STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00446393 & IN00448161. Complaint IN00446393 - State deficiency related to the allegations is cited at R0217. Complaint IN00448161 - State deficiency related to the allegations is cited at R0217. Survey date: December 23, 2024 Facility number: 010937 Residential Census: 94 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/6/25.	R 0000		
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217	Assisted Living at Hartsfield Village	02/10/2025

	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to		10002 Columbia Avenue Munster, Indiana 46321 **This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.** **R0217**	

	be provided. 3. The record for Resident C was reviewed on 12/23/24 at 11:55 a.m. The diagnoses included, but were not limited to, high blood pressure, diabetes, and dementia. A Semi-Annual Assessment, dated 6/24/24, indicated the resident was alert and oriented to person and was modified independent with bed, chair and toilet transfers. The resident required modified equipment and used a cane. The Service Plan was not updated to include the resident's multiple falls. During an interview on 12/23/24 at 3:36 p.m., the Director of Nursing (DON) indicated fall preventions were not included on the service plan because there was no template for it in their EMR (electronic medical record). They used to be included when the facility used paper charts. This citation relates to Complaint IN00446393 and IN00448161. Based on record review and interview, the facility failed to ensure service plans were reviewed and revised as appropriate for 3 of 5 resident records reviewed. (Residents B,		At least semi-annually, the facility shall update the residents' service plan regarding fall prevention or safety precautions. The facility failed to ensure the residents' service plan was updated regarding fall prevention. **Corrective action taken for residents found to have been affected by the deficient practice:** The facility reviewed all residents with falls and added fall prevention to their service plan. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. **To ensure that proper practices continue:**	

C, and E)

Findings include:

1. The record for Resident B was reviewed on 12/23/24 at 12:15 p.m. Diagnoses included, but were not limited to, Parkinson's disease, hypertension (high blood pressure), repeated falls, and transient ischemic attack (a short period of symptoms similar to a stroke).

A Semi-Annual Assessment, dated 9/14/24, indicated the resident had mild cognitive impairment, needed one-person physical assist for transfers, and needed one-person physical assist with bathing / showering.

A Progress Note, dated 10/12/24, indicated the resident had an unwitnessed fall in his bathroom, which resulted in two abrasions to his right knee.

A Progress Note, dated 10/18/24, indicated the resident fell alone in his bathroom trying to wash his hair in the sink.

A Progress Note, dated 12/9/24, indicated the resident had an unwitnessed fall when he attempted to walk from his bed to the bathroom.

Director of Nursing/Designee will re-educate the nursing staff regarding
the requirement for the facility to add fall prevention or safety precautions to
the residents' service plan.

The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random audits of compliance for residents with falls for the next six
months to ensure compliance with this plan of correction. Representatives
from the QAA Committee will review the QA tool monthly. After six months, the committee will determine if the facility has achieved at least 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 six- month period and will again be reviewed by
the QAA Committee. This practice will continue until the facility has achieved
at least 100% compliance and has ensured the deficient practice will not recur.

	A Service Plan, reviewed on 12/23/24, lacked any fall prevention or safety precautions. During an interview on 12/23/24 at 3:36 p.m., the Director of Nursing (DON) indicated fall preventions were not included in the service plans because there was no template for it in their EMR (electronic medical record). They used to be included when the facility used paper charts. 2. The record for Resident E was reviewed on 12/23/24 at 2:53 p.m. Diagnoses included, but were not limited to, hypertension, wedge compression L-5 (lumbar disk 5), disorder of the trigeminal nerve, and a history of falling. An Admission Assessment, dated 10/8/24, indicated the resident was cognitively intact, needed one-person physical assist for transfers, and needed one-person physical assist with bathing / showering. A Progress Note, dated 10/28/24, indicated the resident had an unwitnessed fall in her bathroom.		**Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 6 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** February 10, 2025	

A Progress Note, dated 11/7/24, indicated the resident fell alone in her bathroom, resulting in a skin tear to her arm and severe back pain. She was taken to the hospital for evaluation.

A Progress Note, dated 12/13/24, indicated the resident fell and had a bruise to her face and left arm.

A Service Plan, reviewed on 12/23/24, lacked fall prevention or safety precautions.

During an interview on 12/23/24 at 3:36 p.m., the Director of Nursing indicated fall preventions were not included in the service plans because there was no template for it in their EMR (electronic medical record). They used to be included when the facility used paper charts.

3. The record for Resident C was reviewed on 12/23/24 at 11:55 a.m. The diagnoses included, but were not limited to, high blood pressure, diabetes, and dementia.

