PRINTED:	08/03/2023
FORM API	PROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155469	A. BUILDING B. WING	<u></u>	07/06/2023
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	I
	HOBART			2 49TH AVE RT, IN 46342	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG F 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
Bldg. 00		he Investigation of Complaints 410185, IN00411679, IN00412121,	F 0000		
	Complaint IN0040 the allegations are	9415 - No deficiencies related to cited.			
	Complaint IN0041 the allegations are	0185 - No deficiencies related to cited.			
	-	1679 - Federal/State deficiencies ations are cited at F677, F690,			
	-	2121 - Federal/State deficiencies ations are cited at F677.			
		2151 - Federal/State deficiencies ations are cited at F686.			
	Survey dates: July	5 and 6, 2023			
	Facility number: 00 Provider number: 1 AIM number: 100	155469			
	Census Bed Type: SNF/NF: 94 Total: 94				
	Census Payor Type Medicare: 15 Medicaid: 69 Other: 10	e:			
	Total: 94 These deficiencies	reflect State Findings cited in			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE
Craig Clerr	ions		Administr	ator	07/24/2023

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES	
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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUILDING B. WING	<u>00</u>	3) DATE SURVEY COMPLETED 07/06/2023
	provider or suppli F HOBART	ER	4410 V	address, city, state, zip cod V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICI REGULATORY	SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
F 0677 SS=D Bldg. 00	 483.24(a)(2) ADL Care Provis §483.24(a)(2) A carry out activition necessary servion nutrition, groomin hygiene; Based on observation interview, the face (activities of daily residents related to 3 residents review E, and G) Findings include: 1. The closed rectors on 7/5/23 at 1:58 to the facility on 3 were not limited to and sixth cervical opening into the se for feeding), and swallowing). The Admission M assessment, dated was cognitively in assistance with be was dependent or There was no care of daily living) care 	ord for Resident D was reviewed p.m. The resident was admitted 5/26/23. Diagnoses included, but to, displaced fracture of the fifth vertebra, gastrostomy status (an stomach from the abdominal wall dysphagia (difficulty finimum Data Set (MDS) 16/2/23, indicated the resident ntact and he required extensive ed mobility and transfers. He a staff for bathing.	F 0677	Please accept the following as th facility's credible allegation of compliance. This plan of correction does not constitute ar admission of guilt or liability by th facility and is submitted only in response to the regulatory requirement. The Facility respectfully requests paper compliance for this survey. F677 ADL Care Provide for Dependent Residents What correctiv action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D is no longe in the facility. Resident E receive a shower. Resident G had ADL care plan put into place and nail care completed. How the facility will identify other residents havin the potential to be affected by th same deficient practice and what corrective action will be taken; A dependent residents, who requir assistance with nail care and showers, have the potential to be affected by the same alleged	n ne s s d e or e or e d t ll e

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	CRS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 155469 B. WING				OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 07/06/2023	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342						
CASA O (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C Wednesday and Sa 6/7/23, indicated t no other document Documentation on related to bathing, documentation on Day shift: 6/2-6/4 6/25-6/28/23. On 6 coded. Evening shift: 6/2 6/23-6/26, and 6/2 6/21, 6/22, and 6/2 6/21, 6/22, and 6/2 1nterview with the 7/6/23 at 5:22 p.m showers were not 2. Interview with indicated he could had a shower. The record for Res at 1:21 p.m. The n facility on 6/8/23. not limited to, stro rhabdomyolysis (a The 6/15/23 Admi assessment, indicated cognitively intact. assistance with be was totally depend	Resident E on 7/6/23 at 2:35 p.m., n't remember the last time he sident E was reviewed on 7/5/23 resident was admitted to the Diagnoses included, but were ke, end stage renal disease, and breakdown of muscle tissue). sission Minimum Data Set (MDS) ted the resident was He required extensive d mobility and transfers and	HOB/ PREFIX TAG	ART, IN 46342 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROV DEFICIENCY) deficient practice. What me will be put into place or what systemic changes will be m ensure that the deficient pr does not recur; Staff were re-educated on providing dependent residents with assistance with per resident of care/preferences, includit Care and showers as well a need to have ADL care pla place. How the corrective action(s) will be monitored ensure the deficient practic not recur, i.e., what quality assurance programs will be into place; DON/Designee Audit 10 random residents, re ADL assistance, to ensure are being assisted with Nai and Showers per the reside plan of care/preference as having ADL care plan in place. Director of Nursing/designee will prese summary of the audits to th Quality Assurance committe monthly for 4 months. The if determined by the Quality Assurance committee, aud and monitoring will be done quarterly and present quart the QA meeting. Monitorin be on going. Date by which systemic corrections will be	BE PRIATE assures at ade to actice at's plan ing Nail as the n in to we will 3 times a focus quiring they I Care ents' well as ent a ne ee reafter, / iting a will h	(X5) COMPLETION DATE		
	-	e with ADL's including bed ransfers, toileting, and bathing. erventions listed.		completed: 7/24/2023				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5I4V11

