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 B. WING	04/19/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00399022, IN00399243, IN00399594, IN00403395, IN00403601, IN00404937, IN00405500, IN00405595, and IN00406294. Complaint IN00399022 - Federal/State deficiencies related to the allegations are cited at F692. Complaint IN00399243 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00399594 - Federal/State deficiencies related to the allegations are cited at F550. Complaint IN00403395 - Federal/State deficiencies related to the allegations are cited at F686 and F690. Complaint IN00403601 - Federal/State deficiencies related to the allegations are cited at F624 and F684. Complaint IN00404937 - Federal/State deficiencies related to the allegations are cited at F686 and F692. Complaint IN00405500 - Federal/State deficiencies related to the allegations are cited at F609. Complaint IN00405595 - No deficiencies related to the allegations are cited. Complaint IN00406294 - Federal/State deficiencies related to the allegations are cited at F624 and F804. Survey dates: April 18 and 19, 2023	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Craig Clemons	Administrator	05/04/2023

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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	Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 10 Medicaid: 65 Other: 21 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/21/23.			
F 0550 SS=B Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of			

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	diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on record review and interview, the facility failed to ensure registered voters residing in the facility had the opportunity to vote in the last general election. This had the potential to affect 25 of 25 registered voters residing in the facility. (Resident D) Finding includes: Interview with Resident D on 4/18/23 at 12:00 p.m., indicated he was not offered to vote in the election last year. The record for Resident D was reviewed on 4/18/23 at 1:30 p.m. Diagnoses included, but were not limited to, type 2 diabetes and high blood pressure.	F 0550	F550 Residents Rights/Exercise of Rights 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.	05/09/2023

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	The 3/13/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. Interview with the Activity Director on 4/18/23 at 1:30 p.m., indicated the last time anyone was there for the residents to vote was April 2022. She indicated the travel board sent out the packet for the residents to vote and it arrived late to the facility for the election in November 2022, therefore the residents didn't get to vote. When she contacted the board about the packet being late, they indicated some other facilities had that issue as well but nothing could be done since it was well after the election. The Activity Director provided a list of 25 registered voters currently residing in the facility. This Federal tag relates to Complaint IN00399594. 3.1-3(a)(1)		Immediate action taken for those residents identified? Resident D was registered to vote. How the facility identified other residents? All residents who were registered to vote had the potential to be affected by this deficient practice. Measures put into place/System changes? The Activity Director was re-educated on the importance of residents' rights to include the right to vote. The Administrator/ Designee will be responsible for validating that registered voters have the opportunity to vote. How will the corrected actions be monitored? The Administrator or Designee will complete an audit of registered voters quarterly to ensure that they have the opportunity to vote. The Administrator is responsible for compliance of this deficiency. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 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. Date of Compliance: 05/09/2023	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of			

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	abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure an allegation of physical abuse was reported timely to the State Survey Agency for 1 of 3 allegations of abuse reviewed. (Resident R) Finding includes: The record for Resident R was reviewed on 4/19/23 at 10:25 a.m. Diagnoses included, but	F 0609	F609 Reporting of Alleged Violation 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	05/09/2023

