STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
		155469	B. WI	NG		07/02	/2021
	PROVIDER OR SUPPLIEI HOBART	R	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	Licensure Survey. Investigation of Co Complaint IN0035 Federal/State defici- allegations are cited Survey dates: 6/27 Facility number: 0 Provider number: AIM number: 1002 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type Medicare: 7	7, 6/28, 6/29, 6/30, 7/1 and 7/2/21 00366 155469 288900	F 00	000			
	Medicaid: 69 Other: 7 Total: 83						
	accordance with 41						
F 0550	Quality review con	•					
SS=D Bldg. 00	existence, self-de communication w and services insid	Exercise of Rights ent Rights. a right to a dignified					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

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.

Event ID: F4R211 Facility ID: 000366 If continuation sheet Page 1 of 66

PRINTED: 08/03/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							RM APPROVED IB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469		JILDING	ONSTRUCTION 00	(X3) DATE COMPI 07/02	SURVEY LETED
	PROVIDER OR SUPPLIE HOBART	R		4410 W	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	resident with respeach resident in a environment that enhancement of recognizing each facility must prote the resident. §483.10(a)(2) The access to quality diagnosis, severit source. A facility maintain identical regarding transfe provision of servicall residents regall residents regall residents regall resident has her rights as a real a citizen or resident can exit without interferent or reprisal from the \$483.10(b)(2) The free of interferent and reprisal from or her rights and	the right to exercise his or sident of the facility and as ent of the United States. e facility must ensure that exercise his or her rights are, coercion, discrimination, he facility. e resident has the right to be ce, coercion, discrimination, the facility in exercising his to be supported by the roise of his or her rights as					
		on, record review and	F 05	550	The facility request		07/23/2021

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interview, the facility failed to ensure each

resident's dignity was maintained related to

wearing a hospital gown during the daytime for 2 of 3 residents reviewed for dignity. (Residents 4

Event ID:

F4R211

Facility ID: 000366

citation

If continuation sheet

paper compliance for this

Submission of this plan of

Page 2 of 66

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	
		155469	B. W	ING		07/02/	2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				/ 49TH AVE		
CASA OF	HOBART				RT, IN 46342		
		OT A TEMPLIT OF PERIODS	ı		· I	1	975
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	and 23)				correction does not constitute		
	Eindings in dude.				admission or agreement by th	е	
	Findings include:				provider of the truth of facts	0.0	
	1. On 6/27/21 at 11:40 a.m. and 1:52 p.m., Resident				alleged or correction set forth		
		<u>-</u>			the statement of deficiencies.		
	4 was observed in bed wearing a hospital gown.				plan of correction is prepared		
	On 6/20/21 at 0:27	om and 1.55 nm the resident			submitted because of requirer	nent	
		a.m., and 1:55 p.m., the resident			under state and federal law.		
	was observed in bed	d wearing a hospital gown.			Please accept this plan of		
	On 6/20/21 -+ 0:24	a m the regident was al			correction as our credible		
On 6/29/21 at 9:24 a.m., the resident was observed in bed wearing a hospital gown.					allegation of compliance. Plea	se	
	in bed wearing a ho	spital gowii.			find enclosed this plan of		
	The record for D:	dont 1 was reviewed on 6/20/21			correction for this survey.		
		dent 4 was reviewed on 6/28/21			F FFO Decidents - Districts		
		oses included, but were not			F 550 Resident's Rights		
	-	e care, dependence on			Compositive actions while 1911	_	
		en, history of respiratory	Corrective actions which will be				
		tive disorder, type 2 diabetes			accomplished for those reside		
	_	l pressure, major depressive			found to have been affected b	y tne	
	disorder, and anxiet	y disorder.			deficient practice:		
	The Admission Mir	nimum Data Set (MDS)			R4 was provided with		
		/21/21, indicated it was very			appropriate clothing. R4 rema	ins	
		sident to choose what clothes			at his baseline for mood and		
	to wear.	mut didiles			behavior		
					R23 was provided with		
	The Ouarterly MDS	S assessment, dated 4/24/21,			appropriate clothing. R23 rem	ains	
	•	nt was moderately impaired for			at his baseline for mood and	G.110	
		The resident had no behaviors			behavior		
	_	of care. He was an extensive			20.144101		
		on physical assist for bed					
		personal hygiene, and the			1. How the facility will ident	ifv	
		lid not occur during the			other residents having the	3	
	assessment reference				potential to be affected by the		
					same deficient practice.		
	There was no Care	Plan indicating the resident			· All residents may have	the	
		hospital gown in bed every			potential to be affected by the		
	day.	1 8 20 - 21			same deficient practice.		
	- <i>J</i> -				James demoising produces.		
	Interview with the I	Director of Nursing on 6/30/21			2. The measures the facility	y	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155469	B. WI	NG		07/02/	2021
		<u> </u>	1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			49TH AVE		
CASA OF	HOBART				RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY 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
		ted she did not know why the			will take or systems the facility		
	resident was not dre	essed in street clothes.			will alter to ensure that the		
	2. Interview with Resident 23 on 6/27/21 at 1:43				problem will be corrected and	WIII	
					not recur.		
	p.m., indicated he would like to be dressed in regular clothes. The resident stated, "This is what				· An audit tool will be	oro	
	_	to wear" as he was pointing to			developed to ensure residents		
	1	to wear as he was pointing to			wearing appropriate clothing's least five random residents wil		
	the gown.				selected per audit. This will be		
	On 6/28/21 at 10:00	a.m., and 1:57 p.m., the			completed three times weekly		
	resident was observed in bed dressed in a				4 weeks the 2x weekly for 6	101	
	hospital gown.				months. Any deficiencies will be	_{oe}	
	nospital go initi				corrected immediately.		
	On 6/29/21 at 9:26 a.m., 12:05 p.m., and 2:51 p.m.,				· Inservice will be provide	d on	
		served in bed dressed in a			the following topic:		
	hospital gown.				o Resident rights and		
					maintaining an environment th	at	
	On 6/30/21 at 9:35	a.m., 10:24 a.m., and 1:27 p.m.,			promotes enhancement of qua	ality	
		served in bed dressed in a			of life and recognizing each		
	hospital gown.				person's individuality		
	On 07/01/21 at 9:45	5 a.m., CNA 3 and CNA 4 were			3. Quality Assurance Plans	to	
	providing morning	care for the resident. When			monitor facility performance to		
		NA 4 dressed the resident in a			make sure that corrections are		
	hospital gown, she	did not ask the resident what			achieved and are permanent.		
	he wanted to wear.				· All plan of correction au	dit	
					will be reported by the Directo	r of	
		A 3 at that time, indicated she			Nursing and or ADON to the		
		resident to get dressed, but he			Quality Assurance Committee		
	refused all the time	, so she did not offer today.			reviewed by the Committee pe	er	
					Month for four Months and		
		dent 23 was reviewed on			recommendations given in ord		
	_	. Diagnoses included, but were			assist in ensuring that the facil	ity	
	not limited to, stroke, acquired absence of right				stay in compliance and if		
	left above the knee, vascular dementia with				concerns are identified the Qu	· ·	
	behaviors, obstructive and reflux uropathy,				Assurance Committee will add	on	
	peripheral vascular disease, epilepsy, heart failure,				additional Months until		
	type 2 diabetes, high blood pressure, atherosclerotic heart disease				Compliance is sustained.		
	ameroscierone near	t disease			4. Dates when corrective		
					4. Dates when corrective		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155469	B. W.	NG		07/02	/2021
NAME OF P	DOMDED OF STIPPT TER			STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
	ROVIDER OR SUPPLIER	•			49TH AVE		
CASA OF	HOBART			HOBART, IN 46342			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION mum Data Set (MDS)		TAG		22	DATE
	•	/30/21, indicated the resident			action will be completed: <u>July</u> 2021	<u> 23,</u>	
		red. The resident needed			<u> </u>		
		h 1 person physical assist for					
	dressing, and extensive assist with 2 person						
	_	personal hygiene. The resident					
	had no pressure ulc	ers, but was at risk for					
pressure ulcers. There was no Care Plan the resident preferred to be dressed in a hospital gown during the day. Interview with the Director of Nursing on 7/1/21 at							
		ed the CNA should have offered					
	the resident to get d	ressed.					
	3.1-3(t)						
F 0638	483.20(c)						
SS=E	-	at Least Every 3 Months					
Bldg. 00	- ' '	erly Review Assessment sess a resident using the					
	-	ess a resident using the estrument specified by the					
	•	ed by CMS not less					
	• •	ice every 3 months.					
		view and interview, the facility	F 0	638	The facility request		07/23/2021
	_	Quarterly Minimum Data Set			paper compliance for this		
		timely for 5 of 38 residents			citation		
		ments were reviewed.					
	(Residents 21, 18, 1	3, 24, and 17)			Submission of this plan of		
	Findings include:				correction does not constitute		
	Findings include:				admission or agreement by the provider of the truth of facts	C	
	1. The record for Ro	esident 21 was reviewed on			alleged or correction set forth	on	
	7/2/21 at 9:00 a.m.				the statement of deficiencies.		
					plan of correction is prepared	and	
		rly Minimum Data Set (MDS)			submitted because of requirer	ment	
	•	ted on 2/10/21. Another			under state and federal law.		
	· ·	essment, was not completed			Please accept this plan of		
	until 6/29/21.		1		correction as our credible		1

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 5 of 66

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		155469	B. W	ING		07/02/	2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			/ 49TH AVE		
CASA OF	HOBART				RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	``	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IL	DATE
					allegation of compliance. Plea	se	
	2. The record for R	esident 18 was reviewed on			find enclosed this plan of	- =	
	7/2/21 at 9:00 a.m.				correction for this survey.		
	There was a Quarter	rly Minimum Data Set (MDS)			F 638 Quarterly Assessment		
	assessment complet	ed on 2/19/21 and then not			·		
	again until 6/17/21.				Corrective actions which will b	e	
					accomplished for those reside	ents	
	3. The record for R	esident 13 was reviewed on			found to have been affected b	y the	
	7/2/21 at 9:00 a.m.				deficient practice:		
A Quarterly Minimum Data Set (MDS)					· R21's Minimum Data Se	et	
		npleted on 2/6/21 and then not			(MDS) is updated		
	again until 6/29/21.				R18's Minimum Data So	et	
					(MDS) is updated		
		esident 24 was reviewed on			R13's Minimum Data So	et	
	7/2/21 at 9:00 a.m.				(MDS) is updated		
	A O	Deta Cat (MDC)			R24's Minimum Data So	et	
		um Data Set (MDS) assessment			(MDS) is updated	o t	
	was completed on 2 $6/2/21$.	1/12/21 and then not again until	R17's Minimum Data Set				
	U/ Z/ Z 1 •				(MDS) is updated		
	5. The record for R	esident 17 was reviewed on					
	7/2/21 at 9:00 a.m.				1. How the facility will ident	tifv	
	2 - 0 0				other residents having the	J	
	A Quarterly Minim	um Data Set (MDS) assessment			potential to be affected by the		
	was completed on 2	· · ·			same deficient practice.		
	•				· All residents may have	the	
	There was no other	Quarterly assessment			potential to be affected by the		
	completed.				same deficient practice.		
		MDS Coordinator on 7/2/21 at			2. The measures the facility	y	
		d she was aware the			will take or systems the facility	/	
	-	essments were not completed			will alter to ensure that the		
	within 120 days.				problem will be corrected and	will	
					not recur.		
	3.1-31(d)(2)				· An audit tool will be		
					developed to ensure resident's		
					MDS are completed timely (ev	ery	
					3 months), transmitted and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2021		
	PROVIDER OR SUPPLIEI HOBART	?	4410	ET ADDRESS, CITY, STATE, ZIP COD W 49TH AVE ART, IN 46342	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			ENATE COMPLETION DATE Tive ected eted eks . Any
F 0640 SS=B Bldg. 00	483.20(f)(1)-(4) Encoding/Transm Assessments	itting Resident		4. Dates when corrective action will be completed: <u>Ju</u> 2021	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155469	B. W	ING		07/02	/2021
NAME OF I	PROVIDER OR SUPPLIER	·	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
		X			49TH AVE		
CASA OF	FHOBART			HOBAR	T, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	requirement-	ading data Within 7 days					
	§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's						
		cility must encode the					
		ion for each resident in the					
	facility:	ion for each resident in the					
	(i) Admission assessment.						
	(ii) Annual assessment updates.						
	(iii) Significant cha	ange in status					
	assessments.						
	(iv) Quarterly review assessments.						
	(v) A subset of items upon a resident's						
	transfer, reentry, discharge, and death.						
	. ,	ace-sheet) information, if					
	there is no admiss	sion assessment.					
	8/83 20(f)(2) Tran	nsmitting data. Within 7					
	- ',','	y completes a resident's					
		cility must be capable of					
		CMS System information					
		contained in the MDS in a					
	format that confor	ms to standard record					
	layouts and data	dictionaries, and that					
	passes standardiz	zed edits defined by CMS					
	and the State.						
	8483 20/f\/2\ Tror	nsmittal requirements.					
	. , , ,	ter a facility completes a					
	-	ment, a facility must					
		smit encoded, accurate,					
	· ·	S data to the CMS System,					
	including the follow	_					
	(i)Admission asse	•					
	(ii) Annual assess						
	(iii) Significant cha	ange in status assessment.					
		rection of prior full					
	assessment.						
	(v) Significant cor	rection of prior quarterly					
	assessment.						
	(vi) Quarterly revie	⊅ /W/	ı				I

