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

FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 07/06/2023 |

| 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 IN00409415, IN00410185, IN00411679, IN00412121, and IN00412151.<br><br>Complaint IN00409415 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00410185 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00411679 - Federal/State deficiencies related to the allegations are cited at F677, F690, F693, and F921.<br><br>Complaint IN00412121 - Federal/State deficiencies related to the allegations are cited at F677.<br><br>Complaint IN00412151 - Federal/State deficiencies related to the allegations are cited at F686.<br><br>Survey dates: July 5 and 6, 2023<br><br>Facility number: 000366<br>Provider number: 155469<br>AIM number: 100288900<br><br>Census Bed Type:<br>SNF/NF: 94<br>Total: 94<br><br>Census Payor Type:<br>Medicare: 15<br>Medicaid: 69<br>Other: 10<br>Total: 94<br><br>These deficiencies reflect State Findings cited in | F 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Craig Clemons | Administrator | 07/24/2023 |

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

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| | accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 7/13/23. | | | |
| F 0677<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; | | | |
| | Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependent residents related to showers and nail care for 3 of 3 residents reviewed for ADL care. (Residents D, E, and G)<br><br>Findings include:<br><br>1. The closed record for Resident D was reviewed on 7/5/23 at 1:58 p.m. The resident was admitted to the facility on 5/26/23. Diagnoses included, but were not limited to, displaced fracture of the fifth and sixth cervical vertebra, gastrostomy status (an opening into the stomach from the abdominal wall for feeding), and dysphagia (difficulty swallowing).<br><br>The Admission Minimum Data Set (MDS) assessment, dated 6/2/23, indicated the resident was cognitively intact and he required extensive assistance with bed mobility and transfers. He was dependent on staff for bathing.<br><br>There was no care plan related to ADL (activities of daily living) care.<br><br>The June 2023 Bath and Skin Report sheet, indicated the resident's shower days were | F 0677 | 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>The Facility respectfully requests paper compliance for this survey. F677 ADL Care Provided for Dependent Residents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D is no longer in the facility. Resident E received a shower. Resident G had ADL care plan put into place and nail care completed. 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; All dependent residents, who require assistance with nail care and showers, have the potential to be affected by the same alleged | 07/24/2023 |

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| | Wednesday and Saturday. Documentation on 6/7/23, indicated the resident refused. There was no other documentation on the sheet.<br><br>Documentation on the June 2023 Task Report related to bathing, indicated there was no documentation on the following dates:<br><br>Day shift: 6/2-6/4, 6/6, 6/8-6/13, 6/15-19, 6/21, and 6/25-6/28/23. On 6/5, 6/7, and 6/29/23, "n/a" was coded.<br><br>Evening shift: 6/2-6/9, 6/11-6/12, 6/16-6/20, 6/23-6/26, and 6/28/23. On 6/10, 6/13, 6/14, 6/15, 6/21, 6/22, and 6/27/23, "n/a" was coded.<br><br>Interview with the Director of Nursing (DON) on 7/6/23 at 5:22 p.m., indicated the resident's showers were not documented.<br><br>2. Interview with Resident E on 7/6/23 at 2:35 p.m., indicated he couldn't remember the last time he had a shower.<br><br>The record for Resident E was reviewed on 7/5/23 at 1:21 p.m. The resident was admitted to the facility on 6/8/23. Diagnoses included, but were not limited to, stroke, end stage renal disease, and rhabdomyolysis (a breakdown of muscle tissue).<br><br>The 6/15/23 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. He required extensive assistance with bed mobility and transfers and was totally dependent for bathing.<br><br>A Care Plan, dated 6/22/23, indicated the resident required assistance with ADL's including bed mobility, eating, transfers, toileting, and bathing. There were no interventions listed. | | deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on providing dependent residents with assistance with per resident's plan of care/preferences, including Nail Care and showers as well as the need to have ADL care plan in place. 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; DON/Designee will Audit 10 random residents 3 times weekly for 4 months, with a focus on dependent residents, requiring ADL assistance, to ensure they are being assisted with Nail Care and Showers per the residents' plan of care/preference as well as having ADL care plan in place. 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. Date by which systemic corrections will be completed: 7/24/2023 | |

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The June 2023 Bath and Skin Report Sheet, indicated the resident's shower days were Wednesday and Saturday. Documentation on 6/14/23 indicated the resident had a bed bath. There was documentation indicating the resident would need an actual shower on 6/17/23. There was no other documentation related to bathing and/or showers.

Documentation on the June 2023 Task Report related to bathing, indicated the resident received a bed bath on 6/14, 6/20, 6/22, and 6/23/23. The resident received a shower on 6/22/23. There was no further documentation related to bathing on the Task Report.

