PRINTED: 10/07/2024

CPARTMENT OF HEALTH AND HUN	MAN SERVICES		FORM APPROVED
ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED

155662 B. WING 09/09/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 503 OTIS R BOWEN DR REHABILITATION CENTER AT HARTSFIELD VILLAGE MUNSTER, 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 APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000				
Bldg. 00				
	This visit was for the Investigation of Complaint	F 0000	This plan of correction	
	IN00442394.		represents the center's	
	G 1: (D)00442204 F 1 1/4 (1 6 : :		allegation of compliance. The	
	Complaint IN00442394 - Federal/state deficiencies		following combined plan of	
	related to the allegations are cited at F694 and F880.		correction and allegation of	
	roou.		compliance is not an admission	
	Unrelated deficiency is cited.		to any of the alleged deficiencies and is submitted at	
	officiated deficiency is cited.		the request of the Indiana	
	Survey date: September 9, 2024		Department of Health.	
	,		Preparation and execution of	
	Facility number: 010758		this response and plan of	
	Provider number: 155662		correction does not constitute	
	AIM number: 200229550		an admission or agreement by	
			the provider of the truth of the	
	Census Bed Type:		facts alleged or conclusions set	
	SNF/NF: 2		forth in the statement of	
	SNF: 98		deficiencies. The plan of	
	Total: 100		correction is prepared and/or	
	Census Payor Type:		executed solely because it is required by the provision of	
	Medicare: 65		federal and state law.	
	Medicaid: 2		rederar and state law.	
	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 0554	400 40(-)(7)			
SS=D	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp			
Bldg. 00	Resident Sell-Admin Meds-Cillically Approp			
Diag. 00	Based on observation, record review and	F 0554	 F554	09/25/2024
	interview, the facility failed to ensure a resident	1 0337	The resident has the right to	07/23/2024
	was assessed to self administer medications for a		self-administer medications if the	

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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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155662	B. WI	NG		09/09	/2024
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DELIABII	ITATION CENTER	AT HARTSEIELD VIII LAGE			TIS R BOWEN DR		
KEHABII	LITATION CENTER	R AT HARTSFIELD VILLAGE		MUNS	TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	random observation	n of a medication left at the			interdisciplinary team has		
	bedside. (Resident	D)			determined that this practice is	s	
					clinically appropriate. The faci	lity	
	Finding includes:				failed to ensure a resident wa	S	
					assessed to self- administer		
	On 9/9/24 at 1:53 p	o.m., Resident D was observed			medications for a random		
	lying in her bed. Th	nere was pill in a medication			observation of a medication le	eft at	
	cup on her overbed	table. She indicated it was			the bedside. (Resident D)		
	Imodium and the n	urse had given it to her.			, , , , ,		
					Corrective action taken for		
	The resident's recor	rd was reviewed on 9/9/24 at			residents found to have been	n	
	1:20 p.m. The resid	lent was admitted to the facility			affected by the deficient		
	on 8/30/24. Diagno	ses included, but were not			practice:		
		litis, Diabetes Mellitus and			The medication was removed	from	
	anemia.				the bedside of Resident D.		
					Nursing staff conducted a swe	еер	
	The Brief Interview	v for Mental Status assessment,			of the facility to ensure there	-	
	dated 8/31/24, indi	cated the resident was			no other medications		
	cognitively intact.				inappropriately stored at patie	nts'	
					bedsides.		
	There was not an a	ssessment to self administer					
	medications or a Pl	nysician's order to self			Identification of other reside	nts	
	administer medicat				having the potential to be		
					affected by the same deficie	nt	
	During an interview	v on 9/9/24 at 1:58 p.m., the			practice:		
	Assistant Director	of Nursing (ADON) indicated			No other patients were identifi	ied to	
	the resident did not	have a self medication			have been affected.		
	assessment and sho	ould not have any pills in her					
	room. She entered	the room and asked the			To ensure that proper practi	ces	
	resident about the r	nedication. The resident			continue:		
	indicated it was Im	odium and the nurse had given			The Director of Nursing/Desig	nee	
		N removed the medication to			will educate nursing staff rega		1
	verify what it was.	She indicated it was an agency			assessment for self-administra	_	
		she would speak with her.			of medications. All patients		
					admitting to the facility for a		
	The current "Pharm	naceutical Services Policy"			short-term rehabilitation stay v	will	
		ents who have orders for			be assessed for		
	· ·	of medication will have drug			self-administration of medicati	ion	[

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delivered by a licensed nurse/QMA...."

