

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  04/28/2016
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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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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00198053.</p> <p>Complaint IN00198053 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157.</p> <p>Survey dates: April 24, 25, 26, 27, &amp;, 28, 2016</p> <p>Facility number: 010758 Provider number: 155662 AIM number: 200229550</p> <p>Census bed type: SNF/NF: 22 SNF: 61 Total: 83</p> <p>Census payor type: Medicare: 40 Medicaid: 16 Other: 27 Total: 83</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Thank you for considering this Plan of Correction Please feel free to contact me should you have any questions or need additional information Susan Finn, Administrator 219-934-0590</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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F 0155 SS=E Bldg. 00	<p>Quality review completed by 32883 on 5/2/16.</p> <p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on record review and interview, the facility failed to ensure advance directives were honored related to initiating Cardiopulmonary Resuscitation (CPR) for a resident who was Do Not Resuscitate (DNR) status for 1 of 1 residents reviewed for choices. This had the potential to affect the 51 DNR residents who resided in the facility. (Resident #94)</p> <p>Finding includes:</p>	F 0155	Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b>	05/28/2016

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	<p>The closed record for Resident #94 was reviewed on 4/26/16 at 2:25 p.m. The resident's diagnoses included, but were not limited to, Parkinson's, heart failure, and history of pneumonia.</p> <p>An admission Physician's order dated 12/31/15, indicated the resident was a full code which meant CPR would be initiated during the event of cardiac arrest.</p> <p>An entry in the Social Service progress notes dated 1/8/16 at 4:03 p.m., indicated the resident was now a DNR per Medical records.</p> <p>The resident's face sheet was updated on 1/11/16 to reflect the DNR status.</p> <p>An entry in the Nursing progress notes dated 2/10/16 at 9:45 a.m., indicated therapy notified Nursing staff the resident became unresponsive at the completion of therapy. Therapy wheeled the resident to his room, he was transferred onto the bed and CPR was initiated. The Nurse Practitioner who was on duty was notified. The ambulance service was called and the resident's family was notified. The resident was a DNR and all paperwork was signed and in the chart. Orders were received to discontinue</p>		<p><b>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. F155</b></p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive. The facility failed to ensure advance directives were honored related to initiating CPR for 1 resident who was a DNR status. <b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Resident 94 is no longer a patient at this facility. Resident 94 did have the following in place, which is in accordance with facility policy: DNR order was in the medical record, DNR paperwork was complete and on file, and patient's medical record chart binder identified the patient as having a DNR status.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents with DNR orders have the potential to be affected. <b>To ensure that proper practices continue:</b> The DON/Designee will re-educate facility staff regarding the facility</p>	

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	<p>CPR. CPR was then stopped, family was in agreement with discontinuing CPR. The ambulance service arrived on scene and called the time of death at 10:00 a.m. along with their Medical Director.</p> <p>The plan of care dated 1/8/16, indicated the resident was a DNR. The interventions included, but were not limited to, uphold wishes, offer advanced directive information if requested, and change advanced directives if needed.</p> <p>Interview with Social Worker #1 on 4/27/16 at 2:50 p.m., indicated advance directives were gone over at the time of admission and documentation was placed in the chart. She indicated if a resident went from a full code to a DNR, documentation was to be completed in the chart and the order updated.</p> <p>Interview with LPN #7 on 4/27/16 at 3:00 p.m., indicated the resident's advance directive status was filled out and a pink sheet was put in the front of the chart and an order was placed in the computer. If a resident was a full code and switched to a DNR, the chart was updated as well as the orders. The LPN also indicated the residents have wrist bands to indicate their code status.</p> <p>On 1/7/16 the DNR sheet was completed</p>		<p>policy for advance directives. This education will include identification of a patient's DNR status on the individual patient medical record chart binder as well as verification of code status by a nurse if and when appropriate. The DON/Designee will conduct an audit of all residents with DNR orders to ensure the following are in place: DNR order in the medical record, DNR paperwork complete and on file in medical record, and the medical record chart binder indicates the patient's DNR code status. DON/Designee will initiate a monitoring tool and conduct audits of new admissions with DNR code status as well as current patients/residents that have new orders for DNR status for four weeks to ensure compliance with this plan of correction. An exam will be given to staff after the in-servicing is complete to validate that the staff understands the protocol for following advanced directives following re-education. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed</p>	

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	<p>and signed by the resident's family and Physician. The pink form was completed as well as two additional forms on white paper.</p> <p>Interview with the Director of Nursing (DON) on 4/28/16 at 11:03 a.m., indicated the resident went unresponsive on his way back from therapy. The resident was rushed back to his room and a code was called and CPR was initiated. When the resident's chart was checked, it was determined the resident was a DNR and orders were received to stop CPR. The DON indicated she would rather error on the side of caution and initiate CPR rather than not.</p> <p>Interview with Certified Occupational Therapy Aide (COTA) #1 on 4/28/16 at 11:10 a.m., indicated if a resident went unresponsive in therapy, she would first notify Nursing. She indicated there was supposed to be a symbol on the wrist band to indicate if the resident was a DNR. She also indicated some residents don't wear their wrist band so that would be another reason she would let the Nurse know.</p> <p>Interview with Rehab Tech #1 on 4/28/16 at 11:15 a.m., indicated he would notify Nursing if a resident had a change in condition. He also indicated the</p>		<p>by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audit tools again throughout the next 12 months, to ensure that this deficient practice will not recur. All findings will be taken to the Quality Assurance Committee.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p><b>Completion Date:</b> May 28, 2016 The facility respectfully requests a face-to-face IDR. The facility contends that the citation and/or the scope and severity assigned is not justified. The facility requests the opportunity to present additional rationale and evidence for consideration and review at a face-to-face meeting. It is my understanding that ISDH will contact the Administrator to schedule such meeting. Thank you.</p>		

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	<p>residents were supposed to wear a wrist band which would indicate their code status.</p> <p>Further interview with the DON on 4/28/16 at 11:30 a.m., indicated an investigation was not completed related to the incident. She indicated again, the resident went unresponsive and was taken to his room and CPR was initiated. She indicated when the resident's orders were reviewed, CPR was stopped. She indicated she did not know if the resident had his wrist band on at the time. She also indicated no inservicing on Advance Directives was completed after the incident.</p> <p>The facility Advance Directives policy was reviewed on 4/28/16 at 12:24 p.m. The policy was provided by the Admissions Coordinator and identified as current. The policy indicated the following: "At the time of admission, the resident/patient or their representative will be provided with the Indiana Advance directives booklet. Facility staff will refer residents, families or legal representatives to the resident's personal physician and/or attorney for discussion and assistance regarding Advance Directives and decisions regarding life-sustaining measures."</p>			

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F 0157 SS=D Bldg. 00	<p>"The resident's Advance Directive shall be copied and maintained in the resident's medical record. An acknowledgment of receipt of information concerning Advance Directives and related laws will be maintained in the resident's medical record."</p> <p>"Each medical record binder will be labeled in such a manner to quickly identify Advance Directive(s)."</p> <p>"Code status shall be verified by a nurse if and when appropriate."</p> <p>"Facility staff is provided education on issues concerning advance directives. The training includes at least annual educational programs for employees, residents, families and the community regarding advance directives and care or resident refusing treatment."</p> <p>3.1-4(f)(6) 3.1-4(f)(8)</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician</p>			