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	were not limited to, chronic obstructive pulmonary disease (COPD) and anxiety disorder. The Annual Minimum Data Set (MDS) assessment, dated 3/1/23, indicated the resident was moderately impaired for daily decision making. A Behavior Note, dated 4/8/23 at 7:53 p.m., indicated the resident claimed someone hit her in her head after receiving medication from the writer while her eyes were closed. The resident indicated someone came in behind the writer. No one entered the room after the writer left the room. The resident was resting comfortably in bed. She denied any pain at that time. Will continue to monitor. The next entry was a Psychosocial Note, dated 4/10/23 at 12:14 p.m. The entry indicated the Social Service Director (SSD) met with the resident on 4/10/23 to inquire about the incident that was reported over the weekend. The resident informed the SSD that she was fine and that she believed she was having a bad dream. The resident appeared to be in a happy mood and was not currently exhibiting any signs or symptoms at that time. SSD will continue to follow up. An Incident Report, dated 4/10/23, indicated it was discovered in a Nurses' Note, dated 4/8/23, that the resident notified a staff nurse that someone hit her in the head while her eyes were closed after her medication administration. The nurse stated in her note that no one entered the room after the nurse did. On 4/10/23, an investigation was initiated related to the allegation. The Physician and POA were made aware of the situation and had no concerns.		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: Investigation for allegation involving Resident (R) was completed without findings. Resident (R) Psychosocial assessment was completed and remains within baseline. 2) How the facility identified other residents: All the residents have the potential to be affected by this alleged practice. 3) Measures put into place/ System changes: Facility staff was re-educated on Abuse and Neglect Policy. Staff is to report all allegations immediately to Abuse Coordinator or Manager on duty. 4) How the corrective actions will be monitored: The Administrator or Designee will complete Abuse drills 1 time weekly for 4 weeks and monthly thereafter to ensure compliance with facility reporting guidelines. 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	

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	On 4/17/23, the investigation was complete. Interview with the resident indicated she was having a bad dream. Staff reported that no one came in the resident's room behind the nurse after administering her medications. Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/19/23 at 10:37 a.m., indicated during the investigation it was determined the resident had a bad dream. Follow up interview with the ADON on 4/19/23 at 11:55 a.m., indicated the incident happened on the weekend and when she came in on Monday she ran a 72 hour report for all the residents and that was when she found the documentation regarding the alleged physical abuse. The nurse who documented the incident has already been inserviced regarding abuse and reporting. This Federal tag relates to Complaint IN00405500. 3.1-13(g)(1) 3.1-28(c)		Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 05/09/2023	
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on record review and interview, the facility failed to ensure a resident was provided education related to medication use prior to discharge for 1 of 3 residents reviewed for discharge planning.	F 0624	F 624 Preparation for Safe/Orderly/Discharge The facility requests paper compliance for this citation.	05/09/2023

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	(Resident K) Finding includes: The closed record for Resident K was reviewed on 4/19/23 at 11:39 a.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, chronic kidney disease, major depressive disorder, bipolar, anxiety, and hypertensive kidney disease. The resident was discharged from the facility on 4/8/23. The Quarterly Minimum Data Set (MDS) assessment, dated 3/28/23, indicated the resident was cognitively intact and had received insulin injections, antipsychotics, antidepressants, and opioids within the last 7 days. A Physician's Order, dated 4/5/23, indicated it was okay to discharge the resident home and home health was to evaluate and treat. A Nurses' Note, dated 4/7/23 at 2:14 p.m., indicated the resident was discharging home with her daughter. The resident was educated on how to check her blood sugar and a return demonstration had been completed. There was no further documentation related to medication education. A Nurses' Note, dated 4/8/23 at 1:58 p.m., indicated the resident was discharged. There was no other documentation in the entry. The Discharge Planning Review, dated 4/5/23 at 9:13 a.m., indicated the resident's medications were sent with her. Interview with the Assistant Director of Nursing on 4/19/23 at 3:15 p.m., indicated the resident was		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 K no longer resides in the facility. 2) How the facility identified other residents: All residents who discharge have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: Licensed nurses will be re-educated on the discharge policy to include resident education. 4) How the corrective actions will be monitored: The Director of Nursing or Designee will audit discharges 5 days a week during clinical meeting for 4 weeks then two times a week thereafter to ensure that the discharge/transfer paperwork is complete, and education was included. The Director of Nursing is responsible for compliance of this deficiency.	

