STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REHABILITATION CENTER AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DR MUNSTER, IN 46321

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00442394. Complaint IN00442394 - Federal/state deficiencies related to the allegations are cited at F694 and F880. Unrelated deficiency is cited. Survey date: September 9, 2024 Facility number: 010758 Provider number: 155662 AIM number: 200229550 Census Bed Type: SNF/NF: 2 SNF: 98 Total: 100 Census Payor Type: Medicare: 65 Medicaid: 2 Other: 33 Total: 100 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/11/24.	F 0000	***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 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.***	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review and interview, the facility failed to ensure a resident was assessed to self administer medications for a	F 0554	**F554** The resident has the right to self-administer medications if the	09/25/2024

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

Susan Seydel | Administrator | 09/26/2024

Any defiencystatement 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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	random observation of a medication left at the bedside. (Resident D) Finding includes: On 9/9/24 at 1:53 p.m., Resident D was observed lying in her bed. There was pill in a medication cup on her overbed table. She indicated it was Imodium and the nurse had given it to her. The resident's record was reviewed on 9/9/24 at 1:20 p.m. The resident was admitted to the facility on 8/30/24. Diagnoses included, but were not limited to endocarditis, Diabetes Mellitus and anemia. The Brief Interview for Mental Status assessment, dated 8/31/24, indicated the resident was cognitively intact. There was not an assessment to self administer medications or a Physician's order to self administer medications. During an interview on 9/9/24 at 1:58 p.m., the Assistant Director of Nursing (ADON) indicated the resident did not have a self medication assessment and should not have any pills in her room. She entered the room and asked the resident about the medication. The resident indicated it was Imodium and the nurse had given it to her. The ADON removed the medication to verify what it was. She indicated it was an agency nurse on duty and she would speak with her. The current "Pharmaceutical Services Policy" indicated, "...Residents who have orders for self-administration of medication will have drug delivered by a licensed nurse/QMA...."		interdisciplinary team has determined that this practice is clinically appropriate. The facility failed to ensure a resident was assessed to self- administer medications for a random observation of a medication left at the bedside. (Resident D) **Corrective action taken for residents found to have been affected by the deficient practice:** The medication was removed from the bedside of Resident D. Nursing staff conducted a sweep of the facility to ensure there were no other medications inappropriately stored at patients' bedsides. **Identification of other residents having the potential to be affected by the same deficient practice:** No other patients were identified to have been affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will educate nursing staff regarding assessment for self-administration of medications. All patients admitting to the facility for a short-term rehabilitation stay will be assessed for self-administration of medication upon admission. The self-administration of medication	

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			assessment will be completed as part of the clinical admission assessment. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random audits of new admission charts once weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of five 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 at 100% compliance. The systemic plan will be randomly initiating this audit tool once monthly throughout the next three months to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be	

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			reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** September 25, 2024	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on observation, record review and interview, the facility failed to ensure a resident's PICC (peripheral inserted central catheter, a device used to administer medications intravenously) dressing was changed as ordered for 1 of 2 residents reviewed for intravenous care. (Resident B) Finding includes: On 9/9/24 at 9:30 a.m., Resident B was observed lying in bed. There was a PICC inserted in his left upper arm. During an interview at that time, QMA 1 indicated the PICC dressing was dated 8/26/24. The resident's record was reviewed on 9/9/24 at 9:50 a.m. The resident was admitted on 8/28/24. Diagnoses included, but were not limited to, osteomyelitis (bone infection) of the vertebrae, Parkinson's disease, anemia and weakness. The Admission Minimum Data Set assessment, dated 9/3/24, indicated the resident had significant cognitive impairment and was dependent on staff assistance for toileting and transfers. A Physician's Order, dated 9/2/24, indicated to	F 0694	**F694** Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders. The facility failed to ensure a resident's PICC dressing was changed as ordered for 1 of 2 residents reviewed for intravenous care. (Resident B) **Corrective action taken for residents found to have been affected by the deficient practice:** The PICC dressing was changed per MD order on the date of survey. Resident B was a short term patient now discharged from the facility. **Identification of other residents having the potential to be affected by the same deficient practice:** No other patients were identified to be affected.	09/25/2024

