STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center at Hartsfield Village	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to ensure personal care signs were not posted in a resident's room and meals were served timely to each resident's table for 4 of 4 residents reviewed for dignity. (Residents 14, 21, 9, and 107)Findings include:1. During a random observation on 8/13/25 at 9:00 a.m., a sheet of paper listing Resident 14's swallowing guidelines was posted on the wall next to the doorway of the resident's bathroom. On 8/14/25 at 9:20 a.m., the sign remained in the resident's room. The record for Resident 9 was reviewed on 8/14/25 at 9:32 a.m. Diagnoses included, but were not limited to, Alzheimer's and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 6/7/25, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. The resident was dependent with eating and received a mechanically altered diet. The resident did not have a Care Plan related to posting personal care signs in her room. During an interview on 8/18/25 at 3:20 p.m., the Director of Nursing indicated the sign had been removed. 2. During a random observation on 8/13/25 at 10:08 a.m., a sheet of paper listing Resident 21's swallowing guidelines was posted on the wall above her bed. On 8/14/25 at 1:30 p.m., the information related to the swallowing guidelines remained on the resident's wall. The record for Resident 21 was reviewed on 8/13/25 at 2:20 p.m. Diagnoses included, but were not limited to, Parkinson's disease and dysphagia (difficulty swallowing). The admission Minimum Data Set (MDS) assessment, dated 7/20/25, indicated the resident was cognitively impaired for daily decision making. The resident would hold food in her mouth or cheeks or would have residual food in her mouth after meals. The resident received a mechanically altered diet. The resident did not have a Care Plan related to posting personal care signs in her room. During an interview on 8/18/25 at 3:20 p.m., the Director of Nursing indicated the sign had been removed. 3. During a random observation on 8/12/25 at 12:46 p.m., Resident 9 was in his room in bed eating his lunch. A sheet of paper listing the resident's swallowing guidelines was posted above his bed. On 8/13/25 at 9:42 a.m., 8/14/25 at 9:23 a.m., 8/15/25 at 8:40 a.m. and 12:05 p.m., and on 8/18/25 at 8:47 a.m., the swallowing guidelines continued to be posted above the resident's bed. The record for Resident 9 was reviewed on 8/15/25 at 11:39 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 6/23/25, indicated the resident was cognitively impaired for daily decision making. The resident required set up or clean up assistance with eating. The resident also received a mechanically altered therapeutic diet. The resident did not have a Care Plan related to posting personal care signs in his room. During an interview on 8/18/25 at 3:20 p.m., the Director of Nursing indicated the sign had been removed. 4. During an observation of the noon meal on 8/12/25 at 12:12 p.m., Resident 107 was seated at a table in his high back wheelchair. There was another resident seated at the table with him and other residents seated at a table in front of him. There were a total of 13 residents in the dining room. At 12:29 p.m., the resident was resting his head on the table. He had not received his tray yet and his table mate ate in front of him as well as the residents at the other table. Resident 107 was the last resident to receive his tray at 12:33 p.m. At that time, a CNA sat down next to him and proceeded to feed him.The record for Resident 107 was reviewed on (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/14/25 at 10:13 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and dysphagia (difficulty swallowing). The admission Minimum Data Set (MDS) assessment, dated 8/6/25, indicated the resident was cognitively impaired for daily decision making and he required substantial/maximum assistance with eating. He held food in his mouth and/or cheeks or had residual food in his mouth after meals. He received a mechanically altered therapeutic diet. During an interview on 8/18/25 at 10:35 a.m., the Director of Nursing was informed the resident received his tray last while the other residents were eating around him. No additional information was provided. 