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	01/29/2025

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00450254, IN00450652, and IN00451800. Complaint IN00450254 - Federal/State deficiencies related to the allegations are cited at F677, F686 and F921. Complaint IN00450652 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00451800 - Federal/State deficiencies related to the allegations are cited at F677 and F921. Survey dates: January 21, 22, 23, 24, 27, 28, and 29, 2025 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 4 Medicaid: 67 Other: 18 Private: 3 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Casa of Hobart (“the provider”) submits this Plan of Correction (“POC”) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1)are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (“CMS”), the state of Indiana or any other entity; or (2) to serve, in any way to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Falon Wendel	RN, DON	02/16/2025

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	Quality review completed on 2/5/25.		inadmissible in any proceeding on that basis. The provider offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The provider respectfully requests a desk review of the following plans of correction.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure a resident was assessed to self-administer medications and had Physician's Orders to self-administer for 1 of 1 resident reviewed for self-administration of medication. (Resident G) Finding includes: During random observations on 1/21/25 at 11:28 a.m. and 2:56 p.m., on 1/22/25 at 9:45 a.m., 1:31 p.m. and 3:10 p.m., and on 1/23/25 at 5:45 a.m., an Albuterol hand-held inhaler was observed on Resident G's over bed table. During an interview on 1/21/25 at 11:30 a.m., the resident indicated she used the inhaler for rescue breathing at least daily. The record for Resident G was reviewed on 1/22/25 at 4:23 p.m. Diagnoses included, but were not limited to COPD (Chronic Obstructive Pulmonary Disease), acute respiratory failure, Alzheimer's disease, anxiety disorder, high blood	F 0554	**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.** **F554 Resident Self Admin Meds-Clinically Appropriate** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **A self-administration assessment was completed for Resident G, she was deemed appropriate to self administer medications. MD was notified and an order was received to self-administer PRN albuterol inhaler. Care plan was updated.** How the facility will identify other	02/25/2025

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	pressure, and bipolar disorder. The 11/14/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident's vision was adequate and she wore glasses. A Care Plan, revised on 5/14/24, indicated the resident was at risk for complications including shortness of breath experienced while lying flat and upon exertion secondary to COPD. The approaches were to administer aerosol or bronchodilators as ordered. A Physician's Order, dated 8/19/24, indicated Albuterol Sulfate HFA Inhalation Aerosol Solution 108, administer inhale one puff orally every 6 hours as needed for wheezing. There was no self-administration assessment or a physician's order for the resident to self-administer her own inhaler. During an interview on 1/23/25 at 10:05 a.m., the Director of Nursing had no additional information to provide. The current 2/15/21 "Self-Administration of Medications-Clinically Appropriate" policy, provided by Nurse Consultant 1 on 1/23/25 at 11:45 a.m., indicated a resident may only self-administer medications after the IDT has determined which medications may be self-administered. The IDT will determine at a minimum if the resident had the capacity to follow directions, the resident's cognitive status was evaluated, and the resident's ability to understand and store medication securely. 3.1-11(a)		residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **All facility residents with medication orders have the potential to be affected by the same alleged 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 educated on self-administration of medications policy, with emphasis on not to leave medications at the residents' bedside unless an assessment and order for self-administration have been completed.** **Respiratory Therapist reviewed residents with PRN rescue inhalers and assessed if self-administration is appropriate.** 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; **Facility Angel's will audit 5 residents 2 days per week for 6 months to ensure no medication is improperly stored at the bedside and any medication noted at bedside has an assessment and order for self-administration.**	

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			The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. - - - - **F554 Resident Self Admin Meds-Clinically Appropriate** **Facility Angel's will audit 5 residents 2 days per week for 6 months to ensure no medication is improperly stored at the bedside and any medication noted at bedside has an assessment and order for self-administration.** Resident Identifier Does resident have medication visible at bedside? Y/N If yes, does the resident have a self-administration assessment completed and an order for self-administration? Y/N If yes, is there a care plan for medication self-administration? Y/N	

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			Reviewed by: **_____** **___ Date_____** - -	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation and interview, the facility failed to ensure a resident's privacy was maintained related to a Nurse Practitioner (NP) completing an assessment of a peg tube (a tube inserted directly into the stomach for nutrition) in a common area for 1 of 1 resident reviewed for tube feeding. (Resident C) Finding includes:	F 0583	**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.** - **F583 Personal**	02/25/2025

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	During a random observation on 1/28/25 at 11:34 a.m., a CNA removed Resident C from the dining room when the lunch trays had arrived, due to the resident being NPO (nothing my mouth). The resident was placed in the hallway right outside of the room. At that time, an NP entered the memory care unit and asked the Infection Prevention Nurse for a pair of gloves. The NP donned the pair of gloves and lifted up the resident's shirt to observe the peg tube (a tube inserted directly into the stomach for nutrition) in the middle of the hallway. She did not take the resident to a private area to make her assessments. The resident's stomach and peg tube were exposed for all to see. The record for Resident C was reviewed on 1/27/25 at 2:03 p.m.. Diagnoses included, but were not limited to, peg tube, falls, dysphagia (difficulty swallowing), type 2 diabetes, palliative care, Parkinson's disease, psychotic disorder, severe dementia with agitation, high blood pressure, restlessness and agitation. The 12/24/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and was dependent on staff for most of his activities of daily living, including bathing. The resident had a feeding tube and received 51% or more of his nutrition through the tube and 501 cubic centimeters (cc) of fluids through the tube. During an interview on 1/28/25 at 11:50 a.m., the NP had no additional information to provide. During an interview on 1/28/25 at 4:15 p.m., the Director of Nursing indicated she had called the NP's physician supervisor and informed him of her concerns. She had no additional information to provide.		**Privacy/Confidentiality of Records** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident C remains in the facility, privacy has been maintained during care and assessments. No signs of psychosocial distress have been noted due to this alleged deficient practice.** 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 facility residents have the potential to be affected by the same alleged 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 and contracted providers were educated to not provide care, assessment and services in common areas to ensure that residents' privacy is maintained.** How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place. **DON/Designee will observe staff and contracted providers in 3 common areas/unit**	

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	3.1-3(p)(4)		**hallways twice weekly x 6 months to ensure resident's privacy is maintained during assessment and care.** **The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.** **-** **-** **-** **-** **-** **-** **-** **-** **-** **F583 Personal Privacy/Confidentiality of Records** **DON/Designee will observe staff and contracted providers in 3 common areas/unit hallways twice weekly x 6 months to ensure resident's privacy is maintained during assessment and care.** **Unit** **Were staff observed providing care and services in common areas?**	

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			Y/N **Were vendors, contracted staff, providers, providing care and services in common areas?** **Y/N** **Comments** - - - - - - - - - - - - - - **Reviewed by:** _____ _____**Date**_____ -	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances Based on record review, and interview, the facility failed to file a grievance form, thoroughly investigate, and resolve grievances for missing personal items that were reported to staff for 1 of 1 resident reviewed for grievances. (Resident 23)	F 0585	**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**	02/25/2025

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	Finding includes: During an interview on 1/21/25 at 9:52 a.m., Resident 23 indicated she was missing a teal blue outfit and had told many people about the issue. The outfit had been missing for over 2 months and nothing was done about it. On 1/27/25 at 10:23 a.m., The resident was observed in her wheelchair watching she television. She indicated she had not filed a grievance for the missing clothing. She indicated she spoke with laundry staff and she had no follow up. The record for Resident 23 was reviewed on 1/27/25 at 10:00 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body), hypertension (high blood pressure), depression, anemia (low iron), and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 10/27/24, indicated the resident was cognitively intact. The resident had impairment on one side of the upper and lower extremity and used a wheelchair. There was no grievance/concern form filed for the resident's first missing clothing. During an interview on 1/27/25 at 2:48 p.m., Laundry Aide 1 indicated she was aware of the missing teal outfit. She indicated she had personally labeled the outfit and knew exactly what was missing. She had not been able to locate the clothing for a while and had not filed a grievance to replace the resident's personal belongings. During an interview on 1/28/25 at 9:51 a.m., the		**only in response to the regulatory requirement.** **F585 Grievances** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident 23 remains in the facility, grievance have been filed and follow-up resolution have been discussed with the son and resident.** 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 facility residents have the potential to be affected by the same alleged 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. **All staff was held, reviewed policy on the grievance process, ensuring that all verbal grievances have been filed in writing so it can be investigated and resolved accordingly.** **Resident council was held, residents were made aware of the grievance process. Posting is available in prominent locations on how to file a grievance and who the**	

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	Director of Nursing (DON) indicated she understood a grievance should have been filed for the missing items. 3.1-7(a)(2)		**grievance officer is.** **Director of Customer Experience visited cognitively intact residents and ensured that any outstanding grievance had been filed and resolved.** **Facility Angels will discuss any grievance that has been brought to their attention during rounds at the morning meetings.** How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place. **Director of Customer Service/Designee will perform rounding and interview 5 residents twice weekly for 6 months, to ensure that grievance have been filed, investigated and resolved.** **The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance.** **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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			- **F585 Grievances** **Director of Customer Service/Designee will perform rounding and interview 5 residents twice weekly for 6 months, to ensure that grievance have been filed, investigated and resolved.**	

