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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  A. BUILDING 00 COMPLETED 12/23/2024  NAME OF PROVIDER OR SUPPLIER  ASSISTED LIVING AT HARTSFIELD VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  ID MOUNTERS NAME OF DESCRIPTION (X5)	7
NAME OF PROVIDER OR SUPPLIER  ASSISTED LIVING AT HARTSFIELD VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  STREET ADDRESS, CITY, STATE, ZIP COD 10002 COLUMBIA AVE MUNSTER, IN 46321  (X5)	7
ASSISTED LIVING AT HARTSFIELD VILLAGE  10002 COLUMBIA AVE MUNSTER, IN 46321  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  ID (X5)	7
ASSISTED LIVING AT HARTSFIELD VILLAGE  10002 COLUMBIA AVE MUNSTER, IN 46321  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  ID (X5)	7
ASSISTED LIVING AT HARTSFIELD VILLAGE  MUNSTER, IN 46321  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5)	N
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5)	N
PROVIDER'S PLAN OF CORRECTION (AS)	N
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETIC	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
R 0000	
Pida 00	
Bldg. 00  This visit was for the Investigation of Complaints  D. 0000	
This visit was for the Investigation of Complaints R 0000 IN00446393 & IN00448161.	
11004403/3 & 1100440101.	
Complaint IN00446393 - State deficiency related to	
the allegations is cited at R0217.	
Complaint IN00448161 - State deficiency related to	
the allegations is cited at R0217.	
Communitative December 22, 2024	
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.	
Quanty review completed on 1/0/25.	
R 0217 410 IAC 16.2-5-2(e)(1-5)	
Evaluation - Deficiency	
Bldg. 00	
Based on record review and interview, the facility $R = 0217$ Assisted Living at Hartsfield $02/10/20$	.5
failed to ensure service plans were reviewed and  Village	
revised as appropriate for 3 of 5 resident records reviewed. (Residents B, C, and E)  10002 Columbia Avenue Munster, Indiana 46321	
reviewed. (Residents B, C, and E)  Munster, Indiana 46321	
Findings include: This plan of correction	
represents the center's	
1. The record for Resident B was reviewed on allegation of compliance. The	
12/23/24 at 12:15 p.m. Diagnoses included, but following combined plan of	
were not limited to, Parkinson's disease, correction and allegation of	
hypertension (high blood pressure), repeated compliance is not an admission	
falls, and transient ischemic attack (a short period to any of the alleged	
of symptoms similar to a stroke).  deficiencies and is submitted at	
the request of the Indiana State	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE	
Alyssa Fusco 01/23/2025	