3.1-3(t)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure proper medication storage related to insulin pens and multi-dose vials not labeled when opened or expired for 3 of 5 medication carts and 1 of 1 medication rooms reviewed. (D Wing 1st Floor Cart, A Wing 1st Floor Cart, D Wing 2nd Floor Cart, 1st Floor Medication Room)Findings include:1. The 1st Floor Medication Room was observed with RN 2 on [DATE] at 11:01 a.m. Inside the refrigerator was an opened multi-dose vial of Tuberculin (a medication used for tuberculosis testing). The vial was dated as opened [DATE]. The label on the vial indicated to discard after 30 days. 2. The 1st Floor D Wing medication cart was observed with LPN 1 on [DATE] at 11:11 a.m. There was an insulin lispro pen with no open date and an insulin glargine pen with no open date. 3. The 1st Floor A Wing medication cart was observed with LPN 1 on [DATE] at 11:13 a.m. There was a Novolog insulin pen with no open date, a Lantus insulin pen with no open date, and an insulin lispro pen with no open date which was only labeled with a room number. 4. The 2nd Floor D Wing medication cart was observed with RN 3 on [DATE] at 11:21 a.m. There was a Lantus insulin pen with an open date of [DATE] and an insulin lispro pen with an open date of [DATE].During an interview on [DATE] at 10:00 a.m., the Director of Nursing (DON) was made aware of the medication labeling and storage concerns and any applicable policies were requested.The current and undated Vials and Ampules of Injectable Medications policy, provided by the DON on [DATE] at 10:15 a.m., indicated the date opened, and the initials of the first person to use the vial must be recorded on the multidose vials either on the vial label itself or an accessory label affixed for that purpose. Once opened guidelines recommend discarding multidose vials (other than some insulins) 28 days after use.The current and undated Medication Labels policy, provided by the DON indicated all prescription medication labels should include the following: for injectables and liquids the strength, amount and time to be given, prescriber's name, and patient's name and room number.The Lantus (insulin glargine) medication instructions insert indicated, an opened Lantus Kwik Pen should be used within 28 days of first use. Once opened, the pen should be stored at room temperature (below 86 F) and used within 28 days.The Novolog (insulin aspart) medication instructions insert indicated, Novolog insulin, both in vials and pens, expires 28 days after it has been opened, even if it has been refrigerated.The Humalog (insulin lispro) medication instructions insert indicated, throw away the Humalog pen you are using after 28 days, even if it still has insulin left in it.3.1-25(j)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had a physician's order and an assessment indicating they were able to self-administer their own medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 136)Finding includes:During a random observation on 8/12/25 at 11:05 a.m., one pill was observed in a medicine cup on Resident 136's overbed table. At that time, the resident indicated it was an AREDS (an eye vitamin) tablet. She indicated the nurse gave her two, but she was saving one to take in the evening like she did at home. She indicated she informed the staff that she took the pills at separate times, but they kept bringing both in the morning. During an observation on 8/15/25 at 8:50 a.m., the resident unwrapped an AREDS tablet from a tissue that was in the drawer of her overbed table. At that time, the resident indicated she again saved it from the morning pills the nurse gave her so she could take it in the afternoon. The record for Resident 136 was reviewed on 8/13/25 at 3:41 p.m. Diagnoses included, but were not limited to, congestive heart failure and acute respiratory failure.The 8/9/25 Nurse's admission Assessment indicated the resident was cognitively intact for daily decision making, and required moderate assistance with activities of daily living (ADLs).A Physician's Order, dated 8/9/25, indicated PreserVision AREDS-2, 2 tablets once each morning. There was no order for self-administration.The 8/9/25 Self-Administration Assessment indicated it was not appropriate for the resident to self-administer any medications.During an interview on 8/18/25 at 3:24 p.m., the Director of Nursing (DON) was informed of the findings and offered no additional information.A policy titled, Self-Administration of Medication, received as current from the DON on 8/18/25 at 1:00 p.m. indicated, . Residents are permitted to [self-administer medications] if the facility's interdisciplinary team determines that the practice is safe for the resident and for other residents of the facility and there is a prescriber's order to self-administer.3.1-11(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to ensure a Physician's Order was in place for a resident with a back brace and skin discolorations were assessed and monitored for 1 of 1 resident reviewed for positioning and range of motion and 2 of 3 residents reviewed for