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 8 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/02/2021	
	PROVIDER OR SUPPLIER F HOBART		STREET 4410 V HOBAI		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	transfer, reentry, (viii) Background (an initial transmiss resident that does assessment. §483.20(f)(4) Data transmit data in thor, for a State white approved by CMS the State and app Based on record reversided to successfull Set (MDS) assessment residents whose MI reviewed. (Resident Findings include: 1. The record for R 7/2/21 at 9:00 a.m. The 5/18/21 Quarte assessment indicate was not exported or R 7/2/21 at 9:00 a.m. The 6/10/21 Signifit (MDS) assessment exported or transmit as The record for R 7/2/21 at 9:00 a.m. The 5/24/21 Quarte for R 7/2/21 at 9:00 a.m.	view and interview, the facility by export the Minimum Data ent in timely manner for 6 of 38 DS assessments were tts 20, 2, 14, 16, 22, and 24) desident 20 was reviewed on rly Minimum Data Set (MDS) d it had been completed but transmitted. desident 2 was reviewed on cant Change Minimum Data Set was completed but was not	F 0640	The facility request paper compliance for this citation Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. plan of correction is prepared submitted because of require under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Pleafind enclosed this plan of correction for this survey. F640 Encoding/Transmittal Resident Assessment Corrective actions which will accomplished for those reside found to have been affected by deficient practice:	on The and ment be ents by the

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 9 of 66

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLETED
		155469	B. Wl	ING		07/02/2021
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF 1	PROVIDER OR SUPPLIE	R			V 49TH AVE	
CASA O	F HOBART				RT, IN 46342	
	1 1102/11(1					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					(MDS) was transmitted	
4. The record for Resident 16 was reviewed on				R2's Minimum Data Sei	1	
	7/2/21 at 9:00 a.m.				(MDS) was transmitted	
					R14's Minimum Data S	et
		erly Minimum Data Set (MDS)			(MDS) was transmitted	
		mpleted but was not exported			R16's Minimum Data So	et
	or transmitted.				(MDS) was transmitted	
					R22's Minimum Data So	et
		Resident 22 was reviewed on			(MDS) was transmitted	
	7/2/21 at 9:00 a.m.				R24's Minimum Data S	et
	TI 5/04/01 0	1.16°			(MDS) was transmitted	
	1	erly Minimum Data Set (MDS)				
		mpleted but was not exported			4 11 (1 6 33)	
	or transmitted.				1. How the facility will ident	шту
	(The of feet	D: 1 24 1			other residents having the	
	7/2/21 at 9:00 a.m.	Resident 24 was reviewed on			potential to be affected by the	
	//2/21 at 9:00 a.m.				same deficient practice.	41
	The 6/2/21 Owester	rly Minimum Data Set (MDS)			· All residents may have	
		mpleted but was not exported			potential to be affected by the	
	or transmitted.	impleted but was not exported			same deficient practice.	
	of transmitted.				2. The measures the facilit	
	Interview with the	MDS Coordinator on 7/2/21 at			will take or systems the facility	- · · · · · · · · · · · · · · · · · · ·
		ed she was aware the			will alter to ensure that the	'
	·	essments were not exported			problem will be corrected and	will
	timely.	essments were not exported			not recur.	WIII
					· An audit tool will be	
					developed to ensure resident's	s
					MDS are completed timely (ev	
					3 months), transmitted and	
					approved by CMS. At least fiv	e
					random residents will be select	
					per audit. This will be complet	
					three times weekly for 4 week	
					then 2x weekly for 6 months.	l l
					deficiencies will be corrected	
					immediately.	
					Inservice will be provide	ed
					with the MDS coordinators on	l l
					following topic:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	E SURVEY PLETED 2/2021
	ROVIDER OR SUPPLIER		4410 V	ADDRESS, CITY, STATE, ZIP CO V 49TH AVE RT, IN 46342	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE
F 0676 SS=D Bldg. 00	§483.24(a) Based assessment of a r the resident's nee must provide the r services to ensure activities of daily licircumstances of condition demons was unavoidable. ensuring that:	-(5)(i)-(iii) ing (ADLs)/Mntn Abilities on the comprehensive esident and consistent with ds and choices, the facility necessary care and e that a resident's abilities in ving do not diminish unless the individual's clinical trate that such diminution This includes the facility		Ø Timely encoding and transmission of MDS assessments to the CM. 3. Quality Assurance monitor facility performa make sure that correctic achieved and are permated. All plan of correct will be reported by the District Nursing and or ADON to Quality Assurance Commerciations given assist in ensuring that the stay in compliance and concerns are identified to Assurance Committee with additional Months until Compliance is sustained. 4. Dates when correct action will be completed 2021	S system Plans to ance to ons are anent. Consider to of the mittee and the per and in order to the facility if the Quality will add on the consider to the consider to the consider the quality will add on the consideration the quality will be quality will add on the consideration the quality will add on the consideration the quality will be quality will add on the consideration the quality will be quality will add on the consideration the quality will be quality will add on the quality will be	

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 11 of 66

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/02/2021			
	PROVIDER OR SUPPLIER HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	appropriate treatm maintain or improvout the activities of those specified in section §483.24(b) Activition The facility must properties accordance with profollowing activities §483.24(b)(1) Hyggrooming, and orange section includes \$483.24(b)(2) More ambulation, includes \$483.24(b)(3) Elim §483.24(b)(4) Dinimand snacks, §483.24(b)(5) Corr(i) Speech,	eent and services to ye his or her ability to carry if daily living, including paragraph (b) of this es of daily living. rovide care and services in aragraph (a) for the of daily living: siene -bathing, dressing, il care, bility-transfer and ing walking,					
	Based on observation interview, the facility who needed limited living (ADLs) receit of 5 residents revisiving. (Resident 62 Finding includes: On 6/27/21 at 2:33 pin his room ambulated.	al communication systems. on, record review and ty failed to ensure residents assist with activities of daily ved help related to nail care for ewed for activities of daily 2) p.m., Resident 62 was observed ting to the bathroom. His toe g and hanging over the front of	F 0676	The facility request paper compliance for this citation Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. plan of correction is prepared submitted because of requirement under state and federal law. Please accept this plan of	on The and		

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

Event ID:

F4R211 Facility

Facility ID: 000366

If continuation sheet

Page 12 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPLETED	
ANDILAN	OF CORRECTION	155469	B. WING		<u></u>	- 07/02/2021	
		100700				01/02/	ZUZ I
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					49TH AVE		
CASA OF	HOBART		- 1	HOBAR	T, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	The record for Resi	dent 62 was reviewed on			correction as our credible		
	_	. Diagnoses included, but were			allegation of compliance. Plea	se	
	not limited to, lack of coordination, Alzheimer's,				find enclosed this plan of		
	dysphagia, diabetes				correction for this survey.		
	hallucinations, and	delusions.					
					F676 ADL's		
	_	ange Minimum Data Set (MDS)					
		assessment, dated 4/8/21, indicated he was			Corrective actions which will b		
		y impaired for decision making			accomplished for those reside		
	-	ensive 1 person physical assist			found to have been affected b	y the	
	with personal hygic	ene.			deficient practice:		
	A revised Care Plan	n, dated 5/4/21, indicated he			· R62's toenails were cut		
		with ADL care such as			Resident remains within basel		
	_	nd bathing. The interventions			for mood and behavior.		
		not limited to, provide			for mood and pondvior.		
	assistance with AD	-			How the facility will ident	tifv	
					other residents having the	y	
	Interview with the	Director of Nursing (DON) in			potential to be affected by the		
		., indicated the resident was			same deficient practice.		
		skin assessments and ADL			· All residents may have	the	
		ould not allow the staff to			potential to be affected by the		
	assess his toe nails.				same deficient practice.		
					'		
	3.1-38(a)(3)(E)				2. The measures the facility	у	
					will take or systems the facility	/	
					will alter to ensure that the		
					problem will be corrected and	will	
					not recur.		
					· An audit tool will be		
					developed to ensure resident's		
					nails are cut and ADL's provid		
					At least five random residents		
					be selected per audit. This will		
					completed three times weekly	for	
					4 weeks the 2x weekly for 6		
					months. Any deficiencies will be	be	
					corrected immediately.		
					· Inservice will be provide	ed on	
					the following topic:		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155469	A. BUILDING B. WING	00	COMPLETED 07/02/2021
	PROVIDER OR SUPPLIEF F HOBART	R	4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				o Resident are being provided with the necessary services at receives assistance with activity of daily living. 3. Quality Assurance Plans monitor facility performance to make sure that corrections are achieved and are permanent. All plan of correction aud will be reported by the Director Nursing and or ADON to the Quality Assurance Committee reviewed by the Committee reviewed by the Committee reviewed by the Committee permanent in the facility of the commendations given in order assist in ensuring that the facility in compliance and if concerns are identified the Quality Assurance Committee will additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 2021	nd Ities Sto O O O O O O O O O O O O O O O O O O O
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene; Based on observation	ed for Dependent Residents esident who is unable to s of daily living receives the es to maintain good g, and personal and oral on, record review and ty failed to ensure dependent	F 0677	The facility request paper compliance for this	07/23/2021
	residents received a (activities of daily l	iving) related to bathing,		citation Submission of this plan of	

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 14 of 66

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 07/02/2021 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 residents reviewed for ADL's. (Residents C, 4, correction does not constitute and 23) admission or agreement by the provider of the truth of facts Findings include: alleged or correction set forth on the statement of deficiencies. The 1. On 6/28/21 at 11:17 a.m., Resident C indicated plan of correction is prepared and he doesn't always get two showers a week. He submitted because of requirement also indicated he needed a shave. The resident under state and federal law. had a growth of facial hair. Please accept this plan of correction as our credible On 6/29/21 at 9:41 a.m., 11:50 a.m., and 1:44 p.m., allegation of compliance. Please the resident continued to have a heavy growth of find enclosed this plan of facial hair. correction for this survey. On 6/30/21 at 10:07 a.m., the resident was F677 ADL provided for dependent observed being taken into the shower room. At residents 10:44 a.m., the resident indicated he received a shower but he still had not received a shave. He Corrective actions which will be indicated he would like a shave if someone could accomplished for those residents give him one. found to have been affected by the deficient practice: The record for Resident C was reviewed on 7/1/21 at 10:56 a.m. Diagnoses included, but were not Resident C was shaven and limited to, stroke, COVID-19, chronic pain, and left provided ADL care above the knee amputation. Resident 4 was provided a bath and bathing (bed bath) is The Annual Minimum Data Set (MDS) scheduled 2x/week assessment, dated 3/29/21, indicated the resident Resident 23 was shaven, was cognitively intact for daily decision making fingernails were cut, and oral care and needed extensive assistance with bathing and provided. ADL care is provided personal hygiene. daily. The Care Plan, dated 1/29/19 and reviewed on How the facility will identify 3/29/21, indicated the resident required assistance other residents having the of staff for ADL care such as locomotion, potential to be affected by the dressing, personal hygiene, and bathing. same deficient practice. Interventions included, but were not limited to, All residents may have the provide assistance with ADL's as needed. potential to be affected by the same deficient practice. The resident's scheduled shower days were

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 15 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/02/2021	
	PROVIDER OR SUPPLIER HOBART		4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY OF Wednesday and Sat	LSC IDENTIFYING INFORMATION urday evening.	TAG	2. The measures the facilit	ty DATE
		d 6/9, 6/16, and 6/23/21, nt had received a shower.		will take or systems the facilit will alter to ensure that the problem will be corrected and not recur.	
		mentation in the bathing task		· An audit tool will be	
	to determine if the resident received a complete bed bath or a shower for May and June 2021.			developed to ensure resident ADL's provided for dependen residents. At least five randor	t
	The documentation in the bathing task, indicated the resident needed one person physical			residents will be selected per audit. This will be completed	three
	assistance for bathing on 5/5, 5/6, 5/14, 5/24, 5/26, 5/29, 6/3, 6/5, 6/8, 6/9, 6/12, 6/13, 6/14, 6/16, 6/17,			times weekly for 4 weeks the weekly for 6 months. Any	2x
	5/29, 6/3, 6/8, 6/9, 6/12, 6/13, 6/14, 6/16, 6/17, 6/18, 6/19, 6/21, 6/22, 6/23, 6/26, 6/27, and 6/28/21.			deficiencies will be corrected immediately.	
	_	ed one person physical assist e on 6/26, 6/27, 6/28, 6/29, 6/30		 Inservice will be provident the following topic: 	ed on
		vas no documentation		o Dependent resident are	
	indicating what type completed.	e of personal hygiene was		being provided with the necesservices and receives assistated with activities of daily living.	•
		Director of Nursing on 7/1/21 at			
	indicate what type of resident should have requested. 2. On 6	d the bathing sheets did not of bath was given and the e received a shave as /27/21 at 11:40 a.m. and 1:52		 Quality Assurance Plan monitor facility performance to make sure that corrections ar achieved and are permanent. 	o e
	1 * ·	s observed in bed wearing a hose times, his nails were long s unshaven.		 All plan of correction at will be reported by the Directon Nursing and or ADON to the Quality Assurance Committee 	or of
	was observed in bed	a.m., and 1:55 p.m., the resident d wearing a hospital gown. At s were long and dirty and he		reviewed by the Committee p Month for four Months and recommendations given in or assist in ensuring that the fac stay in compliance and if	er der to
	in bed wearing a ho long and dirty and h			concerns are identified the Quasimance Committee will ad additional Months until Compliance is sustained.	•
	On 6/30/21 at 9:38	a.m., the resident was observed			

F4R211

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	3 <u>00</u>		COMPLETED
		155469	B. WING			07/02/2021
			CTDI	EET ADDRESS, CITY	V CTATE ZID COD	
NAME OF P	ROVIDER OR SUPPLIER	8				
04040	LIODADT			0 W 49TH AVE		
CASA OF	F HOBART		HOI	BART, IN 46342	<u>′</u>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVII	DER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	7 (EACH CORI	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFE	DEFICIENCY)	DATE
	in bed wearing a ho	spital gown. His nails were		4. Date	s when corrective	
	_	10:35 a.m., Activity Aide 1 was		action will	be completed: July	23.
	-	providing nail care to		2021	·	
		asked to provide nail care to		=		
	Resident 4.	1				
	The record for Resident 4 was reviewed on 6/28/21					
		oses included, but were not				
		e care, dependence on				
		en, history of respiratory				
		tive disorder, type 2 diabetes				
		l pressure, major depressive				
	disorder, and anxiet					
	disorder, und dimire	disorder.				
	The resident receive	ed Hospice Services weekly				
	from the nurse and	•				
	nom the harse and	C1716.				
	The Quarterly MDS	S assessment, dated 4/24/21,				
		nt was moderately impaired for				
		The resident had no behaviors				
	_	of care. He was an extensive				
		on physical assist for bed				
	-	personal hygiene, and the				
		did not occur during the				
	assessment reference					
	assessment referenc	ce periou.				
	The Core Dian date	ed 1/21/21, indicated the				
		sistance from staff for ADL				
	_					
		otion, dressing, personal				
		g. An approach was to				
	provide assistance v	with ADLs as needed.				
	Dogumentation in t	he task section indicated the				
		eive a bath or a shower on				
	-	day during the evening shift.				
		ent received a complete bed				
		4/27, and 4/30/21. For the				
		nd 6/2021 there was no				
		resident received a bath or a				
	shower on Monday	s and Thursdays.				

