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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00376162, IN00377302, and IN00378302. Complaint IN00376162 - Substantiated. Federal/State deficiencies related to the allegations are cited at F676. Complaint IN00377302 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00378302 - Substantiated. Federal/State deficiencies related to the allegations are cited at F727. Unrelated deficiencies are cited. Survey dates: April 21 & 22, 2022 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 9 Medicaid: 70 Other: 8 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/26/22.	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.			

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	Based on observation, record review, and interview, the facility failed to provide timely assistance with morning care and incontinence care for 1 of 3 residents reviewed for activities of daily living (ADLs). (Resident B) Finding includes: Resident B was observed and interviewed on 4/21/22 at 9 a.m. She was in bed, her unopened breakfast was placed on the over the bed table. She indicated she had not been bathed nor had any care yet this morning. During an observation and interview on 4/21/22 at 11:30 a.m., Resident B remained in her bed. There had been no observation of a CNA entering her room. RN 2 was in the room with the resident's medications. Resident B indicated no staff had been in her room to assist her with bathing and incontinence care. RN 2 asked CNA 1 if he had assisted the resident and he stated he had not. CNA 1 indicated the resident requested no male staff to provide care for her. Resident B acknowledged this request. RN 2 then proceeded to assist the resident with incontinent care. She indicated the incontinent brief was very wet. The resident's buttock/peri-area was non-reddened. She complained of the area hurting while RN 2 was washing the area. She then indicated she had been incontinent of bowels yesterday and the incontinent brief had not been changed for four hours and she thought this was what the soreness was from. Resident B's record was reviewed on 4/21/22 at 12:23 p.m. the diagnoses included, but were not limited to, COVID-19, respiratory failure, and clostridium difficile.	F 0676	**F676 Activities of Daily Living/MTN Abilities** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B was assisted with morning/incontinence care **2) How the facility identified other residents:** Residents requiring assistance with ADL's have the potential to be affected by the alleged deficient practice. **3) Measures put into place/**	05/09/2022

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	An Admission Minimum Data Set assessment, dated 3/7/22, indicated an intact cognitive status, required limited assistance with bed mobility, toileting, and hygiene, extensive assistance with transfers and bathing,and was always incontinent of bowel and bladder. A Care Plan, dated 3/1/22, indicated assistance was required for ADLs. The interventions included, a full or partial bed bath would be offered on non-shower days and assistance with toileting would be offered. A Care Plan, dated 3/1/22, indicated incontinence of urine. The interventions included, disposable briefs would be used and changed as needed, incontinence care would be completed with each incontinence episode, and the incontinence brief would be checked and changed with routine care rounds and as needed. This Federal tag relates to Complaint IN00376162. 3.1-38(a)(2)(A) 3.1-38(a)(2)(C)		**System changes:** Staff will be re-educated regarding the importance of providing timely assistance with morning care and incontinence care. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete rounds on 3 residents once a day 5 times per week to ensure that residents have received morning care/incontinence care. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **05-09-2022**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, related to medications not given on time, for 1 of 1 resident reviewed for medications. (Resident K) Finding includes: During an observation and interview on 4/22/22 at 11:07 a.m., LPN 3 was at the Medication Cart, outside of Resident K's room and placing medications in a plastic medication cup. LPN 3 indicated the medications were the 8 a.m. medications. She was unable to get the medications out as ordered due to residents being assisted with their breakfast and having to stop to don and doff personal protective equipment (PPE). She indicated she had all the residents on Cherry Hall whose medications she administered. She indicated she had an hour before and an hour after the prescribed time for the administration of the medications. Resident K's record was reviewed on 4/22/22 at 1:09 p.m. The diagnoses included, but were not limited to seizures and multiple sclerosis. The Physician's Orders included the following orders, dated 4/18/22: Lacosamide (anticonvulsant) 150 mg (milligrams) daily for convulsions at 8 a.m. and 200 mg at 8 p.m. Levetiracetam (anticonvulsant) , 1000 mg at 8	F 0684	**F684 Quality of Care** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The physician was made aware that resident K's medications were not given as ordered. Resident K did not have a negative outcome. **2) How the facility identified other residents:** All residents receive medications have the potential to be affected	05/09/2022