Interview with the Director of Nursing (DON) on 7/6/23 at 5:22 p.m., indicated the resident's showers were not documented. 3. On 7/5/23 at 10:10 a.m.,11:50 a.m., and 2:45 p.m., Resident G was observed lying in bed. His left and right hand were both noted to be contracted and he had long fingernails.

Resident G's record was reviewed on 7/5/23 at 11:41 a.m. The resident was admitted to the facility on 6/15/23. Diagnoses included, but were not limited to, cerebral palsy, hydronephrosis (excess fluid in the kidney), and contractures of the left and right hand.

The Admission Minimum Data Set (MDS) assessment, dated 6/22/23, indicated the resident was severely cognitively impaired. The resident required total dependence with one person physical assist for bed mobility, dressing, toilet use, and bathing.

There was no Care Plan related to ADL (activities

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| | of daily living) care.<br><br>There was no documentation the resident had received nail care since admission.<br><br>Interview with the Director of Nursing (DON) on 7/5/23 at 3:19 p.m., indicated the CNA's were supposed to document nail care on the shower sheets, however, the resident did not have any filled out since admission. They were documenting showers using the CNA Tasks for documentation of showers, which did not have a section to document nail care completed.<br><br>This Federal tag relates to Complaints IN00411679 and IN00412121.<br><br>3.1-38(a)(3)(E)<br>3.1-38(b)(2) | | | |
| F 0686<br>SS=D<br>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 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure weekly | F 0686 | Please accept the following as the facility's credible allegation of | 07/24/2023 |

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| | wound measurements were completed for 1 of 3 residents reviewed for pressure ulcers. (Resident H)<br><br>Finding includes:<br><br>On 7/6/23 at 3:04 p.m., Resident H was observed in bed. She had a dressing in place to her coccyx. The dressing was clean, dry, intact, and appeared new. There was no date on the dressing. Interview with CNA 1 at that time, indicated hospice changed the resident's dressing.<br><br>The record for Resident H was reviewed on 7/6/23 at 2:57 p.m. Diagnoses included, but were not limited to, type 2 diabetes, stroke, and chronic kidney disease.<br><br>The Admission Minimum Data Set (MDS) assessment, dated 6/2/23, indicated the resident was moderately impaired for daily decision making and required extensive assistance with bed mobility. The resident had no pressure ulcers.<br><br>There was no care plan related to the pressure ulcer to the coccyx.<br><br>A Physician's Order, dated 6/22/23, indicated the area to the resident's coccyx was to be cleansed with normal saline, pat dry, apply Medihoney (a debriding ointment), and cover with a foam dressing every Monday, Wednesday, and Friday and as needed (prn).<br><br>The June and July 2023 Treatment Administration Records (TAR's) indicated the treatment was signed out as ordered.<br><br>There were no weekly wound measurements available for review. | | 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>The Facility respectfully requests paper compliance for this survey.<br><br>F686- Treatments/ to Prevent/Heal Pressure Ulcers<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>was and no adverse effects were noted related to not receiving a wound assessment every 7 days and not having a care plan in place for the pressure<br><br>Resident H immediately had wound assessed and measurements place as well as a care plan for the pressure ulcer.<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 who have have the potential to be affected by the same alleged deficient practice. | |

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| | Interview with the Director of Nursing (DON) on 7/7/23 at 3:54 p.m., indicated the resident's Power of Attorney (POA) wanted hospice to complete the treatment. She indicated facility staff should not have been signing out the treatment if they didn't complete it.<br><br>The hospice notes for the month of June 2023 identified the area as a stage 2 coccyx wound. There were no weekly wound measurements.<br><br>Additional interview with the DON at 5:30 p.m., indicated measurements were not done weekly because hospice was taking care of the wound per the POA's request. She indicated that should have been documented in the nursing progress notes.<br><br>This Federal tag relates to Complaint IN00412151.<br><br>3.1-40(a)(2) | | 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>Nursing staff were re-educated on ensuring that wound assessments, including wound measurements, are completed and documented every 7 days. Staff were also re-educated related to the nee have a care plan for all pressure ulcers.<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 to review wound documentation, twice weekly for 4 months, to ensure that assessments, including measurements are being completed and documented every 7 days. DON/Designee will also ensure that all residents with pressure ulcers have care plans.<br><br>manager/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. | |

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| | | | Date by which systemic corrections will be completed: 7/24/2023 | |
| F 0690<br>SS=D<br>Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal | | | |