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			Resident identifier **Did the residents verbalize any concern/grievance?** **Y/N** **Has a grievance form been submitted?** **Y/N** **If not,** **Was the resident assisted in completion and submission of the form?** **Y/N** **If yes, was the grievance resolved?** **Y/N**	

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F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified in writing related to a transfer to the hospital for 1 of 3 residents reviewed for hospitalization. (Resident 20) Finding includes: Resident 20's record was reviewed on 1/27/25 at 3:00 p.m. Diagnoses included, but were not limited to, dementia, respiratory failure, muscle weakness, schizophrenia, and osteomyelitis (muscle and bone infection) of left foot and ankle. The Significant Change Minimum Data Set (MDS) assessment, dated 12/2/24, indicated the resident was moderately impaired for daily decision making. The Change in Condition Evaluation, dated 11/6/24, indicated the physician evaluated the resident and ordered for the resident to be sent out to the hospital. Physicians' Notes, dated 1/16/25, indiacted the resident was sent out to the hospital on 1/7/24 due to shortness of breath and hypoglycemia.	F 0623	Reviewed by: _____ ____Date_____ **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.** **F623 Notice requirements Before Transfers /Discharge** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident 20 remains in the facility at this time but in the event of a discharge the resident will have sent to the Responsible Party or P.O.A a copy of the facilities bed hold policy** 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 facility residents have the**	02/25/2025

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	The resident was admitted to the hospital with a toe infection on 11/6/24 and returned to the facility on 11/25/24. The resident was admitted to the hospital on 1/7/25 with septic shock and returned to the facility on 1/15/25. There was no indication the State transfer form was mailed to the resident's responsible party for either admission. During an interview on 1/28/25 at 11:45 a.m., the Director of Nursing (DON) indicated she had no additional information to provide and understood the concern. 3.1-12(a)(6)(A)(ii)		**potential to be affected by the same alleged 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. **Nursing Staff members and medical records dept. were educated on the process to ensure that notification of the facilities bed hold notice occurs.** How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place. **All discharges and transferred out residents reviewed daily in the clinical meeting will be audited for proof of notification of the facility bed hold policy. This process will occur daily for all discharges and transfers out.** **The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. 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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			- - - - - - - - **F623** **Notice requirements Before Transfers /Discharge** - **All discharges and transferred out residents will be audited for proof of notification of the facility bed hold policy. This process will occur daily for all discharges and transfers out. This includes the weekend Manager on duty/Nursing supervisor** - **Resident Identifier** **Did the resident discharge or transfer out of the facility?** **Y/N** **If yes, did the resident receive the discharge notice?** **Y/N** **If yes, was the signed copy uploaded to the EHR** **If not,** **Was the Bed hold policy sent via Mail to the Resp. Party or P.O.A.?** **Y/N** **If yes,** **Was a copy of the stamped envelope uploaded to the residents E.H.R?**	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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			Y/N **If no,** **Comment here** - - - **Reviewer_____** **_____Date____**	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview, the facility failed to ensure residents were involved in decisions about their care related to informing them of new medications for 1 of 7 residents reviewed for participation in care planning. (Resident D) Finding includes: During an interview on 1/21/25 at 2:49 p.m., Resident D indicated the staff did not always tell or inform him of new medications or new physician's orders. The record for Resident D was reviewed on 1/22/25 at 4:10 p.m. Diagnoses included, but were not limited to, acute respiratory failure, COPD (Chronic Obstructive Pulmonary Disease) type 2 diabetes mellitus (DM), heart failure, high blood pressure, chronic kidney disease, osteoarthritis, and depression. The 12/2/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed substantial to maximal assistance with bathing and/or showering. A Physician's Order, dated 12/4/24, indicated Amlodipine 10 milligrams (mg), give one tablet in the morning for high blood pressure. Physician's Orders, dated 1/9/25, indicated Losartan Potassium Oral Tablet 100 mg, give one	F 0657	**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.** **F657 Care Plan Timing and Revision** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident D remains in the facility, a care plan meeting was held, including but not limited to his current medication list was discussed. Care plans on hypertension have been updated, care plan on ABT use has been resolved.** 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 facility residents have the potential to be affected by the same alleged deficient practice.** What measures will be put into	02/25/2025

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	tablet in the morning for high blood pressure and Tamiflu Oral Capsule 75 mg, give one capsule one time a day for 14 days for prophylactic for the flu. There was no documentation in the clinical record the resident was made aware of the new medication regime for his high blood pressure and for the flu. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager indicated the resident was to be made aware of new medications. During an interview on 1/28/25 at 4:00 p.m., the Director of Nursing indicated there was no documentation the resident was made aware of the newly ordered medications. 3.1-35(d)(2)(B)		place or what systemic changes will be made to ensure that the deficient practice does not recur. **Nursing staff were educated on involving both resident and family in decisions regarding their care, and to document the discussion in the medical records.** **Clinical meeting agenda will include review of new medications/orders and documentation of informing resident in their plan of care.** How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place. **The Director of Nursing/designee will audit and interview 5 residents weekly for 6 months, with medication order changes to ensure that residents have been involved in decisions about their care.** **The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. 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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			F657 Care Plan Timing and Revision **The Director of Nursing/designee will audit and interview 5 residents weekly for 6 months, with medication order changes to ensure that residents have been involved in decisions about their care.** **Resident Identifier** **New medication** **Resident notified of new medication?** **Y/N** **Documentation of notification in the medical records?** **Y/N**	

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to receiving showers and assistance with eating for 3 of 9 residents reviewed for ADLs. (Residents D, C, and E) Findings include: 1. During an interview on 1/21/25 at 2:44 p.m., Resident D indicated he was not getting showers on Saturdays. He indicated his showers were supposed to be Wednesdays and Saturdays in the evening time. The record for Resident D was reviewed on 1/22/25 at 4:10 p.m. Diagnoses included, but were not limited to, acute respiratory failure, COPD (Chronic Obstructive Pulmonary Disease) type 2 dm, heart failure, high blood pressure, chronic kidney disease, osteoarthritis, and depression. The 12/2/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed substantial to maximal assistance with bathing and/or showering. The resident did not receive a shower at least two times a week for the months of 10/2024, 11/2024,	F 0677	- - Reviewed by: _____ Date: _____ **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.** **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 E** remains in the facility, and assistance with feeding is provided. **Residents C and D** are receiving showers as per preference. 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 residents requiring assistance with Activities of Daily Living have the potential to be affected by the same alleged deficient practice.** What measures will be put into	02/25/2025

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	and 1/2025. There was no shower or completed bed bath documented on 10/1/24, 11/20/24, 1/4/25, 1/8/25, 1/15/25, and 1/25/25. During an interview on 1/28/25 at 4:15 p.m., the Unit Manager indicated the resident should have a shower at least two times a week. 2. The record for Resident C was reviewed on 1/27/25 at 2:03 p.m.. Diagnoses included, but were not limited to, peg tube, falls, dysphagia (difficulty swallowing), type 2 diabetes, palliative care, Parkinson's disease, psychotic disorder, severe dementia with agitation, high blood pressure, restlessness and agitation. The 12/24/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and was dependent on staff for most of his activities of daily living, including bathing. A Care Plan, revised on 1/14/25, indicated the resident required assistance with ADLs due to dementia. The resident was to receive a shower on Wednesdays and Saturdays evenings. There was no shower documented at least 2 times a week on 11/2, 11/9, 11/13, and 1/22/25 During an interview on 1/28/25 at 4:15 p.m., the Assistant Director of Nursing indicated the resident should have least two showers a week. 3. On 1/23/25 at 8:30 a.m. and 8:48 a.m., Resident E was observed sitting up in bed and eating a bowl of cereal. The bowl was tipped in the opposite direction of the resident and milk was dripping out of the bowl onto her gown. The resident had a		place or what systemic changes will be made to ensure that the deficient practice does not recur; **Staff were re-educated on:** **Providing residents with assistance with their activities of daily living (ADL's) per plan of care/preferences with a special focus on assistance with eating and showers.** **Dining room staff assignments every meal as shown in daily nursing schedule.** **Use of quick entry group in point of care (POC) to identify showers assigned for the shift.** **Restorative Nurse reassessed residents to identify who needs supervision and assistance with feeding.** **Clinical managers reviewed residents shower preferences and schedule to ensure that staff will provide and document shower tasks. Clinical meeting agenda to include review of documentation compliance of POC charting.** 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 observe 5**	