Facility ID: 000366

If continuation sheet

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FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID 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 COMPLETED 00 B. WING 07/06/2023 155469 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART HOBART, IN 46342 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The June 2023 Bath and Skin Report Sheet, indicated the resident's shower days were Wednesday and Saturday. Documentation on 6/14/23 indicated the resident had a bed bath. There was documentation indicating the resident would need an actual shower on 6/17/23. There was no other documentation related to bathing and/or showers. Documentation on the June 2023 Task Report related to bathing, indicated the resident received a bed bath on 6/14, 6/20, 6/22, and 6/23/23. The resident received a shower on 6/22/23. There was no further documentation related to bathing on the Task Report. Interview with the Director of Nursing (DON) on 7/6/23 at 5:22 p.m., indicated the resident's showers were not documented. 3. On 7/5/23 at 10:10 a.m., 11:50 a.m., and 2:45 p.m., Resident G was observed lying in bed. His left and right hand were both noted to be contracted and he had long fingernails. Resident G's record was reviewed on 7/5/23 at 11:41 a.m. The resident was admitted to the facility on 6/15/23. Diagnoses included, but were not limited to, cerebral palsy, hydronephrosis (excess fluid in the kidney), and contractures of the left and right hand. The Admission Minimum Data Set (MDS) assessment, dated 6/22/23, indicated the resident was severely cognitively impaired. The resident required total dependence with one person physical assist for bed mobility, dressing, toilet use, and bathing. There was no Care Plan related to ADL (activities 5I4V11 Facility ID: 000366 Page 4 of 16 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