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	discharged on 4/8/23. She also indicated the resident was discharged with her medications, however, there could have been more documentation related to medication administration education. This Federal tag relates to Complaints IN00403601 and IN00406294. 3.1-12(a)(3)		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: 05/09/2023	
F 0684 SS=E 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 treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure neurological checks were initiated following a fall for 2 of 3 residents reviewed for falls. The facility also failed to ensure transportation was provided for appointments and an ongoing assessment as well as timely treatment was completed related to leg edema for 2 of 3 residents reviewed for a change in condition. (Residents N, C, M, and F) Findings include: 1. The record for Resident N was reviewed on 4/19/23 at 1:45 p.m. Diagnoses included, but were not limited to, hemiplegia (muscle weakness) following a stroke, history of traumatic brain	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.	05/09/2023

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	injury, and vascular dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 2/28/23, indicated the resident was cognitively intact. The resident required moderate assist with bed mobility and transfers. He had one fall with an injury (not major) since the last assessment. A Fall Interdisciplinary Team (IDT) Progress Note, dated 4/14/23 at 5:00 p.m., indicated the resident was found on the floor in his room on his right side in a cradle position. The resident indicated he slipped from his chair. He had an open area to the right eye/eyebrow area with a moderate amount of blood noted. The Physician was notified and orders were obtained to send the resident to the emergency room for evaluation. The resident returned to the facility at 10:18 p.m. with 4 sutures to the right eye/eyebrow area. A Physician's Order, dated 4/14/23, indicated the resident was to have sutures removed from his right eye/eyebrow in 7 days. The area was to be monitored for infection every shift. The Neuro Check Assessment, dated 4/14/23, indicated an initial neuro check was completed, 15 minute checks were completed times 3, and a 30 minute neuro check was completed once. There was no further documentation on the assessment sheet. Interview with the Assistant Director of Nursing on 4/19/23 at 3:15 p.m., indicated the neuro checks should have been resumed when the resident returned from the hospital. 2. The closed record for Resident C was reviewed on 4/18/23 at 2:10 p.m. Diagnoses included, but were not limited to,		1) Immediate actions taken for those residents identified: 1. Resident N was assessed with no negative findings related to neuro checks not being completed as ordered. 2. Resident G no longer resides in the facility. 3. Resident M no longer resides in the facility. 4. Resident F no longer resides in the facility. 3) Measures put into place/ System changes: Staff will be re-educated on following the facility fall protocol, the importance of making sure that residents make it to scheduled appointments and that treatments are followed up timely. 4) How the corrective actions will be monitored: During clinical meeting 5 days a week the Director of Nursing or designee will review falls to ensure that appropriate assessments are completed, review documentation to ensure that treatment and services are rendered timely and that transportation for residents' appointments are made and that the resident went to the appointment. The Director of Nursing is responsible for the compliance of this deficiency. 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	

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	breast cancer, anemia, gastro-esophageal reflux disease (GERD), and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 11/15/22, indicated the resident was cognitively intact. Nurses' Notes, dated 10/31/22 at 7:00 a.m., indicated results were received from the resident's KUB (a kidney, ureter, and bladder x-ray) and abdominal imaging studies. The results were sent to the Nurse Practitioner (NP) and she gave orders to have the resident sent to the emergency room for evaluation of a possible abdominal fistula and pelvic mass. The resident returned to the facility on 11/5/22. Nurses' Notes, dated 11/8/22 at 11:19 a.m., indicated the resident had an oncology appointment for 11/14/22 at 3:00 p.m. and transportation had been arranged. The resident and her daughter had been made aware. At 11:37 a.m., documentation indicated the resident's oncology appointment had been rescheduled for 11/9/22 at 2:30 p.m. Staff were attempting to coordinate transportation for the appointment. There were no Nurses' Notes dated 11/9/22 indicating the resident left for her appointment. A Nurses' Note, dated 11/11/22 at 12:57 p.m., indicated the resident was scheduled for surgery on 12/2/22 at 10:30 a.m. Bowel prep would need to be completed prior to the surgery. A Nurses' Note, dated 12/2/22 at 9:00 a.m., indicated a nurse who worked at the hospital where the resident was having surgery was informed the resident had been NPO (nothing by mouth), had received the ordered prep for surgery,		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: 05/09/2023	