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 17 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey pleted 12/2021	
	PROVIDER OR SUPPLIER HOBART		4410 W	ADDRESS, CITY, STATE, ZIP CO / 49TH AVE RT, IN 46342	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Nurses' Notes, dated care was provided.	d 6/9 and 6/21/21 indicated nail				
	6/30/21 at 3:00 p.m changed computer package the compart the staff to documer shower, and if nail a staff were to provid resident two times a CNA was coming the Interview with the I indicated the only dregarding bathing was documented in the tresident required to The documentation actually received a staff with the Interview with R actually received as 3. Interview with R	DON on 7/1/21 at 10:26 a.m., ocumentation they have vas when the CNA ask section under bathing, the tal dependence for bathing. did not indicate if the resident				
	his fingernails were He also indicated st	long and could be cleaned. aff do not always help him to would prefer the swabs and				
	resident was observ hospital gown. At	a.m., and 1:57 p.m., the ed in bed dressed in a those times the resident was ails were long and dirty.				
	the resident was obs hospital gown. At	a.m., 12:05 p.m., and 2:51 p.m., served in bed dressed in a those times, the resident was ails were long and dirty.				
	On 6/30/21 at 9:35	a.m., the resident was observed				

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 18 of 66

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING O B. WING			(X3) DATE SURVEY COMPLETED 07/02/2021			
	PROVIDER OR SUPPLIEF		4410 W	.ddress, city, state, zip cod 49TH AVE T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated she was g	de #1 was in the room and oing to provide nail care to the ent was unshaven at that time				
	in bed. CNA 5 had resident. Interview	p.m., the resident was observed just finished shaving the with CNA 5 at the time, n light duty was providing male residents.				
	bed. CNA 3 and Comorning care to the received his partial his upper body and He was dressed in a incontinence care was gathered the dirty li washed their hands	ras provided. The CNAs nen, removed their gloves and with soap and water and left CNA offered or rendered oral				
		CNAs at that time, indicated r provide oral care to the				
	6/29/21 at 1:50 p.m not limited to, strok left above the knee, behaviors, obstructi					
	assessment, dated 4 was alert and orient	mum Data Set (MDS) /30/21, indicated the resident ed. The resident needed h 1 person physical assist for				

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 19 of 66

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B.			A. BUILDING <u>00</u>			X3) DATE SURVEY COMPLETED 07/02/2021	
	ROVIDER OR SUPPLIER HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Sive assist with 2 person	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	physical assist for p	ersonal hygiene. The resident ers, but was at risk for					
	6/30/21 at 3:00 p.m should have been tr	Director of Nursing (DON) on ., indicated the resident's nails immed and cleaned as needed been shaved with morning					
	indicated oral care s with morning care.	OON on 7/1/21 at 10:26 a.m., should have been provided					
	3.1-38(a)(2)(A) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)						
F 0684 SS=D Bldg. 00	applies to all treatifacility residents. Ecomprehensive as facility must ensur treatment and care professional stand	a fundamental principle that ment and care provided to Based on the sessment of a resident, the te that residents receive e in accordance with lards of practice, the erson-centered care plan,					
	Based on observation interview, the facility bruising were assess treatments were corresidents reviewed to	on, record review and ty failed to ensure areas of sed and monitored and npleted as ordered for 2 of 2	F 0684		The facility request paper compliance for this citation Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts	9	07/23/2021

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 20 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLI	
		155469	B. W	'ING		07/02/2	2021
NAME OF B			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t.		4410 W	/ 49TH AVE		
CASA OF	HOBART			HOBAF	RT, IN 46342	_	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	1 0 (/07/01 + 2	16 P :1 (G1 1 1)			alleged or correction set forth		
		16 p.m., Resident C had a white			the statement of deficiencies.		
	_	s right lateral forearm. The			plan of correction is prepared		
	-	ted and the resident indicated			submitted because of requirer	ment	
	he didn't get his dre	ssing changed as ordered.			under state and federal law.		
					Please accept this plan of		
		dent C was reviewed on 7/1/21			correction as our credible		
	_	noses included, but were not			allegation of compliance. Plea	ise	
		COVID-19, chronic pain, and left			find enclosed this plan of		
	above the knee amp	outation.			correction for this survey.		
	The Annual Minim	um Data Set (MDS)			F684 Quality of Care		
	The Annual Minimum Data Set (MDS) assessment, dated 3/29/21, indicated the resident				F004 Quality of Care		
	was cognitively intact for daily decision making				Corrective actions which will be		
		we assistance with bed			accomplished for those reside		
		nd personal hygiene. The			· · · · · · · · · · · · · · · · · · ·		
		dependent on staff for			found to have been affected b	y u le	
	transfers.	dependent on starr for			deficient practice:		
	uansicis.				Resident C's wound on	the	
	Nurses' Notes, date	d 5/21/21 at 4:06 p.m.,			right lateral arm was treated a		
		nt came to the writer that			now is healed.	iii G	
		d his right arm was bleeding			Resident D's skin		
		how he did it. A 0.7 centimeter			discoloration on the on upper	are	
		rea to the right lateral arm was			lower extremities were monitor		
		was red in color. He had no	and are now fading. No signs and				
		New orders were received.			symptoms of discomfort noted		
	A Physician's Order	r, dated 5/21/21, indicated the			1. How the facility will iden	tify	
	-	s to be cleansed with normal			other residents having the		
	saline and oil emuls	sion was to be applied. The			potential to be affected by the		
	area was to be cove	red with a dry dressing on			same deficient practice.		
		y and Friday, day shift. The			· All residents may have	the	
		hanged for soilage or removal			potential to be affected by the		
	as needed every shi	ft.			same deficient practice.		
		was not listed on the May			2. The measures the facilit	-	
		tment Administration Records			will take or systems the facility	/	
	(TARs).				will alter to ensure that the		
					problem will be corrected and	will	
	Nurses' Notes, dated	d 5/28/21 at 4:47 a.m., indicated			not recur.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPL	ETED
		155469	B. W	ING		07/02/	/2021
		<u> </u>		CTREET	ADDRESS CITY STATE ZIP COP		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
04040	LIODADT				/ 49TH AVE		
CASA OF	HOBART			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the resident continu	ed with a dressing clean, dry,			· An audit tool will be		
	and intact to the rig	ht arm and sacrum without any			developed to ensure that a we	eklv	
	active bleeding or d	•			skin assessment is performed	-	
					all residents. This will be		
	Interview with the Director of Nursing on 7/1/21 at				completed two times weekly for	or 4	
		ed the resident's dressing			weeks the 1x weekly for 6		
		ated and the treatment orders			months. Any deficiencies will be	oe .	
	put on the TAR.				corrected immediately.		
					Nursing staff were in		
	Interview with the V	Wound Nurse on 7/2/21 at			serviced on the following topic): :	
		d she was not aware the			o Perform resident weekly		
	· · · · · · · · · · · · · · · · · · ·	to his right lateral arm. She			skin assessment, MD notificat		
		to notify her when a skin			of any observed alteration in s		
		On 6/28/21 at 11:19 a.m.,			integrity and treatment and	/KII I	
		erved in the dining room			monitoring in place.		
		nair. She had multiple areas of			mornioning in place.		
		upper and lower extremities.			3. Quality Assurance Plans	: to	
	<u> </u>	apper une to wer endemness.			monitor facility performance to		
	On 6/29/21 at 9·53	a.m., the resident was observed			make sure that corrections are		
		seated in her geri chair. The			achieved and are permanent.	•	
	areas of discoloration	_			All plan of correction au	dit	
					will be reported by the Directo		
	On 6/30/21 at 9·56	a.m., she was observed in the			Nursing and or ADON to the	. 01	
		l in her geri chair. The areas of			Quality Assurance Committee	and	
		ined to her upper and lower			reviewed by the Committee pe		
	extremities.	apper and to wer			Month for four Months and		
					recommendations given in ord	ler to	
	The record for the r	esident was reviewed on			assist in ensuring that the faci		
		. Diagnoses included, but were			stay in compliance and if	,	
	_	oral infarct, falls, anxiety,			concerns are identified the Qu	ality	
	depression, and den				Assurance Committee will add	-	
	= spression, and den				additional Months until	. 511	
	The Significant Cha	ange Minimum Data Set (MDS)			Compliance is sustained.		
	-	/5/21, indicated the resident			Compilation to dustained.		
		ively impaired and required			4. Dates when corrective		
		assistance with bed mobility			action will be completed: July	23	
	and transfers.	assistance with oca modific			2021	<u>,</u>	
	and numbrons.				2021		
	A Care Plan dated	5/28/21, indicated the resident					
		ations in skin integrity. The					
	at 1151 101 alter		1		I		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CO	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED		
		155469	B. WING		07/02/2021	
	PROVIDER OR SUPPLIER F HOBART	t	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
mo	interventions includ	led, but were not limited to, g daily ADL (activities of daily	no			
	The 6/24/21 Skin Assessment indicated the resident had no skin impairments.					
	indicated the reside her bilateral arms at purple/black area to 1 centimeter (cm) x right upper calf mea purple/black area to measuring 1.5 cm x bruises were noted measuring 6 cm x 2	ted 6/30/21 at 3:00 p.m., nt was noted with bruises to nd legs. There was a her right lower calf measuring (by) 3 cm, a purple area to her assuring 3 cm x 1 cm, a her right upper inner arm 1 cm. A cluster of purple/red to her right lower arm cm, and a cluster of purple/red ower arm measuring 7 cm x 2.5				
	7/1/21 at 10:35 a.m	Director of Nursing (DON) on ., indicated the areas of ld have been identified, tored.				
	dated 9/1/20, provid 7/1/21 at 3:32 p.m.,	e and Non-Pressure" policy, ded by the Administrator on indicated when bruises are applications the nurse will				
	This Federal tag rel	ates to Complaint IN00351910.				
	3.1-37(a)					
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Ulcer §483.25(b) Skin Ir	o Prevent/Heal Pressure				

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 23 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/02/2021	
	PROVIDER OR SUPPLIER F HOBART		4410 V	ADDRESS, CITY, STATE, ZIP COD N 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	a resident, the face (i) A resident rece professional stand pressure ulcers ar pressure ulcers ur condition demons unavoidable; and (ii) A resident with necessary treatme with professional s promote healing, p new ulcers from d Based on observation interview, the facili relieving devices we foot was repositions which resulted in ar pressure ulcer to the for 1 of 3 residents (Resident 23) Finding includes: On 6/27/21 1:45 p.r bed. At that time, h against the foot boad directly on the matt elevated, nor was th devices under the for specialty air mattres On 6/28/21 at 10:00 observed in bed. A pressed against the laying directly on the	apprehensive assessment of illity must ensure that- ives care, consistent with lards of practice, to prevent and does not develop aless the individual's clinical trates that they were pressure ulcers receives and services, consistent and services, consistent at and services, and trated to ensure pressure ere in place and the resident's and from against the foot board an acquired deep tissue injury about most the bed and was laying aress. His foot was not here any pressure relieving bot. The resident was at that time, his left foot was not here any pressure relieving that the time, his left foot was not here any pressure relieving that that time, his left foot was not here any pressure relieving that that time, his left foot was not here any pressure relieving and the resident was that that time, his left foot was not here any pressure relieving and the resident was not here any pressure relieving that the pressure relieving and the resident was not here any pressure relieving the resident was not here	F 0686	The facility request paper compliance for this citation Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies plan of correction is prepared submitted because of require under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Ple find enclosed this plan of correction for this survey. F 686 Treatment/Prevent PU Corrective actions which will accomplished for those resid found to have been affected deficient practice:	he n on The d and ement ase