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	<p>intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to promptly notify the resident's interested family member of new Physician Orders related to lab tests and results for 1 of 1 residents reviewed for notification of change of the 1 resident who met the criteria for notification of change. (Resident #B)</p> <p>Finding includes:</p> <p>On 4/25/16 at 9:46 a.m., Resident #B's Power of Attorney was interviewed. At</p>	F 0157	Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b>	05/28/2016

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	<p>that time, she indicated the resident had a change in her condition with blood noted in her bowel movement. The facility indicated they were going to get labs done, however, no one let her know the results of the test.</p> <p>The record for Resident #B was reviewed on 4/26/16 at 9:11 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder, shortness of breath, osteoarthritis, Alzheimer's disease, dementia, and anxiety.</p> <p>Physician orders dated 1/5/16 and on the current Physician Order Sheet for 4/2016 indicated Warfarin (a medication used to thin the blood) 2 milligrams (mg) daily.</p> <p>Nursing notes dated 2/17/16 at 6:47 a.m. indicated resident noted with bright red blood in stool. Physician notified no new orders received in writing. Monitor and if condition worsens notify Physician.</p> <p>The next documented entry in Nursing notes was on 2/18/16 (29 and 1/2 hours later) at 1:25 p.m., by the Nurse Practitioner, which indicated the resident was seen for bright red blood in her stool. The exam was discussed with the resident's daughter. New orders for a Complete Blood Count (CBC) were obtained. The daughter requested the</p>		<p><b>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. F157</b></p> <p>A facility must immediately inform the resident and/or legal representative/family member when there is the following: an accident involving the resident which results in injury, a significant change in the resident's overall status, a need to alter treatment significantly, a decision to transfer or discharge the resident, a change in room or room assignment or a change in resident rights. The facility failed to promptly notify the resident's interested family member of new Physician Orders related to lab tests and results for 1 of 1 residents reviewed. <b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Resident B: The resident's interested family member was notified by the Nurse Practitioner on 2/18/16 of a change in condition noted 2/17/16. The Nurse Practitioner reviewed the resident's current medications and associated routine labs with the Resident B's interested family member on 5/10/2016. <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All</p>		

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	<p>CBC to be drawn with the next Prottime (PT) and International Normalized Ratio (INR) (labs to monitor how thin the blood was) which were already scheduled for 2/26/16. All concerns were addressed with the resident's daughter.</p> <p>Nursing notes dated 2/26/16 at 2:27 p.m., indicated the Physician was notified about labs. Meds were to remain the same and PT/INR were to be repeated on March 11. There was no documentation the resident's Power of Attorney (her daughter) was notified of the new order or lab results.</p> <p>Nursing notes dated 3/11/16 indicated INR was 1.8. The resident was on Coumadin 2 mg daily. New order to repeat INR in one week. There was no documentation indicating the daughter was notified of the new Physician's order.</p> <p>Nursing notes dated 3/19/16 indicated the resident's labs were received and reviewed with the Physician. The resident was to continue with current Coumadin (Warfarin) orders and to repeat the INR in 1 week. There was no documentation of the resident's daughter being notified of the new orders.</p> <p>The 2/26/16 CBC results indicated the resident's hemoglobin (the amount of</p>		<p>residents with new physician orders, new lab results, meeting the criteria for a significant change in their overall clinical status, or the need to alter treatment significantly have the potential to be affected. <b>To ensure that proper practices continue:</b> Nursing staff will be re-educated regarding documentation in the medical record of notification to a resident's interested family member of a new physician order, new lab results, significant change in their overall clinical status or the need to alter treatment significantly. The DON/Designee will initiate and complete a monitoring tool and conduct random audits 5 x/week for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 50 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the</p>		

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F 0164 SS=D Bldg. 00	<p>oxygen in the blood) was 11 (a low value, normal 11.5-16). The Red Blood Cells were also low with a value of 3.6 (normal 4.2-5.7). The PT was 17.5 a high value (normal 12-14.5) and the INR was 1.4 indicating the resident was receiving a low dose of Warfarin.</p> <p>The 3/11/16 PT results were 21.8 a high value with an INR of 1.8. The 3/19/16 PT results were 24.6, a high value with an INR of 2.1</p> <p>Interview with Director of Nursing (DON) on 4/27/16 at 8:45 a.m. indicated the resident's POA (daughter) was not notified of the lab results or the new Physician Orders on the above mentioned dates. She further indicated the resident's daughter had not been notified of the blood in the stool until the next day.</p> <p>This Federal Tag relates to Complaint IN00198053.</p> <p>3.1-5(a)(3)</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations,</p>		<p>facility has achieved at 100% compliance The systematic plan will be randomly initiating all audit tools again throughout the next 12 months, to ensure that this deficient practice will not recur.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p><b>Completion Date:</b> May 28, 2016 The facility respectfully requests a face-to-face IDR. The facility contends that the citation and/or the scope and severity assigned is not justified. The facility requests the opportunity to present additional rationale and evidence for consideration and review at a face-to-face meeting. It is my understanding that ISDH will contact the Administrator to schedule such meeting. Thank you.</p>	

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	<p>medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review, and interview, the facility failed to maintain a resident's privacy related to the Physician being overheard from a distance discussing the resident's medical condition for 1 of 1 residents reviewed for privacy. (Resident #118)</p> <p>Finding includes:</p> <p>On 4/25/16 at 3:26 p.m., a male's voice was overheard from the conference room located in the facility's lobby. The male stated "You had a big bowel movement today. Good for you." After walking</p>	F 0164	Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b>	05/28/2016

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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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	<p>towards the male's voice down the first floor hallway, the man speaking inside a resident's room, was Resident #118's Physician. The Physician then started talking about how he thought they had better put the resident's Foley catheter back in due to not wanting his kidneys to shut down and his bladder to retain urine. The Physician's voice could be heard all the way down the hallway by the exit/entrance doors to the 100 hall. The Physician continued to speak about the resident's condition until he left the room.</p> <p>The record for Resident #118 was reviewed on 4/27/16 at 9:48 a.m. The resident's diagnoses included, but were not limited to, metabolic encephalopathy, dementia without behavioral disturbance, high blood pressure, heart failure, diabetes type 2, chronic kidney disease, retention of urine, anxiety, acute kidney failure, constipation, history of urinary stones.</p> <p>Interview with the Administrator and Director of Nursing on 4/27/16 at 8:45 a.m., indicated the resident's Physician should have closed the door to provide privacy for the resident. The Administrator indicated she would be speaking to the Medical Director regarding the issue.</p>		<p><b>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. F164</b></p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. The facility failed to maintain a resident's privacy related to the physician being overheard discussing the resident's medical condition for 1 of 1 residents reviewed for privacy.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Resident 118 is no longer a patient at the facility.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents have the potential to be affected. <b>To ensure that proper practices continue:</b> The Medical Director reviewed the cited regulation related to a patient's right to privacy with the physician in question. This physician also re-signed the Confidentiality Statement provided by the facility and signed by each Medical Staff Practitioner. In addition, all staff and contracted service personnel will be in-serviced regarding residents' right to privacy. The DON/Designee will initiate and complete a monitoring tool and</p>		