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	plastic spoon positioned backwards in her mouth and was making a gagging noise. The restorative nursing aide was walking by the resident's room and was immediately notified. During an interview at the time, Restorative CNA 1 indicated the resident was normally a "set up" for meals and that something must be wrong with the resident. The record was reviewed for Resident E on 1/23/25 at 10:04 a.m. Diagnoses included but were not limited to, depression, muscle weakness, age related cataract, and encephalopathy. A Quarterly Minimum Data Set (MDS) assessment, dated 10/20/24, indicated the resident was cognitively intact for daily decision making. The resident required supervision/touching assistance for eating . Oral hygiene required partial to moderate assistance, and toileting hygiene, shower/bathing, upper and lower body dressing required substantial/maximum assistance. A Care Plan, revised on 1/20/24, indicated the resident had impaired visual function related to cataracts and glaucoma. A Care Plan, revised on 1/20/24, indicated the resident required assistance with Activities of Daily Living (ADLs) including bed mobility, eating, transfers, toileting and bathing related to weakness and diagnosis of osteoarthritis. Interventions were to assist with meal consumption, eating and drinking as needed, and assist with oral and personal hygiene as needed. A Physician's Order, dated 1/22/25, indicated to administer 1 gram of Ceftriaxone (antibiotic)		**residents that require assistance with feeding, twice weekly for 6 months, to ensure that staff is providing assistance during meals. DON/Designee will audit and interview 5 residents, twice weekly for 6 months, to ensure that residents are receiving showers as scheduled. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. 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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	intravenously (IV) daily for a Urinary Tract Infection (UTI) for 10 days. Nurses' Notes, dated 1/22/2025 at 10:08 a.m., indicated the resident was experiencing increased confusion. Nurses' Notes, dated 1/21/2025 at 9:00 p.m., indicated the resident had spit out medication, had been yelling and screaming, refused meals, and refused care. The Physician was notified and new orders were received for a midline IV (intravenous) access and IV antibiotic. During an interview on 1/24/25 at 11:12 a.m., the Director of Nursing indicated the resident should have had supervised meal consumption. This citation relates to Complaints IN00450254 and IN00451800. 3.1-38(a)(3)		- - - - - - **F677 ADL Care Provided for Dependent Residents** **DON/Designee will observe 5 residents that require assistance with feeding, twice weekly for 6 months, to ensure that staff is providing assistance during meals.** **Resident Identifier** **Resident invited to the dining room for supervision?** **Y/N** **Staff provided assistance during meals?** **Y/N** **Name of staff providing feeding assistance**	

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			DON/Designee will audit and interview 5 residents, twice weekly for 6 months, to ensure that residents are receiving showers as scheduled. **Resident Identifier** **Shower Schedule** **Dates shower/bath received** **Resident acknowledged receiving shower/bath** **Y/N/NA** **Comments**	

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			Reviewed by: _____ _ **Date:** _____	
F 0679 SS=C Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, record review, and interview, the facility failed to provide a personalized activity program for cognitively impaired and dependent residents related to ongoing stimulation and being invited to activities for 1 of 1 resident reviewed for activities. (Resident 81) Finding includes: On 1/21/25 at 10:13 a.m., Resident 81 was observed sitting in her wheelchair. She was crying and rocking herself back and forth in her chair. There was no television on or music playing. On 1/21/25 at 3:50 p.m., the resident was observed awake in her wheelchair with her head down. The television was not on. During a family interview on 1/22/24 at 9:49 a.m., the resident's niece indicated she walked in and her aunt was screaming and hollering out. She indicated the television was not on when she got there. On 1/22/25 at 1:35 p.m. and 2:51 p.m., the resident was observed lying awake in bed. The television was not on and there was no music playing. On 1/23/25 at 8:30 a.m. and at 8:48 a.m., the resident was observed sitting up in bed, the television was not on.	F 0679	**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.** **F679 Activities Meet Interest/Needs of Each Resident** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident 81 remains in the facility, activities assessment and preferences were performed and activity care plan was initiated to reflect resident's activity needs and preferences.** 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 residents in the facility have the potential to be affected by the alleged 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;	02/25/2025

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	On 1/24/25 at 8:39 a.m., the resident was observed in her room. She was awake lying in bed staring straight ahead at the television. The television was off and there was no music playing. On 1/24/25 at 9:00 a.m., the Activity Director was observed delivering the daily chronicle to the resident. She placed the chronicle on her bedside table and walked back out. During an interview at the time, the Activity Director Katherine indicated the resident receives one on ones. She indicated she had had only been in her role for 1 month and would try and locate documentation. On 1/24/25 at 9:03 a.m., the Activity Director went to check if the resident had her television on, and asked the resident if she would like the daily chronicle read for her, or if she wanted music played. The record for Resident 81 was reviewed on 1/23/25 at 10:04 a.m. Diagnoses included, but were not limited to, depression, muscle weakness, age related cataract, and encephalopathy. A Quarterly Minimum Data Set (MDS) assessment, dated 10/20/24, indicated the resident was cognitively intact for daily decision making. The resident required supervision/touching assistance for eating . Oral hygiene required partial to moderate assistance, and toileting hygiene, shower/bathing, upper and lower body dressing required substantial/maximum assistance. A Care Plan, revised on 1/20/24, indicated the resident had impaired visual function related to cataracts and glaucoma.		**Activity Director was in-serviced on:** **Performing activity assessment upon admission, quarterly and as needed** **Providing activities that meet the needs and preferences of each resident** **Documenting activities provided, including 1:1 activities** **Initiating and reviewing activity care plans** **Activity team was in-serviced on how to provide and document 1:1 activities per plan of care.** **Activity team conducted re-assessment of residents' activity needs and preferences, and reviewed activity care plans.** 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; **Administrator/Designee will audit and observe 5 residents twice weekly for 6 months, to ensure that residents are offered and participating in activities that meet their needs and preferences.** **The administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance.**	

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	There was no activity care plan. Activity one-on-one documentation indicated the last one-on-one visit for the resident was on 1/18/25. During an interview on 1/27/25 at 2:11 p.m., the Director of Nursing indicated she understood the concern and music or the television should have been on for the resident. 3.1-33(a)		**Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.** **F679 Activities Meet Interest/Needs of Each Resident** **Administrator/Designee will audit and observe 5 residents twice weekly for 6 months, to ensure that residents are offered and participating in activities that meet their needs and preferences.** **Resident Identifier** **Activity Need/Preference** **(Group/Independent/1:1)** **Activity Performed** **Documented in medical records** **Y/N** **Activity care plan in place** **Y/N**	

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			Reviewed by:_____ _____Date_____ _____	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure non-pressure areas were monitored, assessed, and bandages were changed for 1 of 1 resident reviewed for skin conditions non-pressure related, blood pressure parameters were followed for 1 of 1 resident reviewed for dialysis, and a resident was assessed and monitored post cataract surgery for 1 of 1 resident reviewed for vision and hearing. (Residents G and 82) Findings include:	F 0684	**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.** **F684 Quality of Care** What corrective action(s) will be accomplished for those residents found to have been affected by the	02/25/2025

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	1. During an interview 1/21/25 at 11:28 a.m., Resident G indicated her double vision was back and she had told the staff about it. She indicated she had cataract surgery a couple of months prior and was afraid something else was wrong. The record for Resident G was reviewed on 1/22/25 at 4:23 p.m. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), acute respiratory failure, Alzheimer's disease, anxiety disorder, high blood pressure, and bipolar disorder. The 11/14/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident's vision was adequate and she wore glasses. There was no Care Plan for vision. A referral, dated 7/11/24, indicated the resident was to schedule for cataract surgery. The appointments were made for the right eye on 8/26/24 at 12:30 p.m. and the left eye on 9/17/24 at 10:30 a.m. There was no documentation in the clinical record the resident had the cataract surgery. There were Physician's Orders, dated 9/11/24, for Prednisone eye drops and for Polytrim antibiotic eye drops post cataract surgery. There was no assessment or monitoring of the resident documented after she returned from having cataract eye surgery on 9/11/24. Physician's Orders, dated 9/18/24, indicated orders for Prednisone and Polytrim eye drops again for		deficient practice. **Resident G remains in the facility, cataract post operative report was obtained and reviewed on 1/28/25, plan/recommendation is to return to clinic as needed. Vision care plan was initiated, and an appointment to the optometrist was scheduled due to complaints of double vision. Resident 82 returned to the hospital on 2/7/25, hospital admission is not related to alleged deficient practice.** 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 residents in the facility have the potential to be affected by the alleged 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; **Nursing team members were educated on:** **Change in condition assessment policy, including documentation of performed procedures/surgery; assessment and monitoring of resident post procedure/surgery** **Medication administration of medications with parameters** **Procedure with return**	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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	post cataract surgery. There was no documentation in the clinical record the resident left the facility to have cataract surgery for the other eye, nor was there an assessment or any kind of monitoring when the resident returned. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager, indicated she would expect nursing staff to document in the clinical record when a resident left for an appointment and compete an assessment after the resident returned from having cataract surgery. During an interview on 1/28/25 at 4:15 p.m., the Unit Manager had no additional information to provide The current 10/1/2020 "Change in Condition Assessment" policy provided by the Director of Nursing (DON) on 1/29/25 at 10:45 a.m., indicated resident assessment was to be completed upon admission, re-admission, and with change in condition. When a change in resident condition was identified, the RN/LPN must complete an assessment including vital signs and any complaints of pain. Resident assessment was to documented in the resident's medical record. 2. During an observation on 1/23/25 at 6:52 a.m., Resident 82 was sitting on the side of the bed with his shirt off. There was a soiled, foul smelling bandage located on his lower back. The bandage had dried brown drainage noted and was crinkled and rolling down. There was also another clear bandage with a gauze observed just above the soiled one. There was a drainage bag filled with liquid coming from a drain under the foul smelling		**demonstration on managing and treatment of drains.** **Identifying residents with appointments through PCC calendar daily** **Wound care nurse identified current residents with drains, assessment performed and orders reviewed and updated.** **Wound care nurse to assess and monitor drain sites, and ensure that treatment orders are in place and performed.** **Clinical team, in coordination with MD/NP, reviewed medication orders with parameters.** **Clinical meeting agenda to include reviewing appointments and procedure notes from ancillary services from the day prior to ensure assessment, monitoring, follow up and documentation are in place.** How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place. **Director of Nursing/Designee will audit 3 residents with drain site, once weekly x 6 months, to ensure that assessment, output monitoring and dressing changes are performed as ordered.** **Director of Nursing/Designee will audit 5 residents with medication parameters, once**	

