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
	155662		07/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 20, 21, 22, 23, 24, and 27, 2015 Facility number: 010758 Provider number: 155662 AIM number: 200229550 Census bed type: SNF: 69 SNF/NF: 36 Total: 105 Census payor type: Medicare: 47 Medicaid: 13 Other: 45 Total: 105 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Thank you for considering this Plan of Correction. Pleasefeel free to contact me should you have any questions or need additionalinformation. Thank you, Susan Finn,Administrator 219-934-0590 Susan.m.finn@comhs.org	
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests,			

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.

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	assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure each resident had a choice regarding the number of showers received during the week for 1 of 3 residents reviewed for choices of the 4 residents who met the criteria for choices. (Resident #111) Finding includes: On 7/20/15 at 11:40 a.m., Resident #111 indicated the facility determines when and how many showers we get a week. He further indicated he receives two showers a week now, but would prefer three showers a week. The record for Resident #111 was reviewed on 7/23/15 at 9:25 a.m. The resident's diagnoses included, but were not limited to, acute renal failure and high blood pressure. The Annual Minimum Data Set (MDS) assessment dated 6/15/15 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident was interviewed for the Preference Section which indicated it was very important to choose	F 0242	Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 **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.** **F242** The residenthas the right to choose activities, schedules, and health care consistent withhis or her interests, assessments, and plans of care; interact with members ofthe community both inside and outside the facility; and make choices aboutaspects of his or her life in the facility that are significant to	08/23/2015

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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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	what clothes to wear and very important to choose between a tub bath, shower, and bed bath. The CNA assignment sheet indicated there was no documentation indicating the resident preferred a shower three times a week. The shower book indicated the resident received his showers on Wednesday and Saturday evenings. The showers were set up according to their room numbers and what bed the resident resided in. Interview with LPN #1 on 7/23/15 at 9:55 a.m., indicated the residents were assigned their showers according to their room number and bed. She further indicated they do accommodate residents if they want more showers a week. Continued interview further indicated the resident had not asked her personally for more showers. Interview with the Assistant Director of Nursing #1 (ADoN) on 7/23/15 at 10:00 a.m., indicated upon admission the facility staff do ask the residents their preferences regarding bed time, awake time and showers. However, she was unaware if they write the information down. She further indicated that as far as she knew, the resident had not been asked		theresident. The facility failed to ensure each resident had a choice regarding numberof showers received during the week for one resident. **Corrective action taken for residents foundto have been affected by the deficient practice:** Resident 111:Shower preferences were reviewed with this resident. ADON updated showerassignment sheet and CNA assignment sheet to reflect current preference. **Identification of other residents havingthe potential to be affected by the same deficient practice:** Allresidents with have the potential to be affected. **To ensure that proper practices continue:** TheDON/Designee will interview each resident to review their shower preferences,to include number of showers per week. Changes in preference will be added tothe shower assignment sheet and CNA assignment sheet. Residentpreferences for care, to include number of showers per week, will be discussedat the time of admission. This information will be made available to directcare/nursing staff as applicable. Nursing staff will be in-serviced regardingreviewing and honoring resident's preferences for showers and the process	

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	recently his shower preferences related to how many times a week he would prefer to bathe. Interview with the Resident #111 on 7/23/15 at 10:07 a.m., indicated he still would like to have three showers a week. 3.1-3 (u)(1)		forupdating CNA assignment sheet and shower assignment sheet as applicable. TheDON/Designee will initiate a monitoring tool and conduct random resident interviewsto discuss shower preferences and review shower and CNA assignment sheets 2x/weeklyfor 4 weeks to ensure compliance with this plan of correction. Each week, aminimum of 20 audits will be conducted to monitor compliance and/or identifytrends to review with the facility's QAA Committee. After the fourth week, theQAA Committee will review all audit tools and will determine if the facilityhas achieved at least 90% compliance with practices at which time themonitoring will cease. If the QAA Committee determines that less than 90%compliance has been achieved, the monitoring tools will continue for another 4week period and will again be reviewed by the QAA Committee. This practice willcontinue until the facility has achieved at least 90% compliance and hasensured the deficient practice will not recur. **Quality Assurance Plan to monitorcompliance with this Plan of Correction:** Identifiedconcerns shall be reviewed by the facility's QAA Committee. Recommendations forfurther corrective action will be	

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			discussed and implemented as needed. **CompletionDate:** August 23, 2014	
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure each resident's medication regimen was free from unnecessary drugs related to the lack of documentation and monitoring of a resident's blood glucose for 1 of 5 residents reviewed for unnecessary	F 0329	Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 **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**	08/23/2015