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	3.1-3(p)(2)		<p>conduct observations 5x/weekly for four weeks to ensure compliance with protecting patient's privacy related to this plan of correction. Each week, a minimum of 20 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audit tools again throughout the next 12 months, to ensure that this deficient practice will not recur. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed. <b>CompletionDate:</b> May 28, 2016 The facility respectfully requests a face-to-face IDR. The</p>	

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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to being dressed in an institutional manner of a hospital gown for 1 of 3 residents reviewed for dignity of the 7 residents who met the criteria for dignity. (Resident #69)</p> <p>Finding includes:</p> <p>On 4/24/16 at 11:45 a.m., Resident #69 was observed in bed wearing a hospital gown.</p> <p>On 4/25/16 at 11:00 a.m., the resident was observed in bed dressed in a purple short sleeved shirt.</p>	F 0241	<p>facility contends that the citation and/or the scope and severity assigned is not justified. The facility requests the opportunity to present additional rationale and evidence for consideration and review at a face-to-face meeting. It is my understanding that ISDH will contact the Administrator to schedule such meeting. Thank you.</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b></p>	05/28/2016

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	<p>On 4/25/16 at 2:15 p.m., the resident was observed in bed wearing a hospital gown.</p> <p>On 4/26/16 at 9:00 a.m., 11:15 a.m., and 2:25 p.m., the resident was observed in bed wearing a hospital gown.</p> <p>On 4/27/16 at 10:15 a.m., the resident was observed in bed wearing a hospital gown.</p> <p>Interview with the CNA #3 at that time, indicated she had cleaned the resident already and provided morning care. CNA #3 indicated the resident did have clothes in her closet and did not know why the resident was always dressed in a hospital gown.</p> <p>The record for Resident #69 was reviewed on 4/25/16 at 2:16 p.m. The resident's diagnoses included, but were not limited to, dementia, depressive disorder, Alzheimer's disease, high blood pressure, and atherosclerotic disease.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 4/14/16 indicated the resident had short and long term memory problems. The resident was severely impaired for decision making. The resident needed extensive assistance with two person physical assist for bed</p>		<p><b>and/or executed solely because it is required by the provision of federal and state law. F241</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility failed to ensure a resident's dignity was maintained related to being dressed in a hospital gown while in bed for 1 of 3 residents reviewed. <b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Resident 69 is severely impaired for decision making; however, she is offered preferences for clothing which are to be honored by staff. Facility staff clarified family preference for resident wearing hospital gowns when in bed; family stated they have "no problem" with resident wearing hospital gowns when in bed for comfort. Plan of Care updated accordingly. Facility staff also purchased a nightgown and robe to offer resident as an additional choice of comfortable clothing to wear while in bed.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents with impaired decision making capacity have the potential to be affected. <b>To ensure that proper practices continue:</b> DON/Designee will re-educate CNA staff regarding continually</p>	

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	<p>mobility. The resident needed extensive assist with one person physical assist for dressing, and toilet use. The resident and/or the family were not interviewed for her preferences.</p> <p>The current plan of care updated 4/2016 indicated there was no care plan for the resident's preference to be dressed in a hospital gown.</p> <p>Interview with LPN #1 on 4/27/16, at 10:25 a.m., indicated the resident had clothes in her closet and there was no reason why she could not be dressed in her clothes rather than a hospital gown.</p> <p>3.1-3(t)</p>		<p>offering clothing choices to all residents and honoring their preferences. The DON/Designee will initiate and complete a monitoring tool and conduct observations 5x/weekly for four weeks to ensure compliance with honoring individual preferences for clothing related to this plan of correction. Each week, a minimum of 20 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audit tools again throughout the next 12 months, to ensure that this deficient practice will not recur <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly throughout the</p>		

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F 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's call light was within reach for 1 of 28 residents observed during Stage 1. (Resident #201)</p> <p>Finding includes:</p> <p>On 4/25/16 at 9:05 a.m., Resident #201 was observed in her room seated in a wheelchair at the bedside. The resident's</p>	F 0246	<p>year. Recommendations for further corrective action will be discussed and implemented as needed. <b>Completion Date:</b> May28, 2016 The facility respectfully requests a face-to-face IDR. The facility contends that the citation and/or the scope and severity assigned is not justified. The facility requests the opportunity to present additional rationale and evidence for consideration and review at a face-to-face meeting. It is my understanding that ISDH will contact the Administrator to schedule such meeting. Thank you.</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b></p>	05/28/2016

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	<p>call light was on the opposite side of the bed. At that time, the resident indicated she could not reach her call light, and was in need of assistance.</p> <p>On 4/26/16 at 2:25 p.m., Resident #201 was observed in her room seated in a wheelchair at the bedside. The resident's call light was on the opposite side of the bed wrapped around the rail. At that time, the resident indicated she could not reach her call light.</p> <p>On 4/26/16 at 3:27 p.m., Resident #201 was observed in her bed. The resident's call light was hanging on the side of the bed on the floor. At that time, the resident indicated she could not find her call light, and was in need of assistance.</p> <p>The record for Resident #201 was reviewed on 4/26/16 at 3:40 p.m. Diagnoses included, but were not limited to, hypertension, urinary tract infection, atrial fibrillation, surgical aftercare on the digestive system, and osteoarthritis.</p> <p>The 30 Day Minimum Data Set (MDS) assessment dated 4/8/16, indicated the resident's Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact for decision making. The resident was an extensive assist for bed mobility. The</p>		<p><b>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. F246 A</b> resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences. The facility failed to ensure a resident's call light was within reach for 1 of 28 residents observed. <b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Resident 201 is continuously monitored to ensure call light is within her reach. To determine if any other residents had been affected by the deficient practice, rounds were immediately completed by DON/designee of all resident rooms to ensure call lights were within reach. All other call lights were found to be within resident reach. <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents have the potential to be affected. <b>To ensure that proper practices continue:</b> DON/Designee will re-educate facility staff. Staff is to ensure call light is within reach upon each</p>				

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	<p>resident's Range of Motion indicated the resident's upper extremities were impaired on both sides.</p> <p>Interview with ADON (Assistant Director of Nursing) #1 on 4/27/16 at 1:07 p.m., indicated the resident was capable of using the call light and she would expect any staff member to make sure the call light was within reach at all times.</p> <p>3.1-3(v)(1)</p>		<p>interaction with a patient or resident. The DON/Designee will initiate and complete a monitoring tool and conduct observations 5x/weekly for four weeks, on all three shifts, to ensure compliance with this plan of correction. Each week, a minimum of 30 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audit tools again throughout the next 12 months, to ensure that this deficient practice will not recur <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly throughout the year. Recommendations for further corrective action will be discussed and implemented as</p>	