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	change the PICC line dressing every seven days with a transparent dressing. The September 2024 Treatment Administration Record lacked documentation the PICC dressing had been changed on 9/2/24. A Progress Note, dated 8/28/24, indicated the resident had been admitted to the facility that day. There was a left upper arm PICC with a dressing dated 8/26/24. During an interview on 9/9/24 at 9:35 a.m., LPN 1 indicated the dressing was to be changed every seven days, and it was due to be changed that day. The dressing had not been changed since admission. The document, "Care and Maintenance Chart", indicated a PICC dressing should be changed, "...On admission, 24 hours after insertion, weekly and PRN (as needed)...." This citation relates to Complaint IN00442394.		**To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nursing staff regarding facility procedure as it relates to PICC care, specifically adherence to MD orders for dressing monitoring and changing. All patients with a PICC present shall have physician orders in place for care; PICC dressings should be changed weekly and as needed. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random audits once weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of 6 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 at 100% compliance.	

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			The systemic plan will be randomly initiating this audit tool once monthly throughout the next three months to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** September 25, 2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure infection control measures were in place and implemented related to staff (LPN 1) not donning the appropriate PPE (personal protective equipment) during a dressing change for 1 of 2 residents reviewed for intravenous care. (Resident B) Finding includes: On 9/9/24 at 10:41 a.m., LPN 1 was observed changing the PICC (peripheral inserted central catheter) dressing to Resident B's left upper arm. LPN 1 was wearing a face mask and gloves. He did not have a gown on. There was a sign posted on the resident's door	F 0880	**F880** The facility must establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable disease. The facility failed to ensure infection control measures were in place and implemented related to staff (LPN 1) not donning the appropriate PPE during a dressing change for 1 of 2 residents reviewed for intravenous care. (Resident B) **Corrective action taken for residents found to have been**	09/25/2024

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	which indicated the resident was on Enhanced Barrier Precautions. All persons entering the room had to sanitize their hands and staff performing direct care were to wear gloves and a gown. There was a PPE bin outside the resident's door with gowns and masks. During an interview with LPN 1 at the time of the observation, he indicated he thought the sign was for the resident's roommate. LPN 1 then indicated he should have a gown on and donned one at that time. The resident's record was reviewed on 9/9/24 at 9:50 a.m. The resident was admitted on 8/28/24. Diagnoses included, but were not limited to, osteomyelitis (bone infection) of the vertebrae, Parkinson's disease, anemia and weakness. The Admission Minimum Data Set assessment, dated 9/3/24, indicated the resident had significant cognitive impairment and was dependent on staff assistance for toileting and transfers. A Physician's Order, dated 9/2/24, indicated to change the PICC line dressing every seven days with a transparent dressing. The current policy, "Prevention and Management of Multi-Drug Resistant Organisms", indicated, "...Enhanced Barrier Precautions...high contact resident care activities:...Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator..." and, "...Gloves and gown prior to the high contact care activity...." This citation relates to Complaint IN00442394.		**affected by the deficient practice:** LPN 1 was wearing a face mask and surgical gloves; LPN 1 donned a gown at the time of observation. Resident B is a short term patient who is now discharged from the facility. **Identification of other residents having the potential to be affected by the same deficient practice:** No other residents were identified to have been affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate LPN 1 in a 1:1 session. Education will reinforce the employee's understanding of enhanced barrier precautions to be followed while providing care and will review facility signage currently in use. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct random observations of staff providing care once weekly for four weeks to ensure compliance with this plan of correction. Each week, a minimum of six 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	

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			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 at 100% compliance. The systemic plan will be randomly initiating this audit tool once monthly throughout the next three months to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee monthly or more frequently as needed. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** September 25, 2024	