>R407 The facility failed to ensure a system was in place to analyze patterns of known infectious symptoms.</p> <p>Corrective action taken for residents found to have been affected by the deficient practice: The monthly infection control logs from October 2014 and December 2014 were reviewed by an ad hoc QAA Committee to further identify trends. The January 2015 and February 2015 infection verification reports were reviewed by an ad hoc QAA Committee to identify trends.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents residing at Assisted</p>				

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	1/2015 and 2/2015.		<p>Living at Hartsfield Village have the potential to be affected.</p> <p>To ensure that proper practices continue:</p> <p>The infection control nurses will be in-serviced on timely completion of monthly Infection Control Logs, to include identification and investigation of trends.</p> <p>The Administrator will be in-serviced on thorough investigation practices related to outbreaks reported to a State Agency.</p> <p>The Administrator/designee will initiate a monitoring tool and will conduct monthly audits of Infection Control Logs for 6 months to ensure compliance with this plan of correction. After 6 months, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tool will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p>Quality Assurance Plan to monitor compliance with this Plan</p>		

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			<p>of Correction: Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p>Completion Date: April 12, 2015</p>		