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure the resident and/or the resident's responsible party were invited to care conferences periodically after each assessment for 2 of 4 residents reviewed for the participation in care planning of the 4 residents who met the criteria for the participation in care planning. (Resident #B &amp; #100)</p> <p>Findings include:</p> <p>1. On 4/25/16 at 9:47 a.m., Resident #B's</p>	F 0280	<p>needed. <b>Completion Date: May 28, 2016</b></p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b></p>	05/28/2016

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	<p>Power of Attorney (her daughter) was interviewed. At that time, the daughter indicated the facility had not invited her to a care plan meeting in over a year, since the new Administration had taken over. She indicated she had always attended the meetings.</p> <p>The record for Resident #B was reviewed on 4/26/16 at 9:11 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder, shortness of breath, osteoarthritis, Alzheimer's disease, dementia, and anxiety.</p> <p>A Quarterly Minimum Data Set (MDS) assessment had been completed on 3/3/16.</p> <p>The care plan had been updated on 3/2016.</p> <p>The last documented care conference note dated 1/7/15 indicated the resident and family were invited to the care plan meeting and the resident's daughter had attended.</p> <p>Social Service Progress notes dated 12/2015 through 4/26/16 indicated there was no documentation a care conference meeting had been held with the resident or daughter.</p>		<p><b>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. F280</b></p> <p>The resident and/or responsible party has the right to participate in planning care and treatment or changes in care and treatment. The facility failed to ensure the resident and/or the resident's responsible party were invited to care conferences periodically after each assessment for 2 of 4 residents reviewed. <b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Resident B: The resident and/or the responsible party were invited to attend a care plan conference with IDT representation. Care plan conference was held on 5/10/2016. Resident 100: The resident and/or the responsible party were invited to attend a care plan conference with IDT representation. Care plan conference is scheduled to be held on 5/16/2016. To determine if other residents had been affected by the deficient practice, an audit of care plan conference completion for all residents was done. Any residents found to have an overdue care conference were notified by Social Services and invited to attend a resident care conference <b>Identification of other residents having the</b></p>		

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	<p>On 4/26/16 at 2:14 p.m., Social Worker (SW) #1 was interviewed. At that time, the SW indicated she had not had a care plan meeting with the resident's daughter in a long time. She indicated her system was to call the families and set up the care plan meetings. She indicated a care conference was to be held with the resident and family at least quarterly and within the first 30 days for the new residents. SW #1 indicated she had been the only Social Worker for awhile and it was hard to plan and set up meetings for all the residents. She further indicated the facility now had another social service person with plans to hire a third one and she would be able to focus on the Second floor for the residents who were going to be more long term placement.</p> <p>2. Interview with Resident #100's responsible party member on 4/25/16 at 10:27 a.m., indicated he had not attended a Care Plan Conference for the resident nor received notice about a Care Plan Conference in over a year.</p> <p>The record for Resident #100 was reviewed on 4/26/16 at 10:14 a.m. Review of the Care Conference Notes indicated the last Quarterly Care Conference was scheduled on 4/15/15.</p> <p>Interview with Social Worker #1 on 4/27/16 at 2:23 p.m., indicated she had</p>		<p><b>potential to be affected by the same deficient practice:</b> All residents have the potential to be affected. <b>To ensure that proper practices continue:</b> The Administrator has in-serviced the Social Service staff regarding inviting each resident and/or responsible party to schedule a care conference with IDT representation per minimum guidelines and as needed. Participation in the care conference will be documented in the medical chart. Administrator/designee will initiate and complete a monitoring tool which will follow each resident's initial, quarterly or annual assessment to schedule care plan conference to ensure compliance with this plan of correction. Each week, an audit will be conducted of every resident scheduled for an initial, quarterly or annual review during the corresponding week to monitor compliance with this plan of correction 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that 100% compliance has not been achieved, the monitoring tools will continue for another four week period and will again be reviewed</p>	

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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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F 0309 SS=D Bldg. 00	<p>not scheduled any face-to-face the Care Conferences in over a year and the Care Conferences should be scheduled quarterly.</p> <p>3.1-35(c)(2)(C)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to ensure bruises and/or skin lesions were assessed and monitored for 3 of 3 residents reviewed for skin conditions (non-pressure related) of the 5 residents who met the criteria for skin conditions (non-pressure related). (Residents #56, #62, and #69)</p>	F 0309	<p>by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audit tools again throughout the next 12 months, to ensure that this deficient practice will not recur.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed. <b>Completion Date:</b> May 28, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b></p>	05/28/2016

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	<p>Findings include:</p> <p>1. On 4/24/16 at 5:11 p.m., Resident #62 was observed with a dark purple discoloration to the top of her left hand located between her thumb and index finger.</p> <p>The record for Resident #62 was reviewed on 4/25/16 at 3:06 p.m., the resident's diagnoses included, but were not limited to, anemia, history of falling and abnormality of gait and mobility.</p> <p>An entry in the Nursing Progress notes dated 4/23/16 at 5:53 p.m., indicated the resident was found on the floor. The resident indicated that she was trying to reach for a book and fell. A skin tear was noted to the resident's right posterior calf. There was no documentation related to bruising to the resident's left hand.</p> <p>Interview with the resident on 4/26/16 at 1:40 p.m., indicated that she received the bruise when she slipped out of her wheelchair.</p> <p>There was no documentation in the Nursing Progress notes between the dates of 4/23/16 and 4/27/16 related to a bruise on the resident's left hand, nor had an "event" entry been completed in the</p>		<p><b>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. F309</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with assessment and plan of care. The facility failed to ensure bruises and/or skin lesions were assessed and monitored for 3 of 5 residents reviewed. <b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Resident 62: Head to toe assessment performed on this resident. All areas of skin alteration have been identified and the medical record has been updated as appropriate with regard to facility policy. Resident 69: Head to toe assessment performed on this resident. All areas of skin alteration have been identified and the medical record has been updated as appropriate with regard to facility policy. Resident</p>		

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	<p>electronic medical record.</p> <p>Review of the Treatment book on 4/27/16 at 9:11 a.m., indicated there was no Non-pressure Skin sheet for Resident #62 for review.</p> <p>On 4/27/16 at 2:45 p.m., LPN #4 confirmed the presence of the bruise to the resident's left hand. The LPN proceeded to the computer and indicated the only event report that was completed was for the resident's skin tear. The LPN indicated she had not noticed the bruise. She indicated if she would have noticed it, she would have informed the Physician, asked the CNA's if they had noticed anything previously, and have completed an incident report as well as completed "event" charting in the computer.</p> <p>An "event" entry was completed on 4/27/16 at 3:51 p.m., which indicated the resident had a bruise to the left anterior hand that measured 5.9 centimeters (cm) x 3.5 cm. The bruise was documented as being black and blue in color. 2. On 4/25/16 at 8:33 a.m., Resident #69 was observed in bed. At that time, there was a discolored area that was purple and red in color noted to her right forearm. The resident was wearing a short sleeved shirt. The resident was also wearing one</p>		<p>56: Head to toe assessment performed on this resident. All areas of skin alteration have been identified and the medical record has been updated as appropriate with regard to facility policy. To determine if any other residents had been affected by the deficient practice, audit was completed of all residents' skin integrity. To correct if there were any skin alterations found, the medical record was updated as appropriate with regard to facility policy, including family and physician notification.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents with the potential for alteration in skin integrity have the potential to be affected. <b>To ensure that proper practices continue:</b> The DON/Designee will in-service the nursing staff regarding identification and documented monitoring of bruises and/or skin lesions. Nurses will be educated regarding completion of an event in the patient's medical record for any identified alteration in skin integrity. The DON/Designee will initiate and complete a monitoring tool and conduct direct skin observations 3x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 30 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA</p>	