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	and she was waiting on transportation. Transportation had not arrived and the resident had the potential of having to reschedule the surgery. The resident's daughter was waiting for her at the receiving facility and was aware of the concern with transportation. The Physician was notified as well. The writer attempted to schedule alternate transportation who informed the writer there were no availabilities. In addition, another transport company was contacted and 1:30 p.m. was the only time available. The nurse at the hospital was informed of this and indicated the resident would need to reschedule. At 12:33 p.m., the resident's daughter was at the facility and information regarding the surgery and transportation was reiterated. The resident's daughter requested to speak with the Administrator at that time. Nurses' Notes, dated 12/6/22 at 10:10 a.m., indicated the outpatient surgery center was contacted to discuss rescheduling the resident's surgery. The surgery center instructed the facility to contact the resident's physician. At 10:13 a.m., the Physician's office was contacted about rescheduling the surgery and they indicated they would call the facility back. At 11:16 a.m., the nurse from the Physician's office contacted the facility about rescheduling the surgery. The Physician wanted clarification on why the appointment was missed on 12/2/22 and it was explained to them that it was a transportation issue that was out of their hands. The nurse at the Physician's office indicated they would see what they could do and get back to the facility. Nurses' Notes, dated 12/9/22 at 1:58 p.m., indicated the resident's surgery had been rescheduled for 12/16/22 at 11:00 a.m. and she would need to be at the hospital at 8:00 a.m. The			

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CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

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resident would also need to complete the bowel prep again prior to surgery. Transportation was arranged at that time.

The resident left the facility on 12/16/22 for her surgery and she did not return afterwards.

Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 4/19/23 at 10:37 a.m., indicated the resident did not get to her appointment on 11/9/22 due to transportation issues, however, there was no documentation in the nursing notes to disclose that information. The resident went out to the physician's office on 11/11/22 and surgery was scheduled for 12/2/22. The ADON indicated transportation was set up with (name of transport company) due to her payor source and they did not show up that day. She indicated they called other transportation companies and were not able to get her a ride to the surgery that day. The ADON indicated there was no documentation in nursing notes which indicated the resident missed her appointment on 11/9/22 due to transportation issues, and there was no documentation the resident even left the facility for the appointment on 11/11/22.

3. The closed record for Resident M was reviewed on 4/19/23 at 8:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, cellulitis of the left lower limb, gangrene, neuropathy, and end stage renal disease. The resident was admitted to the facility on 1/26/23 and discharged on 2/16/23.

The Admission Minimum Data Set (MDS) assessment, dated 2/2/23, indicated the resident was cognitively intact.

Nurses' Notes, dated 1/27/23 at 2:51 a.m., indicated

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the resident had a wound vacuum present to her left foot due to gangrene and partial amputation of her foot. The wound vac could be removed and discarded on 1/30/23.

Nurses' Notes, dated 2/10/23 at 3:20 p.m., indicated the resident was having pain and swelling to her left lower extremity. The Physician was made aware and orders were received for a STAT (immediate) doppler (a test to rule out a blood clot) and x-ray to the left lower extremity. The resident was made aware of the orders.

Physician's Orders, dated 2/10/23, indicated the resident was to have a doppler of the left lower extremity STAT due to swelling and an x-ray of the left lower leg.

The left femur and knee x-ray was completed on 2/11/23 and the left leg doppler was completed on 2/13/23.

There was no further documentation in the Nurses' Notes after 2/10/23 related to the swelling and pain in the left lower leg.

There was also no documentation of the Physician being notified the x-ray and doppler were not completed STAT as ordered.

A Radiology Note, dated 2/13/23 at 8:51 a.m., indicated the radiology results from 2/11/23 had been reviewed and discussed with the Physician, no new orders were obtained at that time. The resident and her family were made aware.

