| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155469 | A. BUILDING 00<br>B. WING | 03/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| CASA OF HOBART | 4410 W 49TH AVE<br>HOBART, IN 46342 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00429937, IN00430114, IN00430302, and IN00430628.<br><br>Complaint IN00429937 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00430114 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00430302 - Federal/State deficiencies related to the allegations are cited at F554.<br><br>Complaint IN00430628 - Federal/State deficiencies related to the allegations are cited at F580 and F686.<br><br>Survey dates: March 25 & 27, 2024<br><br>Facility number: 000366<br>Provider number: 155469<br>AIM number: 100288900<br><br>Census Bed Type:<br>SNF/NF: 96<br>Total: 96<br><br>Census Payor Type:<br>Medicare: 8<br>Medicaid: 66<br>Other: 22<br>Total: 96<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | | |

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

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| | Quality review completed on 4/4/24. | | | |
| F 0554 SS=D Bldg. 00 | 483.10(c)(7)<br>Resident Self-Admin Meds-Clinically Approp<br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>Based on observation, record review, and interview, the facility failed to ensure a resident had Physician's Orders and an assessment to self-administer medication, for 1 of 1 resident reviewed for self-administration of medications. (Resident C)<br><br>Finding includes:<br><br>During an observation, on 3/25/24 at 1:22 p.m., Resident C was observed in bed in her room. There was a canister of fluticasone propionate and salmeterol (inhaler for difficulty breathing) 100 mcg (micrograms)/50 mcg on her over the bed table in front of her. She indicated that she self-administered the inhaler.<br><br>During an observation, on 3/27/24 9:27 a.m., the resident was in bed. There was a canister of fluticasone propionate and salmeterol on the over the bed table. She indicated she self-administered the inhaler twice a day and it was her own personal medication brought from home.<br><br>The record for Resident C was reviewed on 3/27/24 at 10:05 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and asthma.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/13/24, indicated the resident was cognitively intact and able to make decisions. | F 0554 | Casa of Hobart<br>Complaint Survey: 3/27/2024<br><br>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br><br>F554 Resident Self Admin Meds-Clinically Appropriate<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Resident C- Medication was immediately removed from the bedside and stored properly.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; | 04/20/2024 |

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| | There was no Physician's Order to self-administer medications.<br><br>There was no self-administration of medication assessment completed for the resident.<br><br>During an interview with the Nurse Consultant, on 3/27/24 at 1:12 p.m., she indicated there should have been an assessment and order for this resident to self-administer medication.<br><br>The current 2/15/21 "Self- Administration of Medication Program" policy, provided by the Nurse Consultant, indicated If a resident requested to self-administer medications, it is the responsibility of the IDT (Interdisciplinary Team) to determine that it was safe, before the resident may self-administer medications.<br><br>This citation relates to Complaint IN00430302.<br><br>3.1-11(a) | | What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>Staff were educated on not leaving medications at resident bedside unless there is an order for self-administration and a self-administration assessment completed.<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;<br><br>Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside and any medication noted at bedside has orders for self-administration.<br><br>The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. | |

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| | | | Date by which systemic corrections will be completed: 4/20/2024 | |
| F 0580 SS=D Bldg. 00 | 483.10(g)(14)(i)-(iv)(15)<br>Notify of Changes (Injury/Decline/Room, etc.)<br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate | | | |

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| | assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br><br>Based on record review and interview, the facility failed to ensure a resident's Responsible Party was notified of a change in condition, related to pressure sores, for 1 of 3 residents reviewed for notification of family/Responsible Party. (Resident D)<br><br>Finding includes:<br><br>Resident D's closed record was reviewed on 3/25/24 at 2:02 p.m. The diagnoses included, but were not limited to, pneumonia, respiratory failure, and dementia. The resident was re-admitted from the hospital on 2/8/24.<br><br>Cross reference F686.<br><br>A Nurse Practitioner (NP) Progress Note, dated 2/13/24 at 9:08 a.m., indicated the resident was observed in a soiled bed and an unstageable | F 0580 | Casa of Hobart<br><br>Complaint Survey: 3/27/2024<br><br>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br><br>F580 Notify of changes (Injuries/Decline/Room, Etc.)<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: | 04/20/2024 |

