STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R0000	This visit was for a State Residential Licensure Survey. Survey dates: October 10 & 11, 2012 Facility number: 010937 Provider number: 010937 AIM number: NA Survey team: Lara Richards, RN, TC Heather Tuttle, RN Census bed type: Residential: 73 Total: 73 Census payor type: Other: 73 Total: 73 Sample: 10 These state residential findings are cited in accordance with 410 IAC 16.2. Quality review 10/15/12 by Suzanne Williams, RN	R0000		

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 determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R0090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review and interview, the facility failed to ensure an area of large contusion (bruising) was reported to the State Agency for 1 of 1 resident reviewed with large areas of bruising in the sample of 10. (Resident #6) Findings include: The closed record for Resident #6 was reviewed on 10/10/12 at 2:30 p.m. Documentation in the Nursing progress notes on 5/22/12 at 2:00 p.m., indicated the resident had two small bruises to her coccyx area. Documentation on 5/23/12 at 2:00 a.m., indicated the resident had a small purple bruise to the coccyx area. An entry in the Nursing progress notes dated 5/24/12 at 6:10 a.m., indicated a dark purple bruise remained to the coccyx area. An entry in the Nursing progress notes dated 5/27/12 at 8:05 p.m., indicated the resident was observed	R0090	1. The resident was not affected by this alleged citation. The bruise was the result of a fall, the resident was evaluated and treated in the Emergency Room and subsequently visited the physician. Coumadin orders were adjusted for this resident by the physician due to the nature of the bruising.2. Residents who have injuries whether known or unknown origin would potentially be indirectly affected for lack of reporting.3. The Accident/Incident policy will be updated to comply with ISBH reporting requirements, specifically relative to defining parameters for what would be considered a "large bruise". Staff will be in-serviced on the updated policy.4. Monitoring will be completed by the Administrator/Designee for six months. A 20% random sample of Incident/Accident Reports per month will be selected. The Medical Chart will be reviewed to ensure injuries or bruises are reported per policy. Results of this audit will be included in the quarterly Quality Assurance review to ensure compliance.	11/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	to have a large "midnite" purple color bruise over entire right buttock, going down back of right thigh, all the way to bend of right leg. Interview with the resident's responsible party at the time, indicated that she was not aware of the resident's bruise to the right buttock and back of entire right thigh down to bend of knee. She indicated when she had the resident in the Emergency Room on 5/23/12, the bruise was just on her buttock. Interview with the Administrator on 10/11/12 at 3:00 p.m., indicated an investigation was completed related to how the bruise occurred; however, the large area of bruising was not reported to the State Agency.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R0154	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 and interview, the facility failed to ensure the kitchen was clean and in good repair related to dirty wall tile, dirty convection ovens, a broken steamer, and dirty garbage cans for 1 of 1 kitchen area. This had the potential to effect 73 residents who resided in the facility and receive food from the kitchen. Findings Include: 1. On 10/10/12 at 9:40 a.m., during the Brief Kitchen Sanitation Tour, the following was observed: A. The entire lower white wall tile below the dish machine and the three compartment sink was dirty with dried areas of dirt and food splattered. B. The white plastic stands that held the dish machine soap were dirty. 2. On 10/11/12 at 10:30 a.m., during the Full Kitchen Sanitation Tour, the following was observed: A. The inside of both convection	R0154	1. Observation 1. Walls and plastic stand were cleaned the day of the observation. Observation 2. The oven, walls,and skillet were cleaned the day of he observation. The steamer was delimed and repaired on October 16. The garbage cans were replaced on October 23. 2. Residents who are served meals from the kitchen could potentially be affected. 3. Observation 1.A. Kitchen staff were in-serviced on cleaning walls each time the floor was power washed to remove any over spray. 1.B. Cleaning the plastic stand was added to the cleaning schedule. Observation 2. A. The oven cleaning schedule was revised, delegating the responsibility for cleaning to one cook position. All cooks were in-serviced on cleaning spills directly after meals. B. The Food Production Supervisor was in-serviced on checking walls after the hood cleaning to ensure any over spray is removed. C. Kitchen staff was in-serviced on proper handling of the steamer to avoid damage. D. The Cooks were in-serviced on all cleaning assignments after meal	11/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	oven doors were dirty and food stained. The bottom of both ovens had old burned food noted throughout. B. The top of the white wall tile located between the ovens, stove, grill and large skillet was noted with a large amount of grease and dirt. C. The inside pan of the lower steamer was dirty. There was also a piece of plastic laying in the pan. Interview with the Dietary Food Manager at the time, indicated the steamer did not work because the piece was broken off of the side. D. The lower heat lamps above the steam table were dirty with dried food spillage. The silver hood was also noted to be dirty with dried food spillage. E. The three garbage cans located in the kitchen were dirty and food stained. Interview with the Dietary Food Manager on 10/11/12 at 11:00 a.m., indicated all of the above was in need of cleaning and/or repair.		service. E. Garbage cans have been replaced. 4. Monitoring will be completed by Administrator/Dietary Manager/Designee for completion of the cleaning checklist. The Administrator/Designee will randomly tour the kitchen twice a month for six months to ensure compliance. Results of the tours will be included in our quarterly Quality Assurance for any necessary training or updates to cleaning schedules to maintian compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R0296	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review and interview, the facility failed to ensure licensed staff stayed with the resident while medications were taken for 2 of 5 residents observed during medication administration. (Residents #9 and #10) Findings include: On 10/10/12 at 12:05 p.m., LPN #2 was observed preparing medications for Resident #9. She placed a 25 milligram (mg) tablet of bethanechol chloride (a medication used for bladder spasms) and a 5 mg oxybutynin (a medication used for bladder spasms) tablet into a medication cup. The LPN proceeded to walk into the Main Dining Room and place the medication cup in front of the resident. She then proceeded to walk back into the Nurses' Station. She indicated at this time that she will go back later and see if the resident took his medication. She indicated the resident liked to wait for his food before taking his pills.	R0296	1. The nurse did return to the tables to ensure the residents had taken their medications. LPN 2 was also re-educated. 2. Residents whose medications are administered by LPN staff may potentially be affected.3. Policy for "Administration of Medication" will be reviewed/updated. LPNs will be in-serviced on the updated policy. Resident preferences will be considered in policy update. Policy changes will also be communicated to the Residents.4. Pharmacist consultant will monitor medication pass during consultant visits every 60 days for six months. Results of monitoring will be included in Quality Assurance and used to re-educate LPNs as necessary.	11/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 12:10 p.m., the LPN placed a 50 mg Tramadol (a pain medication) tablet into a medication cup for Resident #10. Again, the LPN walked into the Main Dining Room and placed the medication cup in front of the resident. She did not wait for the resident to take her medication. Review of the facility policy and procedure titled "Administration of Medications-Oral" provided by LPN #1 on 10/11/12 at 10:08 a.m., who identified the policy as current, indicated the following: "Administer oral medication and remain with resident while he/she takes the medication." Interview with LPN #1 at the time, indicated LPN #2 should have stayed with the residents while they took their medication.			