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 24 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155469	B. W	ING		07/02/	2021
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
04040	LIODADT				/ 49TH AVE		
CASA OF	F HOBART			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	On 6/29/21 at 9:26	a.m., 12:05 p.m., and 2:51 p.m.,			· R23's skin assessment		
	the resident was obs	served in bed. At those			was completed. R23 was prov	rided	
	times, his left foot v	was pressed against the foot			with heel lift boots for pressure		
		d was laying directly on the			relief. Open area on the corne		
		was not elevated, nor was there			his left toe is being treated and		
	any pressure relieving devices under the foot.				R23's received daily skin care		
					inspection. Pressure area to the		
	On 6/30/21 at 9:35	a.m., the resident was observed			left lateral foot remained stable		
		e, his left foot was pressed			and treatment and monitoring		
		rd of the bed and was laying			place.		
	_	ress. His foot was not					
		nere any pressure relieving			1. How the facility will ident	tifv	
	devices under the fo				other residents having the	,	
					potential to be affected by the		
	On 6/30/21 at 1:27	p.m., the resident was observed			same alleged deficient practic		
		e, his left foot was laying			· All residents may have		
		ress and was not elevated, nor			potential to be affected by the		
	-	ure relieving devices under			same deficient practice.		
	the foot.	e			Came Consisting produces		
					2. The measures the facility	v	
	7/1/21 at 9:45 a.m.,	CNA 3 and CNA 4 were going			will take or systems the facility	-	
		care to the resident. The			will alter to ensure that the		
	-	g a sock to his left and it was			problem will be corrected and	will	
		v. CNA 3 removed his sock			not recur.		
	-	reat toenail was observed with			· An audit tool will be		
		was a small open area noted in			developed to ensure that wee	kly	
		e. There was a large dark			skin assessment of residents	-	
		ed area on the bottom of the			place. At least five random		
	-	e resident's foot was very dry			residents will be selected per		
	and had a large amo	ount of dried scaly skin. There			audit. This will be completed t	hree	
		es observed all over the			times weekly for 4 weeks the		
	mattress.				weekly for 6 months. Any		
					deficiencies will be corrected		
	After morning care,	, the Wound Nurse was			immediately.		
		en areas on the resident's body.			Inservice will be provide	ed on	
	•	•			the following topic:		
	Interview with the	Wound Nurse on 7/1/21 at			o Weekly monitoring of		
	10:30 a.m., indicate	ed the resident had no open		resident's skin condition during			
		e present time. She indicated			routine care and skin check	-	
		e open areas immediately.			schedule. Any abnormalities n	oted	
	l	- ·	1		1		

F4R211

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		155469	B. W	/ING		07/02	/2021	
				CTD FFT A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	1						
04040	LIODADT				49TH AVE			
CASA OF	F HOBART			HOBAR	RT, IN 46342			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					will be assessed, referred to			
	The record for Resi	dent 23 was reviewed on			MD/NP for interventions.			
		. Diagnoses included, but were			o Pressure Ulcer preventi	on		
	-	e, acquired absence of right			protocol which includes but no			
		vascular dementia with			limited to: turning and			
		ve and reflux uropathy,			repositioning and offloading; u	ise of		
		disease, epilepsy, heart failure,			pressure relieving devices, da			
	type 2 diabetes, high				skin care using skin barrier	y		
	atherosclerotic hear	•			creams and skin protectants			
	ameroseicione near	t discuse			Greatile and skill protectalits			
	The Quarterly Mini	mum Data Set (MDS)			Quality Assurance Plans	s to		
		/30/21, indicated the resident			monitor facility performance to			
		red. The resident needed			make sure that corrections are			
		h 1 person physical assist for			achieved and are permanent.	-		
		sive assist with 2 person			All plan of correction au	ıdit		
	-	personal hygiene. The resident			will be reported by the Directo			
		ers, but was at risk for			Nursing and or ADON to the	1 01		
	pressure ulcers.	cis, out was at lisk for			Quality Assurance Committee	and		
	pressure dicers.				reviewed by the Committee pe			
	The Core Plan date	ed 5/3/21, indicated the resident			Month for four Months and	5 1		
		nal status in regards to the				lar ta		
		ently change positions in bed.			recommendations given in ord			
	ability to independe	entry change positions in bed.			assist in ensuring that the faci	шу		
	Th. C Dl 1-4-	1.5/2/21 :1:4-141:14			stay in compliance and if	1:4		
	· ·	d 5/3/21, indicated the resident			concerns are identified the Qu	-		
	-	pairment to skin integrity			Assurance Committee will add	ı on		
		ty, incontinence, and a history			additional Months until			
	of pressure ulcers.				Compliance is sustained.		1	
	Diaminia I O I	1-4-15/2/21 ::. 1:			A Data wit			
	-	, dated 5/3/21, indicated to			4. Dates when corrective	00		
	suspend or offload l	heels when in bed.			action will be completed: <u>July</u>	<u>23, </u>		
	TEL 1 . 1	1 11 12			<u>2021</u>			
		d weekly skin assessment was						
		h indicated the resident had no						
	open areas or new s	kin issues.						
	NIINI	17/1/21 -4 10.50						
	· ·	d 7/1/21 at 10:50 a.m., indicated						
		rent skin issues. A Deep						
		to the left lateral foot which						
		meters (cm) by 3.0 cm. The						
	wound bed was nec	rotic with no drainage. A skin						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUILE B. WING		00	COMPL 07/02/	ETED	
	PROVIDER OR SUPPLIEF	2	4	410 W	DDRESS, CITY, STATE, ZIP COD 49TH AVE T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	tear was observed to measured 1 cm by 0 to the wound bed we Physician was notificated obtained. The Woot resident on the next Physician's Orders, cleanse the left later pat dry. Apply skin apply as needed every ointment to left greater for skin tear until result of the pattern of the interview with Woota.m., indicated she assessment for the interview between the Physician and opreper every shift for Doctor to see the rewas next week. She not in the room, so last skin assessment approximately 1 week.	the left great toe, which of the left great toe, which of the some drainage. The fied and new orders were and Physician would see the rounding day. Indicated to ral foot with normal saline and prep daily until resolved. May be solved. Indicated to rounding every day shift the solved. Indicated the skin resident. She observed a (DTI) to the bottom of the left in tear which looked like an the left great toe. She notified reders were received for skin the DTI and for the wound sident on his next visit which the indicated his heel boot was a new one was obtained. Her the was completed on 6/24/21 teek ago and the resident had no			CROSS-REFERENCED TO THE APPROPRIAT	TE .	
	offloaded while in l	sident's foot was to be beed and should not be against the foot board.					
	provided by the Dir 11:45 a.m., indicate conducted by the lie documented in the record. Daily, durin observe the residen were noted this will	, "Wound Prevention" policy, sector of Nursing on 7/1/21 at and weekly skin checks will be seensed nurse and will be resident's electronic medical and routine care, the CNA will t's skin. When abnormalities the communicated to the sche licensed nurse will proceed					

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 27 of 66

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155469	B. WI	NG		07/02/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				49TH AVE		
CASA OF	HOBART				T, IN 46342		
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	and or skin event. All					
		the following nursing care					
	_	nmended and indicated.					
	Pressure relief: As	-					
		ent with pillows and other					
		Skin hygiene: Daily with care					
		ith lotion, to keep it soft.					
		the skin for signs and					
	symptoms of skin b	reakdown.					
	3.1-40(a)(1)						
F 0688 SS=D Bldg. 00	§483.25(c) Mobility §483.25(c)(1) The resident who enter	Decrease in ROM/Mobility y. facility must ensure that a rs the facility without limited bes not experience					
	reduction in range resident's clinical o	of motion unless the condition demonstrates range of motion is					
	§483.25(c)(2) A re	sident with limited range of					
	- , , , ,	ppropriate treatment and					
	services to increas	se range of motion and/or to					
	prevent further de	crease in range of motion.					
	receives appropria assistance to mair with the maximum unless a reduction demonstrably una	voidable.					
	interview, the facilit therapy was being p Physician related ap	on, record review and ty failed to ensure restorative performed as ordered by the oplication of splints (an	F 06	588	The facility request paper compliance for this citation		07/23/2021
		rice) for 1 of 5 residents I range of motion. (Resident D)			Submission of this plan of correction does not constitute		
	1	6 (1 (1 2)	1		23200.0 4000 1100 0011000000		

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 28 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2021		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
	F HOBART	•		W 49TH AVE	
	- HUBAKT		ПОВА	RT, IN 46342	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	admission or agreement by t	DATE
	Finding includes:			provider of the truth of facts	ine
	i mang meraacs.			alleged or correction set fort	h on
	On 6/28/21 at 11:19	a.m., Resident D was observed		the statement of deficiencies	
	in the dining room	seated in her geri chair. She		plan of correction is prepare	d and
	did not have her and	i-contracture device in her left		submitted because of require	ement
	hand.			under state and federal law.	
				Please accept this plan of	
		a.m., the resident was observed		correction as our credible	
	_	room in her geri chair. Her		allegation of compliance. Ple	ease
		rice was observed in her right		find enclosed this plan of	
	hand. correction for this survey.				
	The record for the r	esident was reviewed on		F688 Increase/Prevent decre	ease in
	6/28/21 at 2:09 p.m	. Diagnoses included, but were		ROM/mobility	
	not limited to, cerel	oral infarct, falls, anxiety,			
	depression, and den	nentia.		Corrective actions which will	be
				accomplished for those resid	lents
	_	ange Minimum Data Set (MDS)		found to have been affected	by the
		/5/21, indicated the resident		deficient practice:	
		ively impaired and required			
		assistance with bed mobility		· Resident D's	
	and transfers.			anti-contracture device is ap	·
	4 PM - 1 1 0 1	1 . 1 . (/ / / 0.1		on her left hand and is being	
		c, dated 6/4/21, indicated		monitored as ordered.	
	further contraction.	oply to left hand to prevent		1 How the facility will ide	ntify
	Turmer contraction.			How the facility will ide other residents having the	nuny
	A Care Plan dated	6/4/21, indicated the resident		potential to be affected by th	e
		breakdown due to contraction		same deficient practice.	<u> </u>
		terventions included, but were		· All residents may have	e the
		y splint to palm of hand daily.		potential to be affected by th	
	, 11 .			same deficient practice.	
	There was no docur	mentation to indicate the staff		,	
	were donning the sp	olint daily as ordered.		2. The measures the facil	lity
				will take or systems the facil	ity
		Director of Nursing (DON) on		will alter to ensure that the	
		., the resident was to have her		problem will be corrected an	d will
		vice applied to her left hand		not recur.	
daily as per the Physician's Order.			· An audit tool will be		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155469	A. BUILDING B. WING	00	COMPLETED 07/02/2021
	PROVIDER OR SUPPLIER HOBART		4410 W	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-42(a)(2)			developed to ensure resident splint devices are applied and monitored appropriately. At le five random residents will be selected per audit. This will be completed weekly for 4 weeks 2x weekly for 6 months. Any deficiencies will be corrected immediately. Inservice will be provide proper applications of splints other anti-contracture devices. 3. Quality Assurance Plans monitor facility performance to make sure that corrections are achieved and are permanent. All plan of correction as will be reported by the Director Nursing and or ADON to the Quality Assurance Committee reviewed by the Committee phonth for four Months and recommendations given in or assist in ensuring that the fact stay in compliance and if concerns are identified the Quaditional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 2021	l ast e s the ed on and s. s to co e e udit or of e and er der to illity uality d on
F 0692 SS=D Bldg. 00	§483.25(g) Assiste	n Status Maintenance ed nutrition and hydration.			

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 30 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 07/02/2021			
	PROVIDER OR SUPPLIER F HOBART	2	4410 V	ADDRESS, CITY, STATE, ZIP COD N 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION
	gastrostomy and jejunostomy, and resident's comprefacility must ensure \$483.25(g)(1) Maparameters of nutusual body weight range and electroresident's clinical that this is not pospreferences indicated the maintain properate status provides a status related to me completed for residential risk for 2 of 2 residential (Residents 2 and 63). Findings include: 1. On 6/29/21 at 1122's lunch tray into be room with the resident refused the resident refused. The record for Residents 2 and 63 imited to, hemiple a stroke, type 2 dial	intains acceptable ritional status, such as t or desirable body weight lyte balance, unless the condition demonstrates sible or resident ate otherwise; Iffered sufficient fluid intake r hydration and health; Iffered a therapeutic diet attritional problem and the ler orders a therapeutic diet. Ion, record review and ty failed to ensure residents ble parameters of nutritional al consumption records not ents who were nutritionally at ents reviewed for nutrition.	F 0692	The facility request paper compliance for this citation Submission of this plan of correction does not constitut admission or agreement by provider of the truth of facts alleged or correction set fort the statement of deficiencies plan of correction is prepare submitted because of require under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please in the plan of correction for this survey. F692 Nutrition/Hydration States.	the h on s. The d and ement

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 31 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 07/02/2021	
	PROVIDER OR SUPPLIER		4410 V	ADDRESS, CITY, STATE, ZIP COD N 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	blood pressure).			Maintenance	
	assessment, dated 6 was moderately impand he needed superesident had sustain 5% or more within. The Care Plan, date resident received a resident received a resident had a histor Interventions includencourage oral intal contraindicated and and monitor intake. On 5/10/21, the resident was moderately impact to the property of the contraindicated and and monitor intake.	d 6/10/21, indicated the general regular diet. The ry of weight loss. led, but were not limited to, see of food and fluids if not provide, serve diet as ordered and record every meal. dent weighed 150 pounds. On t weighed 137 pounds, an 8.6%		Corrective actions which will be accomplished for those reside found to have been affected be deficient practice: R2's meal/nutritional consumption is being monitor and documented appropriatel was admitted under hospice on 7/14/2021 R63's meal/nutritional consumption is being monitor and documented appropriatel How the facility will identify the potential to be affected by the same deficient practice.	ents by the ed y. R2 care ed y.
		d Consumption log, indicated umented on the following		All residents may have potential to be affected by the same deficient practice.	
	Dinner: 5/31/21 The June 2021 Food Consumption log, indicated meals were not documented on the following dates:			2. The measures the facilit will take or systems the facilit will alter to ensure that the problem will be corrected and not recur. An audit tool will be	y
	Breakfast: 6/14 and	1 6/22/21		developed to ensure resident	s
	Lunch: 6/7, 6/14, a	nd 6/22/21		monitored and documented appropriately and any signific	ant
	Dinner: 6/1, 6/2, 6/ and 6/29/21	7, 6/11, 6/13, 6/20, 6/26, 6/27,		weight changes are addresse appropriate. At least five rand residents will be selected per	d as
Interview with the Director of Nursing on 7/1/21 at 10:26 a.m., indicated the food consumption logs			audit. This will be completed weekly for 4 weeks the 2x we	ekly	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/02/2021	
	ROVIDER OR SUPPLIEF		4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
CASA OF (X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF should have been of 12:10 p.m., Resider bed. Her lunch tray bed table in front of to eat, however, the just staring at her for meal and a health sh On 7/1/21 at 8:03 a her wheelchair in the breakfast tray was p 6 sat down to assist She needed cueing She was served a purity super cereal and mit shake on her tray. The record for Resi 6/29/21 at 10:35 a.r were not limited to, dysphagia, acute kin high blood pressure syncope, and dement The 3/3/21 Signific (MDS) assessment, alert and oriented at set up help for eatin pounds with a signi The Care Plan, date resident required a r resident required as resident was to mo meal.	a.m., the resident was sitting in the main dining room. Her collaced in front of her and CNA and cue the resident to eat. It to eat and drink her fluids. Indeed meal, which included lik. She did not have a health dent 63 was reviewed on m. Diagnoses included, but major depressive disorder, dancy failure, pain, anxiety, e., osteoarthritis, repeated falls, intia. The resident was not and needed supervision with the mean of the mean of the resident was given by the mean of the mean o	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) for 6 months. Any deficiencies be corrected immediately. Inservice nursing staff proper monitoring and documentation of resident's nutritional intake and timely notification of MD and dietitia resident's significant weight changes for interventions 3. Quality Assurance Plan monitor facility performance make sure that corrections a achieved and are permanent. All plan of correction a will be reported by the Direct Nursing and or ADON to the Quality Assurance Committee Month for four Months and recommendations given in o assist in ensuring that the factor in concerns are identified the Committee will act additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 2021	es will fon an of ns to to to tre t. audit tor of ee and per rder to cility Quality dd on
	_	/21 which was 129 pounds.			