Interview with the Assistant Director of Nursing (ADON) on 4/19/23 at 10:37 a.m., indicated there was no documentation in the Nurses' Notes regarding the pain and swelling after 2/10/23. She

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	indicated the contracted x-ray company could not get anyone to the facility for the STAT views of the leg and the doppler on 2/10/23, they had 4 hours for a STAT procedure to be completed, and there was no documentation of the Physician being notified the x-ray and doppler were not completed STAT as ordered.4. Resident F's closed record was reviewed on 4/18/23 at 11:51 a.m. The resident admitted to the facility on 1/24/23 and discharged on 2/24/23. The diagnoses included, but were not limited to, hemiplegia/hemiparesis (one sided muscle weakness) following stroke and heart disease with heart failure. The Discharge Minimum Data Set (MDS) assessment, dated 2/24/23, indicated the resident's memory was ok, and he had modified independence for making decisions regarding tasks of daily life. He required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. A Post Fall Observation, dated 2/21/23 at 2:45 p.m., indicated the resident had an unwitnessed fall in his room. The resident stated he was sitting in the wheelchair and was reaching for his urinal but lost his balance and fell out of his wheelchair. A Neuro Check Assessment, dated 2/21/23 at 2:40 p.m., was initiated with vital signs and checks completed for initial, 3-15 minute checks, 2-30 minute checks, 6-1 hour checks, and 2 shifts. The last four shifts were left incomplete. Interview with the Assistant Director of Nursing on 4/19/23 at 11:39 a.m., indicated the neuro checks should have been completed. This Federal tag relates to Complaints IN00399243 and IN00403601.			

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	3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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 record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services related to following updated Physician's Orders for 2 of 3 residents reviewed for pressure ulcers. (Residents E and G) Findings include: 1. Resident E's closed record was reviewed on 4/18/23 at 9:39 a.m. The resident was admitted to the facility on 11/8/22 and discharged on 1/2/23. The diagnoses included, but were not limited to, dementia without behavioral disturbance, heart failure, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 11/23/22, indicated the resident was severely cognitively impaired. She required	F 0686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer 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. Immediate actions taken for those residents identified:	05/09/2023

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	extensive assistance for bed mobility and toilet use and required total dependence with two persons physical assist for transfers. A Physician's Order, dated 12/2/22, indicated to clean the coccyx wound with normal saline, pat dry, and apply calcium alginate to the wound bed and cover with a foam dressing every Monday, Wednesday, Friday, and as needed. A Wound Care Note, dated 12/21/22, indicated the resident had an unstageable full thickness coccyx wound that measured 3.0 x 3.0 x 5.0 centimeters with moderate purulent exudate (white, yellow, or brown fluid that could be a sign of infection) and 75% granulation tissue. The treatment plan included the application of santyl ointment mixed with a 1 to 1 ratio of mupiricin (antibiotic) ointment. Interview with the Assistant Director of Nursing on 4/19/23 at 11:39 a.m., indicated the treatment orders were not updated per the treatment plan from the wound care doctor on 12/21/22. 2. Resident G's closed record was reviewed on 4/18/23 at 2:07 p.m. He was admitted to the facility on 12/19/22 and discharged on 1/10/23. The diagnoses included, but were not limited to, fracture of the right femur, arthritis, stroke, and heart failure. The Discharge Minimum Data Set (MDS) assessment, dated 1/12/23, indicated the resident's memory was okay and he was independent in regards to making decisions for tasks of daily life. He required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene. He had 1 unstageable pressure ulcer due to coverage of the wound bed by slough and/or eschar that was		Resident E no longer resides in the facility. Resident G no longer resides in the facility. 2) How the facility identified other residents: All residents who have pressure areas have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: Staff will be re-educated on the importance of ensuring that residents treatment orders are updated to reflect the current physicians' orders. 4) How the corrective actions will be monitored: Director of Nursing or designee will review wound care documentation 5 days a week during the clinical meeting for 4 weeks then two times a week thereafter to ensure that all wound care orders have been updated. The Director of Nursing is responsible for compliance of this deficiency. 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: 05/09/2023	

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present upon admission/entry or reentry.