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| | pressure ulcer was observed on the coccyx. The Wound Care Nurse and Director of Nursing were notified and the resident was placed on a low air loss bed. The area was described by the NP as a bruising wound.<br><br>There was no documentation that indicated the family/Responsible Party had been notified of the new pressure ulcer.<br><br>A facility skin condition policy, dated 9/1/20 and received as current from the Nurse Consultant, indicated, at the earliest sign of a pressure injury, the resident and Responsible Party would be notified.<br><br>A facility undated Change of Condition policy, received as current from the Nurse Consultant on 3/27/24 at 3:07 p.m., indicated the resident's family member/Responsible Party were to be informed of a significant change in status upon the identified change in condition.<br><br>This citation relates to Complaint IN00430628.<br><br>3.1-5(a)(2) | | Resident D no longer resides in the facility.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>All residents with a change in condition have the potential to be affected by the same alleged deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:<br><br>Nurses were in-serviced on ensuring the physician, resident, and resident responsible party are notified of residents' change in condition, including medication changes, new skin conditions, treatment order changes, and notification is documented in the resident's medical record.<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;<br><br>DON/Designee will randomly audit 5 residents with change in condition 2 times per week with a special focus on: New skin conditions and treatment order | |

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| | | | changes to ensure resident/responsible party notification is completed timely and documented in the medical record.<br><br>The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.<br><br>Date by which systemic corrections will be completed: 4/20/2024<br>="" p=""><br>="" p=""><br>="" p=""><br>="" p=""><br>="" p=""> | |
| F 0686 SS=G Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives | | | |

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| | necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>Based on observation, record review and interview, the facility failed to ensure services to prevent the development of pressure injuries were effectively provided to Resident D, who was admitted to the facility without a pressure ulcer and developed a facility-acquired unstageable pressure ulcer (pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar) and also failed to ensure services were provided to Resident E, who developed a facility-acquired stage three (full thickness tissue loss) pressure ulcer, in accordance with the physician orders, for 2 of 3 residents reviewed for pressure ulcers. This deficient practice resulted in Resident D developing a facility-acquired wound initially identified by the facility as an unstageable pressure injury on the sacrum, that required surgical debridement after re-admission into the hospital.<br><br>Findings include:<br><br>1. Resident D's closed record was reviewed on 3/25/24 at 2:02 p.m. The diagnoses included, but were not limited to, pneumonia, respiratory failure, and dementia. The resident was re-admitted from the hospital on 2/8/24.<br><br>A Quarterly Minimum Data Set assessment, dated 11/18/23, indicated a severely impaired cognitive status, dependent for all activities of daily living, was a risk for pressure ulcers, and had not pressure ulcers.<br><br>A Care Plan, dated 8/11/23, indicated a potential | F 0686 | p="" paraid="335854765" paraeid="{e5b81acc-1278-48ec-bfcb-8587e2f56ed5}{188}"> p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"> p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">Casa of Hobart p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">Complaint Survey: 3/27/2024 p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"> p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an | 04/20/2024 |

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| | for alteration in skin integrity. The interventions, last dated 10/4/23, included to avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, educate the resident/family/caregivers of causative and measures to prevent skin injury, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, keep skin clean and dry, use lotion on dry skin, use a draw sheet or lifting device to move the resident, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.<br><br>The Nurse's Re-admission Assessment, dated 2/8/24 indicated no skin impairment was observed.<br><br>A Weekly Skin Assessment, dated 2/9/24, indicated the skin was intact and there were no concerns.<br><br>The CNA Bathing Task form, indicated bathing had been completed by the staff on February 9, 10, 11, 12, 13, and 14, 2024.<br><br>The CNA Skin Condition Task Form, dated 2/10/24 at 10:59 p.m., indicated, "red area, discoloration, open area" was found and the nurse had been notified.<br><br>The CNA Skin Condition Task Forms did not include documentation to indicate a red discolored open area was observed on February 11, 12, 13, and 14, 2024.<br><br>A Nurse Practitioner (NP) Progress Note, dated 2/13/24 at 9:08 a.m., indicated the NP observed Resident D lying in a soiled bed with an | | admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">Resident D- No longer resides in the facility.<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">Resident | |