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	medications. (Resident #217) Finding includes: The record for Resident #217 was reviewed on 7/22/15 at 3:19 p.m. The resident's diagnoses included, but were not limited to, depression and diabetes. Physician's Order dated 6/18/15 indicated, accuchecks (blood glucose monitoring) four times daily before meals and at bedtime (7:30 a.m., 11:30 a.m., 5:00 p.m., 9:00 p.m.). The Medication Administration Record (MAR) dated June 2015 indicated no evidence of documentation for blood glucose monitoring on the following dates and times: -6/8/15 at 7:30 a.m. -6/14/15 at 7:30 a.m. -6/22/15 at 11:30 a.m. -6/23/15 at 11:30 a.m. -6/27/15 at 11:30 a.m. -6/18/15 at 9:00 p.m. -6/18/15 at 9:00 p.m. -6/21/15 at 9:00 p.m. -6/27/15 at 9:00 p.m. Interview with the Director of Nursing (DoN) on 7/24/15 at 9:11 a.m., indicated there was no evidence of documentation for blood glucose monitoring on 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 the factsalleged or conclusions set forth in the statement of deficiencies. The plan ofcorrection is prepared and/or executed solely because it is required by theprovision of federal and state law.** **F329** Eachresident's drug regimen must be free from unnecessary drugs. The facilityfailed to ensure each resident's medication regimen was free from unnecessarydrugs related to the lack of documentation and monitoring of one resident'sblood glucose. **Corrective action taken for residents foundto have been affected by the deficient practice:** Resident 217– MD/NP reviewed orders for Blood Glucose Monitoring. **Identification of other residents havingthe potential to be affected by the same deficient practice:** Allresidents with orders for blood glucose monitoring have the potential to beaffected. **To ensure that proper practices**	

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	following dates and times: -6/8/15 at 7:30 a.m. -6/14/15 at 7:30 a.m. -6/22/15 at 11:30 a.m. -6/23/15 at 11:30 a.m. -6/27/15 at 11:30 a.m. -6/18/15 at 9:00 p.m. -6/18/15 at 9:00 p.m. -6/21/15 at 9:00 p.m. -6/27/15 at 9:00 p.m. Continued interview with DoN at the time indicated the nursing staff should have documented the resident's blood glucose in the computer and/or the MAR. 3.1-48(a)(3)		**continue:** Nursingstaff will be in-serviced regarding following MD orders, specifically relatedto proper documentation of blood glucose monitoring. TheDON/Designee will initiate a monitoring tool and conduct random audits3x/weekly for 4 weeks to ensure compliance with this plan of correction. Eachweek, a minimum of 30 audits will be conducted to monitor compliance and/oridentify trends to review with the facility's QAA Committee. After the fourthweek, the QAA Committee will review all audit tools and will determine if thefacility has achieved at least 90% compliance with practices at which time themonitoring will cease. If the QAA Committee determines that less than 90% compliancehas been achieved, the monitoring tools will continue for another 4 week periodand will again be reviewed by the QAA Committee. This practice will continueuntil the facility has achieved at least 90% compliance and has ensured thedeficient practice will not recur. **Quality Assurance Plan to monitorcompliance with this Plan of Correction:** Identifiedconcerns shall be reviewed by the facility's QAA Committee. Recommendations forfurther corrective action will be	

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			discussed and implemented as needed. Completion Date: August 23,2015	
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to post the	F 0356	Nursing Care at Hartsfield Village 503 Otis Bowen Drive	08/23/2015

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	nurse staffing data on a daily basis at the beginning of each shift related to an observation of the Daily Staffing sign posted at the entrance of the facility being observed dated 7/16/15 upon entry into the facility on 7/20/15. Finding includes: On 7/20/15 at 9:08 a.m., the Daily Staffing sign was observed posted at the entrance of the facility near the Main Office, it was dated 7/16/15. Interview with the Scheduler on 7/24/15 at 8:44 a.m., indicated she was responsible for posting the Daily Staffing sign on her scheduled work days and she was not aware that the sign was to be posted at the beginning of the first shift. Continued interview at the time with the Administrator indicated she was aware the Daily Staffing sign had not been updated since 7/16/15 and she would designate a member of her staff to ensure the staffing sign was posted daily and at the beginning of the first shift. 3.1-13(a)		Munster, Indiana 46321 **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.** **F356** The facilitymust post nurse staffing data on a daily basis at the beginning of each shift.The facility failed to post the nurse staffing data on a daily basis at thebeginning of each shift related to an observation upon entry into the facilityon 7/20/15. **Corrective action taken for residents foundto have been affected by the deficient practice:** Notapplicable. **Identification of other residents havingthe potential to be affected**	

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			by the same deficient practice: Allresidents have the potential to be affected. **To ensure that proper practices continue:** The facilityscheduler and Nursing Administration (to include ADONs and Supervisors) will bein-serviced related to requirements for daily posting of nurse staffing data atthe beginning of the first shift. The DON/Designeewill initiate a monitoring tool and conduct observation 5x/weekly for 4 weeksto ensure compliance with this plan of correction. Each week, a minimum of 5audits will be conducted to monitor compliance and/or identify trends to reviewwith the facility's QAA Committee. After the fourth week, the QAA Committeewill review all audit tools and will determine if the facility has achieved atleast 90% compliance with practices at which time the monitoring will cease. Ifthe QAA Committee determines that less than 90% compliance has been achieved,the monitoring tools will continue for another 4 week period and will again bereviewed by the QAA Committee. This practice will continue until the facilityhas achieved at least 90% compliance and has ensured the deficient practicewill not recur. **Quality Assurance Plan to**	