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	<p>geri sleeve (protective sleeves designed to maintain skin integrity) to the left arm and there was no geri sleeve observed on the right arm.</p> <p>On 4/27/16 at 10:20 a.m., LPN #1 was asked to perform a skin assessment for the resident. At that time, the LPN removed the resident's right geri sleeve from her arm. There was a red/purple bruise observed on the resident's lower forearm.</p> <p>Interview with LPN #1 at that time, indicated she was unaware of the bruise to the resident's right forearm. She indicated when a bruise was observed, an Event was to be completed and episodic charting would begin.</p> <p>The record for Resident #69 was reviewed on 4/25/16 at 2:16 p.m. The resident's diagnoses included, but were not limited to, dementia, depressive disorder, Alzheimer's disease, high blood pressure, and atherosclerotic disease.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 4/14/16 indicated the resident had short and long term memory problems. The resident was severely impaired for decision making. The resident needed extensive assistance with two person physical assist for bed</p>		<p>Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audit tools again throughout the next 12 months, to ensure that this deficient practice will not recur. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed. <b>Completion Date:</b> May 28, 2016</p>				

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	<p>mobility and extensive assist with one person physical assist for dressing and toilet use.</p> <p>The current and updated 4/2016 plan of care indicated the resident may be at risk for skin breakdown related to cognitive and physical limitation with incontinence and inability to communicate. The Nursing approaches were to apply long sleeves or geri sleeves to bilateral arms to prevent skin tears and bruising.</p> <p>Nursing Progress notes dated 4/20-4/27/16 indicated there was no documentation regarding any bruising to the resident's right forearm.</p> <p>The Events section was reviewed. There were no documented Events noted in the resident's record from 4/20-4/26/16.</p> <p>An Event was initiated by LPN #1 on 4/27/16 at 10:00 a.m. The resident's bruise was described as a triangle shaped red and blue bruise to the right forearm. The bruise measured 2.2 centimeters (cm) by 1.2 cm</p> <p>Interview with the Assistant Director of Nursing (ADON) #1 on 4/27/16 at 11:40 a.m., indicated when a bruise was first observed the nurse was to create an Event in the computer and then proceed with</p>			

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	<p>episodic charting.</p> <p>3. On 4/24/16 at 11:35 a.m., Resident #56 was observed in her room seated in a wheelchair. There was a nickel sized purplish area noted to the resident's right upper cheek.</p> <p>On 4/26/16 at 10:41 a.m., LPN #2 was observed performing a skin assessment for the resident. At that time, she indicated there was a purplish area of irritation to the resident's right upper cheek.</p> <p>Interview with LPN #2 at that time, indicated she was the Nurse currently caring for the resident and she was not currently being monitored for an area to her right upper cheek. She was unaware of the resident having any facial bruising, irritations, and/or lesions. The LPN then checked the computer for verification.</p> <p>The record for Resident #56 was reviewed on 4/25/16 at 3:05 p.m. The resident's diagnoses included, but were not limited to, heart failure, Parkinson's Disease, major depression, and a history of skin cancer.</p> <p>Review of the Nursing Progress notes dated 4/1/16 through 4/25/16 indicated no evidence of documentation related to the nickel sized purplish area to the</p>			

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F 0312 SS=D	<p>resident's right upper cheek.</p> <p>Review of the CNA Shower Sheets, which also included skin assessments by the Nursing staff, dated 2/2/16 through 4/25/16, indicated no evidence of documentation related to the nickel sized purplish area to the resident's right upper cheek.</p> <p>Interview with LPN #8 on 4/27/16 at 9:42 a.m., indicated non-pressure skin assessments and/or monitoring was charted by the Nursing staff in the progress notes.</p> <p>Interview with the Director of Nursing on 4/28/16 at 9:15 a.m., indicated it was her expectation for Nursing staff to assess and complete episodic charting (nursing progress notes) for non-pressure skin related issues such as skin irritations and/or lesions until the area was resolved. Further interview indicated the Nursing staff had assessed the skin irritation on 4/26/16 and had not been documenting the continued monitoring of the facial skin irritation in the Nursing Progress Notes (episodic charting).</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT</p>			

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Bldg. 00	<p><b>RESIDENTS</b></p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a dependent resident was provided with toileting and incontinence care every two hours for 1 of 1 residents reviewed for activities of daily living of the 1 resident who met the criteria for activities of daily living. (Resident #B)</p> <p>Finding includes:</p> <p>Interview with Resident #B's Power of Attorney (her daughter) on 4/25/16 at 9:41 a.m., indicated she does not think her mom gets the help going to the toilet she needed to maintain some urinary continence.</p> <p>On 4/26/16 10:03 a.m., Resident #B was observed being wheeled out of the shower room. At that time, CNA #4 indicated the resident had just received a shower. The CNA indicated her clothes and incontinent brief were changed as well at that time. The resident was taken into the dining room on the second floor to attend the activity of yoga.</p> <p>On 4/26/16 from 10:05 a.m. until 11:10</p>	F 0312	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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. F312</b></p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to ensure a dependent resident was provided with toileting every two hours for 1 of 1 residents reviewed. <b>Corrective action taken for residents found to</b></p>	05/28/2016

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	<p>a.m., the resident remained in the dining room in the activity of yoga.</p> <p>At 11:12 a.m., a visitor came and wheeled the resident out of the dining room to the D-Wing lounge, where they remained visiting.</p> <p>At 11:57 a.m. the visitor wheeled the resident to her room and placed her in the hallway right outside the room. The visitor was observed to place something in her room and then walked out of the room and pushed the resident to the dining room, where she was seated at her table. The resident received her lunch tray at 12:22 p.m.</p> <p>On 4/26/16 at 1:19 p.m., the resident was observed being wheeled out of the dining room by another visitor. The resident was again wheeled to the D-Wing lounge area. At that time, the visitor indicated she was the resident's daughter. The resident's daughter indicated she had arrived at the facility about half way through the lunch and was going to help her mom eat.</p> <p>Continued observation from 1:19 p.m. until 2:38 p.m., the resident remained in the D-Wing lounge area with her daughter. There was no Nursing staff observed at those times, to offer and/or</p>		<p><b>have been affected by the deficient practice:</b> Resident B will be monitored to ensure toileting is offered every two hours and/or as needed.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents who require assistance with toileting have the potential to be affected.</p> <p><b>To ensure that proper practices continue:</b> The DON/Designee will re-educate the nursing staff regarding offering toileting assistance to each resident who requires assistance with toileting at a minimum of every two hours and/or as needed. Education will focus on offering toileting assistance to these residents even when visitors are present or when the resident is involved in an activity. Education for nurses will focus on monitoring CNAs to ensure compliance with this plan of correction. The DON/Designee will initiate and complete a monitoring tool and conduct observations 5x/weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 30 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 100%</p>		