non-pressure skin conditions. (Residents 2, 19 and 135)Findings include:1. On 8/12/25 at 11:24 a.m., Resident 2 was observed seated in her wheelchair in her room. There was a black vest-like back brace in place over her chest and back. She indicated she was supposed to wear it for two fractures in her back. On 8/14/25 at 11:35 a.m., Resident 2 was observed seated in her wheelchair in her room watching television. She had a black vest-like back brace in place over her chest and back. On 8/14/25 at 2:44 p.m., Resident 2 was observed seated in her wheelchair in her room speaking with a visitor. She had a black vest-like back brace in place over her chest and back. Record review for Resident 2 was completed on 8/13/25 at 3:05 p.m. Diagnoses included, but were not limited to, wedge compression fracture of third thoracic vertebra and wedge compression fracture of second thoracic vertebra. The admission Minimum Data Set (MDS) assessment, dated 5/29/25, indicated the resident was cognitively intact and dependent on staff for assistance with ADLs (activities of daily living). A Care Plan, dated 7/19/25, indicated the resident had healing fractures to T2 and T3. There were no interventions related to the back brace. A Care Plan, dated 7/19/25, indicated the resident was non-compliant with the back brace. There were no interventions related to when the resident was supposed to wear the back brace. The hospital After Visit Summary, dated 6/11/25, indicated the resident was to wear a TLSO (thoracic lumbar sacral orthosis) back brace when out of bed. The Physician's Order Summary, dated 8/2025, lacked any orders for a back brace, guidance on when the resident should wear it, or monitoring to the skin under the brace. During an interview on 8/15/25 at 9:44 a.m., the Director of Nursing was made aware of the lack of a Physician's Order for the back brace. No further information was provided. 2. During a random observation on 8/12/25 at 10:28 a.m., Resident 19 was resting in bed. There was a dressing on his right knee and a large purple bruise next to the dressing. On 8/14/25 at 3:14 p.m., the resident's knee was observed with LPN 2. At that time, LPN 2 indicated she did not know if the bruise was from surgery or a fall, or how long the bruise had been present. The record for Resident 19 was reviewed on 8/13/25 at 2:24 p.m. Diagnoses included, but were not limited to, diabetes, sepsis, and lymphoma. The 8/7/25 admission Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment and was dependent in activities of daily living (ADLs) and transfers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, dated 8/1/25, indicated the resident was at risk for complications associated with anticoagulant (blood thinner) therapy. Approaches included observing the skin with each encounter for bruising. The record lacked monitoring of the resident's bruise. During an interview on 8/14/25 at 3:50 p.m., Assistant Director of Nursing (ADON) 1 indicated bruising should be monitored and documented in the resident's record. During an interview on 8/18/25 at 3:24 p.m., the Director of Nursing (DON) was informed of the findings and offered no additional information. 3. During random observations on 8/12/25 at 11:29 a.m., 8/14/25 at 9:48 a.m., and 8/15/25 at 10:58 a.m., bruises were observed to Resident 135's left cheek, right hand, and right arm. During an interview on 8/12/25 at 11:29 a.m, the resident indicated the bruises were from the motor vehicle accident and subsequent hospitalization that led to her admission to the facility. The record for Resident 135 was reviewed on 8/15/25 at 10:05 a.m. Diagnoses included, but were not limited to, fractures of the left wrist and osteoarthritis. A Physician's hospital note, dated 8/4/25, indicated the resident was in a car accident and had an open fracture of her left wrist and a bruise on her left cheek. The 8/8/25 Nurse's admission Assessment indicated the resident was cognitively intact for daily decision making. The assessment did not include documentation of the resident's bruises. An 8/11/25 Physician's Order indicated complete head to toe assessment and document. Measure any bruises or skin tears noted. The record lacked monitoring of the resident's bruises. During an interview on 8/18/25 at 3:24 p.m., the Director of Nursing (DON) was informed of the findings and offered no additional information. 