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upon admission. The

self-administration of medication

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155662	B. WING 09/09/2024			2024	
NAME OF F	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
55114511	ITATION OF STEE	AT 114 DT05151 D 1/11 1 4 0 5			IS R BOWEN DR		
REHABILITATION CENTER AT HARTSFIELD VILLAGE			MUNSI	TER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					assessment will be completed	as	
					part of the clinical admission		
					assessment.		
					The Director of Nursing/Design	nee	
					will initiate and complete a		
					monitoring tool and conduct		
					random audits of new admissi	on	
					charts once weekly for four we		
					to ensure compliance with this		
					plan of correction. Each week		
					minimum of five audits will be		
					conducted to monitor compliar	nce	
					and/or identify trends to review		
					with the facility's QAA Commit		
					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 achieve	d,	
					the monitoring tools will contin	ue	
					for another four week period a	nd	
					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 to		
					once monthly throughout the r	next	
					three months to ensure this		
					deficient practice will not recu	•	
					Quality Assurance Plan to		
					monitor compliance with this	5	
					Plan of Correction:		
					Identified concerns shall be		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155662		A. BUIL B. WING	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD (X3) DATE SURVI COMPLETED 09/09/2024			ETED
	PROVIDER OR SUPPLIER	AT HARTSFIELD VILLAGE		503 OTIS R BOWEN DR MUNSTER, IN 46321			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID REFIX CR	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
				revi Cor frec Rec corr and	iewed by the facility's QAA mmittee monthly or more quently as needed. commendations for furthe rective action will be discu- l implemented as needed mpletion Date: September	r ussed	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluid	ds					
	interview, the facili PICC (peripheral in used to administer r dressing was changeresidents reviewed in B) Finding includes: On 9/9/24 at 9:30 at lying in bed. There upper arm. During a 1 indicated the PICC The resident's recorn 9:50 a.m. The resident osteomyelitis (bone)	on, record review and ty failed to ensure a resident's serted central catheter, a device medications intravenously) ed as ordered for 1 of 2 for intravenous care. (Resident	F 069	Par adn prot and order cha resi care Cor res affe pra The per survitern	rective action taken for idents found to have been tested by the deficient ctice: PICC dressing was char for indents found to have been to have have have have have have have have	ician Insure Vas 2 enous en	09/25/2024
	dated 9/3/24, indica cognitive impairme assistance for toileti	nimum Data Set assessment, ted the resident had significant nt and was dependent on staff ing and transfers.		hav affe pra No	ntification of other residering the potential to be exceed by the same deficientice: other patients were idential affected.	ent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>00</u>	COMPLETED	
		155662 B. WING			09/09/2024	
			STRE	EET ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		OTIS R BOWEN DR		
REHABILITATION CENTER AT HARTSFIELD VILLAGE			NSTER, IN 46321			
KEHADIL	LITATION CENTER	AT HARTSFIELD VILLAGE	IVIOI	NSTER, IN 40321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	change the PICC lin	ne dressing every seven days				
	with a transparent of	lressing.		To ensure that proper pract	ices	
				continue:		
	The September 202	4 Treatment Administration		The Director of Nursing/Desi	gnee	
	Record lacked docu	imentation the PICC dressing		will re-educate nursing staff		
	had been changed of	on 9/2/24.		regarding facility procedure a	as it	
				relates to PICC care, specific	cally	
	A Progress Note, da	ated 8/28/24, indicated the		adherence to MD orders for		
	resident had been a	dmitted to the facility that day.		dressing monitoring and cha	nging.	
	There was a left up	per arm PICC with a dressing		All patients with a PICC pres	ent	
	dated 8/26/24.			shall have physician orders i	n	
				place for care; PICC dressing	gs	
	During an interview	v on 9/9/24 at 9:35 a.m., LPN 1		should be changed weekly a	nd as	
	indicated the dressi	ng was to be changed every		needed.		
	seven days, and it v	vas due to be changed that				
	day. The dressing h	ad not been changed since		The Director of Nursing/Desi	gnee	
	admission.		will initiate and complete a			
				monitoring tool and conduct		
	The document, "Ca	re and Maintenance Chart",		random audits once weekly f	or	
	indicated a PICC da	ressing should be changed,		four weeks to ensure complia	ance	
	"On admission, 2	4 hours after insertion, weekly		with this plan of correction. E	ach	
	and PRN (as neede	d)"		week, a minimum of 6 audits	will	
				be conducted to monitor		
	This citation relates	s to Complaint IN00442394.		compliance and/or identify tr	ends	
				to review with the facility's Q	AA	
				Committee. After the fourth v	veek,	
				the QAA Committee will revie	ew all	
				audit tools and will determine	if the	
				facility has achieved 100%		
				compliance with practices at		
				which time the monitoring wi		
				cease. If the QAA Committee		
				determines that less than 10	*	
				compliance has been achiev	I	
				the monitoring tools will cont		
				for another four week period		
				will again be reviewed by the		
				Committee. This practice will		
				continue until the facility has		
			achieved at 100% compliand	e.		