08/03/2023

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 07/06/2023	
NAME OF PROVIDER OR SUPPLIER CASA OF HOBART			4410 V	^T ADDRESS, CITY, STATE, ZIP COD N 49TH AVE		
CASA O	F HOBART		HOBA	RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 0686 SS=D Bldg. 00	received nail care Interview with the 7/5/23 at 3:19 p.m supposed to docum sheets, however, th filled out since adh documenting show documentation of section to docume This Federal tag re and IN00412121. 3.1-38(a)(3)(E) 3.1-38(b)(2) 483.25(b)(1)(i)(ii) Treatment/Svcs th Ulcer §483.25(b)(1)(i)(ii) Treatment/Svcs th Ulcer §483.25(b)(1) Pri- Based on the cor a resident, the fa (i) A resident recor professional stam pressure ulcers a pressure ulcers a pressure ulcers a pressure ulcers a pressure ulcers a pressure treatm with professional promote healing, new ulcers from	umentation the resident had since admission. Director of Nursing (DON) on ., indicated the CNA's were hent nail care on the shower he resident did not have any mission. They were vers using the CNA Tasks for showers, which did not have a int nail care completed. Hates to Complaints IN00411679 or Prevent/Heal Pressure Integrity essure ulcers. mprehensive assessment of cility must ensure that- eives care, consistent with dards of practice, to prevent and does not develop unless the individual's clinical strates that they were h pressure ulcers receives hent and services, consistent standards of practice, to prevent infection and prevent developing.				
	Based on observat	ion, record review, and lity failed to ensure weekly	F 0686	Please accept the followir facility's credible allegation	-	07/24/202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/06/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD N 49TH AVE		
CASA O	F HOBART			RT, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	E COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ents were completed for 1 of 3		compliance. This plan of		
		for pressure ulcers. (Resident		correction does not constitute a		
	H)			admission of guilt or liability by		
	E' 1' ' 1 1			facility and is submitted only in		
	Finding includes:			response to the regulatory		
	On 7/6/22 of 2.04	p.m., Resident H was observed in		requirement.	te	
		essing in place to her coccyx.		The Facility respectfully reques		
		clean, dry, intact, and appeared			;y.	
	-	o date on the dressing.				
		A 1 at that time, indicated				
		ne resident's dressing.		F686- Treatments/ to Prevent/H	leal	
		B.		Pressure Ulcers		
	The record for Res	sident H was reviewed on 7/6/23				
	at 2:57 p.m. Diag	noses included, but were not		What corrective action(s) will be	e	
	limited to, type 2 d	liabetes, stroke, and chronic		accomplished for those residen		
	kidney disease.			found to have been affected by		
				deficient practice;		
	The Admission M	inimum Data Set (MDS)				
		6/2/23, indicated the resident		was and no adverse effects we	ere	
		paired for daily decision making		noted related to not receiving a		
	-	sive assistance with bed		wound assessment every 7 day		
	mobility. The resi	dent had no pressure ulcers.		and not having a care plan in p	lace	
				for the pressure		
		plan related to the pressure				
	ulcer to the coccys	ζ.		Resident H immediately had		
	A Dhysioian's Ord	er, dated 6/22/23, indicated the		wound assessed and		
		t's coccyx was to be cleansed		measurements place as well as care plan for the pressure ulcer		
		, pat dry, apply Medihoney (a			•	
		t), and cover with a foam		How the facility will identify othe	≏r	
		nday, Wednesday, and Friday		residents having the potential to		
	and as needed (prr			be affected by the same deficie		
		,		practice and what corrective ac		
	The June and July	2023 Treatment Administration		will be taken;		
		ndicated the treatment was		;		
	signed out as ordered.			All residents who have have the	e	
				potential to be affected by the		
	There were no wee available for revie	ekly wound measurements w.		same alleged deficient practice		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 07/06/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
CASA O	F HOBART			RT, IN 46342		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRC DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETIC
TAG	Interview with the 7/7/23 at 3:54 p.m of Attorney (POA the treatment. She not have been sign didn't complete it. The hospice notes identified the area There were no we Additional intervie indicated measure because hospice w the POA's request have been docume notes.	2R LSC IDENTIFYING INFORMATION CDIrector of Nursing (DON) on ., indicated the resident's Power) wanted hospice to complete e indicated facility staff should aing out the treatment if they for the month of June 2023 as a stage 2 coccyx wound. ekly wound measurements. ew with the DON at 5:30 p.m., ments were not done weekly vas taking care of the wound per . She indicated that should ented in the nursing progress elates to Complaint IN00412151.	TAG	 What measures will be put place or what systemic chawill be made to ensure that deficient practice does not Nursing staff were re-educe ensuring that wound assessments, including work measurements, are completed and documented every 7 or Staff were also re-educate to the nee have a care place pressure ulcers. How the corrective action(monitored to ensure the deficient practice will not recur, i.e., quality assurance program put into place; DON/Designee to review with documentation, twice weel months, to ensure that assessments, including measurements are being completed and documenter 7 days. DON/Designee will ensure that all residents with pressure ulcers have care manager/designee will pressure ulcers have care manager/designee will pressure and monitoring will be don quarterly and present quart the QA meeting. Monitorir be on going. 	anges t the recur; cated on ound eted days. d related n for all s) will be eficient what is will be vound kly for 4 ed every l also ith plans. esent a he tee ereafter, y liting e terly at	DATE

AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		X3) DATE SURVEY COMPLETED 07/06/2023	
	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD V 49TH AVE		
CASA OF	- HOBART		HOBA	RT, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION	
⁻ 0690 SS=D Bldg. 00	§483.25(e) Incor §483.25(e)(1) Th resident who is c bowel on admiss assistance to ma or her clinical cor that continence is §483.25(e)(2)For	e facility must ensure that ontinent of bladder and ion receives services and intain continence unless his ndition is or becomes such s not possible to maintain.		Date by which systemic corrections will be completed: 7/24/2023		
	comprehensive a ensure that- (i) A resident who an indwelling cat unless the reside demonstrates tha necessary; (ii) A resident wh indwelling cathet one is assessed as soon as possi clinical condition catheterization is (iii) A resident wh receives appropri to prevent urinar	sed on the resident's assessment, the facility must o enters the facility without heter is not catheterized ent's clinical condition at catheterization was o enters the facility with an er or subsequently receives for removal of the catheter ble unless the resident's demonstrates that necessary; and no is incontinent of bladder iate treatment and services y tract infections and to be to the extent possible.				
	§483.25(e)(3) Fo					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 00 COMPLETED 155469 B. WING 07/06/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART HOBART, IN 46342 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation and interview, the facility F 0690 Please accept the following as the 07/24/2023 facility's credible allegation of failed to ensure a resident with a history of urinary tract infections (UTI) received appropriate compliance. This plan of treatment and services for a foley catheter related correction does not constitute an to a catheter drainage bag located on the floor and admission of guilt or liability by the catheter care orders not obtained timely for 2 of 3 facility and is submitted only in residents reviewed for foley catheters. (Residents response to the regulatory G and L) requirement. F690 Bowel/Bladder Incontinence, Findings include: Catheter. UTI 1. On 7/5/23 at 10:10 a.m. and 11:50 a.m., Resident What corrective action(s) will be G was observed lying on his bed. His catheter accomplished for those residents drainage bag was noted to be sitting on the floor found to have been affected by the near the window. The tubing contained yellow deficient practice; urine with no sediment noted. Residents G was and no adverse Resident G's record was reviewed on 7/5/23 at effects related to foley catheter 11:41 a.m. Diagnoses included, but were not bag touching the floor. Foley limited to, cerebral palsy, hydronephrosis (excess Catheter bag immediately fluid in the kidney), and history of urinary tract changed. infection (UTI). Resident L- was assessed and no The Admission Minimum Data Set (MDS) adverse effects were noted related assessment, dated 6/22/23, indicated the resident to catheter care orders not being was severely cognitively impaired. The resident in place and catheter care was required total dependence with one person provided. physical assist for bed mobility, toilet use, and bathing. He had an indwelling catheter and an How the facility will identify other ostomy. residents having the potential to be affected by the same deficient A Care Plan, dated 7/5/23, indicated the resident practice and what corrective action had a foley catheter and left nephrostomy tube. will be taken; Interventions included, but were not limited to, 5I4V11 Facility ID: 000366

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		DF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u>				3) DATE SURVEY COMPLETED 07/06/2023
NAME OF PROVIDER OR SUPPLIER		4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	-	inks routinely each shift and		All residents who have foley			
	-	ag and tubing below the level		catheters have the potential to b	e		
	of the bladder and	away from the entrance room		affected by the same alleged			
	door.			deficient practice.			
	Interview with the	Director of Nursing on 7/5/23 at		What measures will be put into			
	3:19 p.m., indicate	d the catheter bag should not be		place or what systemic changes	;		
	touching the floor.			will be made to ensure that the			
				deficient practice does not recu			
		titled "Urinary Catheter Care"					
		ne Administrator on 7/6/23 at		Clinical Staff were in- on ensuring	ng		
		icy indicated urinary drainage		catheter care is provided			
		all be positioned to prevent		according to the physician order			
	-	directly.2. On 7/5/23 at 12:15		and resident plan of care and th	at		
	-	vas observed in his wheelchair		foley catheter bags should not			
		by. The resident had a foley		touch the floor.			
	catheter in place.				h -		
	The second for Dec	ident L was reviewed on 7/5/23		How the corrective action(s) will			
	at 2:27 p.m.	sident L was reviewed on 7/3/23		monitored to ensure the deficier			
	at 2.27 p.m.			practice will not recur, i.e., what quality assurance programs will			
	Diagnoses include	d, but were not limited to,		put into place;	De		
	-	sfunction of the bladder and					
	dependence on ren			DON/Designee will randomly au	Idit		
		· ,		5 residents with foley catheters			
	The Quarterly Mir	nimum Data Set (MDS)		weekly to ensure that catheter			
		5/2/23, indicated the resident		care is being performed accordi	ng		
		tact and he had an indwelling		to physician orders and plan of	-		
	catheter.	-		care and that foley bags are not			
				touching the floor.			
		Plan, indicated the resident					
	-	ling urinary catheter related to		The Director of Nursing/designe	e		
	-	ease and neuromuscular		will present a summary of the			
		bladder. Interventions		audits to the Quality Assurance			
		not limited to, avoid		committee monthly for 6 months			
		nage, change the catheter per		Thereafter, if determined by the			
		ler, position drainage bag below		Quality Assurance committee,			
		dder, and report signs and		auditing and monitoring will be			
	symptoms of urina	ry tract infection (UTI).		done quarterly and present			
				quarterly at the QA meeting.			