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			monitorcompliance with this Plan of Correction: Identifiedconcerns shall be reviewed by the facility's QAA Committee. Recommendations forfurther corrective action will be discussed and implemented as needed. **CompletionDate:** August 23, 2015	
F 0371 SS=E Bldg. 00	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 and interview, the facility failed to store and prepare food under sanitary conditions related to sanitation solution being below normal range, dented food cans, frozen hamburger patties open to air, and black grime on the lift door of the ice machine. Findings include: On 07/20/2015 at 9:15 a.m., an initial tour of the kitchen was conducted with the Dietary Manager and the following was observed: A. The sanitation solution bucket in the food preparation area was tested by the	F 0371	Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 **This plan of correction representsthe center's allegation of compliance. The following combined plan ofcorrection and allegation of compliance is not an admission to any of thealleged deficiencies and is submitted at the request of the Indiana State Departmentof Health. Preparation and execution of this response and plan of correctiondoes not constitute an admission or agreement by the provider of the truth ofthe facts alleged or conclusions set forth in the statement of deficiencies.The plan**	08/23/2015

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	Dietary Manager and the test strip registered 150 parts per million of quaternary solution. Interview with Dietary Aide #1 at that time, indicated she was not sure how often to change the solution in the bucket. Further interview indicated she does changes the solution before each meal prep. Interview with the Dietary Manager at that time indicated, the bucket should be changed at least every two hours and should be between 200 to 400 parts per million of quaternary solution. B. Two dented food cans were observed on the second to the last shelf in the storage room, one peach pie filling can and one crushed pineapple can. Interview with the Dietary manager at that time, indicated that the cans were suppose to be pulled from the shelf and given to her then thrown away. C. One box of frozen hamburger patties were observed unwrapped with a crystallized substance on them and open to air. Interview with the Dietary Manager at that time indicated the hamburger patties were suppose to be covered. D. The ice maker was observed to have a black substance underneath the lift door. The Dietary Manager wiped the area with		**of correction is prepared and/or executed solely because it isrequired by the provision of federal and state law.** **F371** The facility must procure food from sources approved or consideredsatisfactory by Federal, State or local authorities; and store, prepare, distributeand serve food under sanitary conditions. The facility failed to store andprepare food under sanitary conditions related to sanitation solution beingbelow normal range, dented food cans, frozen hamburger patties open to air, andblack grime on the lift door of the ice machine. **Corrective action taken forresidents found to have been affected by the deficient practice:** Sanitation solution in the food preparation area was disposed ofimmediately. Two dented cans observed in the storage room were disposed ofimmediately. One box of hamburger patties left open to air were disposed ofimmediately. The ice machine was thoroughly cleaned and sanitized immediately. **Identification of other residentshaving the potential to be affected by the same deficient practice:** All residents have the potential to be	

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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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	her finger and indicated the black substance should not be there and the ice machine should be cleaned once a week. Review of current policy "Quaternary Solution" provided by the Dietary Manager indicated, "...2... the solution must read between 200 ppm and 400 ppm, ...5. Change solution after each use/when solution becomes cloudy/ or after 2 hours if not used." Review of current policy "Storage Procedures: Frozen Storage" dated 2009, provided by Dietary Manager indicated, "...3. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn..." Review of current policy "Storage Procedures: Storage of Damaged Containers" dated 2009, provided by the Dietary Manager indicated, "....4. Do not use any can that is dented, rusted, leaking or bulging." Review of current policy "Cleaning Instructions: Ice Machine and Scoop" dated 2009, provided by Dietary Manager indicated, "The ice machine and scoop will be cleaned and sanitized on a routine basis...4. Scrub all machine surfaces and		affected. **To ensure that proper practicescontinue:** All dietary staff will be in-serviced on preparation and changing ofsanitation solution. All dietary staff will be in-serviced on proper food storage,specifically in relation to monitoring for dented/damaged cans and properstorage of frozen food items. Ice Machines will be added to a Preventive Maintenance schedule to bemaintained by the Maintenance Director/ Designee. All maintenance staff will bein-serviced related to routine cleaning of the ice machines. The Food Service Director/Designee will initiate a monitoring tool andconduct random audits 3x/weekly for 4 weeks to ensure compliance with this planof correction. After the fourth week, 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 monitoringtools will continue for another 4 week period and will again be reviewed by theQAA Committee. This practice will continue until the facility has achieved atleast 90% compliance and has ensured the deficient	

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
	155662		07/27/2015

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	door gaskets inside and out with a hot detergent solution." 3.1-21(i)(3)		practice will not recur. The Maintenance Director/Designee will initiate a monitoring tool andconduct random audits 3x/weekly for 4 weeks to ensure compliance with this planof correction. After the fourth week, 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 monitoringtools will continue for another 4 week period and will again be reviewed by theQAA Committee. This practice will continue until the facility has achieved atleast 90% compliance and has ensured the deficient practice will not recur. **Quality Assurance Plan to monitorcompliance with this Plan of Correction:** Identified concerns shall be reviewedby the facility's QAA Committee. Recommendations for further corrective actionwill be discussed and implemented as needed. **Completion Date:** August23, 2015	