

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2014
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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: June 23, 24, 25, 26, & 27, 2014</p> <p>Facility number: 010758 Provider number: 155662 AIM number: 200229550</p> <p>Survey team: Heather Tuttle, R.N. T.C. Lara Richards, R.N. (6/23, 6/25, & 6/26/14) Cynthia Stramel, R.N. Yolanda Love, R.N. 6/23, 6/25-6/27/14 Janelyn Kulik, R.N. 6/24/14</p> <p>Census bed type: SNF: 94 SNF/NF: 16 Total: 110</p> <p>Census payor type: Medicare: 37 Medicaid: 9 Other: 64 Total: 110</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Dear Ms. Kulik, Enclosed is Nursing Care at Hartsfield Village's Plan of Correction and associated QA Monitoring Tools for Survey Event ID RCYW11. The facility would appreciate a revisit as soon as possible. Thank you for your attention to this matter. Please do not hesitate to contact me should you need additional information. I look forward to working with you. Respectfully submitted, Susan M. Finn Administrator Phone: 219-934-0590 x102</p>	
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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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F000282 SS=D	<p>Quality review completed on July 3, 2014, by Janelyn Kulik, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow Physician Orders related to blood sugars and laboratory results for 1 of 5 residents reviewed for Unnecessary Medications of the 5 residents who met the criteria for Unnecessary Medications. (Resident #81)</p> <p>Findings include:</p> <p>The record for Resident #81 was reviewed on 6/25/14 at 9:09 a.m. The resident was admitted to the facility on 4/25/14. The resident's diagnoses included, but were not limited to, stroke, compensated congestive heart failure, diabetes mellitus, coronary artery disease, atrial fibrillation, and arterial insufficiency.</p> <p>Review of Physician Orders dated</p>	F000282	<p>Nursing Care 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. F282 The services provided or arranged by the facility must be</p>	07/27/2014	

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	<p>6/19/14 indicated labs Basic Metabolic Panel (BMP) and Complete Blood Count (CBC), and renal panel. Fax results to Doctor (telephone number listed).</p> <p>Review of the Referral summary signed by the resident's consulting Physician (name) on 6/19/14 indicated recommendations will check CBC, BMP and check renal function. If alright will increase Lasix 40 milligrams twice a day.</p> <p>Review of the CBC and BMP lab results indicated they were drawn on 6/20/14 with the results faxed to the facility on 6/20/14 at 8:15 a.m. At the bottom of the lab page indicated "No new orders."</p> <p>Review of Nursing Progress Notes dated 6/20/14 at 2:16 p.m. indicated son aware of lab results as well as Doctor (name) with no new orders and will continue to monitor as ordered.</p> <p>Interview with the Second Floor Unit Manager on 6/26/14 at 9:00 a.m., indicated the nurse had called the on call Physician for the resident's primary Physician and not the consulting Physician who originally ordered the labs. She further indicated the labs were faxed on Monday 6/23/14 to the consulting Physician who ordered the labs.</p>		<p>provided by qualified persons in accordance with each resident's written plan of care. The facility failed to follow Physician Orders related to blood sugars and laboratory results for 1 resident reviewed for Unnecessary Medications. Corrective action taken for residents found to have been affected by the deficient practice: Resident 81 – Labs were drawn as ordered on 6/20/14. Patient's family and attending physician were made aware of results on this date. Labs were faxed to the ordering physician on 6/23/14. New orders were received from the ordering physician on 6/26/14 and carried out on that date. Family and attending physician were made aware of new orders and lab results. Resident 81 – MD reviewed all blood glucose results from the identified time period of 5/20/14 – 7/14/14. MD modified orders for blood glucose monitoring and notification parameters and orders were carried out by facility.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents with orders for labs to be drawn or blood glucose monitoring have the potential to be affected. To ensure that proper practices continue: Nursing staff will be in-serviced regarding following orders and MD notification, specifically notification</p>	