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	<p>assist the resident to the use the bathroom.</p> <p>At 2:33 p.m., on 4/26/16, CNA #2 was asked if she had taken the resident to the bathroom since she had started her shift at 2:00 p.m. The CNA indicated she had not, but would go and get her now.</p> <p>On 4/26/16 at 2:38 p.m., the resident was placed on the toilet. At that time, CNA #2 was unaware as to when the last time the resident had used to the bathroom. She indicated, end of shift report was to be provided by the CNA who was leaving, but that did not happen today.</p> <p>Interview with CNA #1 on 4/26/16 at 2:40 p.m., indicated she had taken care of Resident #B earlier in the day, and was working a double shift. She indicated she had not checked or taken the resident to the toilet at all since she received her shower earlier in the morning. The CNA indicated she was going to toilet her after lunch, but had to stay in the dining room with the residents while they finished eating. When lunch was over, the CNA indicated the resident's daughter was there visiting, and she was going to take her to the bathroom when she left.</p> <p>Interview with LPN #2 on 4/26/16 at 2:45 p.m., indicated she was Resident</p>		<p>compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audittools again throughout the next 12 months, to ensure that this deficientpractice will not recur. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewedmonthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed. <b>Completion Date:</b> May28, 2016</p>		

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	<p>#B's nurse. The LPN indicated she does not ask the CNAS if they made sure they were toileting the residents every 2 hours.</p> <p>The record for Resident #B was reviewed on 4/26/16 at 9:11 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder, shortness of breath, osteoarthritis, Alzheimer's disease, dementia, and anxiety.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 3/3/16 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 4, indicating she was severely impaired for decision making and not alert and oriented. The resident was coded as having no behaviors. The resident needed extensive assist with two person physical assist for transfers, toileting, and personal hygiene. The resident was frequently incontinent of urine and bowel and was not on any toileting program.</p> <p>The current and updated 3/2016 plan of care indicated the resident was frequently incontinent of bladder and required extensive assist with her toileting needs. The Nursing approaches were to check for incontinence and the need to use the toilet approximately ever two hours.</p> <p>A bladder assessment dated 3/3/16</p>			

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F 0315 SS=D Bldg. 00	<p>indicated the resident had multiple urinary incontinent episodes daily. The needs of the resident were to assist to the toilet and the resident eliminated on the toilet.</p> <p>Interview with the ADON #1 on 4/26/16 at 3:00 p.m., indicated the residents were to be checked and/or changed and taken to the toilet every two hours.</p> <p>3.1-38(a)(2)(C)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to follow their policy regarding proper Foley (indwelling urinary) catheter care for 1 of 3 residents reviewed for urinary catheter use of the 3 residents who met the criteria for urinary catheter use. (Resident #78)</p>	F 0315	Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b>	05/28/2016

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	<p>Finding includes:</p> <p>On 4/26/16 at 11:11 a.m., the resident was observed in the hallway sitting in his wheelchair. At that time, the resident was observed with an indwelling Foley catheter.</p> <p>On 4/26/2016 at 3:50 p.m., Foley catheter care was observed with LPN #3. The resident was put into bed and his brief was removed. The LPN wet a washcloth with the solution of periwash. She began to retract the foreskin and cleansed the head of the penis and around the head, and back on top again. The nurse went back into the bathroom for a dry washcloth and began to dry the area she had previously cleaned. She then attached his brief and pulled up his pants.</p> <p>The record for Resident #78 was reviewed on 4/25/16 at 2:41 p.m. The resident's diagnoses included, but were not limited to, heart failure, stroke, hemiplegia, major depressive disorder, urinary retention, and personal history of other diseases of urinary system with recent hematuria.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 3/16/16 indicated the resident's Brief Interview</p>		<p><b>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. F315</b></p> <p>The facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. The facility failed to follow their policy regarding proper Foley(indwelling urinary) catheter care for 1 of 3 residents reviewed for urinary catheter use of the 3 who met the criteria for urinary catheter use. Foley catheter care was observed for 1 of 3 residents who met the criteria for urinary catheter use.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Resident 78: The</p>		

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	<p>for Mental Status (BIMS) score was an 11 indicating the resident's cognition was moderately impaired for decision making. The resident needed extensive assist with 1 person physical assist for dressing, toilet use and personal hygiene. The resident was frequently incontinent of bowel and bladder.</p> <p>Physician orders dated 3/22/16 indicated an indwelling Foley catheter 16 French and 30 cubic centimeters (cc) balloon for the diagnosis of urinary retention, and Foley catheter care every shift (days, evenings, nights).</p> <p>Physician Orders dated 3/24/16, 4/5/16, and 4/15/16 indicated Urinalysis (UA) and Culture and Sensitivity (C&amp;S).</p> <p>The Medication Administration Records (MARS) for 3/2016 and 4/2016 were reviewed. The resident had received Bactrim DS (an antibiotic) 800/160 milligram (mg) tablet for 7 days for a diagnosis of a Urinary Tract Infection (UTI) from 3/27/16 thru 4/1/16, and then continued on the same medication and dose from 4/2/16 thru 4/12/16. The resident was started on Cephalexin (an antibiotic) 250 mg three times a day for a diagnosis of a UTI from 4/1/16 thru 4/4/16. The resident was started on Cipro (an antibiotic) 250 mg twice daily for</p>		<p>indwelling urinary catheter was removed. <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents with an indwelling urinary catheter have the potential to be affected. <b>To ensure that proper practices continue:</b> The DON/Designee will re-educate nursing staff regarding the policy for Catheter Care Procedure. The DON/Designee will initiate and complete a monitoring tool and conduct observations of catheter care 2x/weekly for four weeks, on all three shifts, to ensure compliance with this plan of correction. Each week, a minimum of eight 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audittools again throughout the next 12 months, to ensure that this deficientpractice</p>	

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	<p>diagnosis of a UTI from 4/17/16 thru 4/24/16.</p> <p>The care plan dated 3/25/16 indicated potential for complication related to need for urinary indwelling catheter. The Nursing interventions included "to have the urinary indwelling catheter remain free of complications daily, and ....provide catheter care every shift."</p> <p>The Catheter Care Procedure Policy dated effective 6/1/15 and deemed current by ADON #1 was reviewed. The policy indicated for the resident to lie on his back and expose the perineal area, for the nurse to wash hands and put on non sterile gloves. The policy then directed, "In the male resident retract the foreskin if uncircumcised, and begin at the tip of the penis washing in a circular motion then progress outward cleaning the proximal 1/3 of the catheter. Continue to wash the penis, scrotum and inner thighs. Gently pat area dry with a towel drying the areas in the same fashion as washing." Then, staff should remove gloves and wash hands.</p> <p>Interview on 4/24/16 at 11:51 a.m. with Assistant Director of Nursing (ADON) #1, indicated Resident #78 had a Foley catheter due to the diagnoses of urinary retention.</p>		<p>will not recur. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed. <b>Completion Date:</b> May 28, 2016 The facility respectfully requests a face-to-face IDR. The facility contends that the citation and/or the scope and severity assigned is not justified. The facility requests the opportunity to present additional rationale and evidence for consideration and review at a face-to-face meeting. It is my understanding that ISDH will contact the Administrator to schedule such meeting. Thank you.</p>		