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| | unstageable pressure ulcer on the coccyx. The note indicated the NP notified the Wound Care Nurse and Director of Nursing (DON), and the resident was placed on a low air loss bed. The area was described by the NP as a bruising wound. There were no measurements or further description of the area documented and no treatment orders given.<br><br>A NP Progress Note, dated 2/14/24 at 12:37 p.m., indicated the Administrator had informed her the resident had been declining. The resident was assessed as cachectic (wasting with loss of muscle mass) and was unresponsive to verbal stimuli. The blood pressure was 84/53 and temperature was 101.9 and the resident had a new pressure area. An order was received to transfer him to the Emergency Room for an evaluation.<br><br>The clinical record did not include documentation to indicate an assessment of the open area had been completed by a licensed nurse between 2/10/24 when it was observed by staff and 2/13/24 when the area was observed and documented by the Nurse Practitioner.<br><br>The clinical record did not include documentation to show treatment orders for the unstageable coccyx wound were received from the NP or the physician between 2/10/24 when an open area was first documented by facility staff and 2/14/24 when the resident was sent to the hospital for a change in condition.<br><br>A Significant Change Minimum Data Set (MDS) assessment, dated 2/14/24, indicated a severely impaired cognitive status, no behaviors, dependent for all activities of daily living, was always incontinent of bowel and bladder, dependent on tube feedings, and had one | | E's treatment orders were updated and added to the Treatment Administration Record flow sheet.<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">All residents with treatment orders have the potential to be affected by the same alleged deficient practice.<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"> | |

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| | unstageable pressure ulcer that was not present on admission.<br><br>There was no updated Pressure Ulcer Care Plan which included interventions to provide complete pressure relief to the coccyx wound.<br><br>An Emergency Room Physician's Note, dated 2/14/24, indicated Resident D was evaluated at 1:23 p.m. The resident's blood pressure measurement was 114/95 mm/Hg, the heart rate measurement was 102 bpm (beats per minute), and the temperature measurement was 98.5 degrees Fahrenheit. The resident was assessed to have bilateral pneumonia and was admitted for antibiotic treatment and also debridement of a pressure ulcer on the sacrum (coccyx).<br><br>Hospital Wound Care Notes, dated 2/14/24. indicated the wound was assessed as a full thickness wound, stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) with palpable bone palpable. The wound measured 15.0 centimeters (cm) L (length) by 10.0 cm W (width). There was no depth documented. The note indicated the wound had no drainage and the the peri-wound was fragile.<br><br>The Debridement Procedure Notes of the sacral wound, dated 2/19/24, indicated the preoperative diagnosis was unstageable sacral decubitus ulcer and postoperative diagnosis was a stage four sacral decubitus ulcer.<br><br>A scanned photograph of the area from the hospital, dated 2/14/24, was reviewed on 3/28/24. The photograph indicated the wound was a large area with a blackened/brown covering on the sacrum/coccyx skin area, with a reddened partial thickness loss area on the left buttock under the | | p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">Staff were re-educated on the following:<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}<br>{122}">Treatments are to be properly documented in Electronic Treatment Administration Record (ETAR) at the time care is rendered.<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">When a new skin impairment/wound is identified. An assessment is to be documented, physician notified, responsible party notified, and treatment orders obtained and initiated.<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">A Weekly wound assessment is completed and documented timely in the resident record. | |