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	<p>Further review of Physician Orders dated 4/15/14 and on the current Physician recap dated 6/2014 indicated accu checks four times a day and call Physician if (less than) <60 or (greater than) >260.</p> <p>Review of the Diabetic Chart indicated on 5/20/14 at 7:30 a.m., the resident's blood sugar was 275. On 5/23/14 at 9:00 p.m., the resident's blood sugar was 280. On 5/31 at 9:00 p.m., the resident's blood sugar was 271. On 6/3 at 5:00 p.m., the blood sugar was 261 and on 6/3 at 9:00 p.m., the blood sugar was 299.</p> <p>Review of Nursing Progress Notes dated 5/20-6/4/14 indicated there was no evidence the resident's Physician was notified of the blood sugars above 260 on the above mentioned dates.</p> <p>Interview with the Second Floor Unit Manager on 6/26/14 at 9:10 a.m., indicated there was no documentation in the Nursing Progress Notes, on the Vital record or on the diabetic flow sheets the Physician was notified of the blood sugars greater than 260.</p> <p>3.1-35(g)(2)</p>		<p>of lab results and notification required for blood glucose monitoring.</p> <p>The DON/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure compliance with this plan of correction. Each week, a minimum of 45 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 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 tools 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: July 27, 2014</p>		

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F000311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure a Restorative nursing evaluation was completed for 1 of 3 residents reviewed for Rehabilitation of the 32 residents who met the criteria for Rehabilitation. (Resident #15)</p> <p>Findings include:</p> <p>The record for Resident #15 was reviewed on 6/25/14 at 1:34 p.m. The resident's diagnoses included, but was not limited to, right side cerebrovascular accident (stroke) and history of dementia.</p> <p>A Physician's order dated 2/12/14, indicated the resident was to receive Physical and Occupational therapy 5 times a week for 8 weeks.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 2/17/14, indicated the resident was an extensive assist for transfers. The resident was also documented as receiving Physical and Occupational therapy.</p>	F000311	<p>Nursing Care 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. F311</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities. The facility failed to ensure a Restorative nursing evaluation was completed for 1 resident reviewed for Rehabilitation. Corrective action</p>	07/27/2014			

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	<p>Review of the 30 day MDS Assessment dated 3/10/14, indicated the resident remained an extensive assist for transfers and continued to receive Physical and Occupational therapy.</p> <p>A therapy order dated 5/22/14, indicated the resident was to be discharged from Physical, Occupational and Speech skilled services. A recommendation was made for the Restorative Nursing program.</p> <p>The Quarterly Restorative Assessment note dated 5/12/14, indicated the resident was one assist with activities of daily living, transferred with the sit to stand lift and used a wheelchair as a mode of transport. Documentation also indicated the resident received skilled therapy services.</p> <p>Interview with CNA #2 on 6/26/14 at 12:00 p.m., indicated the resident was a sit to stand lift for transfers. The CNA also indicated the resident could not transfer on her own. The CNA indicated the resident was not receiving restorative services.</p> <p>Interview with the Restorative Nurse on 6/26/14 at 12:05 p.m., indicated the resident was not receiving restorative services. She indicated the resident had</p>		<p>taken for residents found to have been affected by the deficient practice: Resident 15 – Resident was evaluated by Restorative Nursing on 6/26/14. Resident is currently receiving restorative nursing services.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents discharging from skilled therapy with recommendation for Restorative Nursing services have the potential to be affected.</p> <p>To ensure that proper practices continue: All nursing and therapy staff will be in-serviced regarding the process for referral and timely evaluation of a patient transitioning from skilled therapy to restorative services.</p> <p>The DON/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure compliance with this plan of correction. Each week, all patients discharged from skilled therapy with recommendation for Restorative Nursing services will be audited 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 at least 90% compliance with practices at which time the monitoring will</p>		

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F000323 SS=G	<p>not been evaluated since being discharged from therapy on 5/21/14.</p> <p>Interview with the Assistant Director of Nursing (ADoN) on 6/26/14 at 12:35 p.m., indicated the Restorative evaluation should have been completed in a more timely manner.</p> <p>3.1-38(a)(2)(B)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure each resident was free from accidents related to a transfer with the Hoyer lift with only one assist which resulted in 19 sutures as well as a fractured tibia for 1 of 4 residents reviewed for accidents of the 7 residents who met the criteria for accidents. (Resident #77)</p>	F000323	<p>cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools 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: July 27, 2014</p> <p>Nursing Care 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</p>	07/27/2014			