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 33 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/02/2021	
	ROVIDER OR SUPPLIER		4410 W	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
ing	A Registered Dietiti 6/8/21 at 1:32 p.m., 12.2% weight loss or resident had poor or consumption record Recommend to incr meals and weekly w	ian's (RD) progress note, dated indicated the resident has a over the last 30 days. The ral intake per food s, with 0-25% at most meals. ease ready care shakes to all	me		BATE
	The meal consumpt of 5/2021 and 6/202 documented on 5/7, 6/17, and 6/18/21. documented on 5/7, 6/7, 6/13, 6/17, and not documented on 5/20, 5/21, 5/31, 6/ and 6/28/21.	ion intake logs for the months 21 indicated breakfast was not 5/8, 5/9, 5/18, 5/21, 6/1, 6/13, The lunch meal was not 5/8, 5/9, 5/18, 5/21, 5/24, 6/1, 16/18/21. The dinner meal was 5/3, 5/5, 5/7, 5/8, 5/16, 5/19, 1, 6/3, 6/9, 6/11, 6/13, 6/21, 6/26, Director of Nursing on 6/30/21			
		ed the meal consumption logs ompleted and the resident was hake at all meals.			
	3.1-46(a)(1)				
F 0695 SS=E Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must e needs respiratory tracheostomy care is provided such o professional stand comprehensive pe	eostomy Care and atory care, including and tracheal suctioning. Insure that a resident who care, including and tracheal suctioning, are, consistent with lards of practice, the erson-centered care plan, s and preferences, and			

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 34 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLE			LETED	
		155469	B. WING 07/02/2021			/2021	
		<u> </u>	1	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			V 49TH AVE		
CASA OF	F HOBART				RT, IN 46342		
				HODAI	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	483.65 of this sub	•					
		on, record review, and	F 0	F 0695 The facility request			07/23/2021
		ty failed to provide proper			paper compliance for this		
		l services related to oxygen at			citation		
		e, physician orders for oxygen,					
	_	dification bottles, and			Submission of this plan of		
		g the oxygen tubing for 4 of 4			correction does not constitute		
		for oxygen. (Residents 46, 148,			admission or agreement by th	е	
	4, and 18)				provider of the truth of facts		
					alleged or correction set forth		
	Findings include:				the statement of deficiencies.		
					plan of correction is prepared		
		0:00 a.m. and 2:28 p.m., Resident			submitted because of requirer	ment	
		bed. The nasal cannula was			under state and federal law.		
	1	strils) and the oxygen			Please accept this plan of		
	concentrator was se	et at 5 liters.			correction as our credible		
					allegation of compliance. Plea	ise	
		a.m. and 11:36 a.m., the			find enclosed this plan of		
		oncentrator was set at 4 1/2			correction for this survey.		
		tubing was not dated. At 2:57					
	1 ~	as holding the oxygen cannula			F 695 Respiratory/Tracheosto	my	
		concentrator was set at 4 1/2			Care and Suctioning		
	liters. The oxygen	tubing was not dated.					
					Corrective actions which will be		
		a.m., 11:43 a.m., 1:44 p.m., and			accomplished for those reside		
	_	ent's oxygen was not in her			found to have been affected b	y the	
		concentrator was set at 2 1/2			deficient practice:		
	liters and the tubing	g was not dated.					
					· R46's oxygen set-up ar		
		a.m. and 11:15 a.m., the			settings are corrected and is r		
		as not in her nares. The			set per md order, O2 tubing is		
	'`	r was set at 2 1/2 liters and the			dated and changed per policy	, O2	
	oxygen tubing was	not dated.			cannula placed on nostrils		
					appropriately, R46's O2		
		dent 46 was reviewed on			saturation remains within base	eline.	
	_	. Diagnoses included, but were			No signs of distress noted.		
	· ·	e, anoxic brain damage,			· R148's oxygen set-up a		
		ehavior disturbance, heart			settings are corrected and is r		
	failure, and oxygen	dependent.			set per md order, O2 tubing is		
					dated and changed per policy	, O2	

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 35 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/02/2021	
	PROVIDER OR SUPPLIER HOBART		4410 \	ADDRESS, CITY, STATE, ZIP COD W 49TH AVE IRT, IN 46342	
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	(X5) COMPLETION
TAG		LISC IDENTIFYING INFORMATION mum Data Set (MDS)	TAG	cannula placed on nostrils	DATE
	· ·	/14/21, indicated the resident paired for daily decision making		appropriately, R148's O2 saturation remains within bas	eline
		tygen during the assessment		No signs of distress noted.	Cilito.
	reference period.			R4's oxygen set-up and is	
	The Care Plan, date	d 6/21/21, indicated the		settings are corrected and is set per md order, O2 tubing is	
	-	tygen therapy to relieve		dated and changed per policy	I
		ygen) related to the diagnosis th. The resident at times		R4's O2 saturation remains w baseline. No signs of distress	
	would remove her o	exygen tubing. Interventions		noted.	
included, but were not limited to, administer		not limited to, administer		1 Llow the facility will iden	4:6.
oxygen as ordered.				How the facility will identify other residents having the	luly
		c, dated 4/30/21, indicated the		potential to be affected by the	
		ive oxygen by the way of a ninister at 3 liters per minute as		same deficient practice. All residents may have	tho
		ortness of breath or oxygen		potential to be affected by the	I
		0. The oxygen tubing, mask,		same deficient practice.	
	or cannula were to li Wednesday.	pe changed weekly on		2. The measures the facili	tv
	-			will take or systems the facilit	-
	•	e, dated 5/9/21, indicated the meter (oxygen saturation) and		will alter to ensure that the	L. GIL
		be monitored every shift.		problem will be corrected and not recur.	WIII
				· An audit tool will be	
		tment Administration Record e prn oxygen had not been		developed to ensure that resident's oxygen therapy is	
	signed out as being			administered correctly per do	ctor's
	The Level 2021 Med	lication Administration Record		order and ensure that the O2	
		ne resident's oxygen saturation		tubing's and humidifiers are checked and dated appropria	tely
		shift. Her oxygen saturation		per policy. At least five rando	-
	was above 90% eac	h shift.		residents will be selected per audit. This will be completed	three
	Interview with the l	Director of Nursing on 7/1/21 at		times weekly for 4 weeks the	
	10:26 a.m., indicate	d the resident would pull her		weekly for 6 months. Any	
		oxygen should have been ered. She also indicated the		deficiencies will be corrected immediately.	
	tubing should have			Nursing staff has been	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/02/2021	
	PROVIDER OR SUPPLIER HOBART		4410 V	ADDRESS, CITY, STATE, ZIP COD N 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF 2. On 6/27/21 at 3: observed in his root	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION 16 p.m., Resident 148 was in in bed. The oxygen nasal his nares and the oxygen t at 2 1/2 liters.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) in-serviced on proper oxygen set-up: O2 rate, correct concentrator set-up, checking functionality of humidification bottles, proper dating of oxyg	p the
	the resident's oxyge liters and the tubing On 6/29/21 at 11:37 resident's oxygen co	7 a.m. and 1:44 p.m., the oncentrator was set at 2 1/2		tubing and proper documenta of respiratory services provide the resident's medical record 3. Quality Assurance Plan monitor facility performance to make sure that corrections are	ed on . s to o
	6/30/21 at 10:00 a.r were not limited to,	dent 148 was reviewed on n. Diagnoses included, but COVID-19, oxygen dependent, nentia without behavior		achieved and are permanent. All plan of correction are will be reported by the Director Nursing and or ADON to the Quality Assurance Committee reviewed by the Committee p Month for four Months and recommendations given in or	udit or of e and eer
	Set (MDS) assessm the resident was set decision making an the assessment refer			assist in ensuring that the factories stay in compliance and if concerns are identified the Quastrance Committee will ad additional Months until Compliance is sustained.	uality
	resident required ox hypoxia related to t Interventions include administer oxygen a			4. Dates when corrective action will be completed: <u>July</u> 2021	<u>, 23.</u>
	resident was to rece nasal cannula at 3 li Interview with the I 10:26 a.m., indicate concentrator should	c, dated 5/18/21, indicated the live oxygen by the way of a ters per minute continuously. Director of Nursing on 7/1/21 at d the resident's oxygen have been set at the correct should have been dated. 3.			

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	TE SURVEY IPLETED 12/2021
	PROVIDER OR SUPPLIER		4410 W	ADDRESS, CITY, STATE, ZIP / 49TH AVE RT, IN 46342	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
140	On 6/27/21 at 11:34 was observed in bed both nares and his oper minute. The hu oxygen concentrato oxygen tubing was On 6/28/21 at 9:52 was observed in bed oxygen in both nare was now dated 6/27 date on the oxygen set at 4 liters per minute. The humidiff 6/29/21 at 9:24 in bed with a nasal nares. The humidiff 6/27/21, however, to oxygen tubing. The record for Resi at 2:40 p.m. Diagnolimited to, palliative supplemental oxygen failure, schizoaffeet mellitus, high blood disorder, and anxiet. The Quarterly MDS indicated the reside decision making. The control of the contr	a.m., and 1:53 p.m., Resident 4 d. He had a nasal cannula in oxygen rate was set at 4 liters midification bottle on the r was dated 6/16/21. His not dated. a.m., and 1:55 p.m., the resident d with a nasal cannula for es. The humidification bottle 1/21, however, there was no tubing. The oxygen rate was nute. a.m., the resident was observed cannula for oxygen in both fication bottle was now dated there was no date on the dent 4 was reviewed on 6/28/21 poses included, but were not exact according to the care, dependence on en, history of respiratory give disorder, type 2 diabetes d pressure, major depressive by disorder. So assessment, dated 4/24/21, and was moderately impaired for the resident had no behaviors of care. He was an extensive on physical assist for bed personal hygiene, and the lid not occur during the				
		for adverse consequences y failure. An approach was to				

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 38 of 66

	MENT OF DEFICIENCIES AN OF CORRECTION				(X3) DATE COMPI 07/02	LETED
	OF PROVIDER OR SUPPLIE	R	4410	ET ADDRESS, CITY, STATE, ZIP COD I W 49TH AVE ART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	had an order for pri- history of shortness respiratory distress administer oxygen importance of keep setting. Stress more Physician's Orders, change oxygen tub (label) every night needed. Physician's Orders, apply nasal cannula as needed for short saturation was less The Treatment Adn the month of 6/202 change had been si resident's oxygen s being in the high 90 Interview with the at 3:00 p.m., indica humidification bott and dated. She was a prn order for oxy Resident 18 was ob closed. Her oxygen nasal cannula. Her and her humidifica On 6/28/21 at 11:0 observed in bed wi liters. Her tubing r	ed 1/9/21, indicated the resident in oxygen therapy related to sof breath and history of. Nursing approaches were to as ordered and explain the bing oxygen at the prescribed e oxygen may not be better. dated 6/8/21, indicated to ing and mask or cannula, shift on Wednesdays and as dated 5/3/21, indicated may a oxygen at 4 liters per minute ness of breath or if oxygen than 92%. ministration Record (TAR), for 1, indicated the oxygen tubing gned out on 6/19/21. The aturation was documented as				

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 39 of 66

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE (A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 02/2021
	PROVIDER OR SUPPLIER HOBART		4410 \	r address, city, state, zii W 49TH AVE JRT, IN 46342	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO TI- DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
TAG	On 6/29/21 at 12:00 observed in bed wit liters. Her tubing re humidification bott! The record for the record f	o p.m., the resident was he her oxygen infusing at 3 emained undated and her le was dated 6/16/21. esident was reviewed on m. Diagnoses included, but diabetes, acute respiratory elirium, anxiety, and mum Data Set (MDS) /3/21, indicated the resident derstood, she was totally for care, and she required r, dated 6/8/21, indicated mg and mask or cannula. It with approved wipe with every Wednesday and as	TAG	DEFICIENCY	E AFFROPRIATE	DATE
	The "Oxygen Admi 3/2004, provided by	inistration" policy, dated the Administrator on 7/1/21 at I make sure the oxygen abeled properly.				