A Physician's Order, dated 12/20/22, indicated to cleanse the coccyx wound with normal saline, pat dry, apply hydrafera blue to the wound bed, and cover with a dry dressing every Monday, Wednesday, Friday, and as needed for soiled or dislodged dressings.

A Wound Care Note, dated 12/21/22, indicated the resident had an unstageable deep tissue injury (DTI - a purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear) to the coccyx measuring 3.0 x 1.5 centimeters. The treatment plan included a gauze island dressing with border gauze, apply three times per week for 30 days and discontinue the hydrafera blue (a wound dressing).

A Wound Care Note, dated 1/12/23, indicated the resident had an unstageable DTI to the coccyx measuring 5.5 x 4.0 x 3.0 centimeters with moderate serous exudate, 20% necrotic tissue, 20% slough, 30% granulation tissue and it had deteriorated since the last assessment. The treatment plan included santyl application once daily for 30 days with aliginate calcium once daily for 30 days with a bordered gauze dressing applied.

Interview with Assistant Director of Nursing on 4/19/23 at 11:39 a.m., indicated the hydrafera blue order was not updated and discontinued on 12/21/22 per the Wound Care Note.

This Federal tag relates to Complaints IN00403395 and IN00404937.

3.1-40(a)(2)

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (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 (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. §483.25(e)(3) For a resident with fecal 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 record review and interview, the facility failed to ensure residents with urinary tract infections (UTI) received the necessary treatment	F 0690	F690 Bowel/Bladder Incontinence, Catheter, UTI The facility requests paper	05/09/2023

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	and services related to prompt treatment for 1 of 3 residents reviewed for urinary tract infections. (Resident P) Finding includes: Resident P's record was reviewed on 4/19/23 at 10:11 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, vascular dementia without behavioral disturbance, and chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/23, indicated the resident was cognitively intact for daily decision making. She required limited assistance with one person physical assist for bed mobility, transfers, and toilet use. She was occasionally incontinent of bladder and always continent of bowel. A Nurses' Note, dated 1/5/23 at 10:19 a.m., indicated the Infectious Disease Nurse Practitioner ordered Ertapenem Sodium solution (IV antibiotic) for treatment for a UTI and discontinued the order for Keflex (an antibiotic). A Nurses' Note, dated 1/5/23 at 7:44 p.m., indicated the pharmacy was going to deliver the Ertapenem Sodium solution during the scheduled evening delivery time. A Nurses' Note, dated 1/6/23 at 12:00 p.m., indicated the pharmacy delivered the Ertapenem Sodium solution and the infusion would be started at bedtime. A Physician's Order, dated 1/5/23, indicated Ertapenem Sodium solution (antibiotic) reconstituted 1 gram intravenously at bedtime for ten days.		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 P assessed with no negative outcome and the physician was notified of the missed doses of antibiotic therapy. 2) How the facility identified other residents: All residents who receive antibiotics have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: Licensed staff will be re-educated on the policy and procedures for assuring that medications are available for the residents to prevent a delay in treatment. 4) How the corrective actions will be monitored: During the clinical meeting the Director of Nursing or designee will review documentation 5 days a week for 4 weeks then two times a week thereafter to ensure that the	

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	The January 2023 Medication Administration Record (MAR), indicated the Ertapenem medication was not marked as administered on 1/5/23, 1/9/23, 1/12/23, and 1/13/23 at 9:00 p.m. Interview with the Assistant Director of Nursing on 4/19/23 at 1:56 p.m., indicated the order for the antibiotic was put in on the night shift of 1/5/23, however, the pharmacy would not run it that late so she had called it in as a stat medication and it was delivered on 1/6/23. The resident missed the dose on 1/9/23 due to insurance reasons and there was not a follow-up, which should have occurred. They should have continued the medication for the full 10 doses. This Federal tag relates to Complaint IN00403395. 3.1-41(a)(2)		residents receive medications as ordered. The Director of Nursing is responsible for compliance of this deficiency. 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: 05/09/2023	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (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- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake			