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	<p>Findings include:</p> <p>On 6/26/14 at 2:20 p.m., Resident #77 was observed lying in bed. The resident's bed was in a low position with bolsters noted to both sides. The resident was observed with a leg cast to his left leg. The resident's daughter was seated in a chair next to the bed.</p> <p>The record for Resident #77 was reviewed on 6/26/14 at 2:33 p.m. The resident was admitted to the facility on 4/22/10 and his latest return to the facility after a hospitalization was on 4/23/14. The resident's diagnoses included, but were not limited to, dementia, weakness, difficulty walking, high blood pressure, glaucoma, and anemia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 3/28/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 9. The resident had no behaviors. He needed extensive assist with two person physical assist with bed mobility and transfers and he used a wheelchair.</p> <p>Review of the care plan dated 5/28/14 indicated the resident may be at risk for falls related to had a history of falls. The Nursing approaches were to have floor</p>		<p>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. F323</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents. The facility failed to ensure each resident was free from accidents related to a transfer with the Hoyer lift with only one assist which resulted in 19 sutures as well as a fractured tibia for one resident. Corrective action taken for residents found to have been affected by the deficient practice: Resident 77 – Resident identified as requiring two-person assist for transfer. Educated staff on need for two-person assist for transfer. Resident's plan of care reviewed and updated. Staff member that was involved in the transfer of Resident 77 was disciplined.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents using a mechanical lift to assist</p>				

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	<p>mats times two while in bed, bolsters in bed, dycem in geri chair, keep bed in lowest, locked position, keep call light within reach and to use a mechanical lift for transfers. The Nursing approach regarding the mechanical lift was dated 7/24/13.</p> <p>Review of Physician Orders dated 12/10/13 was to discontinue sit to stand lift and start hoyer lift for transfers.</p> <p>Review of Nursing Progress Notes dated 5/26/14 at 4:00 p.m., indicated resident up in Hoyer lift being transferred to geri chair. "CNA stated I looked down and noticed blood coming from leg." Resident noted with large skin tear to left lower leg. Small amount of bleeding, skin edges not well approximated, white fleshy skin noted. Searched room environment for any evidence of blood on equipment, bedside table, bed and floor and none was found. Instructed CNA to place resident back in bed. MD (Medical Doctor) telephoned order received to send resident to ER (Emergency Room) for evaluation and treatment of skin tear. Telephoned daughter and notified of status.</p> <p>Continued review of Nursing Progress Notes dated 5/26/14, at 9:15 p.m., indicated the resident returned to facility</p>		<p>with transfer have the potential to be affected. To ensure that proper practices continue: All residents using a mechanical lift to assist with transfer will be re-evaluated by skilled therapy for proper transfer technique. All care plans will be reviewed and updated as needed. All nursing staff will be in-serviced on the facility's transfer policy and proper use of mechanical lifts. The DON/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure compliance with this plan of correction. Each week, a minimum of 45 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 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 tools 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</p>		

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	<p>via ambulance. Telephoned the hospital nurse and report received. Resident noted with a soft cast to left leg and received 19 sutures to skin tear.</p> <p>Review of the left Tibia and Fibula x-ray report dated 5/26/14 indicated "Impression: Oblique fracture through the distal tibial diaphysis is not displaced. Vascular calcifications with soft tissue swelling."</p> <p>Review of the 5/26/14 incident and accident investigation of unknown origin provided by the facility on 6/26/14 at 3:00 p.m., indicated the resident did not know what happened. The injury was a skin tear to the left leg.</p> <p>Review of CNA #1's first statement dated 5/26/14 indicated "On May 26, 2014 I was working evenings. At 4 p.m., I was in room (Resident #77's room number) transferring (Resident #77's room number) into chair for dinner. I asked resident to lift leg up when resident started to lift his left leg I noticed blood on leg. I got him into chair reported to nurse then I put pressure on wound after we placed resident back in bed."</p> <p>Review of CNA #1's second statement dated 5/27/14 indicated "I was in room (Resident #77's). Resident had his legs</p>		<p>facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed. Completion Date: July 27, 2014</p>				

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	<p>over the side of the bed. He was yelling 'I'm tied down, get me up, I'm tied down.' So I placed his legs back into the bed and proceed (sic) to get him dressed to get him up for dinner. I got resident up into hoyer pulled him from over the bed over to the geri chair. At that time resident left foot was bumping leg rest. I ask him to please lift up his leg. When he did I noticed his leg was bleeding. I lowered him into chair yelled for nurse grab a wash cloth and applied pressure. (sic) Nurse came in advised me there was a bathroom light going off. I went and answered light. When I came back she told me and the other aide to get him back in bed he was going to the hospital. So we placed him back in the bed by the hoyer."</p> <p>Continued review of the incident and accident form indicated there was an interview with the nurse who was on duty that day, taking care of Resident #77. Review of LPN #3's interview indicated CNA #1 did not ask the nurse for help with Resident #77.</p> <p>Review of the current and undated Hoyer Lift Policy provided by the Director of Nursing indicated "The purpose was to transfer residents from bed to wheelchair who are obese, large framed, or unable to assist themselves. The procedure was to</p>			