A Semi-Annual Assessment, dated 6/24/24, indicated the resident was alert and oriented to person and was modified independent with bed, chair and toilet transfers. The resident required modified equipment and used a cane.

The Service Plan was not

updated to include the resident's multiple falls.

During an interview on 12/23/24 at 3:36 p.m., the Director of Nursing (DON) indicated fall preventions were not included on the service plan because there was no template for it in their EMR (electronic medical record). They used to be included when the facility used paper charts.

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Based on record review and interview, the facility failed to ensure service plans were reviewed and revised as appropriate for 3 of 5 resident records reviewed. (Residents B, C, and E)

Findings include:

1. The record for Resident B was reviewed on 12/23/24 at 12:15 p.m. Diagnoses included, but were not limited to, Parkinson's disease, hypertension (high blood pressure), repeated falls, and transient ischemic attack (a short period of symptoms similar to a stroke).

A Semi-Annual Assessment, dated 9/14/24, indicated the resident had mild cognitive impairment, needed one-person physical assist for transfers, and

	needed one-person physical assist with bathing / showering. A Progress Note, dated 10/12/24, indicated the resident had an unwitnessed fall in his bathroom, which resulted in two abrasions to his right knee. A Progress Note, dated 10/18/24, indicated the resident fell alone in his bathroom trying to wash his hair in the sink. A Progress Note, dated 12/9/24, indicated the resident had an unwitnessed fall when he attempted to walk from his bed to the bathroom. A Service Plan, reviewed on 12/23/24, lacked any fall prevention or safety precautions. During an interview on 12/23/24 at 3:36 p.m., the Director of Nursing (DON) indicated fall preventions were not included in the service plans because there was no template for it in their EMR (electronic medical record). They used to be included when the facility used paper charts.			

2. The record for Resident E was reviewed on 12/23/24 at 2:53 p.m. Diagnoses included, but were not limited to, hypertension, wedge compression L-5 (lumbar disk 5), disorder of the trigeminal nerve, and a history of falling.

An Admission Assessment, dated 10/8/24, indicated the resident was cognitively intact, needed one-person physical assist for transfers, and needed one-person physical assist with bathing / showering.

A Progress Note, dated 10/28/24, indicated the resident had an unwitnessed fall in her bathroom.

A Progress Note, dated 11/7/24, indicated the resident fell alone in her bathroom, resulting in a skin tear to her arm and severe back pain. She was taken to the hospital for evaluation.

A Progress Note, dated 12/13/24, indicated the resident fell and had a bruise to her face and left arm.

A Service Plan, reviewed on 12/23/24, lacked fall prevention or safety precautions.

During an interview on 12/23/24 at 3:36 p.m., the Director of Nursing indicated fall preventions were not included in the service plans because there was no template for it in their

EMR (electronic medical record). They used to be included when the facility used paper charts.

3. The record for Resident C was reviewed on 12/23/24 at 11:55 a.m. The diagnoses included, but were not limited to, high blood pressure, diabetes, and dementia.

A Semi-Annual Assessment, dated 6/24/24, indicated the resident was alert and oriented to person and was modified independent with bed, chair and toilet transfers. The resident required modified equipment and used a cane.

The Service Plan was not updated to include the resident's multiple falls.

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2. The record for Resident E was reviewed on 12/23/24 at 2:53 p.m. Diagnoses included, but were not limited to, hypertension, wedge compression L-5 (lumbar disk 5), disorder of the trigeminal nerve, and a history of falling.

An Admission Assessment, dated 10/8/24, indicated the resident was cognitively intact, needed one-person physical assist for transfers, and needed one-person physical assist with bathing / showering.

A Progress Note, dated 10/28/24, indicated the resident had an unwitnessed fall in her bathroom.

A Progress Note, dated 11/7/24, indicated the resident fell alone in her bathroom, resulting in a skin tear to her arm and severe back pain. She was taken to the hospital for evaluation.

A Progress Note, dated

12/13/24, indicated the resident fell and had a bruise to her face and left arm.

A Service Plan, reviewed on 12/23/24, lacked fall prevention or safety precautions.

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3. The record for Resident C was reviewed on 12/23/24 at 11:55 a.m. The diagnoses included, but were not limited to, high blood pressure, diabetes, and dementia.

A Semi-Annual Assessment, dated 6/24/24, indicated the resident was alert and oriented to person and was modified independent with bed, chair and toilet transfers. The resident required modified equipment and used a cane.

The Service Plan was not updated to include the resident's multiple falls.

During an interview on 12/23/24 at 3:36 p.m., the Director of Nursing (DON) indicated fall preventions were not included on the service plan because

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S	TITLE	(X6) DATE

SIGNATURE		