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i i		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUIL		nstruction 00	(X3) DATE SURVEY COMPLETED	
155662		B. WING 09/09/2024				2024	
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HARTSFIELD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 503 OTIS R BOWEN DR MUNSTER, IN 46321					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention Based on observation		F 088	0	The systemic plan will be randomly initiating this audit to once monthly throughout the rathree 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 discuss and implemented as needed. Completion Date: September 2024	sed	09/25/2024
	interview, the facility control measures we related to staff (LPN appropriate PPE (peduring a dressing characteristic previewed for intraversal properties). On 9/9/24 at 10:41 at changing the PICC catheter) dressing to LPN 1 was wearing not have a gown on	ty failed to ensure infection ere in place and implemented N 1) not donning the ersonal protective equipment) tange for 1 of 2 residents enous care. (Resident B) a.m., LPN 1 was observed (peripheral inserted central b Resident B's left upper arm. a face mask and gloves. He did	F 000		The facility must establish and maintain an infection preventic and control program designed help prevent the development transmission of communicable disease. The facility failed to ensure infection control measure in place and implemente related to staff (LPN 1) not donning the appropriate PPE during a dressing change for 1 residents reviewed for intraver care. (Resident B)	on to and ures d of 2	09/23/2024
	There was a sign po	sted on the resident's door	1	J	residents found to have been	1	ĺ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00			COMPLETED	
		155662		B. WING			09/09/2024	
NAME OF P	ROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD			
DELIABII	ITATION OFNITED	AT HADTSEIELD VIII LAGE			IS R BOWEN DR			
KEHABIL	ITATION CENTER	R AT HARTSFIELD VILLAGE		MONS	ΓER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		e resident was on Enhanced			affected by the deficient			
		a. All persons entering the room			practice:			
		r hands and staff performing			LPN 1 was wearing a face ma	ısk		
		wear gloves and a gown. There			and surgical gloves; LPN 1 do			
		ide the resident's door with			a gown at the time of observa			
	gowns and masks.				Resident B is a short term pat			
					who is now discharged from the	ne		
	_	w with LPN 1 at the time of the			facility.			
		icated he thought the sign was						
		ommate. LPN 1 then indicated			Identification of other reside	nts		
	he should have a go	own on and donned one at that			having the potential to be			
	time.				affected by the same deficie	nt		
					practice:			
		rd was reviewed on 9/9/24 at			No other residents were identi	ified		
		lent was admitted on 8/28/24.			to have been affected.			
	_	l, but were not limited to,						
		e infection) of the vertebrae,			To ensure that proper practic	ces		
	Parkinson's disease	, anemia and weakness.			continue:			
					The Director of Nursing/Desig	nee		
		nimum Data Set assessment,			will re-educate LPN 1 in a 1:1			
		ated the resident had significant			session. Education will reinfor			
		ent and was dependent on staff			the employee's understanding			
	assistance for toilet	ing and transfers.			enhanced barrier precautions			
					followed while providing care	and		
	_	r, dated 9/2/24, indicated to			will review facility signage			
	_	ne dressing every seven days			currently in use.			
	with a transparent d	dressing.						
	and the state of t	WD			The Director of Nursing/Desig	nee		
		"Prevention and Management			will initiate and complete a			
	_	stant Organisms", indicated,			monitoring tool and conduct			
		er Precautionshigh contact			random observations of staff	,		
		ties:Device care or use:			providing care once weekly fo			
	_	catheter, feeding tube,			weeks to ensure compliance was the compliance was t			
	•	lator" and, "Gloves and			this plan of correction. Each w			
	gown prior to the h	igh contact care activity"			a minimum of six audits will be			
	This - 14-71 1 7	- A- C1-i INIO0442204			conducted to monitor complian			
	inis citation relates	s to Complaint IN00442394.			and/or identify trends to review			
					with the facility's QAA Commit			
					After the fourth week, the QAA			
					Committee will review all audi	t	I	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155662	B. WING	<u> </u>	09/09/2024
		1.00002	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
				TIS R BOWEN DR	
REHABIL	LITATION CENTER	R AT HARTSFIELD VILLAGE	MUNS	TER, IN 46321	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				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 achieve	
				the monitoring tools will contin	
				for another four week period a	
				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 to	I
				once monthly throughout the	next
				three months to ensure this	
				deficient practice will not recu	r.
				Quality Assurance Plan to	
				monitor compliance with thi	
				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 discus	ssed
				and implemented as needed.	
				and implemented do needed.	
				Completion Date: September	25.
				2024	-,

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