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F000371 SS=D	<p>explain to resident and bring hoyer lift to bedside and request a second or third attendant to assist as needed."</p> <p>Interview with the Director of Nursing on 6/27/14 at 9:15 a.m., indicated the facility's policy regarding Hoyer lifts was for two people to be present at all times while the lift was in use. She further indicated the CNA had been inserviced on the policy before and was aware of it.</p> <p>Interview with the Staff Development Nurse on 6/27/14 at 11:30 a.m., indicated it was the facility's policy to use two staff members when using the Hoyer lift to transfer a resident.</p> <p>3.1-45(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to labeling food, disposing of leftover food and</p>	F000371	Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 This plan of correction represents the center's allegation of compliance. The following	07/27/2014

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	<p>vegetables, dried food spillage in microwave ovens and storage of clean cups in 1 of 1 kitchens and 2 of 3 serveries throughout the facility. The facility also failed to ensure a refrigerator was monitored for being at the correct temperature for 1 of 3 nutrition pantries throughout the facility. (The Main Kitchen, the Special Care Unit servery, the first floor servery and the first floor nutrition pantry)</p> <p>Findings include:</p> <p>1. During the Kitchen Sanitation tour on 6/23/14 at 9:10 a.m., with the Dietary Food Manager, the following was observed:</p> <p>a. In the walk in refrigerator there was a tossed salad covered with plastic wrap, there was no date on the salad. There was also a plastic container of sliced tomatoes, there was no date on the plastic container. A plastic container of tomato sauce was dated 6/16/14. There was also a plastic container of stewed tomatoes dated 6/17/14 which was labeled, "use for Thursday dinner." There were 2 fresh cucumbers in a plastic bin that were soft to touch. There was 1 red pepper in a plastic bin that was wilted in appearance.</p> <p>Interview with the Dietary Food Manager</p>		<p>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. F371</p> <p>The facility must procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. The facility failed to ensure food was stored and prepared under sanitary conditions related to labeling food, disposing of leftover food and vegetables, dried food spillage in microwave ovens and storage of clean cups in kitchens and serveries through the facility. The facility also failed to ensure a refrigerator was monitored for being at the correct temperature in a nutrition pantry. Corrective action taken for residents found to have been affected by the deficient practice: All food that was identified as not being</p>	

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	<p>at the time, indicated the salad was a staff salad but it should still have a date on it. The Dietary Food Manager also indicated the facility's left over food policy was to keep food for 72 hours then discard.</p> <p>b. Three plastic cups, which were identified as clean by the Dietary Food Manager, were stacked wet on top of each other.</p> <p>c. On 6/23/14 at 9:35 a.m., in the Special Care servery, dried food debris was observed in the microwave</p> <p>d. In the First floor servery at 9:41 a.m., there was dried red spillage on top of the soup cans located in a cabinet.</p> <p>Review of the facility Leftover policy on 6/23/14 at 3:30 p.m., which was provided by the Dietary Food Manager and identified as current, indicated the following: "Leftover foods may be stored in the refrigerator for no longer than 3 days."</p> <p>2. On 6/26/14 at 3:20 p.m., the medication room on the first floor was observed. The nutrition refrigerator's outside temperature gauge read 50 degrees Fahrenheit and should be maintained at or below 41 degrees. There was not an internal thermometer. The refrigerator contained items for resident's</p>		<p>properly labeled was disposed of immediately. Two cucumbers that were identified as being "soft to touch" were disposed of immediately. Red pepper that was "wilted" in appearance was disposed of immediately. Three wet plastic cups that were observed to be stacked were cleaned and sanitized. The microwave in the Special Care servery was cleaned immediately. The spillage in the first floor server was cleaned immediately. The soup cans noted with spillage on top were disposed of immediately. Maintenance inspected all refrigerators in the Main kitchen, Medication rooms, Nutrition rooms and Serveries to ensure they each have a thermometer and are running at the correct temperatures. All nutrition refrigerators have been removed from medication rooms. Medication room refrigerators only contain medications and the temperature will be monitored by nursing staff once daily.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.</p> <p>To ensure that proper practices continue: All dietary staff will be in-serviced on proper food storage and preparation to include labeling and disposal of leftover food. All dietary staff will be in-serviced on assignments related to cleaning and</p>	