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	a.m. and 8 p.m. Depakote sprinkles (anticonvulsant) 125 mg, give 6 capsules at 8 a.m., 2 p.m., and 10 p.m. Gabapentin (anticonvulsant/nerve pain) 300 mg at 8 a.m., 1 p.m., and 6 p.m. Baclofen (muscle relaxant) 20 mg at 8 a.m.,1 p.m., 6 p.m., and 9 p.m. The Medication Administration Record (MAR), dated 4/2022, reviewed on 4/22/22 at 1:22 p.m., indicated the 1 p.m. dose of gabapentin and baclofen had been administered at 1 p.m. The MAR, dated 04/02022, at 3:25 p.m., indicated the depakote sprinkles dose had been given at 2 p.m. The following web sites were reviewed on 4/22/22 at 2 p.m.: www.vimpat.com (lacosamide). The medication guide indicated to take the medication exactly as the Healthcare Provider ordered. www.pfizer.com (levetiracetam). The medication was to be taken every 12 hours. www.depakote.com. The medication guide indicated to take the medication exactly as the Healthcare Provider ordered. www/jlaccess data.fda.gov. The gabapentin was to be taken exactly as prescribed. Cherry Hall was observed on 4/22/22 at 3:25 p.m., there were 26 residents on the hall and three residents were on isolation protocols. On 4/22/22 at 3:27 p.m., LPN 3 indicated she had volunteered to work in the Dining Room for breakfast. There were six residents in there and		by the allege deficiency. A medication audit for the last 14 days was completed to identify any medications given after the time they were ordered by the physician. **3) Measures put into place/ System changes:** Staff will be re-educated on medication management and the importance of following physicians' orders. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete 3 medications audits per week to ensure that medications are being given timely. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:**	

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	she fed two of the residents. She indicated there were two rooms on the Cherry Hall she was not assigned to for medication pass (four residents). The Corporate RN was interviewed on 4/22/22 at 3:35 p.m., she indicated LPN 3 was assigned to assist with passing room trays, then she was to complete her medication administration. LPN 1 never notified any of the Administration Nurses she was behind and needed help. A facility medication administration policy, dated 2/17/2020, and received from the Corporate RN as current, indicated the medications were to be administered within one hour of their prescribed time. 3.1-37		**05-09-2022**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, interview, and record review, the facility failed to ensure a Care Planned intervention to prevent injury due to a fall was in place, related to a mat on the floor was not in place next to the bed, for 1 of 3 residents reviewed for falls. (Resident E) Finding includes:	F 0689	**F689 Free of Accident Hazards/Supervision Devices** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.*	05/09/2022

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	During observations on 4/22/22 at 8:45 a.m. through 9:43 a.m., Resident E was lying in her bed, the bed was in low position. There was a mat on the floor, lying away from the side of the bed. CNA 4 indicated the mat on the floor was not next to the bed on 4/22/22 at 9:43 a.m. Resident E's record was reviewed on 4/22/22 at 8:42 a.m. The diagnoses included, but were not limited to, dementia. A Significant Change Minimum Data Set assessment, dated 3/24/22, indicated a severely impaired cognitive status, required extensive assistance of two for bed mobility and had one fall with no injury. A Care Plan, dated 1/28/22, indicated a risk for falls. The interventions included, a fall mat would be utilized on the floor next to the bed. This Federal tag relates to Complaint IN00377302. 3.1-45(a)(2)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident E floor mat was placed beside the bed correctly **2) How the facility identified other residents:** All residents who utilize fall interventions have the potential to be affected by the allege deficiency. A fall risk audit was completed to ensure that all interventions were in place **3) Measures put into place/ System changes:** Staff will be re-educated on falls, fall interventions and prevention.	

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			4) How the corrective actions will be monitored: Director of Nursing or designee will complete rounds on 3 residents at least once a day 5 times per week to ensure that residents have their fall interventions in place. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05-09-2022**	
F 0727 SS=C Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may			

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	serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) was scheduled in the facility for at least 8 consecutive hours a day, 7 days a week. This had the potential to affect 87 of 87 residents who reside in the facility. Finding includes: The Nursing Staff Schedules, dated March 20, 2022 through April 19, 2022 were reviewed on April 22, 2022 at 1:15 p.m. The schedules indicated there was no RN coverage on Saturday March 26, 2022, Sunday March 27, 2022, Saturday April 9, 2022, and Sunday April 10, 2022. The Regional Consultant was interviewed in April 22, 2022 at 2:25 p.m. and indicated there had not been RN coverage for eight consecutive hours on March 26, 2022, March 27, 2022, April 9, 2022, and April 10, 2022. This Federal tag relates to Complaint IN00378302. 3.1-17(b)(3)	F 0727	**F727** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Facility reviewed labor assignments and ensured Registered Nurse (RN) was scheduled in the facility for at least 8 consecutive hours a day, 7 days a week. **2) How the facility identified other residents:** All residents have the potential to be affected by this alleged	05/09/2022