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F 0329 SS=D Bldg. 00	<p>Interview with CNA #7 on 4/26/16 at 3:08 p.m., indicated that she does perform Foley catheter care on the residents by wiping the tubing with antiseptic wipes.</p> <p>Interview with ADON #1 on 4/27/16 at 1:40 p.m., indicated she would expect the staff member to follow the care policy to perform the task. She further indicated the nurse did not perform the catheter care correctly and she would need to educate the staff.</p> <p>3.4-41(a)(2)</p> <p>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.</p> <p>Based on a comprehensive assessment of a</p>			

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	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs related to the lack of proper indications for the continued use of psychotropic medications for 1 of 5 resident reviewed for unnecessary medications. (Resident #100)</p> <p>Finding includes:</p> <p>The record for Resident #100 was reviewed on 4/26/16 at 10:14 a.m. Diagnoses included but were not limited to dementia with behaviors and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, completed on 10/9/15, indicated the resident had mild depression and no mood or behavior issues.</p> <p>The current and updated Care Plan indicated the resident was at risk for</p>	F 0329	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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. F329</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. The facility failed to ensure each resident's drug regimen was free from unnecessary drugs related to the lack of proper</p>	05/28/2016

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	<p>adverse consequences related to antipsychotic medication use. The approaches included, but were not limited to, administer medications as ordered, gradual dose reduction review at least quarterly, observe for central nervous system disturbances, and pharmacy review at least quarterly.</p> <p>The Physician's Orders dated 12/24/15 included orders for Celexa (an anti-depressant medication) 10 milligrams (mg) every other day and Zyprexa (an antipsychotic medication) 5 mg every night.</p> <p>A Consultant Pharmacist's Medication Regimen Review sheet dated 10/23/15 indicated the resident was on Zyprexa 5 mg nightly at bedtime for dementia with behavior disturbances and was due for a re-evaluation of the dosage. The Pharmacist's recommendation was to reduce the Zyprexa to 2.5 mg nightly at bedtime. The Physician indicated she declined the recommendation. There was no evidence of documentation providing a specific rationale as to why a dose reduction attempt would or would not be contraindicated at that time.</p> <p>A Consultant Pharmacist's Medication Regimen Review sheet dated 11/24/15 indicated the resident was on Zyprexa 5</p>		<p>indications for the continued use of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Resident 100: Resident 100 most recently had a reduction in psychotropic medication in April 2016. Medication review completed by Pharmacist. Recommendation discussed with attending Physician. Medical Director and attending Physician reviewed Resident 100's medication regimen with orders received to discontinue psychotropic medication due to stability of Resident 100's mood and behavior. Facility staff will continue to monitor Resident 100 for mood and/or behavior indicators.</p> <p>To determine if any other residents had already been affected by the deficient practice, Director of Nursing/designee completed 100% audit of resident antipsychotic drug usage in relation to gradual does reduction. Physician was contacted if GDR attempt had not been completed or physician had not documented rationale for no reduction <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents with orders for antipsychotic medication have the potential to be affected. <b>To</b></p>	

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	<p>mg nightly at bedtime and Celexa 10 mg every other day. The resident was discussed in the behavior meeting on 11/20/15 and her last depression score indicated she suffered from mild depression. The Pharmacist's recommendation was to increase the Celexa to 10 mg every day. The Physician indicated she declined the recommendation, "Patient dosing appropriate, Thanks." There was no evidence of documentation providing a specific rationale as to why a dose reduction attempt would or would not be contraindicated at that time.</p> <p>A Consultant Pharmacist's Medication Regimen Review sheet dated 4/9/16 indicated the resident was on Zyprexa 5 mg nightly at bedtime and Celexa 10 mg every other day and was due for a re-evaluation of the dosages. She was discussed in the behavior meeting on 4/8/16 and staff mentioned she had declined and was showing no signs of behaviors. The Pharmacist recommendation was to reduce the Zyprexa to 2.5 mg nightly for 2 weeks then discontinue. The Physician indicated, "Stop Celexa. Do not stop Zyprexa, Thanks." There was no evidence of documentation providing a specific rationale as to why a dose reduction attempt would be</p>		<p><b>ensure that proper practices continue:</b> The attending physician has been re-educated by the Medical Director related to clearly documenting a specific rationale for continued use of psychotropic medications. Each month, the Behavior Management Committee will review Gradual Dose Reduction (GDR) requests and Physician responses in order to monitor compliance with this plan of correction and/or identify trends to review with the facility's QAA Committee. This monitoring will continue monthly for three months. After the third month, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another one month period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audittools again throughout the next 12 months, to ensure that this deficientpractice will not recur</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA</p>	

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F 0431 SS=D Bldg. 00	<p>contraindicated for the Zyprexa.</p> <p>Review of the Nursing Progress notes dated 8/2015 through 4/2016 indicated no documentation of any continued behaviors.</p> <p>Review of the Physician's Progress notes dated 8/11/15, 10/22/15, 12/21/15, and 2/23/16 indicated no documentation related to behaviors.</p> <p>Interview with the Director of Nursing (DON) on 4/26/16 at 1:20 p.m., indicated the Physician had been made aware of proper documentation for the indication of use related to psychotropic medications. Continued interview with the DON on 4/28/16 at 11:55 a.m., indicated there had been no behavior monitoring and or tracking completed for the resident.</p> <p>3.1-48(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS 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</p>		<p>Committee. Findings from all audit tools will continue to be reviewed monthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p><b>Completion Date:</b> May 28, 2016 The facility respectfully requests a face-to-face IDR. The facility contends that the citation and/or the scope and severity assigned is not justified. The facility requests the opportunity to present additional rationale and evidence for consideration and review at a face-to-face meeting. It is my understanding that ISDH will contact the Administrator to schedule such meeting. Thank you.</p>		

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	<p>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 record review, the facility failed to ensure multidose medications related to insulin vials and inhalers were dated when opened for 1 of 3 units throughout the facility. (The First floor)</p> <p>Finding includes:</p> <p>On 4/28/16 at 10:02 a.m., two vials of Levemir Insulin were observed in the</p>	F 0431	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b></p>	05/28/2016