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 40 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l /			· ′	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1				COMPLETED 07/02/2021	
		155469	B. WI	NG	/2021			
	ROVIDER OR SUPPLIER			4410 W	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	1	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)		DATE	
	3.1-47(a)(6)							
F 0698 SS=D Bldg. 00	require dialysis reconsistent with propractice, the composate plan, and the preferences. Based on record revialled to provide the for residents who reto not assessing or record for Residents revision. The record for Residents revision includes: The record for Residents revision includes:	ceive such services, ofessional standards of orehensive person-centered residents' goals and riew and interview, the facility encessary care and services eceived Hemodialysis related monitoring the access site for ewed for dialysis. (Resident dent 50 was reviewed on Diagnoses included, but were phalopathy, arteriovenous sence of left leg above the entia with behavioral diabetes mellitus, c kidney disease with stage 1 onic kidney disease, acute re, end stage renal disease, and 1 dialysis. mum Data Set (MDS) (25/21, indicated the resident ed, and received dialysis as	F 06	98	The facility request paper compliance for this citation Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. plan of correction is prepared submitted because of requirer under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Pleafind enclosed this plan of correction for this survey. F 698 Dialysis Corrective actions which will be accomplished for those reside found to have been affected be deficient practice: R50's pre-dialysis assessment and access site as	on The and ment se se	07/23/2021	
	-	Monday, Wednesday, and			assessed and documented da			

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 41 of 66

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUILDING <u>00</u> COMPLETED		(X3) DATE SURVEY COMPLETED 07/02/2021	
NAME OF E	PROVIDER OR SUPPLIEF	<u>.</u>		ET ADDRESS, CITY, STATE, ZIP COD	•
		•		W 49TH AVE	
CASA OF	F HOBART		HOB	ART, IN 46342	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	PRIATE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Friday.			as ordered. R50 remains a	
	DI COL	1 . 15/2/21 . 1 1		baseline functioning and is	
	1 -	dated 5/3/21, indicated		receiving dialysis as sched	uled.
		gns and assessment every day /ednesday and Friday.		1. How the facility will id	lontify.
	· ·	or fistula has bruit and thrill		 How the facility will in other residents having the 	lentiny
		resent. Assess access site and		potential to be affected by	the
		rse signs in progress note.		same deficient practice.	
	1	ess site for redness, swelling,		· All residents may ha	ve the
	· ·	notify physician with any		potential to be affected by	
		iment in progress note.		same deficient practice.	
	Assess for bruit and	thrill, document (+) for		·	
	present, (-) for abse	nt every shift.		2. The measures the fac	cility
				will take or systems the fac	cility
	The Medication Ad	ministration Record (MAR)		will alter to ensure that the	
		2021 indicated the pre-dialysis		problem will be corrected a	and will
		completed on 5/12, 5/17, 6/21,		not recur.	
	6/23, and 6/28/21.			· An audit tool will be	
				developed to ensure that re	
		nonths of 5/2021 and 6/2021		receiving dialysis treatmen	
	indicated the access	_		assessed daily and access	
		stula and bruit every shift,		are checked and documen This will be completed thre	
	_	as being completed for the /17, 5/27, 6/19, 6/23, and			
		g shift on 6/10 6/14, and		weekly for 4 weeks the 2x for 6 months. Any deficience	-
		0/21 for the night shift.		be corrected immediately.	PICO MIII
	5. 15.21, und on 0/2	o. 21 for the hight shift.		Nursing staff has be	en
	Interview with the l	Director of Nursing on 7/2/21 at		in-serviced on proper care	
		ed the pre-dialysis assessment		dialysis- monitoring, observ	
		assessment was to be		and documentation	,
	completed as ordere	ed by the physician.			
				3. Quality Assurance Pl	ans to
	3.1-37(a)			monitor facility performance	e to
				make sure that corrections	
				achieved and are permane	
				· All plan of correction	
				will be reported by the Dire	
				Nursing and or ADON to th	
				Quality Assurance Commit	
				reviewed by the Committee	e per 📗

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUILDING B. WING	00	COMPLI 07/02/2	ETED	
	ROVIDER OR SUPPLIER HOBART		4410 W	ADDRESS, CITY, STATE, ZIP COD 7 49TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
				Month for four Months and recommendations given in ord assist in ensuring that the facil stay in compliance and if concerns are identified the Qu Assurance Committee will add additional Months until Compliance is sustained. Dates when corrective action to be completed: July 23, 2021	ality I on	
F 0757 SS=D Bldg. 00	Drugs §483.45(d) Unnect Each resident's drug from unnecessary drug is any drug w					
	duplicate drug the	xcessive dose (including rapy); or excessive duration; or				
	§483.45(d)(3) With or	nout adequate monitoring;				
	§483.45(d)(4) With for its use; or	nout adequate indications				
	consequences whi	ne presence of adverse ich indicate the dose d or discontinued; or				
	reasons stated in p (5) of this section. Based on record rev	combinations of the paragraphs (d)(1) through riew and interview, the facility	F 0757	The facility request		07/23/2021
	failed to ensure med	lications were held per blood		paper compliance for this		

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 43 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 07/02/2021	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	-
CASA OF	HOBART			N 49TH AVE RT, IN 46342	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		for 1 of 5 residents reviewed		citation	
	for unnecessary me	dications. (Resident 2)			
	Finding includes:			Submission of this plan of correction does not constitute	e
	C			admission or agreement by t	
	The record for Resi	dent 2 was reviewed on 6/29/21		provider of the truth of facts	
		noses included, but were not		alleged or correction set forth	n on
		gia (muscle weakness) following		the statement of deficiencies	
		betes, dysphagia (difficulty		plan of correction is prepared	
		rthostatic hypotension (low		submitted because of require	ement
	blood pressure).			under state and federal law.	
	Th. M. E 5 dec	. Minimum D-4- C-4 (MDC)		Please accept this plan of	
		Minimum Data Set (MDS) /4/21, indicated the resident		correction as our credible	
	· ·	paired for daily decision		allegation of compliance. Ple find enclosed this plan of	ase
	making.	bailed for daily decision		correction for this survey.	
	making.			correction for this survey.	
	A Physician's Order	r, dated 5/3/21, indicated the		F 757 Drug Regimen is Free	<u>, </u>
	•	eive Midodrine (a medication		from Unnecessary Drugs	
	to treat low blood p	ressure) HCl 10 milligrams		It is the facility policy to ensu	re
	(mg), give 1 tablet l	by mouth three times a day for		that each resident's drug reg	imen
		lood pressure). The		is free from unnecessary dru	gs.
		be held if the resident's systolic		Corrective actions which w	ill
	blood pressure (top	number) was over 100.		be accomplished for those	
				residents found to have been	en
	-	lication Administration Record		affected by the deficient	
	* **	ne resident's systolic blood		practice:	
		r than 100 on the following		R 2's Midodrine order	was
	dates and the medic	ation was given:		discontinued on 5/28/21.	
	6:00 a.m.: 5/4-5/19	and 5/21-5/25/21		How the facility will iden	ntify
				other residents having the	
	2:00 p.m.: 5/3-5/19	and 5/21-5/24/21		potential to be affected by the	e
				same deficient practice.	
	10:00 p.m.: 5/3-5/1	6, 5/19, and 5/21-5/24/21		All residents may have the	
		21.0		potential to be affected by the	e
		Director of Nursing on 7/1/21 at		same deficient practice.	
		ed the Midodrine should have			.
	_	ood pressure parameters		2. The measures the facility	-
	ordered by the phys	sician.		will take or systems the facili	ty

F4R211

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/02/2021
	PROVIDER OR SUPPLIE F HOBART	R	4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIE	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) will alter to ensure that the problem will be corrected and	DATE
				not recur. An audit tool will be developed to ensure that all medications are administered signed off in EMAR. At least random residents will be select This will be completed three week for 2 weeks then 2x a vertor 6 months Inservice will be provide the following topic: All medications with parameters are monitored and documented. Notification of attending physician if results outside the parameters. 3. Quality Assurance Plan monitor facility performance to make sure that corrections and achieved and are permanent. All plan of corrections and will be reported by the Direct Nursing and or ADON to the Quality Assurance Committee performance to the complete stay in compliance and if concerns are identified the Quality Assurance Committee performance and if concerns are identified the Quality Assurance Committee will additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 2021	d and five coted. a veek ded on d are us to co re . udit or of e and oer der to cility uality d on

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 45 of 66

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		 JILDING	00	COMPL 07/02/	ETED	
	PROVIDER OR SUPPLIER HOBART		4410 W	ADDRESS, CITY, STATE, ZIP COD 49TH AVE IT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0758 SS=D Bldg. 00	Use §483.45(e) Psychology and the following categorial include, but the following categorial includes including the following categorial includes a compression of the facility of the facility includes the medical specific condition and documented in the system of the facility of the facility includes the facility of th	Psychotropic Meds/PRN ptropic Drugs. Sychotropic drug is any rain activities associated asses and behavior. These are not limited to, drugs in gories: at; and rehensive assessment of a sy must ensure that sidents who have not used as are not given these drugs tion is necessary to treat a as diagnosed and a clinical record; sidents who use as receive gradual dose chavioral interventions, portraindicated, in an effort				

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

Event ID:

F4R211 Facility ID:

Facility ID: 000366

If continuation sheet

Page 46 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUILDING <u>00</u> COMI		(X3) DATE SURVEY COMPLETED 07/02/2021
	PROVIDER OR SUPPLIER F HOBART	4410 W	ADDRESS, CITY, STATE, ZIP COD V 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure psychotropic medications were monitored for side effects and effectiveness for 1 of 5 residents reviewed for unnecessary medications. (Resident 62) Finding includes: The record for Resident 62 was reviewed on 6/30/21 at 1:58 p.m. Diagnoses included, but were not limited to, lack of coordination, Alzheimer's, dysphagia, diabetes, mood disorder, hallucinations, and delusions. The Significant Change Minimum Data Set (MDS) assessment, dated 4/8/21, indicated he was severely cognitively impaired for decision making and required an extensive 1 person physical assist with personal hygiene. His medications received in the past 7 days included, but were not limited to, antipsychotics, antidepressants, and anti-anxiety medications. The June 2021 Physician Order Summary indicated Lorazepam (an anti-anxiety medication) 0.5 mg (milligrams) and 0.25 mg daily, Zyprexa (an antipsychotic medication) 10 mg twice daily, and Zoloft (an antidepressant medication) 50 mg	F 0758	The facility request paper compliance for this citation Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. plan of correction is prepared submitted because of requirer under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. F 758 Free from unnecessary Psychotropic Meds It is the facility policy to ensure that each resident's drug regir is free from unnecessary drug Corrective actions which will be accomplished for those residents found to have been affected by the deficient	on The and ment se

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 47 of 66

N OF CORRECTION	IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CO A. BUILDING B. WING	00	X3) DATE SURVEY COMPLETED 07/02/2021
	R	4410 V	V 49TH AVE	
summary (EACH DEFICIENT REGULATORY OF Defore bedtime. There was no docuresident was being and/or effectivenest psychotropic medical interview with the 10:25 a.m., indicate been monitored ewelfectiveness for the medications. The "Psychoactive policy, dated 3/21/2 Administrator on 7 management of psyconsist of evaluating and desired in the summary of the summary o	mentation to indicate the monitored for side effects is for the use of the above cations. Director of Nursing on 7/1/21 at ed the resident should have ery shift for side effects and it use of his psychotropic Medication Management" 21, provided by the /1/21 at 3:32 p.m., indicated the yehoactive medications will not geffectiveness and	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) practice: R 62's medications were reviewed. Psychotropic medications were monitored for side effects and effectiveness a is now properly documented on the eMAR. R62 remains at baseline of functioning. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and we not recur. An audit tool will be developed to ensure that all medications that requires monitoring (i.e. psychotropic medications) are administered a signed off in EMAR. At least fiver random residents will be selected per audit. This will be completed three a week for 2 weeks then 2 a week for 6 months Inservice will be provided the following topic: All medications that requires monitoring are monitored for side effects and effectiveness and documented properly on eMAR	vill and e ed d 2x d on s de
	SUMMARY (EACH DEFICIENT REGULATORY OF Defore bedtime). There was no document resident was being and/or effectivenest psychotropic medical. Interview with the 10:25 a.m., indicate been monitored every effectiveness for the medications. The "Psychoactive policy, dated 3/21/21 Administrator on 7 management of psychosist of evaluating monitoring for any	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) before bedtime. There was no documentation to indicate the resident was being monitored for side effects and/or effectiveness for the use of the above psychotropic medications. Interview with the Director of Nursing on 7/1/21 at 10:25 a.m., indicated the resident should have been monitored every shift for side effects and effectiveness for the use of his psychotropic medications. The "Psychoactive Medication Management" policy, dated 3/21/21, provided by the Administrator on 7/1/21 at 3:32 p.m., indicated the management of psychoactive medications will consist of evaluating effectiveness and monitoring for any adverse side effects.	There was no documentation to indicate the resident was being monitored for side effects and/or effectiveness for the use of the above been monitored every shift for side effects and effectiveness for the use of his psychotropic medications. The "Psychoactive Medication Management" policy, dated 3/21/21, provided by the Administrator on 7/1/21 at 3:32 p.m., indicated the management of psychoactive medications will consist of evaluating effectiveness and monitoring for any adverse side effects.	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION before bedtime. There was no documentation to indicate the resident was being monitored for side effects and/or effectiveness for the use of the above pay-chotropic medications. Interview with the Director of Nursing on 7/1/21 at 10:25 a.m., indicated the resident should have been monitored every shift for side effects and effectiveness for the use of his psychotropic medications. The "Psychoactive Medication Management" policy, dated 3/21/21, provided by the Administrator on 7/1/21 at 3:32 p.m., indicated the management of psychoactive medications will consist of evaluating effectiveness and monitoring for any adverse side effects. 3.1-48(a)(3) The "Psychoactive Medication Management" policy, dated 3/21/21, provided by the Administrator on 7/1/21 at 3:32 p.m., indicated the management of psychoactive medications will consist of evaluating effectiveness and monitoring for any adverse side effects. 3.1-48(a)(3) The measures the facility will after to ensure that the problem will be corrected and v not recur. An audit tool will be developed to ensure that all medications that requires monitoring (i.e psychotropic medications) are administered signed off in EMAR. At least fiv random residents will be select per audit. This will be complete three a week for 2 weeks then it a week for 6 months. Inservice will be provided the following topic: All medications that requires monitoring are monitored for side effects and effectiveness