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| | blackened/brown area.<br><br>The Hospital Wound Care Notes indicated the area on the coccyx was debrided on 2/19/24 and a wound vacuum was placed.<br><br>During an interview, on 3/27/24 at 1:15 p.m., the Nurse Consultant indicated the facility had determined the Wound Program was not being implemented correctly and had made some changes to improve the program. She had not realized "it was that bad."<br><br>During an interview, on 3/27/24 at 2:25 p.m., the Administrator indicated the NP had asked her to come to the resident's room to look at the wound. The Administrator acknowledged she was not a nurse and was unable to assess the area. The Nurse Consultant indicated the resident's health was declining and acknowledged skin areas were not being assessed at that time and the Director of Nursing was responsible for ensuring the pressure areas were assessed. The Director of Nursing and the Wound Nurse at the time were no longer employed at the facility.<br><br>During an interview, on 3/27/24 at 3 p.m., the Administrator indicated the CNA who had found the skin concern on 2/10/24, was no longer employed at the facility.<br><br>A facility skin condition policy, dated 9/1/20, and received as current from the Nurse Consultant, indicated a wound assessment would be initiated and documented in the resident's record when pressure and/or other non-pressure skin conditions were identified by a licensed nurse.2. During an observation on 3/27/24 at 9:15 a.m., CNA 1 was observed repositioning Resident E onto the left side so the Wound Nurse could | | p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}<br>{122}">DON/designee will randomly audit 5 residents with pressure ulcers weekly to ensure any newly identified pressure areas have an assessment documented in the resident's record, treatment orders are obtained, and Treatment Administration Record is signed.<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" | |

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| | perform a treatment to a pressure ulcer on the sacrum. The Wound Nurse was observed to remove the bandage from the resident's sacral area, and the pressure ulcer was noted to be red with minimal drainage.<br><br>The record for Resident E was reviewed on 3/27/24 at 11:15 a.m. Diagnoses included but were not limited to, type 2 diabetes, weakness, anemia, anxiety, and high blood pressure.<br><br>The 12/27/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and had no pressure ulcers. The resident needed partial to moderate assistance with rolling to the left and the right, and was at risk for pressure ulcers, however there were none.<br><br>A Skin/Wound Note, dated 3/14/24 at 8:16 a.m., indicated the resident was observed with a facility-acquired pressure wound to the sacrum with blanchable erythema (redness of the skin) covering 10% of the area and 90% of the wound was noted with slough (necrotic tissue) that was non-adherent.<br><br>A Wound Assessment Details Report, dated 3/14/24, indicated the resident experienced a facility-acquired stage three (Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) injury to the sacrum that measured 0.8 centimeters (cm) L (length) by 0.5 cm (width) by unknown depth. The report indicated the wound contained 90% slough.<br><br>Physician's Orders, dated 3/14/24, indicated a new | | paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}<br>{122}"> DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"> Date by which systemic corrections will be completed: 4/20/2024<br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"> | |

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| | order was received to cleanse the facility-acquired sacral wound with wound cleanser and pat dry, apply a thin layer of Medi Honey (a debriding agent indicated for dry to moderately exuding wounds such as: pressure ulcers (partial- and full-thickness) to the wound bed, and cover with a dry dressing in the morning every Monday, Wednesday and Friday.<br><br>There was no documentation on the March 2024 Treatment Administration Record (TAR), for 3/14, 3/15, and 3/18/24 to indicate the Medi Honey treatment was completed as ordered to the sacral pressure ulcer.<br><br>A Care Plan, revised on 3/26/24, indicated the resident had impaired skin breakdown to the sacrum, related to mobility and weakness. The approaches were to administer treatments as ordered and monitor for effectiveness.<br><br>During an interview, on 3/27/24 at 2:30 p.m., the Nurse Consultant indicated the treatment of the Medi Honey was not transcribed onto the TAR, so the nurses could not sign it out after it had been completed. She was unable to provide any documentation to show the treatment was completed in accordance with the physician's orders.<br><br>The current and reviewed 11/1/23 "Skin Condition Assessment and Monitoring Pressure and Non-Pressure" policy, provided by the Nurse Consultant on 3/27/24 at 2:50 p.m., indicated physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration. Other measurements not involving medications shall be documented in the weekly wound assessment or nurses notes. | | p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}"><br><br>p="" paraid="603780912" paraeid="{6aaf562b-d127-4b74-95e5-965e4571ea48}{122}">Casa of Hobart Complaint Survey 3/27/2024 INFORMAL DISPUTE RESOLUTION F686 Treatment Services to Prevent Heal Pressure Ulcers On behalf of Casa of Hobart, we are requesting an informal dispute resolution for F686 referenced on the enclosed 2567. As required, the facility has prepared a Plan of Correction for this deficiency; however, we set forth the following facts. states that the facility failed to assess resident D after an ulcer was identified. This is inaccurate and the facility is providing credible evidence to refute these findings. The facility presented wound assessment documentation to the surveyor proving that an assessment was performed upon identification of the Ulcer related to Resident D. There was documentation in the medical record indicating the date ulcer was identified, location of the ulcer, description of ulcer, intervention, and ulcer stage classification. Resident D- A | |