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	and soiled bandage. On 1/23/25 at 2:40 p.m., the Unit Manager was observed in the resident's room and was asked to look at the bandages on his back. She was able to lift the bandage with the drain and observed the area. There was a very strong, foul smelling odor coming from the bandage. During an interview at that time, she indicated the bandage was dirty and there was a strong odor coming from it. She was unsure if the bandage had ever been changed since he had returned with the drain. At 2:45 p.m., the Wound Nurse removed the bandage from the drain site. At that time, there was a white flange and drain observed. There was a large amount of dried brown drainage on the flange and drain. The Wound Nurse had to use several normal saline pouches and gauze pads to remove the substance that was adhered to the flange and drainage tube. The soiled gauze pad was rank and had a large amount of dried brown drainage noted. The Wound Nurse then attempted to remove the clear bandage and it took several attempts because it was adhered to the resident's back. During an interview with the Wound Nurse at that time, indicated he had never changed either one of the bandages prior to 1/23/25. The treatment was scheduled prn (as needed), so it was not on his list to do. The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on 10/26/24. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis,		**weekly x 6 months, to ensure that medications are administered according to ordered parameters.** **Director of Nursing/Designee will audit 3 residents who had scheduled appointments/procedures, once weekly x 6 months, to ensure assessment, monitoring, follow up and documentation are in place.** **The Director of Nursing /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. 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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	anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making and had an indwelling Foley catheter. A Care Plan, dated 12/9/24, indicated the resident had a drain in place due to a renal abscess. A Physician's Order, dated 1/7/25, indicated to monitor the renal abscess drain site (right accordion drain site) every shift and report any abnormalities to the doctor. May cleanse with wound cleanser or normal saline and cover the drainage site with gauze island with border. May change if soiled or may be removed as needed. The Medication Administration Records (MAR), dated 12/2024 and 1/2025, indicated the right accordion drain site (renal abscess) was not signed out as being monitored on the following days: - Day shift: 12/26 and 12/27, 1/1, 1/4, 1/5, 1/6, 1/8, 1/9, 1/10, 1/12, 1/13, and 1/20/25 - Evening shift: 12/27 and 12/29, 1/7, 1/8, 1/10, 1/16, 1/18, 1/21, 1/22/25 The right accordion drain site bandage to be changed prn was not signed out at all on the 1/2025 MAR/TAR. A Physician's Order, dated 12/10/24, indicated Midodrine (a medication to raise the blood pressure) 10 milligrams (mg), give two tablets by mouth three times a day for hypotension. Hold if systolic (top number) blood pressure was greater than 140 or Diastolic (bottom number) blood pressure was greater than 80.		- - - - - - **F684 Quality of Care** **Director of Nursing/Designee will audit 3 residents with drain site, once weekly x 6 months, to ensure that assessment, output monitoring and dressing changes are performed as ordered.** **Resident Identifier** **Assessment of drain site weekly** **Y/N** **Output documented as ordered** **Y/N** **Dressing changed performed as scheduled** **Y/N** **Director of Nursing/Designee will audit 5 residents with medication parameters, once weekly x 6 months, to ensure that medications are**	

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	The 1/2025 MAR indicated the Midodrine was administered on the following days: 1/2/25 a.m. dose and the blood pressure was 128/87 1/2/25 mid day dose and the blood pressure was 145/76 1/2/25 hs (bedtime) dose and the blood pressure was 113/83 1/18/25 hs dose and the blood pressure was 127/89 1/20/25 a.m. dose and the blood pressure was 122/81 During an interview on 1/23/25 at 3:00 p.m., the Director of Nursing (DON) was made aware of the condition of the foul smelling bandage over the renal abscess area. During an interview on 1/28/24 at 4:00 p.m., the Unit Manager had no additional information to provide regarding the blood pressure medication administration. The current 9/1/2020 "Skin Condition Assessment and Monitoring Pressure and Non-Pressure" policy, provided by the DON as current on 1/28/25 at 5:00 p.m., indicated non-pressure skin conditions will be assessed for healing progress and signs of complications or infection weekly. Dressings which were applied to pressure ulcers, skin tears, wounds, lesions, or incisions shall include the date of the licensed nurse who performed the procedure. The dressing will be checked daily for placement, cleanliness, and signs and symptoms of infection. 3.1-37(a)		**administered according to ordered parameters.** **Resident Identifier** **Medication with Parameter** **Parameters followed as ordered** **Y/N** **Comments** **Director of Nursing/Designee will audit 3 residents who had scheduled appointments/procedures, once weekly x 6 months, to ensure assessment, monitoring, follow up and documentation are in place.** **Resident Identifier** **Date of Appointment/Procedure** **Documentation that resident left and returned to/from**	

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			procedure **Y/N** **Assessment and monitoring post procedure** **Y/N** **Comments** **Reviewed by:** _____ _____ **Date**_____	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on record review and interview, the facility failed to ensure pressure ulcer treatments were completed as ordered and IV (intravenous) antibiotics for a wound infection were administered as ordered for 1 of 1 resident reviewed for pressure ulcers. (Resident F) Finding includes: On 1/21/25 at 10:15 a.m., Resident F was observed	F 0686	**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.** **F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers**	02/25/2025

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	lying in bed. At that time, he was observed with a PICC (peripherally inserted central catheter) in his right upper arm. There were no IV antibiotics infusing at that time. From 10:15 a.m. until 11:40 a.m., there was no IV antibiotic administered to the resident. On 1/22/25 at 9:45 .a.m., the resident was observed in bed. At that time, there was an IV antibiotic bag hanging on the pole that had already infused. The medication was Meropenem with 1/22/25 at 5:00 a.m. handwritten on the label. During a random observation on 1/23/25 at 6:55 a.m. of the medication room on the main station, there were 2 IV antibiotic bags of Vancomycin in one plastic bag that had arrived to the facility on 1/21/25. The record for Resident F was reviewed on 1/22/25 at 1:35 p.m. Diagnoses included, but were not limited to, sepsis, osteomyelitis, arthritis, anxiety, major depressive disorder, pressure ulcer, paraplegia, schizophrenia, and neuromuscular of the bladder. The 10/10/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a Foley (urinary) catheter. The resident had one stage 3 (full-thickness skin loss where the underlying fatty tissue (subcutaneous fat) was visible within the wound, but the bone, tendon, or muscle was not exposed) pressure ulcer and one stage 4 pressure ulcer that were present on admission. The Care Plan, revised on 1/22/25, indicated the resident had actual skin impairments to the right and left hips and the right ischium. The approaches were to administer treatments as		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident F's** treatments are being rendered and documented per physician orders. **Resident F** is receiving all medications including antibiotics per physician orders. 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 residents with pressure ulcers have the potential to be affected by the same alleged 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; **Nurses were re-educated on the following:** **Rendering wound care per physician orders and documenting the care in the Treatment Administration Record (TAR)** **Administering all medications including antibiotics per physician orders and documenting the administration in the Medication Administration Record (MAR)** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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	ordered and monitor for effectiveness. The Care Plan, dated 1/22/25, indicated the resident required IV medication and had a PICC line. The approaches were to administer IV antibiotics as ordered by the physician. The Wound Physician Notes, dated 1/20/25, indicated the resident had a Stage 3 pressure ulcer to the right hip that measured 7.5 centimeters (cm) in length by 4.7 cm in width by 0.6 in depth that was 100% granulation tissue (a new, pink or red, moist tissue that forms at the site of a wound as it heals) with undermining (a condition where tissue damage creates a pocket under the wound surface, making the wound appear larger than it actually was) of 6 cm at 3 o'clock. There was another Stage 3 pressure ulcer to the left hip that measured 10.5 cm in length by 6.2 cm in width by 4.5 cm depth with 100% granulation tissue. There was undermining of 2.5 cm at 9 o'clock. There was a Stage 3 pressure ulcer to the right ischium that measured 5.5 cm in length by 5.7 cm in width by 1 3 cm in depth. There was 100% granulation tissue with undermining at 3 o'clock. All three wounds were present on admission but just had not healed. The resident was admitted to the hospital on 12/20/24 with septic shock and returned back to the facility on 1/9/25 with IV antibiotics for a wound infection. Physician's Orders, dated 11/24/24, indicated to cleanse the right and left hips with normal saline, pat dry, apply Dakin's moistened kerlix to the wound bed, cover with an ABD pad and secure with tape two times a day every a.m. and hs (bedtime).		quality assurance programs will be put into place; **Wound nurse/designee will randomly audit 5 residents requiring wound care weekly for 6 months, with a special focus on residents receiving antibiotics for treatment of wounds to ensure treatments are rendered and documented per orders and antibiotics are administered and documented per orders.** **Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.** **F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers** **Wound nurse/designee will randomly audit 5 residents requiring wound care weekly for 6 months, with a special focus on residents receiving antibiotics for treatment of wounds to ensure treatments are rendered and documented per order and antibiotics are administered and documented**	

