

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2025
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2024	
NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 10002 COLUMBIA AVE MUNSTER, IN 46321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00446393 & IN00448161.</p> <p>Complaint IN00446393 - State deficiency related to the allegations is cited at R0217.</p> <p>Complaint IN00448161 - State deficiency related to the allegations is cited at R0217.</p> <p>Survey date: December 23, 2024</p> <p>Facility number: 010937</p> <p>Residential Census: 94</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 1/6/25.</p>		R 0000				
R 0217 Bldg. 00	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>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)</p> <p>Findings include:</p> <p>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).</p>		R 0217	<p>Assisted Living at Hartsfield Village 10002 Columbia Avenue Munster, Indiana 46321</p> <p>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</p>		02/10/2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Alyssa

Fusco

01/23/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 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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	<p>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.</p> <p>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.</p> <p>A Progress Note, dated 10/18/24, indicated the resident fell alone in his bathroom trying to wash his hair in the sink.</p> <p>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.</p> <p>A Service Plan, reviewed on 12/23/24, lacked any fall prevention or safety precautions.</p> <p>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.</p> <p>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.</p> <p>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.</p>		<p>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.</p> <p>R0217 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.</p> <p>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.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.</p> <p>To ensure that proper practices continue:</p>				

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	<p>A Progress Note, dated 10/28/24, indicated the resident had an unwitnessed fall in her bathroom.</p> <p>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.</p> <p>A Progress Note, dated 12/13/24, indicated the resident fell and had a bruise to her face and left arm.</p> <p>A Service Plan, reviewed on 12/23/24, lacked fall prevention or safety precautions.</p> <p>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.</p> <p>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.</p> <p>The Service Plan was not updated to include the resident's multiple falls.</p> <p>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</p>				<p>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.</p> <p>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.</p> <p>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</p>		