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| | This citation relates to Complaint IN00430628.<br><br>3.1-40(a)(2) | | note written by the Medical Directors Nurse Practitioner on 2/13/24 indicated the identification of the wound and her assessment of the site. (Attachment A) The note included ulcer assessment consisting of: Location/site of wound- coccyx Stage- Unstageable Description- Bruising wound to coccyx Date identified- 2/13/24 Intervention- Low Air Loss Mattress Resident D- A note written by the MPAC Nurse practitioner dated 2/14/24 indicates nursing informed her of Resident D's- Altered Mental Status, again mentioned skin breakdown, and abnormal vitals. The note also details the resident had a cachectic appearance and hospice had been considered during a previous hospitalization. This documentation further proves the residents declining health status. (Attachment B) The 2567 also states that Resident D's skin breakdown was identified on 2/10/2024. What it fails to mention is that the nurse aide that documented in Point of Care documented 3 times on 2/10/24 and 1 time on 2/11/24 with conflicting/inconsistent documentation. also fails to mention that the CNA's documentation has no site/location of the alleged identified skin area. The Surveyor of the "skin tear/open area's" location. There is nothing | |

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| | | | indicating the alleged skin observation was of the sacral area as assumed by the surveyor. (Attachment C) 2/10/24 18:39 Skin Observation –Not Applicable Y. Goins 2/10/24 22:59 Skin Observation- Red Area Discoloration, Skin Tear Y. Goins 2/10/24 22:29 Skin Observation- Red Area Discoloration, Open Area Y. Goins 2/11/24 18:07 Skin Observation- Not Applicable Y. Goins Y. Goins documentation appears errored as the employee documented not applicable at 18:39 on 2/10/24, then documented two different alleged observations at 22:59 2/10/24. The employee worked again the very next day and documented not applicable at 18:07 on 2/11/24. The next 6 documented skin observations in point of care after the 2/10/24 22:59 entry identified no skin breakdown. Y. Goins was the author of one of those 6 entries. (These entries are from 2/11/24 and 2/12/24. The ulcer was identified on 2/13/24.) Why is it ok to assume that Y. Goins 2/10/24 22:59 entries are accurate but question the validity of her documentation on 2/11/24 18:07 indicating not applicable along with all the other staff that documented no identified skin observation between 2/11/24 and 2/12/24? During the survey Resident D's hospital photos were | |

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| | | | reviewed by the surveyor and Nurse Consultant. The Nurse Consultant asked the surveyor to compare the drastic decline in the wound photos from 2/14/24 (day of admission to hospital) and 2/15/24 (day after admission to the hospital). The surveyor acknowledged the drastic decline in the ulcer in just one day. The Nurse Consultant discussed with the survey team the resident's clinical background including Resident D's- hospice referral that was initially the agreed plan of care due to the resident's overall decline. The residents' daughter then declined hospice during a previous hospitalization and instead elected to have a feeding tube inserted. The Nurse Consultant also reminded surveyors of the characteristics of Kennedy Terminal Ulcers and how those characteristics related to Resident D. Resident D's sudden ulcer development and rapid ulcer decline meet the textbook definition of KTU. No matter what intervention was implemented including surgical debridement, the ulcer would continue declining. Development of these sudden ulcer usually indicated death within 2 - 6 weeks of development. See photos (Attachment D 2/14/24), (Attachment E 2/15/24) Hospice order (Attachment F), and Revoked hospice note | |