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	<p>First floor medication refrigerator. Both vials of Insulin had not been dated when they were opened.</p> <p>Interview with LPN #5 at the time, indicated the vials of Insulin had recently been delivered but should have been dated when they were opened.</p> <p>At 10:10 a.m., a Combivent inhaler was observed in the Medication Cart for the "A" hall on the First floor. LPN #6 indicated the inhaler had been opened. There was no date on the label to indicate when the inhaler had been opened. The Pharmacy label on the box indicated the inhaler was to be discarded 90 days after opening.</p> <p>Continued interview with LPN #6 at this time, indicated the inhaler had not been dated when opened.</p> <p>The facility policy titled "Preparation and General Guidelines for Vials and Ampules of Injectable Medications" was reviewed. The policy was provided by the Director of Nursing on 4/28/16 at 10:42 a.m., and identified as current. The policy indicated the following: "The date opened and the initials of the first person to use the vial are recorded on multidose vials (on the vial label or an accessory label affixed for that purpose)."</p>		<p><b>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</b></p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the expiration date when applicable. The facility failed to ensure multidose medications related to insulin vials and inhalers were dated when opened for 1 of 3 units throughout the facility.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b> The two multidose insulin vials were discarded immediately. The one inhaler was discarded immediately. To determine if any other residents were affected by the deficient practice, an audit was immediately completed by the Director of Nursing/designee of all medication storage areas. No other medications were found that were expired or not labeled</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> Residents receiving medication from multidose vials</p>	

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	3.1-25(j)		and/or inhalers have the potential to be affected. <b>To ensure that proper practices continue:</b> The DON/Designee will in-service nurses on pharmacy policy regarding proper labeling of multiuse medications. The DON/Designee will initiate and complete a monitoring tool and conduct audits of the facility's ten medication storage areas weekly for four weeks to ensure compliance with this plan of correction. Each week, ten 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audittools again throughout the next 12 months, to ensure that this deficientpractice will not recur. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from	

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F 0441 SS=D Bldg. 00	<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. (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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by</p>		all audit tools will continue to be reviewed monthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed. <b>Completion Date:</b> May 28, 2016	

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	<p>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, record review and interview, the facility failed to handle and transport clean linens in a manner to prevent the spread of infection for 1 of 3 units. (The Second Floor)</p> <p>Findings include:</p> <p>1. On 4/25/16 at 2:50 p.m. on the second floor unit, CNA #4 was observed walking down the hallway, carrying an unfolded linen underpad fanning it up and down and against her body. The CNA was then observed walking into a resident's room.</p> <p>Interview with CNA #4 on 4/25/16 at 2:56 p.m., indicated she was aware she should not carry linens in the hallway against her body.</p> <p>2. On 4/25/16 at 2:52 p.m., on the second floor unit, CNA #5 was observed walking down the hallway, carrying 3 clean linen underpads tucked under her arm and against her body. At that time, she stopped by a resident's room, walked into the room, where there were 2 CNAS. She stood there and talked with them, then walked out of the room with the 3</p>	F 0441	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b></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. The facility failed to handle and transport clean linens in a manner to prevent the spread of infection for 1 of 3 units</p>	05/28/2016

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	<p>folded underpads still against her body and continued to walk down the hallway into another resident's room.</p> <p>CNA #5 was informed on 4/25/16 at 2:54 p.m., she should not be transporting linens down the hallway against her body. The CNA indicated "Oh, ok thank you."</p> <p>3. On 4/26/16 at 9:25 a.m., on the second floor unit, CNA #1 was observed carrying a clean unfolded linen underpad below her waist and against her body as she walked into resident's room.</p> <p>4. On 4/28/16 at 5:20 a.m., on the second floor unit, CNA #6 was observed standing outside a resident room. At that time, there was a three compartment soiled linen and trash bin by the resident's room. There were 6 clean folded bath towels observed on top of the soiled linen bin.</p> <p>Interview with CNA #6 on 4/28/16 at 5:48 a.m., indicated there were three bins on the linen cart, one for personal soiled linen, one for regular soiled linen, and one for garbage. She further indicated, when asked if the clean towels should have been placed on top of the soiled linen cart, "Probably not."</p>		<p>(second floor). <b>Corrective action taken for residents found to have been affected by the deficient practice:</b> Not applicable <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents on the second floor have the potential to be affected. <b>To ensure that proper practices continue:</b> The DON/Designee will re-educate CNAs on proper transportation of linen in order to adhere to infection control guidelines. The DON/Designee will initiate and complete a monitoring tool and conduct observations 5x/weekly for four weeks, on all three shifts, to ensure compliance with this plan of correction. Each week, a minimum of 25 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly</p>				

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F 0469 SS=D Bldg. 00	<p>The current 7/1/15 Linen and Laundry Handling policy provided by the Director of Nursing (DON) indicated designated nursing staff transport linen from linen closet to resident rooms.</p> <p>Interview with the DON on 4/27/16 at 8:45 a.m., indicated the CNAs should not be carrying the linen against their body or unfolded down the hallway.</p> <p>Interview with the Staff Development Coordinator on 4/28/16 at 9:30 a.m., indicated the CNAs should not be handling the clean linen against their bodies while transporting it down the hallway.</p> <p>3.1-19(g)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to maintain an effective pest control program to ensure the facility was free of pests related to ants in 1 of 3 dining rooms in the facility. (The First Floor Dining Room)</p> <p>Finding includes:</p>	F 0469	<p>initiating all audittools again throughout the next 12 months, to ensure that this deficientpractice will not recur. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewedmonthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed. <b>Completion Date:</b> May 28, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>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</b></p>	05/28/2016	

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	<p>On 4/24/16 at 12:29 p.m., during the First Floor dining room lunch observation, live ants were observed crawling on the floor along the edges of the base boards. The live ants were also observed crawling along the seats of the chairs that were stored along the back wall of the dining room.</p> <p>On 4/26/16 at 8:30 a.m., and 2:20 p.m., live ants were observed crawling on the floor along the edges of the base boards.</p> <p>Interview with the Maintenance Supervisor and the Housekeeping Supervisor on 4/26/16 at 2:41 p.m., indicated there were live ants crawling on the floor along the base boards of the First Floor dining room. Pest control had last been in the facility on 4/25/16, however, they were in the facility to treat the therapy room and some of the resident's rooms.</p> <p>3.1-19(f)(4)</p>		<p><b>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. F469</b></p> <p>The facility must maintain an effective pest control program so the facility is free of pests and rodents. The facility failed to maintain an effective pest control program to ensure the facility was free of pests related to ants in 1 of 3 dining rooms in the facility (first floor dining room).</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b> No residents found to have been directly affected. To immediately rid the facility of ants, Terminix was called out to the facility to spray/treat all inside areas, including first floor dining room. <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents utilizing the first floor dining room have the potential to be affected.</p> <p><b>To ensure that proper practices continue:</b> The Administrator/Designee will</p>		

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			<p>initiate and complete a monitoring tool and conduct observations of the first floor dining area 5x/weekly for four weeks to ensure the facility remains free from pests related to ants. Each week, a minimum of five audits will be conducted to monitor compliance 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systematic plan will be randomly initiating all audittools again throughout the next 12 months, to ensure that this deficientpractice will not recur. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewedmonthly throughout the year. Recommendations for further corrective action will be discussed and implemented as needed. <b>Completion Date:</b> May28, 2016 The facility</p>	

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			respectfully requests a face-to-face IDR. The facility contends that the citation and/or the scope and severity assigned is not justified. The facility requests the opportunity to present additional rationale and evidence for consideration and review at a face-to-face meeting. It is my understanding that ISDH will contact the Administrator to schedule such meeting. Thank you.		