

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Rehabilitation Center at Hartsfield Village		STREET ADDRESS, CITY, STATE, ZIP CODE 503 Otis R Bowen Dr Munster, IN 46321	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582</p> <p>Based on observation, record review and interview, 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)</p> <p>Finding includes:</p> <p>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 lmodium and the nurse had given it to her.</p> <p>The resident's record was reviewed on 9/9/24 at 1:20 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to endocarditis, Diabetes Mellitus and anemia.</p> <p>The Brief Interview for Mental Status assessment, dated 8/31/24, indicated the resident was cognitively intact.</p> <p>There was not an assessment to self administer medications or a Physician's order to self administer medications.</p> <p>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 lmodium 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.</p> <p>The current Pharmaceutical Services Policy indicated, . Residents who have orders for self-administration of medication will have drug delivered by a licensed nurse/QMA</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582</p> <p>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)</p> <p>Finding includes:</p> <p>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.</p> <p>The resident's record was reviewed on 9/9/24 at 9:50 a.m. The resident was admitted on [DATE]. Diagnoses included, but were not limited to, osteomyelitis (bone infection) of the vertebrae, Parkinson's disease, anemia and weakness.</p> <p>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.</p> <p>A Physician's Order, dated 9/2/24, indicated to change the PICC line dressing every seven days with a transparent dressing.</p> <p>The September 2024 Treatment Administration Record lacked documentation the PICC dressing had been changed on 9/2/24.</p> <p>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.</p> <p>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.</p> <p>The document, Care and Maintenance Chart, indicated a PICC dressing should be changed, .On admission, 24 hours after insertion, weekly and PRN (as needed)</p> <p>This citation relates to Complaint IN00442394.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582</p> <p>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)</p> <p>Finding includes:</p> <p>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.</p> <p>There was a sign posted on the resident's door 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.</p> <p>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.</p> <p>The resident's record was reviewed on 9/9/24 at 9:50 a.m. The resident was admitted on [DATE]. Diagnoses included, but were not limited to, osteomyelitis (bone infection) of the vertebrae, Parkinson's disease, anemia and weakness.</p> <p>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.</p> <p>A Physician's Order, dated 9/2/24, indicated to change the PICC line dressing every seven days with a transparent dressing.</p> <p>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</p> <p>This citation relates to Complaint IN00442394.</p>