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	The Treatment Administration Record (TAR) for the month of 11/2024 indicated the treatment for the right and left hips were blank for the hs shift on 11/1, 11/2, 11/4, 11/6, 11/17, 11/18, and 11/24/24. Physician's Orders, dated 12/23/24, indicated to cleanse the right and left hips with normal saline, pat dry, apply gauze roll kerlix moistened with 0.9 saline to the wound bed with alginate calcium with sliver, cover with ABD pad and secure with tape every day and evening shifts. The right ischium was to be cleansed with normal saline, pat dry, apply gauze roll kerlix with sodium hypochlorite gel (anasept) to the wound bed, cover with an ABD pad and secure with tape every day and evening shift. The 12/2024 TAR indicated the treatment for the left and right hips were not signed out as being completed for the evening shift on 12/26, 12/27 and 12/30/24. The 12/2024 TAR indicated the right ischium treatment was not signed out as being completed on 12/26 and 12/27/24 for the evening shift. Physician's Orders, dated 1/9/25, indicated to cleanse the left and right hips with normal saline, pat dry, and apply gauze roll kerlix moistened with 0.9 saline to the wound bed with alginate calcium with sliver, cover with an ABD pad and secure with tape every day and evening shift. The 1/2025 TAR indicated the treatments for the left and right hips were not signed out as being completed on 1/10/25 for the day shift and on 1/9, 1/10, and 1/11/25 for the evening shift. A Physician's Order, dated 1/10/24, indicated		**per orders.** - - **Resident Identifier** **Does the residents have wounds requiring treatment?** **Y/N** **If yes,** **Are the treatment orders being signed on the TAR?** **Y/N** - **Is the resident receiving antibiotic therapy?** **Y/N** - **If yes,** **Is the administration signed off on MAR?** **Y/N** -	

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	Vancomycin HCl Intravenous Solution Reconstituted 1 gram infuse two times a day every a.m., and hs. The Medication Administration Record (MAR) for 1/2025 indicated the Vancomycin was not signed out as being administered on 1/10/25 for both a.m. and hs, and on 1/12/25 for the hs dose. A Physician's Order, dated 1/13/25, indicated Vancomycin HCl Intravenous Solution Reconstituted 1 gram, infuse two times a day at 8:00 a.m. and 8:00 p.m. A Physician's Order, dated 1/13/25, indicated Meropenem Intravenous Solution Reconstituted 1 gram infuse three times a day. The 1/2025 MAR indicated the Vancomycin was not signed out as being administered on 1/18/25 for the 8:00 p.m. dose and 1/20/25 for the 8:00 a.m. dose. The Meropenem was not signed out as being administered on 1/13 at 5 a.m., 1/17 and 1/18 at 9:00 p.m., 1/20 at 1:00 p.m. and 9:00 p.m., and 1/21/24 at 5:00 a.m. and 9:00 p.m. A Physician's Order, dated 1/20/25, indicated Vancomycin HCl Intravenous Solution (Vancomycin HCl) 750 mg intravenously every 12 hours for wound infection. The 1/2025 MAR indicated the Vancomycin was not signed out as being administered on 1/20 and 1/21/25 for the 9:00 p.m. dose. During an interview on 1/23/25 10:37 a.m., the Wound Nurse indicated treatments were to be completed as ordered by the doctor. He worked from 5:00 a.m. until 3:00 p.m., and was not in the facility during the evening times.		- - - - - - - - - - - **Reviewer**_____ _____**Date**_____ _____	

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	During an interview on 1/27/25 at 3:30 p.m., the Unit Manager, indicated the treatments were to completed as ordered and IV antibiotics were to be administered as ordered by the physician. The current 9/1/2020 "Skin Condition Assessment and Monitoring Pressure and Non-Pressure" policy, provided by the DON as current on 1/28/25 at 5:00 p.m., indicated physician-ordered treatments shall be initialed by the staff on the electronic TAR after each administration. This citation relates to Complaint IN00450254. 3.1-40(a)(2)			
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care Based on observation, record review, and interview, the facility failed to ensure the resident received the necessary treatment and foot care related to podiatry visits for 1 of 1 resident reviewed for podiatry care. (Resident 69) Finding includes: On 1/22/25 at 2:37 p.m., Resident 69 indicated he wanted his toe nails cut down and they were too long. He had told every staff member who entered his room this request multiple times. On 1/23/25 at 2:30 p.m., Resident 69 was observed lying in bed watching television. He indicated again that he wanted his toes nails cut and felt his request was going unheard. He indicated he was not senile, his mind was sharp, and he knew what he needed and wanted. Resident 69's toe nails were observed to be long and unkempt looking.	F 0687	**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.** **F687 Foot Care** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 69 remains in the facility and has had foot care rendered including trimming of toenails on 1/25/25 without signs and symptoms of adverse reactions.** How the facility will identify other	02/25/2025

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	He indicated the podiatrist had not cut his nails in months and the staff would not cut his toe nails either. The record for Resident 69 was reviewed on 1/23/25 at 1:39 p.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus with diabetic nephropathy. The Quarterly Minimum Data Set (MDS) assessment, dated 1/4/25, indicated the resident was cognitively intact for daily decision making. The Care Plan, dated 1/4/25, indicated to avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. The last Podiatry Assessment, dated 9/20/24 indicated Resident's 69's toenail length was 2 mm (millimeters). The podiatrist performed a comprehensive pedal exam, reviewed the medical history, and trimmed and debrided the toe nails to the resident's tolerance. There were no signs of infection and the note indicated non-professional treatment would be hazardous to the patient. Recall as medically necessary, but no sooner than 60 days. There were no visits from the podiatrist in January 2025 for Resident 69. During an interview on 1/24/25 at 9:56 a.m., the Social Service Consultant indicated she had no documentation of a missed podiatry appointment in January of 2025 or a rescheduled appointment noted. They would make sure to rescheduled the resident for podiatry services for 2/4/25. 3.1-47(a)(7)		residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **All residents residing in the facility have the potential to be affected by the alleged 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; **Nursing staff were educated regarding providing foot care and trimming nails for non-diabetic residents and following up with podiatry for diabetic residents that require a nail trim.** **Social services performed an audit on residents with podiatry consents, date when last foot care was performed and referral as needed.** **Wound care nurse performed a skin sweep to identify residents with long toenails.** How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place. **Wound nurse/designee will randomly assess 5 residents daily x 2 weeks then 2x/week ensure that foot care is being rendered, and nails are being trimmed per facility protocol.** **Director of Nursing/designee will present a summary of the**	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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			audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. **-** **-** **-** **-** **<u>F687 Foot Care</u>** **Wound nurse/designee will randomly assess 5 residents daily x 2 weeks then 2x/week ensure that foot care is being rendered, and nails are being trimmed per facility protocol.** **Resident identifier** **Does the residents' Toenails require trimming?** **Y/N** **If yes, were the residents' toenails trimmed?** **Y/N** **If not, was follow-up scheduled with Podiatry?** **Y/N** **Comments**	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure smoking materials were locked in a safe place and not in the residents' rooms for 2 of 2 residents reviewed for smoking and halos were on a resident's bed as ordered for 1 of 1 resident reviewed for falls. (Residents G, F and H) Findings include: 1. During a random observation on 1/21/25 at	F 0689	**Reviewed by:** **_____** **_____Date_____** **_____** **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.** **F689 - Free of Accidents Hazards /Supervision /devices**	02/25/2025