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| | incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. | | | |
| | Based on observation and interview, the facility failed to ensure a resident with a history of urinary tract infections (UTI) received appropriate treatment and services for a foley catheter related to a catheter drainage bag located on the floor and catheter care orders not obtained timely for 2 of 3 residents reviewed for foley catheters. (Residents G and L)<br><br>Findings include:<br><br>1. On 7/5/23 at 10:10 a.m. and 11:50 a.m., Resident G was observed lying on his bed. His catheter drainage bag was noted to be sitting on the floor near the window. The tubing contained yellow urine with no sediment noted.<br><br>Resident G's record was reviewed on 7/5/23 at 11:41 a.m. Diagnoses included, but were not limited to, cerebral palsy, hydronephrosis (excess fluid in the kidney), and history of urinary tract infection (UTI).<br><br>The Admission Minimum Data Set (MDS) assessment, dated 6/22/23, indicated the resident was severely cognitively impaired. The resident required total dependence with one person physical assist for bed mobility, toilet use, and bathing. He had an indwelling catheter and an ostomy.<br><br>A Care Plan, dated 7/5/23, indicated the resident had a foley catheter and left nephrostomy tube. Interventions included, but were not limited to, | F 0690 | 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>F690 Bowel/Bladder Incontinence, Catheter, UTI<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Residents G was and no adverse effects related to foley catheter bag touching the floor. Foley Catheter bag immediately changed.<br><br>Resident L- was assessed and no adverse effects were noted related to catheter care orders not being in place and catheter care was provided.<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; | 07/24/2023 |

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| | check tubing for kinks routinely each shift and position catheter bag and tubing below the level of the bladder and away from the entrance room door.<br><br>Interview with the Director of Nursing on 7/5/23 at 3:19 p.m., indicated the catheter bag should not be touching the floor.<br><br>The facility policy titled "Urinary Catheter Care" was provided by the Administrator on 7/6/23 at 4:41 p.m. The policy indicated urinary drainage bags and tubing shall be positioned to prevent touching the floor directly.2. On 7/5/23 at 12:15 p.m., Resident L was observed in his wheelchair seated near the lobby. The resident had a foley catheter in place.<br><br>The record for Resident L was reviewed on 7/5/23 at 2:27 p.m.<br><br>Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder and dependence on renal dialysis.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/2/23, indicated the resident was cognitively intact and he had an indwelling catheter.<br><br>The current Care Plan, indicated the resident required an indwelling urinary catheter related to end stage renal disease and neuromuscular dysfunction of the bladder. Interventions included, but were not limited to, avoid obstruction in drainage, change the catheter per the Physician's order, position drainage bag below the level of the bladder, and report signs and symptoms of urinary tract infection (UTI). | | All residents who have foley catheters 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>Clinical Staff were in- on ensuring catheter care is provided according to the physician order and resident plan of care and that foley catheter bags should not touch the floor.<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 foley catheters weekly to ensure that catheter care is being performed according to physician orders and plan of care and that foley bags are not touching the floor.<br><br>The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. | |

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| | A Physician's Order, dated 6/23/23, indicated the resident was to have a 14 French Coude catheter with a 10 cc (cubic centimeter) bulb. The catheter was to be changed as needed for blockage.<br><br>A Physician's Order, dated 7/5/23, indicated the resident was to have catheter care every shift.<br><br>Interview with the Director of Nursing (DON) on 7/6/23 at 4:41 p.m., indicated the resident was readmitted from the hospital on 6/23/23 and the orders for catheter care were not carried over.<br><br>This Federal tag relates to Complaint IN00411679.<br><br>3.1-41(a)(2) | | Monitoring will be on going.<br><br>Date by which systemic corrections will be completed: 7/24/2023 | |
| F 0693<br>SS=D<br>Bldg. 00 | 483.25(g)(4)(5)<br>Tube Feeding Mgmt/Restore Eating Skills<br>§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, | | | |

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| | 155469 | A. BUILDING 00<br>B. WING | 07/06/2023 |