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F000431 SS=D	<p>use such as applesauce and health shakes. At the time, LPN #2 indicated she believed the midnight staff was responsible for monitoring the refrigerator temperatures.</p> <p>On 6/27/14 at 8:15 a.m., the outside thermometer on the refrigerator read 45 degrees.</p> <p>Interview with the Director of Nursing (DoN) on 6/27/14 at 9:00 a.m., indicated they monitored the refrigerator temperatures randomly and they did not keep temperature logs. She also indicated she was not aware of the nutrition refrigerator not working properly.</p> <p>The current and undated Dietary policy Receiving and Storage was received from the DoN on 6/27/14 at 11:30 a.m. The policy indicated, "Thermometers are kept inside and outside all cooler/freezers and checked twice daily and recorded on form provided".</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS</p>		<p>monitoring serveries and nutrition rooms on all units.</p> <p>All dietary staff and nurses will be in-serviced on monitoring refrigerator temperatures in their designated areas.</p> <p>The Food Service Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure compliance with this plan of correction. After the fourth week, 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 tools 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: July 27, 2014</p>		

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	<p>& BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive 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.</p> <p>Based on observation and interview the facility failed to ensure each resident's medications were securely stored for 1 of 3 medication carts on the Second floor.</p> <p>The facility also failed to ensure each resident's medications were labeled</p>	F000431	Nursing Care 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	07/27/2014			

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	<p>properly for 2 of the 3 units in the facility. (The Special Care Unit, the First and Second Floor)</p> <p>Findings include:</p> <p>1. On 6/26/14 at 3:00 p.m., the medication cart on the Special Care unit was observed. There was a box of over the counter (OTC) cranberry tablets in the top drawer, the box did not have a label on it to indicate who the tablets belonged to. LPN #1 indicated they were Resident #32's and the family had brought them in. The LPN further indicated there was no label on the medication.</p> <p>On 6/26/14 at 3:20 p.m., the medication cart on the First floor was observed. There was a bottle of OTC infant gas drops in the drawer, Resident #131's name was written on the bottle. LPN #2 indicated the family had brought them in. The LPN removed the bottle from the medication cart and indicated she would give them back to the family.</p> <p>Interview with the Director of Nursing (DoN) on 6/27/14 at 9:00 a.m., indicated the above medications were not labeled correctly. She further indicated, the medications should have been labeled with the resident's name, Physician's</p>		<p>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. F431</p> <p>Drugs and biologicals used within the facility must be labeled in accordance with currently accepted professional principles. The facility must store all drugs and biologicals in locked compartments. The facility failed to ensure each resident's medications were securely stored in one medication cart. The facility also failed to ensure each resident's medications were labeled. Corrective action taken for residents found to have been affected by the deficient practice: Resident 32 – The over the counter cranberry tablets were properly labeled and stored in medication cart. Resident 131 – The over the counter infant gas drops were removed from the medication cart and returned to the resident's family. The staff member that left</p>				

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	<p>name, and room number at minimum.</p> <p>2. On 6/26/14 at 8:12 a.m., on the Second Floor, RN #1 walked away from her medication cart leaving it unlocked, unattended and outside of her view. Interview with the RN at the time indicated she had walked away from her cart leaving it unlocked, unattended and outside of her view.</p> <p>Interview with the DoN on 6/27/14 at 9:11 a.m., indicated it was her expectation for nursing staff to secure their medication carts by locking them when they are left unattended.</p> <p>3.1-25 (m)</p>		<p>the medication cart unattended and unlocked was individually educated. All medication carts were audited by nursing staff to ensure that all over-the-counter medications were properly stored and labeled according to facility policy. Identification of other residents having the potential to be affected by the same deficient practice: All residents receiving medication have the potential to be affected. To ensure that proper practices continue: All nurses will be in-serviced on proper storage and labeling of over-the-counter medications and locking medication carts while unattended.</p> <p>The DON/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure compliance with this plan of correction. Each week, a minimum of 21 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 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 tools will continue for another 4 week period</p>		

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p>		<p>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. Completion Date: July 27, 2014</p>	