3.1-37(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision and implement planned interventions related to following swallowing guidelines for 2 of 2 residents reviewed for accidents/ hazards. (Residents 9 and 21)Findings include: 1. On 8/12/25 at 12:46 p.m., Resident 9 was observed in his room in bed eating his lunch. There were straws placed in the resident's beverages. A sign posted above the resident's bed indicated the following swallowing guidelines that were dated 6/23/25:-up for all meals-small sips/bites (cup or spoon)-slow rate-no strawsOn 8/15/25 at 8:40 a.m., the resident was in his room in bed eating his breakfast. At 12:33 p.m., the resident was in his room in bed eating his lunch. On 8/18/25 at 8:47 a.m., the resident was slouched down in his bed eating his breakfast. A straw was observed in his cup of juice that was almost empty. The record for Resident 9 was reviewed on 8/15/25 at 11:39 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 6/23/25, indicated the resident was cognitively impaired for daily decision making. The resident required set up or clean up assistance with eating. The resident also received a mechanically altered therapeutic diet. A Care Plan, dated 6/18/25, indicated the resident received a mechanically altered diet with no added salt and thickened liquids. Interventions included, but were not limited to, speech therapy to evaluate for diet upgrade as warranted and provide assist with intake as needed. A Physician's Order, dated 8/8/25, indicated the resident was to receive a no added salt mechanical soft diet with nectar thick liquids and high protein gelatin with lunch and dinner. During an interview on 8/18/25 at 10:35 a.m., the Director of Nursing was informed the swallowing guidelines were not followed. No additional information was provided. 2. During a random observation on 8/13/25 at 10:08 a.m., a sheet of paper listing Resident 21's swallowing guidelines was posted above the resident's bed. The swallowing guidelines, dated 7/15/25, indicated the resident was not to use straws. On 8/14/25 at 1:30 p.m., the resident was seated in her wheelchair in her room with her husband. The resident's lunch tray was on her over bed table. Straws were observed in the resident's juice, water, and a beverage that had been brought in from the outside. On 8/15/25 at 8:43 a.m., the resident was seated in her wheelchair in the Second Floor dining room eating her breakfast. There were straws in her Ensure and juice. On 8/18/25 at 8:43 a.m., the resident was seated in her wheelchair in the Second Floor dining room eating her breakfast. There were straws in her Ensure and juice. The record for Resident 21 was reviewed on 8/13/25 at 2:20 p.m. Diagnoses included, but were not limited to, Parkinson's disease and dysphagia (difficulty swallowing). The admission Minimum Data Set (MDS) assessment, dated 7/20/25, indicated the resident was cognitively impaired for daily decision making. The resident would hold food in her mouth or cheeks or would have residual food in her mouth after meals. The resident received a mechanically altered diet. A Care Plan, dated 7/23/25, indicated the resident could feed herself at meals with set up assistance related to the aging process status post hospitalization and right displaced proximal humerus fracture. Interventions included, but were not limited to, staff would provide hands on assistance as needed to ensure adequate intake. The August 2025 Physician's Order Summary (POS) indicated the resident received a regular diet with Ensure at breakfast and dinner. During an interview on 8/18/25 at 10:35 a.m., the Director of Nursing was informed the swallowing guidelines were not followed. No additional information was provided. 3.1-45(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to ensure a urinary catheter collection bag was kept below the level of the bladder, and the tubing was kept free from constriction or pulling for 1 of 1 resident reviewed for urinary catheters. (Resident 119)Finding includes: During a random observation on 8/12/25 at 2:56 p.m., Resident 119 was observed resting in bed. The urine collection bag for his Foley catheter (a tube inserted through the urethra to drain the bladder) was on the bed, under a blanket. During a random observation on 8/14/25 at 10:38 a.m., the resident was in his room, seated in his wheelchair. The Foley bag was lying under the wheelchair. The resident was stepping on the tubing with hard-soled shoes.During a random observation on 8/15/25 at 9:50 a.m., the resident was observed resting in bed. The tubing to the urine collection bag for his Foley catheter was pulled taut. The bag was hooked under the wheelchair next to the bed. At that time, RN 1 was in the room, talking with the other resident who resided there.During a random observation on 8/15/25 at 2:15 p.m., the resident was observed resting in bed. The urine collection bag was hooked on the bed frame. The catheter tubing was coming out of the bottom of the resident's narrow pant leg, and under his foot. At that