| 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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| | dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>Based on record review and interview, the facility failed to ensure gastrostomy tube site orders were obtained for cleansing for 1 of 3 residents reviewed for gastrostomy tubes. (Resident D)<br><br>Finding includes:<br><br>The closed record for Resident D was reviewed on 7/5/23 at 1:58 p.m. The resident was admitted to the facility on 5/26/23. Diagnoses included, but were not limited to, displaced fracture of the fifth and sixth cervical vertebra, gastrostomy status (an opening into the stomach from the abdominal wall for feeding), and dysphagia (difficulty swallowing).<br><br>The Admission Minimum Data Set (MDS) assessment, dated 6/2/23, indicated the resident was cognitively intact and he required supervision with eating.<br><br>There was no care plan related to the resident's gastrostomy tube site.<br><br>A Physician's Order, dated 5/18/23, indicated the gastrostomy tube was to be flushed every shift with 100 cc's (cubic centimeters) of water. There were no orders for care to the gastrostomy site.<br><br>Nurses' Notes, dated 6/26/23 at 2:21 p.m., indicated the Physician and the resident's family were at the bedside. The family reported the gastrostomy tube was infected and requested the resident be sent to the emergency room. Orders were received and the resident was transported to the emergency room for evaluation. There was no documentation in the Nurses' Notes or on the eINTERACT transfer form of what the | F 0693 | 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>The Facility respectfully requests Paper Compliance for this survey.<br><br>F693 Tube Feeding Management/Restore Eating Skills<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Resident D is no longer 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 peg tubes 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; | 07/24/2023 |

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| | gastrostomy site looked like.<br><br>Interview with the Director of Nursing (DON) on 7/6/23 at 4:13 p.m., indicated that she and the Physician assessed the tube site and no redness or infection was noted. The resident was sent to the emergency room based on the family's request. The resident returned to the facility that evening with the gastrostomy tube in place. He was treated for constipation and not a tube site infection. The DON indicated the assessment should have been documented and the resident should have had orders for gastrostomy tube site care.<br><br>The facility policy titled, "Gastrostomy/Jejunostomy Site Care" was received from the Administrator on 7/6/23 at 4:41 p.m. The policy indicated site care was to be completed using gauze pads and soap and water. The area surrounding the tube was to be gently cleansed in an outward circular motion. Pat dry after cleansing and do not place a dressing over the site unless otherwise ordered.<br><br>This Federal tag relates to Complaint IN00411679.<br><br>3.1-44(a)(2) | | Clinical staff were re-educated on the need to have a physician order to clean the peg tube site, of residents who have a peg tube, daily.<br><br>Clinical staff were re-educated on the need to have a care plan for the care of all residents who have a peg tube.<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>manager will audit all peg tube orders 3X per week, for 4 months, to ensure that all residents who have peg tubes have an order to clean the peg tube site daily and a care plan for the care of the peg tube.<br><br>DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.<br><br>Date by which systemic corrections will be completed: | |

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| | | | 7-24-23 | |
| F 0921<br>SS=D<br>Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on random observations and interview, the facility failed to keep the residents' environment clean and in good repair related to marred walls, hard water stains on faucets, tiles lifting, trash cans with no garbage bag, dirty floors, and trim falling off of the walls for 2 of 5 units. (Apple Lane and Cherry Court)<br><br>Findings include:<br><br>1. During random observations on Apple Lane, the following was observed:<br><br>a. On 7/6/23 at 1:59 p.m., Room 20 bed 1 was observed. The resident's family was at the beside and the room was clean, the resident's sister said they just swept the floor and cleaned up because the floors were dirty with dried wipes, crumbs, and trash. The bathroom faucet had hard water stains and the sink was dirty. There was no garbage bag in the garbage can next to the resident's bed. There were two residents in the room.<br><br>b. On 7/6/23 at 2:09 p.m., Room 23 bed 1 was observed. The trim behind the resident's bed was loose. The wall behind bed 2 was marred, and a tile was lifting off of the floor under the air conditioner. There were two residents who resided in the room. | F 0921 | 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>The Facility respectfully requests paper compliance for this survey.<br><br>F921<br>Safe/Functional/Sanitary/Comfortable Environment<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Room sink was and trash bag placed in garbage can.<br><br>Trim, floor tile and marred walls repaired in room 23.<br><br>Room 32 floors were cleaned.<br><br>How the facility will identify other residents having the potential to | 07/24/2023 |

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| | 2. During random observations on Cherry Court, the following was observed:<br><br>a. On 7/6/23 at 2:14 p.m., Room 32 was observed with dirty floors. There were two residents residing in the room.<br><br>Interview with the Maintenance Supervisor on 7/6/23 at 2:33 p.m., indicated he was aware the walls were marred and needed to be repainted. He said Blueberry Hall was just remodeled and Cherry Hall was next.<br><br>This Federal tag relates to Complaint IN00411679.<br><br>3.1-19(f) | | be affected by the same deficient practice and what corrective action will be taken;<br><br>All residents 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>Staff were re-educated on the procedure of notifying maintenance/environmental services of any necessary repairs/cleaning needed.<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>Environmental services supervisor/Maintenance department/ will audit 10 rooms per week on alternating units for Environmental/cleaning issues and maintenance issues. Any identified issues will be corrected.<br><br>/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing | |

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| | | | 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: 7/24/2023 | |