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	<p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to ensure bed pans, wash basins and urinals were stored correctly on 3 of 3 units throughout the facility. (The first floor, second floor, and Special Care Unit)</p> <p>Findings include:</p> <p>1. During the Environmental Tour on 6/26/14 at 1:00 p.m., with the Housekeeping Supervisor, the following was observed:</p> <p>a. A plastic wash basin was on the bathroom floor in room A105. The wash basin was not wrapped in a plastic bag. Two residents resided in this room.</p> <p>b. Two plastic wash basins were observed on the bathroom floor in room A107. The wash basins were not wrapped in plastic bags. Two residents</p>	F000441	<p>Nursing Care 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. F441 The facility must establish and maintain an Infection Control Program designed to provide a</p>	07/27/2014	

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	<p>resided in this room.</p> <p>c. A plastic wash basin was positioned on top of the garbage can in the bathroom of room C107. One resident resided in this room.</p> <p>d. A plastic bedpan was placed between the grab bar and the wall in the bathroom of room D102. A toothbrush was also positioned on the shelf of the paper towel dispenser. One resident resided in this room.</p> <p>e. A urinal was placed on the side of the garbage can in room B201. The plastic cap was not on the urinal. One resident resided in this room.</p> <p>f. A wash basin was observed on the bathroom floor in room E108. A tooth brush and tooth paste were also observed on the shelf of the paper towel dispenser. The tooth brush was not covered at this time. One resident resided in this room.</p> <p>Interview with the Housekeeping Supervisor at the time, indicated the bed pans and wash basins should not be on the floor and they should be covered in plastic when not in use.</p> <p>Interview with the Director of Nursing on 6/26/14 at 3:30 p.m., indicated the</p>		<p>safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to ensure bed pans, wash basins and urinals were stored correctly on all units. Corrective action taken for residents found to have been affected by the deficient practice: All wash basins, bed pans, urinals and toothbrushes that were stored incorrectly were discarded immediately. The facility installed hooks labeled with each resident's room number in every resident room to ensure that all wash basins, bed pans and urinals are stored properly for each individual resident. Items will be covered in plastic when not in use. All personal care items will be stored properly for each individual resident. 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:</p> <p>All staff will be in-serviced on the facility infection control policies as well as proper storage of resident's personal care products.</p> <p>The DON/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure compliance with this plan of correction. Each</p>	

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F000465 SS=D	<p>bedpans and wash basins were not to be stored on the floor and should be covered in plastic when not in use.</p> <p>3.1-18(b)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a functional and sanitary environment was maintained in</p>	F000465	<p>week, a minimum of 45 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 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 tools 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: July 27, 2014</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 This plan of correction represents the</p>	07/27/2014	

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	<p>the kitchen and 2 of 3 servery areas related to stained ceiling tiles, stained light fixtures and dusty fan cover. (The Main kitchen and the 1st and 2nd floor serveries)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the Kitchen Sanitation tour on 6/23/14 at 9:10 a.m., with the Dietary Food Manager, the following was observed: <ol style="list-style-type: none"> a. The plastic light fixture located above the steamers was discolored with a light brown substance. b. The fan located next to the hand washing sink had an accumulation of dust and dirt on the cover. c. In the First floor servery at 9:41 a.m., two ceiling tiles above the coffee machine were discolored with a brown substance and water stained. d. In the Second floor servery at 9:50 a.m., two ceiling tiles located above the microwave were water stained. <p>Interview with the Dietary Food Manager at the time, indicated the above areas were in need of cleaning and/or repair.</p>		<p>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. F465</p> <p>The facility must provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility failed to ensure a functional and sanitary environment was maintained in the kitchen and server areas related to stained ceiling tiles, stained light fixtures and dusty fan cover. Corrective action taken for residents found to have been affected by the deficient practice: The plastic light fixture located above the steamers was removed and cleaned immediately. The fan located next to the hand washing sink was taken out of service immediately. All discolored and/or stained ceiling tiles were replaced</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/27/2014
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR 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	
	3.1-19(f)		with new ceiling tiles immediately. 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: Resident rooms and common areas will be checked routinely for discolored and/or stained ceiling tiles to ensure they are replaced timely. Dietary staff will be in-serviced on daily and weekly cleaning assignments related to kitchen sanitation. The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure compliance with this plan of correction. The Food Service Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure compliance with this plan of correction. 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: July 27, 2014		