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155469	B. W	ING		07/02	/2021
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			49TH AVE		
CASA O	F HOBART				RT, IN 46342		
UASA UI	LIODAILI		•	HODAR	(1, IIV 40042		
(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 OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					monitor facility performance to		
					make sure that corrections are	9	
					achieved and are permanent.		
					All plan of correction au		
					will be reported by the Directo	r of	
					Nursing and or ADON to the	'	
					Quality Assurance Committee		1
					reviewed by the Committee pe	er e	
					Month for four Months and	lor to	
					recommendations given in orce assist in ensuring that the faci		
					stay in compliance and if	шу	
					concerns are identified the Qu	ıalitv	
					Assurance Committee will add	•	
					additional Months until		
					Compliance is sustained.		
					4. Dates when corrective		
					action will be completed: July	23,	
					<u>2021</u>		
F 0761	483.45(g)(h)(1)(2)						
SS=D	Label/Store Drugs	_					
Bldg. 00		ng of Drugs and Biologicals					
	"	cals used in the facility					
		n accordance with currently					
	1 ' '	onal principles, and include					
		ccessory and cautionary					
		he expiration date when					
	applicable.						
	§483.45(h) Storaç	ge of Drugs and Biologicals					
	8483 45(h)(1) In a	accordance with State and					
	. , , , ,	facility must store all drugs					
		locked compartments					
		perature controls, and					
		rized personnel to have					

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

access to the keys.

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 49 of 66

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		
		155469	B. WING 07/02/20			/2021	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
					49TH AVE		
	HOBART		HOBART, IN 46342				
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG	BH ICENCT!		DATE
	§483.45(h)(2) The facility must provide separately locked, permanently affixed						
		storage of controlled drugs II of the Comprehensive					
		ention and Control Act of					
	-	ugs subject to abuse,					
	except when the fa	acility uses single unit					
		ribution systems in which					
	the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications						
			F 0	761	The facility request		07/23/2021
			1.0	/ 01	paper compliance for this		07/23/2021
		bedside in the residents' rooms			citation		
		reviewed for medication					
	storage. (Resident 2				Submission of this plan of		
				correction does not constitute			
	Finding includes:				admission or agreement by the		
	On 6/28/21 at 10:00	a.m., Resident 23 was			provider of the truth of facts alleged or correction set forth	on	
		ped. At that time, there were 2			the statement of deficiencies.		
		dication cup on his over bed			plan of correction is prepared		
	-	asked for the surveyor to give			submitted because of requirer		
		im. The medication was			under state and federal law.		
		ver bed table and taken to the			Please accept this plan of		
	nurses' station.				correction as our credible		
	Tukama' '4 T Day	11 -4 10:15 ' 1' 1 1			allegation of compliance. Plea	se	
		I 1 at 10:15 a.m. indicated she			find enclosed this plan of		
	_	the over bed table and the r he was going to take them			correction for this survey.		
	after he had finished	0 0			F 761 Label/store biologicals	:	
	inter no nad minished				Corrective actions which will		
	The record for Resi	dent 23 was reviewed on			be accomplished for those		
	-	. Diagnoses included, but were			residents found to have beer	า	
		e, acquired absence of right			affected by the deficient		
	left above the knee, vascular dementia with				practice:		
		ve and reflux uropathy,			R 23's medications were	_	
		disease, epilepsy, heart failure,			reviewed. R23 was educated t		
	type 2 diabetes, high	-			all medications received will no		
	atherosclerotic hear	t disease	1		left at the bedside. R23 remain	IS	

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 50 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		a. Building <u>00</u>		COMPL	
		155469	B. W	'ING		07/02/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	I		(Y5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710	REGUERITORT	CESC IDENTIFY THIS IN CREATITION	+	1710	within baseline of functioning.		Ditte
	The Quarterly Mini	mum Data Set (MDS)			Within baseline of fariotioning.		
		/30/21, indicated the resident			1. How the facility will ident	tifv	
		ed. The resident needed			other residents having the	y	
		h 1 person physical assist for			potential to be affected by the		
		sive assist with 2 person			same deficient practice.		
	_	personal hygiene. The resident			All residents may have the		
		ers, but was at risk for			potential to be affected by the		
	pressure ulcers.				same deficient practice.		
Physician's Orders, dated 4/29/21, indicated				2. The measures the facilit	y		
		ablet Chewable 500 milligrams			will take or systems the facility	/	
(mg) 1 tablet by mouth two times a day.				will alter to ensure that the			
					problem will be corrected and	will	
		or an assessment for the			not recur.		
	resident to self adm	inister his own medications.			· An audit tool will be		
					developed to ensure that resid	dents	
		Director of Nursing on 6/30/21			take their medications during		
		ted the nurse should not have			medication pass and are not t	o be	
	left the medication	at the bedside.			left with the resident at the		
					bedside. At least five random		
	3.1-25(b)				residents will be selected per		
					audit. This will be completed t	hree	
					a week for 2 weeks then 2x a		
					week for 6 months		
					Inservice will be provide	ea on	
					the following topic:	ad	
					o All residents will be observ	eu	
					when taking medications and medications are not to be left	at	
					the bedside.	aı	
					uie beuside.		
					3. Quality Assurance Plans	s to	
					monitor facility performance to		
					make sure that corrections are		
					achieved and are permanent.	-	
					All plan of correction au	ıdit	
					will be reported by the Directo		
					Nursing and or ADON to the		
					Quality Assurance Committee	and	

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building 00			COMPL	ETED
		155469	B. WING 07/02/2		2021		
				CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE				
CASA OI	F HOBART				T, IN 46342		
<u> </u>	HODAIN			HODAIN	11, 111 40342		
(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)		DATE
					reviewed by the Committee pe	er	
					Month for four Months and		
					recommendations given in ord		
					assist in ensuring that the facil	ity	
					stay in compliance and if		
					concerns are identified the Qu	•	
					Assurance Committee will add	lon	
					additional Months until		
					Compliance is sustained.		
					4. Dates when corrective		
					action will be completed: <u>July</u>	<u>23, </u>	
					<u>2021</u>		
F 0804 SS=F Bldg. 00	Temp §483.60(d) Food a Each resident reco provides- §483.60(d)(1) Foo conserve nutritive appearance; §483.60(d)(2) Foo palatable, attractiv appetizing temper Based on observatio interview, the facilit prepared by method value. This had the	eives and the facility of prepared by methods that value, flavor, and of and drink that is be, and at a safe and	F 08	04	The facility request paper compliance for this citation		07/23/2021
	Finding includes: On 6/27/21 at 8:50	a.m., Dietary Cook 1 was pan of mashed potatoes on			Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. plan of correction is prepared	on The	

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 52 of 66

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/02/2021			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) submitted because of require	DATE		
	a.m., indicated the p lunch had already b the steam table. Sh mashed potatoes we All she still needed	ary Cook 1 on 6/27/21 at 9:19 pureed food preparation for een completed and placed in ealso indicated the greens and ere on the steam table as well. to prepare for lunch was the ted lunch started at 11:30 a.m.		under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Plea find enclosed this plan of correction for this survey.	ase		
	Interview with the I on 6/30/21 at 11:03 lunch on 6/27/21 sh the steam table at 9: too early. The "Pureed Food F by the DFM on 6/30 pureed foods would	Dietary Food Manager (DFM) a.m., indicated the food for ould not have been placed on 00 a.m. She indicated that was reparation" policy provided 0/21 at 1:52 p.m., indicated be heated to a minimum of heit before serving and used		F 804 Nutritive Value/Appear Palatable/Prefer Temp Corrective actions which will I accomplished for those reside found to have been affected to deficient practice: Facility's dietary menu reviewed to ensure that each resident receives and the faci provides food prepared by methods that conserve nutritivalue, flavor and appearance and drink are palatable, attract and at a safe and appetizing temperature	oe ents by the was lity ve		
				1. How the facility will ident other residents having the potential to be affected by the same deficient practice. All residents hat the potential to be affected of same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be correated will not recur.	ve the		

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 53 of 66

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/02/2021	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342		
CASA OI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) Anthen 2x a week for 6 months A 1:1 in-service will be provided to Dietary Manager nutritive value/appearance, palatability and preferred temperature of food In-service will be provided to dietary and nursing staff we prepares and serve meal tray ensure that food temperature maintained when it is served affood is presentable and palatate when served. 3. Quality Assurance Plans monitor facility performance to make sure that corrections are achieved and are permanent. All plan of correction at will be reported by the Director Nursing and or ADON to the Quality Assurance Committee reviewed by the Committee phonth for four Months and recommendations given in ord assist in ensuring that the fact stay in compliance and if concerns are identified the Quality Assurance Committee will additional Months untill Compliance is sustained. 4. Dates when corrective	DATE DATE DATE DATE DATE DATE
F 0812 SS=F	483.60(i)(1)(2) Food			action will be completed: <u>July</u> 2021	<u>23,</u>

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 54 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/02/2021		
	PROVIDER OR SUPPLIEF	2		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG Bldg. 00	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	S483.60(i)(1) - Pro approved or consifederal, state or lo (i) This may include directly from local applicable State a regulations. (ii) This provision facilities from using gardens, subject to applicable safe gractices. (iii) This provision from consuming for facility. §483.60(i)(2) - Storester food in account of the same application.	ocure food from sources dered satisfactory by ocal authorities. de food items obtained producers, subject to and local laws or does not prohibit or prevent g produce grown in facility o compliance with owing and food-handling does not preclude residents bods not procured by the ore, prepare, distribute and ordance with professional	F 081	2	The facility request		07/23/2021	
	failed to ensure foo served under sanita accumulation of du equipment as well a of dust on fans in the refrigerator, food nexposed in the walk areas and 2 of 2 unipotential to affect the food from the kitch Bakersfield pantry, Findings include: 1. During the Initial	d was stored, prepared, and ry conditions related to an st and debris on food as food debris, an accumulation are dish area and walk in the labeled and dated, and food at in freezer in 1 of 1 kitchen the pantries. This had the me 80 residents who received en. (The Main Kitchen, and Main Unit pantry)			paper compliance for this citation Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. plan of correction is prepared submitted because of requirement and restate and federal law. Please accept this plan of correction as our credible allegation of compliance. Plea find enclosed this plan of	on The and nent	07/23/2021	

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet Page 55 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/02/2021		
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD		
CASA OF	HOBART			N 49TH AVE RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	following was obse	rved:		correction for this survey.		
	a. The top of the co	onvection oven had an		F 812 Food procurement,		
	accumulation of du	st and grease.		Store/Prepare serve sanitary	у	
	b. There were food	crumbs and debris on the		Corrective actions which will	be	
	counter where the to	paster was located. The		accomplished for those resident	ents	
	toaster was covered	with plastic.		found to have been affected I	by the	
				deficient practice:		
	-	eamer had an accumulation of		· Facility's kitchen was		
dust and grease.				cleaned thoroughly to ensure		
1.77				dusts, grease, crumbs, and d		
d. There was dried spillage on the juice machine.				were removed on all areas in		
	e. The top of the dishwasher had an accumulation			kitchen. Food areas appropri	ately	
		The large fan in the		covered, labeled, and dated		
		ad an accumulation of dust on		appropriately		
		an cover. The fan was		How the facility will iden	atify.	
	running at the time			other residents having the	iuiy	
	running at the time	of the observation.		potential to be affected by the	_	
	f. The walk in cool	er had dust on the ceiling and		same deficient practice.	^	
	around the fan vent	_		· All residents ha	ove	
				the potential to be affected of		
	g. The plastic lid or	n a container of cream of		same deficient practice.		
		s not secured and the soup				
	was exposed. A pla	astic container of bean and		2. The measures the facili	ty	
	chicken soup was c	overed with aluminum foil.		will take or systems the facilit	-	
	The foil was torn in	sections and the soup was		will alter to ensure		
	exposed. Both item	s were located in the walk in		that the problem will be corre	cted	
	freezer.			and will not recur.		
		in the reach in cooler were		· In-services wer	re	
		vrap. The sandwiches were		provided to dietary staff, inclu	•	
	not dated and the bi	read was hard to touch.		dietary manager on food safe	ety	
				requirements that include		
	-	kitchen tour with the Dietary		procurement of food from app	proved	
		M) and Administrator on		sources, proper storage,		
	6/30/21 at 9:00 a.m	., the following was observed:		preparation, distribution, and		
	and a first			sanitation of kitchen.		
	a. The top of the co	a. The top of the convection oven had an		· Dietary consult	ant	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/02/2021			
	ROVIDER OR SUPPLIER HOBART	2	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION accumulation of dust and grease. b. The top of the steamer had an accumulation of		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) and or Administrator will cond observation of the kitchen to a sanitation and proper storage	DATE Cover of		
	accumulation of duscover. d. The lid on a plas	the dishwashing area had an st on the fan blades and fan tic container of food in the not fastened and the food was		food at least three times week for two weeks then 2x weekly months. 3. Quality Assurance Plans monitor facility performance to make sure that corrections are achieved and are permanent.	for 6 s to o		
	of the above were in already been cleane	DFM at that time, indicated all need of cleaning or had d. She also indicated the food ealed and the sandwiches		 All plan of correction at will be reported by the Directon Nursing and or ADON to the Quality Assurance Committee reviewed by the Committee pomonth for four Months and recommendations given in ore 	or of e and er		
	observed in the Bak a. Three cups of va	6 a.m., the following was tersfield pantry: nilla pudding covered with d in the refrigerator, were not		assist in ensuring that the fac stay in compliance and if concerns are identified the Qu Assurance Committee will ad- additional Months until Compliance is sustained.	uality		
	was observed with a container was not d	paper from a local pizza		4. Dates when corrective action will be completed: <u>July 2021</u>	23,		
	Interview with CNA pudding was delive and the cupcakes windicated both items	A 2 at that time, indicated the red to the unit that morning ere from yesterday. She is needed to be dated and the e shelf needed to be discarded.					