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	11:18 a.m., Resident G was sitting on the side of the bed. At that time, there was a vape (electronic cigarette) laying on the bed next to her. During an interview at that time, the resident indicated she kept the vape with her at all times, but only used it when she went outside to smoke. The record for Resident G was reviewed on 1/22/25 at 4:23 p.m. Diagnoses included, but were not limited to COPD (Chronic Obstructive Pulmonary Disease), acute respiratory failure, Alzheimer's disease, anxiety disorder, high blood pressure, and bipolar disorder. The 11/14/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A Care Plan, revised on 10/23/23, indicated the resident was a smoker. The approaches were to explain the consequences outlined in the policy for smoking and noncompliance. The 10/3/24 Smoking Risk Assessment indicated the resident actively smoked and preferred to continue. The facility needed to store the resident's cigarettes and lighter. During an interview on 1/23/25 at 9:45 a.m., the Unit Manager indicated the vape should not be in the resident's room During an interview on 1/23/24 at 10:30 a.m., the Director of Nursing had no further information to provide. 2. During random observations on 1/21/25 at 10:47 a.m., 1:23 p.m. and 3:10 p.m., Resident F was observed in bed. At those times, the top drawer to		**It is the policy of Casa of Hobart to ensure that care planned interventions are in place for residents who experience falls and incidents.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **Resident G-** Smoking materials have been removed from the bedside for safety and monitoring **Resident F** - Smoking materials have been removed from the bedside for safety and monitoring. Smoking care plan initiated. **Resident H** – Halos are in place as ordered and care planned **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 residents who smoke and those at risk of falls have the potential to be affected by the same alleged 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.** An emergency smoking meeting was held on 1/23/25 with all smokers attending to discuss smoking policy and contracts	

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	his night stand was open. There were two vapes, three packs of cigarettes and two lighters inside the drawer. During an interview at that time, the resident indicated he was not currently smoking because it was too cold outside. The record for Resident F was reviewed on 1/22/25 at 1:35 p.m. Diagnoses included, but were not limited to, sepsis, osteomyelitis, arthritis, anxiety, major depressive disorder, pressure ulcer, paraplegia, schizophrenia, and neuromuscular of the bladder. The 10/10/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no Care Plan regarding smoking. A 10/4/24 Smoking Risk Assessment indicated the resident actively smoked and preferred to continue. The resident needed the facility to store the lighter and cigarettes. A 10/30/24 Smoking Risk Assessment, indicated the resident actively smoked and preferred to continue. The resident needed the facility to store the lighter and cigarettes. A 1/9/25 Smoking Risk Assessment indicated the resident did not smoke currently. During an interview on 1/23/25 at 9:45 a.m., the Unit Manager indicated the cigarettes, lighters, and vapes should not be stored in the resident's room. During an interview on 1/23/24 at 10:30 a.m., the		were obtained. Staff were in-serviced on: Ensuring care planned fall interventions are in place at the time of care planning. Ensuring that all residents are aware of the facilities safe smoking protocol and residents are not allowed to keep their own smoking materials i.e. lighters, cigarettes, tobacco or Vapes Clinical team and IDT reviewed fall care plan interventions of residents who had a fall in the last 30 days. **How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** Facility Angel's will audit 5 residents 2 days per week for 6 months to ensure no smoking materials are kept at bedside. The Director of Nursing /designee will review 5 residents with fall incidents, once weekly x 6	

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	Director of Nursing had no further information to provide. The current 9/2022 "Resident Smoking" policy, provided by Nurse Consultant 1, indicated possessing, carrying, or holding materials used to smoke (including, but not limited to, cigarettes, cigars, loose tobacco, pipes, lighters, and matches) by residents who required supervision was prohibited inside the building. Residents must give smoking materials to staff when they enter the building even if the resident has been assessed to be independent in carrying such materials when off the premises. 3. On 1/22/25 at 2:42 p.m., Resident H was in the bathroom. The resident's bed was observed in the low position and there were no halos (bed mobility assist device) on the resident's bed. On 1/24/25 at 9:26 a.m., Resident H was lying in bed watching television. The bed was in the low position. No bed halos were observed on the resident's bed. The resident indicated he had slid out of the bed several times. Resident H's record was reviewed on 1/22/25 at 3:10 p.m. Diagnoses included, but were not limited to, repeated falls, vascular dementia, moderate without behavioral distance, psychotic disturbance, mood disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/17/24, indicated the resident was cognitively intact. A Progress Note, dated 1/22/25, indicated the interdisciplinary team (IDT) met to review the incident that occurred on 1/2/2025. The root cause of the fall was the resident slid out of the bed. Interventions and the care plan were updated. All		months, to ensure that fall interventions are in place according to care plan. **Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.** - - - - - - - - - - - - - - **F689 - Free of Accidents Hazards /Supervision /devices** Facility Angel's will audit 5 residents 2 days per week for 6 months to ensure no smoking materials are kept at bedside. The Director of Nursing /designee will review 5 residents with fall incidents, once weekly x 6	

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	care planned interventions were in place at time of the incident. New interventions, dated 1/22/25, included implementing halos bilaterally. During an Interview with the Director of Nursing on 1/24/25 at 11:25 a.m., she indicated the intervention of halos to the bed should have been in place for the resident to prevent falls. This citation relates to Complaint IN00450652. 3.1-45(a)(2)		months, to ensure that fall interventions are in place according to care plan. **Resident Identifier** **Fall Intervention** **Observed intervention in place Y/N** **Comments** **Reviewer_____** **_____Date__** **_____**	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure Foley	F 0690	**Please accept the following as the facility's credible allegation**	02/25/2025

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	catheter bags and tubing were kept off of the floor, Enhanced Barrier Precautions (EBP) were maintained and suprapubic catheter site care was completed for 2 of 2 residents reviewed for catheters. (Residents 82 and 49) Findings include: 1. During random observations on 1/22/25 at 9:44 a.m., 1:25 p.m., and 2:06 p.m., and on 1/27/25 at 9:49 a.m., Resident 82 was observed sitting in his wheelchair with a Foley catheter bag hooked on the arm of the wheelchair, making the bag above the resident's waist. During a random observation on 1/23/25 at 6:52 a.m., the resident was sitting on the side of the bed, and the indwelling Foley catheter tubing was on the floor and the drainage bag was hanging on the trash can. CNA 1 was in the resident's room and was going to empty the Foley catheter. The CNA donned a pair of clean gloves to both hands and started to look for the urinal to empty the urine, she could not find one, so she removed the gloves and left the room. She came back to the room with a pink wash basin, and indicated she could not find anymore urinals so she grabbed the basin and was going to empty the urine into it. She donned a pair of clean gloves to both hands, without performing hand hygiene and placed a paper towel on the floor and put the pink wash basin on top of the towel. She picked up the resident's Foley catheter and emptied the urine into the basin. She took the basin into the bathroom and emptied the contents into the toilet. She rinsed out the basin in the sink and with a paper towel she begun to dry the inside. After drying the basin, she opened the resident's drawer and put the basin into the closet. She removed her gloves and left the room.		**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.** **F690 Bowel/Bladder Incontinence, Catheter, UTI** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident 82** returned to the hospital, hospital admission was not related to the alleged deficient practice. **Resident 49 -** received catheter care without adverse reaction. Suprapubic catheter change order have been updated and clarified. Suprapubic catheter have been irrigated as ordered. 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 residents with indwelling catheters have the potential to be affected by the same alleged deficient practice and reviewed orders for care** 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:** **Ensuring catheter care is rendered as per orders.** **Ensuring catheter are irrigated**	

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	During an interview at that time, CNA 1 indicated she was not aware she was supposed to wear an isolation gown when emptying the urinal. The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on 10/26/24. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis, anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making and had an indwelling Foley catheter. A Care Plan, dated 1/22/25, indicated the resident required contact isolation precautions due to ESBL (Extended-Spectrum Beta-Lactamase) in the urine. The approaches were to provide proper PPE and maintain contact isolation precautions. A Care Plan, revised on 1/12/25, indicated the resident was at risk for complications secondary to a Foley catheter. The resident preferred to position the Foley drainage bag on wheelchair arm rest at times. The approaches were to maintain enhanced barrier precautions, and educate the resident on the risks of not following the catheter drainage bag recommendations related to the positioning. A Physician Order, dated 12/9/24, indicated Foley catheter, size 16 French with a balloon size of 10 milliliters (ml) for neurogenic bladder. A Physician Order, date 12/18/24, indicated Enhanced Barrier Precautions (EBP) for infection		**as ordered.** **Ensuring catheter drainage bag/tubing are positioned off the floor** **Staff to don proper PPE when emptying and maintaining catheter.** **Infection Control nurse identified all residents with catheter, reviewed and updated catheter orders.** 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; **Nurse managers/designee will audit 3 residents with catheters 2 times per week for 6 months, to ensure catheter care and irrigation is rendered per orders and catheter is positioned off the floor and to ensure that EBP are maintained.** **The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done**	