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			deficient practice. **3) Measures put into place/ System changes:** Director of Nursing, Administrator, HR and Staff coordinator were educated on the importance of ensuring RN coverage is provided daily for at least 8 consecutive hours. **4) How the corrective actions will be monitored:** An audit tool will be developed to ensure that RN coverage is present on a daily basis to ensure compliance. Administrator or designee is responsible for this audit **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05/09/2022**	
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			

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	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to correct Personal Protective Equipment (PPE) not used by a staff member (CNA 1) when in a resident's room who was on Contact/Droplet Precautions for suspected COVID-19 (Resident J) and failure to communicate a COVID-19 positive status to the	F 0880	**F880 Infection Prevention Control** **The facility requests paper compliance for this citation***This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the*	05/09/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Dialysis Facility and Transport Company prior to arriving at the facility to transport a resident to dialysis (Resident H) for 2 of 3 residents reviewed with COVID-19 or suspected COVID-19. Finding includes: 1) During an observation on 4/21/22 at 8:51 a.m., CNA 1 was in Resident J's room and was assisting the resident. CNA 1 was wearing a gown, N95 mask, gloves, and glasses. When CNA 1 exited the room, the glasses worn were not sealed around the eyes. CNA 1 acknowledged a face shield had not been worn. The entry door of the room had PPE available which included face shields. The sign on the door indicated droplet precautions were to be utilized, which included, the eyes, nose, and mouth were to be fully covered before the room was entered. A facility COVID-19 policy. dated 1/2/2022 and received from the Corporate RN as current, indicated eye protection was to be utilized if a resident is suspected or confirmed to have COVID-19. Resident J's record was reviewed on 4/22/22 at 12:30 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and end stage renal disease. A Physician's Order, dated 4/19/22 at 3 p.m., indicated droplet isolation was initiated due to the resident had not been vaccinated. 2) On 4/21/22 at 8:30 a.m., the Administrator indicated Resident H was positive for COVID-19 and resided on the Red Zone (COVID-19 positive residents).		*provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents/staff identified:** CNA 1 was re-educated on proper use of PPE and is no longer employed Dialysis was made aware of Resident H Covid -19 Positive status Ambulance transport was made aware of Resident H Covid-19 status **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficiency. **3) Measures put into place/ System changes** Staff will be re-educated regarding infection control guidelines, PPE utilization and communication of Covid-19 positive residents to outside vendors. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will complete daily care rounds on at least 5 staff members 5 times per week at varied times/shifts to ensure proper infection control techniques are followed. Also, an audit of Covid-19 positive residents will be completed daily to ensure that outside vendors are aware of resident's current status.	

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	On 4/21/22 at 9:09 a.m., the Transport Company arrived to transport Resident H to dialysis. The Transporter indicated the Transport Company had not been made aware the resident was COVID-19 positive. She would have to notify the company and the Dialysis Center. The Dialysis Center usually would send COVID-19 positive residents to another center. RN 2 then indicated she would notify the Dialysis Center. On 4/21/22 at 9:19 a.m., RN 2 indicated she spoke to the Dialysis Center and Resident H would not be transferred to the Dialysis Center today for dialysis. Resident H's record was reviewed on 4/22/22 at 12 p.m. The diagnoses included, but were not limited to, end stage renal disease. A Physician's Order, dated 2/23/22, indicated dialysis was scheduled on Tuesday, Thursday, and Saturday's. A Physician's Order, dated 4/29/22 at 11 p.m., indicated a COVID-19 positive status and droplet/contact isolation was initiated. The Nurses' Progress Notes, indicated: On 4/21/22 at 9:59 a.m., the Dialysis Center was notified and the resident will now go to another center for dialysis on Tuesday, Thursday, and Saturday's. On 4/21/22, the resident had not received dialysis. On 4/22/22 at 12:24 p.m., a Representative of the Dialysis Center indicated she had received a		**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05-09-2022**	

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	call from the facility on 4/21/22, when the resident should have been on his way to the center, about the COVID-19 positive status. This was the first time the Dialysis Center had been made aware of the positive status. She indicated the resident had been to the Dialysis Center for dialysis the day he tested positive. She indicated if the facility had notified the center earlier, they would have had dialysis set up for him at the other facility and he would not have missed his dialysis appointment. 3.1-18(b)			