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE C	ONSTRUCTION	(X3) DA	TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>				IE SORVEI IPLETED
AND I LAN	or condict nois	155469		WING	00	_	06/2023
				STREET	ADDRESS, CITY, STATE, ZIP C	- D	
NAME OF PROVIDER OR SUPPLIER				V 49TH AVE			
CASA O	F HOBART			HOBA	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A		COMPLETIO
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2	r, dated $6/23/23$, indicated the			Monitoring will be on g	oing.	
		e a 14 French Coude catheter					
		centimeter) bulb. The catheter					
	was to be changed a	as needed for blockage.					
					Date by which systemi	с	
		r, dated $7/5/23$, indicated the			corrections will be		
	resident was to have	e catheter care every shift.			completed: 7/24/2023		
	Interview with the l	Director of Nursing (DON) on					
		indicated the resident was					
	· ·	hospital on $6/23/23$ and the					
		care were not carried over.					
	This Federal tag rel	ates to Complaint IN00411679.					
	3.1-41(a)(2)						
0693	483.25(g)(4)(5)						
SS=D		mt/Restore Eating Skills					
Bldg. 00	§483.25(g)(4)-(5)	-					
Jidg. 00		stric and gastrostomy					
		aneous endoscopic					
		percutaneous endoscopic					
		enteral fluids). Based on a					
		hensive assessment, the					
	facility must ensu	-					
	§483.25(g)(4) A re	esident who has been able					
		ne or with assistance is not					
	-	hods unless the resident's					
	-	lemonstrates that enteral					
	feeding was clinic	ally indicated and					
	consented to by the	ne resident; and					
	§483.25(a)(5) A re	esident who is fed by enteral					
		ne appropriate treatment					
		store, if possible, oral					
		prevent complications of					
	-	cluding but not limited to					
	-	onia, diarrhea, vomiting,	1				

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	LAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ЛLDING	00	COM	PLETED
		155469	B. W.	ING		07/0	6/2023
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
CASA O	F HOBART				V 49TH AVE RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F	BE	COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
into		abolic abnormalities, and		mo			Diffe
	nasal-pharyngeal						
		view and interview, the facility	F 0	(0)	Please accept the following	oo tho	07/24/202
			FU	595			07/24/202
		strostomy tube site orders were			facility's credible allegation		
		ing for 1 of 3 residents			compliance. This plan of		
	reviewed for gastro	ostomy tubes. (Resident D)			correction does not constitu		
					admission of guilt or liability	-	
	Finding includes:				facility and is submitted only	/ in	1
				response to the regulatory		1	
	The closed record			requirement.		1	
	7/5/23 at 1:58 p.m.			The Facility respectfully req	uests		
	the facility on 5/26			Paper Compliance for this s	urvey.		
		, displaced fracture of the fifth					
	and sixth cervical			F693 Tube Feeding			
	opening into the stomach from the abdominal wall				Management/Restore Eatin	a	
		feeding), and dysphagia (difficulty			Skills	9	
	swallowing).	jopnagia (announcy					
	swanowing).				What corrective action(s) wi	ll bo	
	The Admission Mi	nimum Data Set (MDS)			. ,		
		6/2/23, indicated the resident			accomplished for those resi		
					found to have been affected	i by the	
		act and he required			deficient practice;		
	supervision with ea	ating.					
					Resident D is no longer in the	ne	
		plan related to the resident's			facility.		
	gastrostomy tube s	ite.					
					How the facility will identify		1
	-	er, dated 5/18/23, indicated the			residents having the potenti	al to	1
	gastrostomy tube v	vas to be flushed every shift			be affected by the same def	icient	1
	with 100 cc's (cubi	c centimeters) of water. There			practice and what corrective	e action	
	were no orders for	care to the gastrostomy site.			will be taken;		
	Nurses' Notes, date	ed 6/26/23 at 2:21 p.m.,			All residents with peg tubes	have	
		ician and the resident's family			the potential to be affected l		
	-	e. The family reported the			same alleged deficient prac	-	1
		vas infected and requested the					1
	- ·	*			M/bet meesures will be wet	nto	
		the emergency room. Orders			What measures will be put i		
		the resident was transported to			place or what systemic char	-	
		m for evaluation. There was no			will be made to ensure that		
		he Nurses' Notes or on the			deficient practice does not r	ecur;	
	eINTERACT trans	fer form of what the					1