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	control intervention to reduce transmission of multi drug resistant organisms (MDROs). Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices.). A Physician Order, dated 1/22/25, indicated contact isolation related to ESBL in the urine. An urinalysis with a culture and sensitivity, dated 1/22/25, indicated the resident had an urinary tract infection with Klebsiella Pneumoniae (ESBL) that was greater than 100,000 colonies. A Physician Order, dated 1/22/25, indicated Invanz injection solution reconstituted 1 gram. Use 500 milligrams (mg) intravenously every evening shift for an UTI for 10 days. During an interview on 1/23/25 at 7:09 a.m., the Director of Nursing indicated an isolation gown was to be worn due to the resident being in contact isolation because he had ESBL in the urine. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager, indicated the resident had a care plan that he preferred the Foley catheter on the arm rest of the wheelchair. The catheter bag and tubing should not have been on the floor. The current 9/1/2020 "Urinary Catheter Care" policy, provided by Nurse Consultant 2, indicated catheters shall be positioned to maintain a downhill flow of urine to prevent back flow of urine into the bladder or tubing, during transfer, ambulation and body positioning. Urinary		**quarterly and present quarterly at the QA meeting.** - - - - - - - - - - - - - **F690 - Bowel/Bladder Incontinence, Catheter, UTI** **Nurse managers/designee will audit 3 residents with catheters 2 times per week for 6 months, to ensure catheter care and irrigation is rendered per orders and catheter is positioned off the floor and to ensure that EBP are maintained.** **Resident Name** **Catheter care and irrigation provided (observation/interview)** **Y/N** **Catheter drainage bag is off the floor** **Y/N** **Staff maintaining EBP during catheter care, emptying and**	

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	drainage bags and tubing shall be positioned to prevent either from touching the floor directly. The current 9/1/2020 "Infection Prevention and Control Program" provided by Nurse Consultant 2 on 1/23/25 at 1:30 p.m., indicated the facility followed CDC protocols for transmission based precautions (TBP). Residents with known or suspected infections were placed on appropriate TBP.2. During an interview on 1/21/25 at 2:23 p.m., Resident 49 indicated the staff does not drain his catheter bag all night or day, he had to call 911 to get his catheter exchanged, and they do not flush or clean his catheter. On 1/21/25 at 3:39 p.m., the resident had lifted his shirt to show his stomas site and catheter. The catheter was dirty and dried crusted blood around insertion site. On 1/22/25 at 2:58 p.m., the resident indicated no one had cleaned his catheter site today, and they did not flush his catheter yet. The resident lifted his shirt to show his catheter. The catheter was dirty and dried crusted blood remained around the insertion site. The record was reviewed for Resident 49 on 1/22/24 at 2:11 p.m. Diagnoses included, but were not limited to, depression, chronic obstructive pulmonary disease (COPD), quadriplegia, muscle wasting and anxiety. The Quarterly (MDS) assessment, dated 12/18/24, indicated the resident was cognitively intact for daily decision making. Resident had an indwelling catheter. The resident required supervision or touching assistance with toileting hygiene and shower and bathing.		**maintenance (observation)** **Y/N** **Reviewed by:_____ _____Date__ _____**	

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	A Care Plan dated 7/9/24, indicated the resident required assistance with ADLs including bed mobility, eating, transfers, toileting and bathing related to decreased mobility and weakness. Interventions were to assist with personal hygiene as needed and assist with toileting care as needed. A Care plan dated 7/9/24 indicated the resident was at risk for complications secondary to requiring use of a suprapubic catheter. Interventions were to, check tubing for kinks routinely each shift, monitor for pain, and signs and symptoms of a urinary tract infection. A Physician's Order, dated 10/18/24, indicated to perform catheter care every shift. A Physician's Order, dated 10/18/24, indicated the resident had a 16 fr (French) suprapubic catheter with a balloon size of 10 ml (milliliters) and to change every ____ and as needed for dislodgement, leaking or blockage. A Physician's Progress, note dated 1/14/25 indicated the resident called 911 last week due to bladder pain. The resident was sent out to the hospital and returned few hours later. His catheter was exchanged due to obstruction. The Treatment Administration Record (TAR) indicated the order to clean the insertion site was signed out on the TAR as completed on 1/21/25 and 1/22/25. During an interview on 1/22/24 at 3:39 p.m., the Director of Nursing (DON) indicated she understood the concern that the resident's insertion site should be cleaned as ordered and the physician's order should be clear regarding			

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	catheter exchange. No further information was provided. 3.1-41(a)(1)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, record review and interview, the facility failed to ensure food consumption logs and supplements were completed for residents with a history of weight loss for 2 of 3 residents reviewed for nutrition. (Residents F and 82) Findings include: 1. During an interview on 1/21/25 at 10:51 a.m., Resident F indicated he had lost a lot of weight. He was supposed to receive double portions for all the meals, but breakfast was "skimpy" at times. He had only received 1 serving of scrambled eggs for breakfast that morning. The record for Resident F was reviewed on 1/22/25 at 1:35 p.m. Diagnoses included, but were not limited to, sepsis, osteomyelitis, arthritis, anxiety, major depressive disorder, pressure ulcer, paraplegia, schizophrenia, and neuromuscular of the bladder. The 10/10/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a Foley (urinary) catheter. The resident had no oral problems, weighed 118 pounds with no significant weight loss. The resident had one stage 3 pressure ulcer and one stage 4 pressure ulcer that were present on admission.	F 0692	**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.** **F692 Nutrition/Hydration Status Maintenance** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident F remains in the facility, and is receiving double portions as ordered, daily documentation of meal consumption and supplements with ongoing monitoring.** **Resident 82** returned to the hospital, hospital admission was not related to the alleged deficient practice. 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 residents residing in the facility have the potential to be affected by the alleged**	02/25/2025

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	01/29/2025

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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	The Care Plan, revised on 1/14/25, indicated the resident was at risk for impaired nutritional status. The approaches were to provide diet and supplements as ordered. The Care Plan, revised on 1/22/25, indicated the resident had actual skin impairments to the right and left hips and the right ischium. The approaches were to monitor nutritional status, serve diet as ordered, monitor intake and record. The resident weighed 112 pounds on 12/2/24 and weighed 92 pounds on 1/20/25. A Physician Order, dated 1/15/25, indicated double portions at meals. The meal consumption logs indicated there was no breakfast documented on 11/12, 11/28, 12/7, 12/8, 12/29/24, 1/12, and 1/14/25. There was no lunch documented on 10/6, 12/29 , 10/9, 10/11, 10/15, 10/18, 10/19, 10/20, 10/27, 10/30, 11/2,11/3, 11/4, 11/10, 11/12, 11/13, 11/16, 11/18, 11/19, 11/22, 11/23, 11/24, 11/27, 11/28, 11/29, 12/2, 12/4, 12/7, 12/8, 12/19, 12/20, 12/28, 12/29/24, 1/12, 1/14, and 1/15/25. There was no dinner documented on 10/6, 10/8, 10/10, 10/11, 10/12, 10/14, 10/21, 10/25, 12/18, 12/29/24, 1/9, 1/11, 1/18/25. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager indicated meal consumptions should be documented after every meal. 2. During an observation on 1/23/25 at 2:10 p.m., Resident 82 was observed in his room. At that time, his lunch tray was observed on the dresser covered and untouched. He was served meat, potatoes, vegetable and dessert.		**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. **Nursing staff were reeducated regarding the process for assuring that documentation of daily meal consumptions and supplements are completed each. Nutritional Monitoring policy was reviewed with nursing staff.** **Dietary staff was educated on ensuring that meals are prepared following the prescribed diet order.** **Nutrition at Risk meeting was held on 2/4/25, audit of supplements was performed, orders reviewed and updated.** How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place. **The Director of Nursing /designee will audit 5 residents, twice weekly for 6 months, to ensure food consumption logs and supplements are documented and completed.** **Director of Nursing/designee**	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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	The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on 10/26/24. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis, anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and weighed 161 pounds. The resident received a therapeutic diet. A Care Plan, revised on 12/10/24, indicated the resident was at risk for impaired nutritional status due to dialysis. The approaches were to provide the diet and supplements as ordered. A Physician Order, dated 12/11/24, indicated liberal renal diet and a renal liquid supplement in the morning, give one can of Nepro every day. The resident weighed 160 pounds on 12/9/24 and 163 pounds on 1/7/25. The meal consumption logs indicated there was no breakfast documented on 12/7, 12/8/24, 1/12, and 1/14/25. There was no lunch documented on 12/7, 12/8, 12/19, 12/28, 12/31/24, 1/1, 1/12, 1/14, 1/15, 1/19, and 1/23/25. There was no dinner documented on 11/1, 11/4, 11/6, 12/18, 12/28/24, 1/2, 1/12, 1/14, 1/18, 1/25, and 1/27/25 The Medication Administration Record (MAR) for 12/2024 and 1/2025 indicated the renal liquid supplement was signed out as being administered, but lacked documentation of how much was consumed by the resident.		**will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.** - - - - - - - - - - - - - - - **F692 Nutrition/Hydration Status Maintenance** **The Director of Nursing /designee will audit 5 residents, twice weekly for 6 months, to ensure food and supplement consumption logs are documented and completed.** **Resident Identifier** **Meal trays are prepared as ordered** **Y/N**	