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| | | | (Attachment G) _____Kennedy Terminal Ulcer Defined_____ The Kennedy terminal ulcer (KTU) was first coined in 1989 to describe a skin wound that occurs despite best preventative measures and results from the moribund functional status and underlying skin failure associated with the dying process.<br>• They can develop and appear within a matter of hours (usual pressure ulcers develop over approximately 5 days). Its appearance is sudden: in the early AM, the healthy skin is intact, hours later a few small blackish spots appear that may resemble “specks of dirt”, then by mid-afternoon, flat, black blisters emerge that may continue to expand in size.<br>• They are primarily the sacral but they are also seen in other bony prominences, such as the elbows, shoulders, and heels.<br>• The wound is usually , pear-shaped, or butterfly-shaped; > 2 inches in diameter; and may include red, yellow, black, and/or purple discoloration. Kennedy Terminal Ulcer which are not caused by pressure or lack of care but are related to underlying skin failure. The facilities Wound Physician reviewed Resident D’s records and provided his Medical Opinion related to the etiology of | |

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| | | | development and decline of the wound. (Attachment H) p="" paraid="24801899" paraeid="{25006d66-4394-4d1e-a7f1-1237a2f23de0}{104}"> Note: The Nurse consultant comment was documented out of context in during the conversation on 3/27/24 at 1:15pm. The Surveyor asked the Nurse Consultant and Facility Administrator who was responsible for auditing the wound documentation. The Nurse Consultant replied that it was . The surveyor then said to the facility administrator that there are still errors with wound documentation. The Nurse Consultant then replied and that is why the facility made changes to the position of DON (Director of Nursing) and Wound care nurse. We also informed the surveyors that a Performance Improvement Plan was implemented on 3/4/2024 when we realized “it was that bad” referring to the DON’s lack of oversight with documentation and wound nurses' documentation deficits. This conversation was not related to Resident D. It was a general conversation related to monitoring of wound documentation. ------ -Resident E-------- The 2567 mentions that there was an assessment and order initiated on the day of identification of Resident E’s pressure ulcer. It also mentions that there was no | |

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| | | | documentation on the March 2024 TAR for 3/14/24, 3/15/24, and 3/18/24. What fails to mention is there are two notes written by the Facilities Wound Care Nurse on 3/14/24. note was written at 8:00am indicating the family was notified of the pressure area and informed of the treatment ordered. (Attachment I) Second entry on 3/14/24 at 8:16am indicating the application of a hydrogel dressing to the wound and a pressure relieving cushion. This would indicate treatment was rendered on 3/14/24. (Attachment J) Resident E was seen by the Wound Care Physician on 3/18/24. Assessment and treatment of wounds are provided during the physician's rounds. (Attachment K) Also, see the attached order for wound care that was transcribed at the time of receipt from the physician. The order was entered on flowsheet [other orders (no documentation required)] flow sheet which did not provide a space to sign out when treatment was rendered on the TAR. (Attachment L) The 2567 also fails to mention that there was no decline in Resident E's wound between 3/14/24 and 3/18/24. See wound assessment for 3/14/24 (Attachment M) and 3/18/24 assessment (See Attachment K). The Facility Wound Nurse updated the treatment order and TAR flowsheet | |

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| | | | on 3/19/24. Wound Care documentation was signed on the TAR. (Attachment O) The facility presented the above compelling information and in summary the above IDR showed evidence that Resident D's wound was assessed at the time of identification. This evidence also proves that an intervention of a low air loss mattress was put in place at the time of identification as documented in the Nurse Practitioner note on 2/13/24 and as confirmed in the 2567. Our evidence proves the resident was at the end of life and had exhibited an overall decline per the Nurse Practitioners note on 2/14/24. The Wound Care Physician has also provided his medical opinion and confirms that the ulcer that developed was indeed a Kenndey Terminal Ulcer. It further proves the case that this Ulcer was not caused by pressure or lack of care but was related to underlying skin and system failure. With that said, no intervention would have prevented the ulcers' development or deterioration. The facility refuted that harm was caused as the type of ulcer that developed was unavoidable due to residents' medical condition and his stage in the death and dying process. We refute that there is no documentation of wound treatment being rendered to Resident E with documentation confirming that | |

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| CASA OF HOBART | 4410 W 49TH AVE<br>HOBART, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | care was rendered and there was no decline. The facility respectfully requests the correction of F686 upon review of the above information. | |