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 00 COMPLETED 155469 B. WING 07/06/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART HOBART, IN 46342 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE gastrostomy site looked like. Clinical staff were re-educated on the need to have a physician order Interview with the Director of Nursing (DON) on to clean the peg tube site, of 7/6/23 at 4:13 p.m., indicated that she and the residents who have a peg tube, Physician assessed the tube site and no redness dailv. or infection was noted. The resident was sent to the emergency room based on the family's Clinical staff were re-educated on request. The resident returned to the facility that the need to have a care plan for evening with the gastrostomy tube in place. He the care of all residents who have was treated for constipation and not a tube site a peg tube. infection. The DON indicated the assessment should have been documented and the resident How the corrective action(s) will be should have had orders for gastrostomy tube site monitored to ensure the deficient care. practice will not recur, i.e., what quality assurance programs will be The facility policy titled, put into place; "Gastrostomy/Jejunostomy Site Care" was received from the Administrator on 7/6/23 at 4:41 manager will audit all peg tube p.m. The policy indicated site care was to be orders 3X per week, for 4 months, completed using gauze pads and soap and water. to ensure that all residents who The area surrounding the tube was to be gently have peg tubes have an order to cleansed in an outward circular motion. Pat dry clean the peg tube site daily and a after cleansing and do not place a dressing over care plan for the care of the peg the site unless otherwise ordered. tube. This Federal tag relates to Complaint IN00411679. DON/designee will present a summary of the audits to the 3.1-44(a)(2) Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: Event ID: 5I4V11 Facility ID: 000366 Page 13 of 16 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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08/03/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 00 COMPLETED 155469 B. WING 07/06/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART **HOBART. IN 46342** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 7-24-23 F 0921 483.90(i) SS=D Safe/Functional/Sanitary/Comfortable Environ Bldg. 00 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on random observations and interview, the F 0921 Please accept the following as the 07/24/2023 facility failed to keep the residents' environment facility's credible allegation of clean and in good repair related to marred walls, compliance. This plan of hard water stains on faucets, tiles lifting, trash correction does not constitute an cans with no garbage bag, dirty floors, and trim admission of guilt or liability by the falling off of the walls for 2 of 5 units. (Apple Lane facility and is submitted only in and Cherry Court) response to the regulatory requirement. Findings include: The Facility respectfully requests paper compliance for this survey. 1. During random observations on Apple Lane, the following was observed: F921 Safe/Functional/Sanitary/Comforta a. On 7/6/23 at 1:59 p.m., Room 20 bed 1 was ble Environment observed. The resident's family was at the beside and the room was clean, the resident's sister said What corrective action(s) will be they just swept the floor and cleaned up because accomplished for those residents the floors were dirty with dried wipes, crumbs, and found to have been affected by the trash. The bathroom faucet had hard water stains deficient practice; and the sink was dirty. There was no garbage bag in the garbage can next to the resident's bed. Room sink was and trash bag There were two residents in the room. placed in garbage can. b. On 7/6/23 at 2:09 p.m., Room 23 bed 1 was Trim, floor tile and marred walls observed. The trim behind the resident's bed was repaired in room 23. loose. The wall behind bed 2 was marred, and a tile was lifting off of the floor under the air Room 32 floors were cleaned. conditioner. There were two residents who resided in the room. How the facility will identify other residents having the potential to 5I4V11 Event ID: Facility ID: 000366 Page 14 of 16 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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08/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 07/06/2023	
	PROVIDER OR SUPPLIE	ÜR.	4410 V	ADDRESS, CITY, STATE, ZIP CO V 49TH AVE RT IN 46342	DD	
CASA O (X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C 2. During random the following was a. On 7/6/23 at 2: with dirty floors. T residing in the roo Interview with the 7/6/23 at 2:33 p.m walls were marred said Blueberry Ha Hall was next.	14 p.m., Room 32 was observed There were two residents		RT, IN 46342 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY) be affected by the same practice and what correr will be taken; All residents have the p be affected by the same deficient practice. What measures will be place or what systemic will be made to ensure a deficient practice does of Staff were re-educated procedure of notifying maintenance/environme services of any necessa repairs/cleaning needed How the corrective action monitored to ensure the practice will not recur, i. quality assurance progr put into place; Environmental services supervisor/Maintenance department/ will audit 10 per week on alternating Environmental/cleaning maintenance issues. A identified issues will be corrected. //designee will present a of the audits to the Qua	e deficient ective action botential to e alleged put into changes that the not recur; on the ental ary d. on(s) will be e deficient .e., what rams will be e 0 rooms j units for j issues and iny	(X5) COMPLETIO DATE
				Assurance committee n 6 months. Thereafter, i determined by the Qual Assurance committee, a	nonthly for if lity	

EPARTMENT	FORM APPROVED					
ENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/06/2023		
	ROVIDER OR SUPPLIEF HOBART	2	4410 V	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP TAG DEFICIENCY)			(X5) COMPLETION DATE
				and monitoring will be done quarterly and present quarter the QA meeting. Monitoring be on going.	-	
				Date by which systemic corrections will be completed: 7/24/2023		

5l4V11 Facility ID: 000366 If continuation sheet

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