STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/27/2023

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: September 26 and 27, 2023. Facility number: 010937 Residential Census: 70 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/29/23.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for			

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

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	every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current first aid certificate scheduled for 9 of 21 shifts reviewed. This had the potential to affect all 70 residents residing in the facility. Finding includes: Facility staffing schedules for 9/18/23 through 9/24/23 were reviewed on 9/27/23 at 11:45 a.m. The schedules indicated there were no staff members who were first aid certified on the following dates and shifts: Day shift on 9/21/23 Evening shift on 9/22/23, 9/23/23, and 9/24/23 Midnight shift on 9/19/23, 9/20/23, 9/21/23, 9/23/23, and 9/24/23 Interview with the Director of Nursing (DON) on 9/27/23 at 11:45 a.m., indicated they only made sure the staff were CPR certified and was unaware first aid certification was required. Follow up interview with the DON on 9/27/23 at 1:15 p.m., indicated she had provided some staff with current first aid certification but not all shifts were covered.	R 0117	**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.** **Corrective action taken for residents found to have been affected by the deficient practice:** Nurses and certified nursing assistants have been trained on basic first aid. The facility will have one awake person at all times with basic first aid training and CPR certification. **Identification of other residents having the potential to be**	10/31/2023

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			affected by the same deficient practice: All residents have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will educate nurses and certified nursing assistants on basic first aid annually and on new hire orientation. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct observations of the nursing schedule to ensure one awake staff has basic first aid training and CPR certification 24 hours a day to ensure compliance with this plan of correction. Audits will be conducted 1x/week for four weeks. Each week, audits will be reviewed 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	

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			continue until the facility has achieved at least 100% compliance. The systematic plan will be randomly initiating this audit tool again monthly throughout the next 6 months, to ensure that 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. 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.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure the resident's clinical record was complete and accurate related to Medication Administration Record (MAR) and Treatment Administration Record (TAR) documentation for 1 of 7 residents reviewed. (Resident 4)	R 0349	**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**	10/31/2023

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	Finding includes: Record review for Resident 4 was completed on 9/26/23 at 11:07 a.m. Diagnoses included, but were not limited to, chronic kidney disease, type 2 diabetes mellitus, and anxiety disorder. The Physician's Order Summary, dated 9/2023, indicated ketoconazole (antifungal) cream 2% to groin skin folds twice daily per self and acetaminophen (Tylenol, pain medication) 500 mg (milligrams) 2 tabs every 6 hours as needed. The MAR and TAR, dated 9/2023, indicated under the acetaminophen order "per self" was written in. "Per self" was also written across the administration documentation areas for the ketoconazole cream and the acetaminophen medication and there were no administrations signed off as given. A Self Administration of Medication Assessment, dated 4/7/23, indicated the resident was not able to self-administer any medications and the facility would set up and deliver medications to the resident. Interview with the Director of Nursing (DON) on 9/27/23 at 11:45 a.m., indicated the resident did not self-administer any medications. She was unsure why "per self" had been written in on the MAR and TAR. She had spoken with the nurses, and they indicated the resident had not requested any acetaminophen in a while. She was unable to provide any further documentation that the ketoconazole cream had been given as ordered.		**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.** Clinical records on each resident must be maintained under the supervision of a designated employee of the facility. The facility failed to ensure the clinical record was complete and accurate for 1 of 7 sampled residents. (Resident 4) **Corrective action taken for residents found to have been affected by the deficient practice:** All resident records were checked to ensure that the medication record is properly identified regarding self-medication administration. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents with medication	

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			orders have the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing/Designee will re-educate nurses regarding the expectation that all residents' medication records are complete, accurately documented, readily accessible and systematically organized. The Director of Nursing/Designee will initiate and complete a monitoring tool and conduct audits of all residents' medication orders to ensure compliance with this plan of correction. Audits will be conducted 2x/week for four weeks. Each week, audits will be reviewed 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 least 100% compliance. The systematic plan	

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			will be randomly initiating this audit tool again monthly throughout the next 6 months, to ensure that 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. 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.	