time, CNA 1 was in the room checking on the resident. The record for Resident 119 was reviewed on 8/15/25 at 11:54 a.m. Diagnoses included, but were not limited to, left femur (thigh bone) fracture, urinary retention, and dementia.The 6/29/25 admission Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, required substantial assistance in chair-to-bed transfers, and required an indwelling catheter for urination. A Care Plan, dated 7/7/25, indicated the resident required an indwelling urinary catheter. The short term goal indicated the resident would have their catheter managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma. Approaches included positioning the bag below the level of the bladder.The record lacked documentation of monitoring the tubing and urine collection bag.During an interview on 8/18/25 at 9:23 a.m., the Administrator and Director of Nursing (DON) indicated they would re-educate staff and the resident on monitoring and maintaining the safety of the Foley catheter tubing and bags. A policy titled, Standards of Care for the Resident with an Indwelling Urinary Catheter, received as current from the DON on 8/18/25 at 1:00 p.m. indicated, . Hang the collection bag below the level of the bladder to prevent urine reflux to the bladder . When transporting or ambulating a resident, take care to avoid traction on the catheter and maintain the collection bag below the level of the bladder. 3.1-41(a)(2)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 7 residents observed during medication pass. Four errors were observed during 25 opportunities for errors during medication administration. This resulted in a medication error rate of 16%. (Residents 28 and 116)Findings include:1. On 8/13/25 at 8:24 a.m., RN 4 was observed preparing Resident 28's medications. The resident was going to receive one puff of a Breo Ellipta inhaler 200-25 microgram (mcg), the resident's mouth was to be rinsed after use. The resident was also supposed to receive Miralax (a laxative) 17 grams. The RN added 5 cubic centimeters (cc) of Miralax to a plastic cup and added 4 ounces of water. The RN proceeded to the resident's room. The RN handed the inhaler to the resident, she inhaled it herself and shut the lid and handed it back to the RN. The resident did not rinse her mouth afterwards nor was she instructed by the RN to rinse her mouth. The RN wiped down the inhaler and put it back in the box. She then went to the medication cart and obtained the Miralax mixture and left it on the resident's over bed table to drink. The resident drank all of the Miralax. At 8:47 a.m., the RN was asked to remove the bottle of Miralax from the medication cart. After reading the label, the RN indicated 17 grams was one tablespoon and she only gave the resident 5 cc's which wasn't enough. During an interview on 8/13/25 at 8:47 a.m., RN 4 indicated the marking inside the manufacture lid was not there anymore, so she just gave the 5 cc's and was not aware of how much 17 grams equaled to. Assistant Director of Nursing 1 was at the cart and indicated she should have figured out what the 17 grams equaled to prior to administering the medication. 2. On 8/13/25 at 7:54 a.m., LPN 3 was observed preparing medications for Resident 116. The resident was to receive 10 units of Lantus insulin by the way of an insulin pen. The resident was also going to receive Novolog insulin 5 units by the way of an insulin pen. The LPN dialed up both pens to their respective doses, however, the LPN did not prime the insulin pens prior to administration. During an interview on 8/13/25 at 8:13 a.m., LPN 3 indicated she was aware she needed to prime the insulin pens prior to administration. During an interview on 8/13/25 at 2:45 p.m., the Director of Nursing had no additional information to provide. The Lantus Insulin insert indicated to perform a safety test prior to administration. Dial a test dose of 2 Units. Hold the pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This would help you get the most accurate dose. Press the injection button all the way in and check to see that insulin came out of the needle. The dial would automatically go back to zero after you perform the test. If no insulin came out, repeat the test 2 more times. If there was still no insulin coming out, use a new needle and do the safety test again. Always perform the safety test before each injection. The Novolog insert indicated when using a Novolog Flex Pen for injecting insulin, it was crucial to prime the pen before each injection. Priming ensured that air bubbles were removed from the needle and the cartridge, pen, and needle were working correctly, allowing you to administer the full dose of insulin. 3.1-48(c)(1)