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING			12/23/2024	
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
ACCIOTED LIVING AT HADTOFIELD VIII ACE					COLUMBIA AVE		
ASSISTED LIVING AT HARTSFIELD VILLAGE				MUNSI	ΓER, IN 46321		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	A Semi-Annual Ass	sessment, dated 9/14/24,			Department of Health.		
	indicated the reside	nt had mild cognitive			Preparation and execution of	ŧ l	
	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,				this response and plan of		
					correction does not constitu	te	
					an admission or agreement b		
					the provider of the truth of th	- I	
					facts alleged or conclusions		
					forth in the statement of		
		vo abrasions to his right knee.			deficiencies. The plan of		
		e			correction is prepared and/or	r	
	A Progress Note, dated 10/18/24, indicated the resident fell alone in his bathroom trying to wash				executed solely because it is		
					required by the provision of		
	his hair in the sink.				federal and state law.		
	mo non in the onic.				Touchar and State law		
	A Progress Note, da	ated 12/9/24, indicated the			R0217		
	resident had an unwitnessed fall when he				At least semi-annually, the fac	ility	
	attempted to walk from his bed to the bathroom.				shall update the residents' ser		
	attempted to wark from his occi to the bathroom.				plan regarding fall prevention		
	A Service Plan, reviewed on 12/23/24, lacked any				safety precautions. The facility		
	fall prevention or safety precautions.				failed to ensure the residents'		
					service plan was updated		
	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				regarding fall prevention.		
					Corrective action taken for		
	because there was no template for it in their EMR (electronic medical record). They used to be included when the facility used paper charts.				residents found to have beer	1	
					affected by the deficient		
					practice:		
					The facility reviewed all reside	nts	
	2. The record for Resident E was reviewed on 12/23/24 at 2:53 p.m. Diagnoses included, but				with falls and added fall preve		
					to their service plan.		
					i i		
	were not limited to, hypertension, wedge				Identification of other reside	nts	
	compression L-5 (lumbar disk 5), disorder of the				having the potential to be		
	trigeminal nerve, and a history of falling.				affected by the same deficien	nt	
	,,g.				practice:		
	An Admission Assessment, dated 10/8/24, indicated the resident was cognitively intact,				All residents have the potentia	l to	
					be affected.		
	needed one-person physical assist for transfers,						
	•	rson physical assist with			To ensure that proper practic	ces	
	bathing / showering.				continue:		
oanning / showering.					1	ı	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	î ´		00	COMPL	ETED
			B. WING		·	12/23/2024	
				OTT FEET	ADDRESS SITE OF THE SITE OF		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
ASSISTED LIVING AT HARTSSIELD VILLAGE					COLUMBIA AVE		
ASSISTED LIVING AT HARTSFIELD VILLAGE				IVIUNSI	ΓER, IN 46321		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
					Director of Nursing/Designee	will	
	A Progress Note, dated 10/28/24, indicated the				re-educate the nursing staff		
resident had an unv		witnessed fall in her bathroom.			regarding the requirement for		
					facility to add fall prevention of	or	
	_	lated 11/7/24, indicated the			safety precautions to the		
		in her bathroom, resulting in a			residents' service plan.		
	skin tear to her arm and severe back pain. She				T. D. (		
	was taken to the hospital for evaluation.				The Director of Nursing/Desig	jnee	
	A Progress Note, dated 12/13/24, indicated the				will initiate and complete a		
	-				monitoring tool and conduct random audits of compliance	for	
	resident fell and had a bruise to her face and left				random audits of compliance residents with falls for the nex		
	arm.				months to ensure compliance		
	A Service Plan, reviewed on 12/23/24, lacked fall				this plan of correction.	WILLI	
	prevention or safety precautions.				Representatives from the QA	Δ	
	prevention or safety precautions.				Committee will review the QA		
	During an interview on 12/23/24 at 3:36 p.m., the				monthly. After six months, the		
	Director of Nursing indicated fall preventions				committee will determine if the		
	were not included in the service plans because				facility has achieved at least		
		ate for it in their EMR			compliance with practices at		
	-	l record). They used to be			which time the monitoring will		
	1	facility used paper charts.3.			cease. If the QAA Committee		
		ident C was reviewed on			determines that less than 100		
	12/23/24 at 11:55 a	a.m. The diagnoses included, but			compliance has been achieve	ed,	
		, high blood pressure, diabetes,			the monitoring tools will continu		
	and dementia.				for another six- month period		
					will again be reviewed by the	QAA	
	A Semi-Annual Assessment, dated 6/24/24,				Committee. This practice will		
	indicated the resident was alert and oriented to				continue until the facility has		
	person and was modified independent with bed,				achieved at least 100%		
chair and toilet transfers. The resident required				compliance and has ensured			
	modified equipment and used a cane.				deficient practice will not recu	r.	
	The Service Plan was not updated to include the				Quality Assurance Plan to		
	resident's multiple falls.  During an interview on 12/23/24 at 3:36 p.m., the Director of Nursing (DON) indicated fall				monitor compliance with thi	S	
					Plan of Correction:		
					Identified concerns shall be		
					reviewed by the facility's QAA		
	preventions were not included on the service plan				Committee. Findings from all		
because there was no template for it in their EMR					tools will continue to be review	wed	

State Form Event ID: 76U711 Facility ID: 010937 If continuation sheet Page 3 of 4

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

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

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  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	SUMMARY	STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		T.	AG	DEFICIENCY)		DATE
	(electronic medical record). They used to be included when the facility used paper charts.  This citation relates to Complaint IN00446393 and IN00448161.				monthly for the next 6 months. Recommendations for further corrective action will be discus and implemented as needed.		
					Completion Date: February 10 2025	0,	

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