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 07/02/	ETED	
	PROVIDER OR SUPPLIER	:	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	CROS		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	4. On 7/2/21 at 9:3 observed in the Mai	1 a.m., the following was in Unit pantry:					
	•	tainer with left over food was container was located in the					
		ntaining left over food was bag was located in the					
		Assistant Administrator at that food was to be discarded after					
	Frozen)" policy was 7/2/21 at 9:36 a.m. items would be laber the name of the foor should be sold, conscontents of cans and	(Dry, Refrigerated, and s provided by the DFM on The policy indicated all food eled. The label must include d and the date by which it sumed, or discarded. Leftover d prepared food would be abeled, and dated containers in freezers.					
	3.1-21(i)(3)						
F 0880 SS=E Bldg. 00	infection prevention designed to provide comfortable environ the development a	on & Control					
	program.	on prevention and control					

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 58 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/02/2021			
	PROVIDER OR SUPPLIER HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP	ILD BE COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	I	ntrol program (IPCP) that minimum, the following					
	identifying, reporti controlling infection	ystem for preventing, ng, investigating, and ons and communicable sidents, staff, volunteers,					
	visitors, and other	individuals providing contractual arrangement					
	based upon the fa	•					
	conducted according to §483.70(e) and						
		d national standards;					
	§483.80(a)(2) Written standards, policies,						
	and procedures fo	or the program, which must					
	include, but are no	ot limited to:					
	(i) A system of sur	veillance designed to					
	identify possible c	ommunicable diseases or					
	infections before t	hey can spread to other					
	persons in the fac	-					
	1 ' '	hom possible incidents of					
		ease or infections should					
	be reported;	turn mission by					
	` '	transmission-based					
	of infections:	followed to prevent spread					
	·	risolation should be used					
	1 ' '	risolation should be used uding but not limited to:					
		duration of the isolation,					
	l , ,	ne infectious agent or					
	organism involved	_					
	1 -	that the isolation should be					
	1 ' '	e possible for the resident					
	under the circums	•					
		nces under which the facility					
	must prohibit emp	-					
	1 '	ease or infected skin					
		t contact with residents or					
	their food, if direct	contact will transmit the					

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 59 of 66

PRINTED: 08/03/2021

	T OF HEALTH AND HU R MEDICARE & MEDIC		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/02/2021		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING			onstruction <u>00</u>
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD V 49TH AVE	
CASA O	F HOBART		HOBA	RT, IN 46342	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	disease; and (vi)The hand hygi followed by staff i contact. §483.80(a)(4) A sincidents identifie and the corrective facility. §483.80(e) Linear Personnel must he transport linear sof infection. §483.80(f) Annual The facility will contact its IPCP and updanecessary. Based on observation interview, the facility control guidelines including those to provide the appropriate fact hallway, hand hygimeals, and water refor 3 of 3 meal obsobservations of a because of the control guidelines including those to provide appropriate fact hallway, hand hygimeals, and water refor 3 of 3 meal obsobservations of a because of the control guidelines including those to provide appropriate fact hallway, hand hygimeals, and water refor 3 of 3 meal obsobservations of a because of the control guidelines include: 1. During a randor 10:49 a.m., a transpirate facts and a staff includes.	ene procedures to be nvolved in direct resident ystem for recording d under the facility's IPCP e actions taken by the s. andle, store, process, and o as to prevent the spread	F 0880	The facility request paper compliance for this citation Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth of the statement of deficiencies. It plan of correction is prepared a submitted because of requirem under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of	07/23/2021 end The land ment

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

face covering. At 10:54 a.m., he was transporting

a resident in the hallway and continued to wear

the neck gaiter face covering.

Event ID:

F4R211

Facility ID: 000366

Control

If continuation sheet

correction for this survey.

F880 Infection Prevention and

Page 60 of 66

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/02/2021			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Interview with the Infection Preventionist on		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	7/1/21 at 2:45 p.m.,	indicated the transport staff e been wearing a surgical		Corrective actions which will accomplished for those reside found to have been affected a deficient practice:	ents		
	Guidance Standard 6/22/21, indicated to should continue for visitors that come in 2. During a random a.m., Hospice CNA a resident's room w The CNA proceede was located in the h Interview with the l indicated the gloves the hallway.	n observation on 7/2/21 at 10:33 1 was observed walking out of ith disposable gloves in use. d to get the linen barrel which		The transport staff was in-serviced on the correct PP face covering to utilize per portion of the correct PP face covering to utilize per portion of the covering	E licy. Dives. R14 ed to ime. In ted ter d on ces,		
	Guidance Standard 6/22/21, indicated to when leaving the reducing a meal obsethere were 12 reside room waiting on lumpassing beverages to the meal trays were by the kitchen staff at 12:03 p.m. There passing trays and at offer to provide harms	C Facility Infection Control Operating Procedure, updated or remove and discard gloves sident room or care area.3. rvation on 6/27/21 at 11:58 a.m., ents seated in the main dining nch. A CNA was observed of the residents. The brought into the dining room and were ready to be passed of were 5 facility staff members no time did a staff member d hygiene to the residents of food. Ten of the 12 residents		1. How the facility will ident other residents having the potential to be affected by the same deficient practice. All residents may have potential to be affected by the same deficient practice. 2. The measures the facilit will take or systems the facilit will alter to ensure that the problem will be corrected and not recur. An audit tool will be developed to ensure that properties.	the ty y		

F4R211

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 07/02/2021 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 were able to feed themselves. infection control practices, proper PPE use and handwashing is On 6/28/21 at 11:45 a.m., 12 residents were always observed. DON/designee observed in the dining room waiting for lunch. At will randomly observe staff 3 staff 11:50 a.m., the lunch trays were served. At no 3x weekly for 4 weeks then 2 staff time, did facility staff offer or provide hand weekly for 6 months. Any hygiene to the residents before they ate their deficiencies will be corrected food. Ten of the 12 residents were able to feed immediately. themselves. Nursing staff were in serviced on proper infection control On 6/29/21 at 11:37 a.m., 7 residents were practices, proper PPE donning observed in the dining room feeding themselves and doffing including but not the lunch meal. No staff was observed to offer or limited to mask, respirator provide hand hygiene to them before eating. At at devices, gloves, gown and eye 11:38 a.m., Activity Aide 2 was holding Resident protection, with return 14's hand and walked her over to obtain a clothing demonstration. protector. The two walked hand in hand and the Nursing staff were in aide assisted the resident to sit down and placed serviced on proper handwashing the clothing protector over her clothes. The and ABHS use during every resident was served her lunch tray and started to patient care and every resident eat. No staff provided hand hygiene to the encounter including but not limited resident prior to eating. to serving meal trays, when providing ADL care. Interview with LPN 2 on 6/29/21 at 11:40 a.m., indicated she did not physically provide hand Quality Assurance Plans to hygiene to the residents before lunch was served, monitor facility performance to however, they were supposed to do it in their make sure that corrections are rooms before they come down, but she could not achieved and are permanent. be assured all residents performed hand hygiene All plan of correction audit before they entered the dining room. will be reported by the Director of Nursing and or ADON to the Interview with the Director of Nursing on 6/29/21 **Quality Assurance Committee and** at 11:42 a.m. indicated she was aware hand reviewed by the Committee per hygiene must be performed on all residents prior Month for four Months and to their meals. recommendations given in order to assist in ensuring that the facility 4. On 7/1/21 at 9:45 a.m., CNA 3 and CNA 4 were stay in compliance and if preparing to provide morning care to Resident 23. concerns are identified the Quality Both CNAs performed hand hygiene and donned Assurance Committee will add on clean gloves to both hands. CNA 3 washed the additional Months until

F4R211

PRINTED: 08/03/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		· /	ILDING	nstruction 00	(X3) DATE : COMPL 07/02/	ETED		
NAME OF PROVIDER OR SUPPLIER CASA OF HOBART			STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
140	resident's face, und dried him off. She CNA 4 who was st bed and she provide his scrotum. CNA performed hand hy to empty the Foley clean gloves to both from the catheter. It the bathroom and fit toilet. The CNA caremoved her gloves clean gloves to both hand hygiene. CNA care and indicated to over so she could wresident was rolled CNA 3 washed his same water that has side. After the resishim off and rolled hobtained a wash clear proceeded to wash same water used to The CNAs removed hands with soap and was completed. Interview with both care indicated there must be performed was unaware of the providing peri care resident's back side. Interview with the lateries with the	er arms, and abdomen and gave a soapy wash cloth to anding on the other side of the ed peri care and cleaned under 3 removed her gloves and giene and obtained a cylinder catheter. She donned a pair of a hands and emptied the urine The CNA took the cylinder into tushed the urine down the ame back to the bedside, and donned a clean pair of a hands. She did not perform A 4 had finished with the peri to CNA 3 to roll the resident wash his back side. The over onto his left side and back and buttocks with the did been used to wash his front dent was washed, they dried him onto to his back. CNA 3 to the from the basin and his left leg and foot with the wash the rest of his body. If their gloves and washed their did water when the morning care after glove removal. CNA 3 need to change the water after and then washing the			Compliance is sustained. 4. Dates when corrective action will be completed: July 2021	23.		

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 63 of 66

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPI			ETED	
		155469	B. W	NG _		07/02/	07/02/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER								
CASA OF HOBART				4410 W 49TH AVE HOBART, IN 46342				
1					T			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	COMPLETION	
TAG		at ISC IDENTIFYING INFORMATION nt "Hand Hygiene" policy,		TAG			DATE	
	provided by the Director of Nursing on 7/1/21 at 11:45 a.m., indicated hand hygiene was to be performed immediately after glove removal.							
	performed immedia	arei giove removai.						
	3.1-18(b)							
	,							
F 0921	483.90(i)					İ		
SS=F		anitary/Comfortable Environ						
Bldg. 00	• ,,	Environmental Conditions						
		provide a safe, functional,						
	•	fortable environment for						
	residents, staff an							
		on and interview, the facility	F 09	921	The facility request		07/23/2021	
		inctional and sanitary			paper compliance for this			
		aintained related to lime build			citation			
	_	food spillage on walls and						
		and food spillage on pipes in 1			Submission of this plan of			
		This had the potential to affect or received food from the			correction does not constitute	_		
	kitchen. (The Main				admission or agreement by the	,		
	kitchen. (The Main	(Kitchen)			provider of the truth of facts	on		
	Finding includes:				alleged or correction set forth on the statement of deficiencies. The			
	r manig merades.				plan of correction is prepared			
	During the Initial To	our of the kitchen with Dietary			submitted because of requiren			
	_	at 9:00 a.m., the following was			under state and federal law.	ioni		
	observed:	,,			Please accept this plan of			
					correction as our credible			
	a. The faucet on the	e hand washing sink had an			allegation of compliance. Plea	se		
		ne build up. Food stains were			find enclosed this plan of			
	observed inside of t	he sink.			correction for this survey.			
	b. The wall located	behind the steamer had an			F 921 Safe/Functional/Sanita	ry		
	accumulation of dri	ed food spillage.			comfortable Environment			
	_	age was observed on the			Corrective actions which will b			
	counter legs.				accomplished for those reside			
	1 771	101			found to have been affected by	y the		
		window air conditioning unit			deficient practice:			
	nad an accumulation	n of dust. There was also an	1		 Facility's kitchen was 	l.	I	

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

Event ID:

F4R211

Facility ID: 000366

If continuation sheet

Page 64 of 66

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	X3) DATE SURVEY COMPLETED 07/02/2021			
	PROVIDER OR SUPPLIEF		4410 V	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
	SUMMARY (EACH DEFICIEN REGULATORY OF accumulation of dual ledge housing the a e. The floor tile bel underneath the 3 co accumulation of a b f. An accumulation floor tile underneath dishwashing area, the dishwashing area was debris. Interview with the I on 6/30/21 at 9:15 a	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION st and debris on the window	4410 V	W 49TH AVE	that bood and hen. tify Ve the the ding ty proved ant duct e			
				for two weeks then 2x weekly months. 3. Quality Assurance Planmonitor facility performance to make sure that corrections are achieved and are permanent.	s to o e			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERSTOR	MEDICARE & MEDIC	AID SERVICES			ONIBIN	0. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIF		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
155469		B. WING		07/02/2021			
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD			
			4410 W 49TH AVE				
CASA OF	HOBART		HOBART, IN 46342				
(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	re CO	OMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				· All plan of correction au	dit		
				will be reported by the Director	r of		
				Nursing and or ADON to the			
				Quality Assurance Committee	and		
				reviewed by the Committee pe	er		
				Month for four Months and			
				recommendations given in ord	er to		
				assist in ensuring that the facility			
				stay in compliance and if			
				concerns are identified the Qu	ality		
				Assurance Committee will add	· 1		
				additional Months until			
				Compliance is sustained.			
				,			
				4. Dates when corrective			
				action will be completed: July	23.		
				2021			
				_ 	1		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: F4R211 Facility ID: 000366 If continuation sheet Page 66 of 66