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	to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure a fluid restriction was followed per Physician's Orders related to fluid intake monitoring not documented for 1 of 3 residents reviewed for hydration. (Resident G) Finding includes: Resident G's closed record was reviewed on 4/18/23 at 2:07 p.m. He was admitted to the facility on 12/19/22 and discharged on 1/10/23. The diagnoses included, but were not limited to, fracture of the right femur, arthritis, stroke, and heart failure. The Discharge Minimum Data Set (MDS) assessment, dated 1/12/23, indicated the resident's memory was okay and he was independent in regards to making decisions for tasks of daily life. A Physician's Order, dated 12/20/22, indicated a 1500 cc (cubic centimeter) fluid restriction with a total of 780 cc for nursing daily (330 cc for day shift, 330 cc for evening shift, and 120 cc for night shift). The December and January Medication Administration Record (MAR) indicated the following: - 12/23/22: 120 cc were consumed on day shift, 700 cc on evening shift, and there was no documentation for the night shift -12/25/22: there was no documentation for night shift fluid consumption - 1/2/23: 780 cc were consumed on the day shift,	F 0692	F692 Nutrition/Hydration Status Maintenance 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: 1. Resident G no longer resides in the facility. 2) How the facility identified other residents: All residents who have an order for a fluid restriction in the facility have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: Staff will be re-educated on the importance of documenting and following residents' orders for a fluid restriction. 4) How the corrective actions will be monitored:	05/09/2023

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	330 cc on evening shift, and 120 cc on night shift. Interview with the Assistant Director of Nursing on 4/19/23 at 11:39 a.m., indicated the fluid intakes were not completed for each meal. This Federal tag relates to Complaints IN00399022 and IN00404937. 3.1-46(b)		The DON or designee will audit documentation for meal and fluid consumption to ensure that it is completed and accurate 5 days a week for 4 weeks then two times a week thereafter during the clinical meeting. The Director of Nursing is responsible for compliance of this deficiency. 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: 05/09/2023	
F 0804 SS=C Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.			
	Based on observation, record review, and interview, the facility failed to ensure food temperatures were documented for 1 of 1 meals observed. This had the potential to affect the 93 of 96 residents who received their food from the	F 0804	F804 Nutritive Value/Appear. Palatable/Prefer Temp The facility requests paper compliance for this citation. This Plan of Correction is the	05/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	kitchen. Finding includes: On 4/19/23 at 11:52 a.m., the lunch meal was being served from the steam table in the kitchen. At that time, the Dietary Food Manager (DFM) was asked to see the food temperatures that were taken prior to the start of the tray line. She proceeded to look through the binder that contained the food temperatures. The sheet dated 4/19/23 was blank. The DFM proceeded to ask Cook 1 where the temperatures were and the Cook indicated they were in her car and she wrote them down while she was on her break. The Cook left the kitchen and indicated she needed to go to her car, when she returned several minutes later, she had the temperatures written on a piece of paper. The temperatures were only for lunch and there was no documentation in the binder or on the sheet of paper of breakfast temperatures. Interview with the DFM at that time, indicated the food temperature sheets were to be kept in the binder. This Federal tag relates to Complaint IN00406294. 3.1-21(a)(2)		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: No residents were actually harmed due to food temperature logs not being completed. 2) How the facility identified other residents: No residents were affected by this alleged deficient practice 3) Measures put into place/ System changes: The Dietary Food Manager was re-educated on the importance of completing the food temperature logs in a timely manner. 4) How the corrective actions will be monitored: The administrator will audit the food temperature logs 3 times a week for 3 weeks then then 2 times a week for 2 weeks, then weekly until substantial compliance is met. The administrator is responsible for compliance of this deficiency. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or	

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	04/19/2023

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			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: 05/09/2023	