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	During an interview on 1/27/25 at 3:30 p.m., the Unit Manager indicated food consumptions were to be documented after every meal and the amount of renal supplement should also have documented in the clinical record. The current and revised 1/13/25 "Nutritional Monitoring" policy, provided by Nurse Consultant 2 on 1/29/25 at 9:35 a.m., indicated monitor each meal intake to include food, hydration, and supplement consumption. Record the intake as follows on the medical records: 100%, 75% or more, between 50-75%, between 25-50% and less than 25% 3.1-46(a)(1)		**Meal consumption is documented** **Y/N** **Type of Supplement** **Supplement Consumption is documented** **Y/N** - **Reviewed by:** ____________________________ **___Date______________** -	

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F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on record review and interview, the facility failed to monitor a fluid restriction for 1 of 1 resident reviewed for dialysis. (Resident 82) Finding includes: The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on 10/26/24. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis, anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. He had an indwelling Foley catheter and received dialysis on admission and while a resident. A Care Plan, revised on 12/18/24, indicated the resident was at risk for altered fluid balance related to dialysis and fluid restriction. A Physician Order, dated 12/8/24, indicated for the resident to only have 1200 cubic centimeters (cc) of fluids per day for chronic kidney disease: dietary 780 cc and nursing 420 cc every shift. There was no documentation on the 12/2024 and 1/2025 Medication Administration or Treatment Administration Records to indicate the fluid restriction was being monitored or accounted for by nursing staff. During an interview on 1/29/25 at 10:45 a.m., the Director of Nursing indicated there was no	F 0698	**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.** **F698 Dialysis** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 82** returned to the hospital; hospital admission was not related to the alleged deficient practice. 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 residents requiring dialysis services with fluid restrictions have the potential to be affected by the same alleged 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; **Nursing staff were re-educated to ensure that fluid restrictions per the physician orders are maintained. Fluid Restriction policy was reviewed with nursing and dietary staff.**	02/25/2025

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	documentation in the clinical record regarding for any monitoring of the fluid restriction. The 10/7/2020 "Fluid Restriction" policy indicated management of fluid intake was critical to specific residents, therefore a physician order for fluid restriction would be maintained. Dietary and other departments would be notified of the fluid restriction so they can communicate any fluid given. 3.1-37(a)		**Dietary staff was educated on ensuring fluid restriction orders are reflected in dietary tickets and followed per order. Dietary tickets updated accordingly. Nutrition at Risk meeting was held on 2/4/25, audit of residents on fluid restriction was performed, orders reviewed and updated.** 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; **Director of Nursing/designee will audit 3 residents on fluid restriction, once weekly x 6 months, to ensure monitoring of fluid restriction is ensured. 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. Monitoring will be on going.** - - - - - **F698 Dialysis** - **Director of Nursing/designee**	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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			will audit 3 residents on fluid restriction, once weekly x 6 months, to ensure monitoring of fluid restriction is ensured. **Resident Identifier** **Dietary ticket and meal tray with fluid restriction** **Y/N** **MAR with fluid restriction breakdown** **Y/N** **Monitoring of fluid restriction documented** **Y/N** **Reviewed by:** _____ _____ **Date:** _____ - - -	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, record review and	F 0761	**Please accept the following as**	02/25/2025

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	01/29/2025

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	interview, the facility failed to ensure proper medication storage related to medications prepared in advance, pre-filled saline syringes used to flush PICC (peripherally inserted central catheter) lines and not stored securely, medications and keys left unattended, insulin pens not labeled when opened, and loose pills observed in the medication carts for 1 of 2 units (The Main Station Unit) This had the potential to affect all residents receiving medications from LPN 2. Findings include: 1. During a random observation on 1/23/25 at 5:29 a.m., an unattended medication cart was observed on the Main Station unit. There were seven pre-poured medications in plastic cups on the top of the medication cart with the resident's first name on each of the cups. The medication cart keys were on top of the cart, as well as a box of Ciprofloxacin eye drops, and two bingo (punch out) cards of 30 pills each of Losartan (a medication used to lower the blood pressure) and Finasteride (a medication used for prostate enlargement). During an interview on 1/23/25 at 5:34 a.m., LPN 2 indicated he was in the bathroom and left the items on top of the cart because he was going to put them away, but just had not done that yet. The LPN stated, "I know better not to pre-pour the resident's medications." During an interview on 1/23/25 at 10:00 a.m., the Director of Nursing indicated the nurse was not allowed to pre-pour resident medication. 2. During random observations on 1/21/25 at 10:57		**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.** **F761 Label/Store Drugs & Biologicals** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Medications were immediately secured appropriately. Medication cart keys were secured. Loose pills were removed from the cart and opened medications were labeled appropriately.** **LPN 2 have been provided with 1:1 education and counseling on proper medication storage.** 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 residents have the potential to be affected by the same alleged deficient practice. All Med carts and med rooms have been audited and concerns corrected** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Nurses were re-educated on**	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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	a.m. and 3:01 p.m., on 1/22/25 at 9:45 a.m., 1:23 p.m., and 3:10 p.m., and on 1/23/24 at 6:39 a.m., there was a bag full of pre-filled saline syringes hanging on the IV pole in Resident F's room. During an interview on 1/23/25 at 9:10 a.m., the Director of Nursing indicated the pre-filled saline syringes should not have been stored in the resident's room. The current 9/1/2020 "Medication Storage" policy provided by Nurse Consultant 1 on 1/23/25 at 11:45 a.m., indicated the facility should ensure all medications were stored in a locked cart. 3. During an observation of the medication cart for Apple Lane on 1/28/25 at 9:10 a.m. with the Wound Nurse, the following was observed: - There were five pills in a medication cup with a first name written on it. - A Lovenox syringe with no resident label was loose in the top drawer. - There were 2 Lantus Insulin pens with no resident label or date when opened. - There was a Basaglar insulin pen that was opened with no date. - There were seven loose pills in the second drawer and six loose pills as well as two plastic vials of Refresh eye drops that had no resident name on it in the third drawer. During an interview on 1/28/25 at 9:20 a.m., the Director of Nursing (DON) indicated all loose pills/unlabeled injectables found needed to be disposed of. Insulin pens should be labeled with		**Medication Storage policy, including:** **Preparing medications at the time of administration only** **Ensuring medication bottles, containers, eye drops, insulins are appropriately labeled and stored properly.** **Medication cart keys are kept always secured** **No medications are left unattended on the medication cart and resident bedside.** **All Medication carts and medication rooms have been audited and concerns corrected.** 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 2 medication carts once a week for 6 months, to ensure medications are labeled appropriately and stored properly.** **The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly**	

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	01/29/2025

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	the resident name and date opened. The current 9/1/2020 "Medication Storage" policy provided by Nurse Consultant 1 on 1/23/25 at 11:45 a.m., indicated once a medication was opened, the facility should follow manufacture guidelines with respect to expiration dates. Facility staff should record the date opened on the medication container. The facility should ensure that all medications were each resident were stored in the containers in which they were originally received. 3.1-25(j) 3.1-25(k)		**at the QA meeting.** **F761 Label/Store Drugs & Biologicals** **DON/designee will audit 2 medication carts once a week for 6 months, to ensure medications are labeled appropriately and stored properly.** **Unit /Med cart** **Med cart locked, and keys secured?** **Y/N** **Are pre-poured medications observed?** **Y/N** **Are there loose pills, open and unlabeled medications** **Y/N** **Comments**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			- - - - - **Reviewer_____** **_____Date_____** **_____**	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs Based on observation, record review, and interview, the facility failed to ensure a resident received routine dental services related to decayed and broken teeth for 1 of 3 residents reviewed for dental services. (Resident 73) Finding includes: During an interview on 1/21/25 at 2:57 p.m., Resident 73 indicated the facility was supposed to	F 0791	**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.** **F791 Dental** What corrective action(s) will be	02/25/2025

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	01/29/2025

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	follow up with the dentist after she cracked her tooth. She had seen a dentist over a year ago and he indicated she needed an extraction. There had been no follow up since. The record for Resident 73 was reviewed on 1/22/25 at 1:55 p.m. Diagnoses included, but were not limited to, anxiety disorder, depression, kidney failure, and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 12/24/24, indicated the resident was cognitively intact. The resident had no cracked, loosed, or chipped teeth. There was no dental care plan. A Dental Note, dated 11/22/23, indicated the resident required an oral surgeon for extraction of #14 and #16 root tips. A Social Service Note, dated 12/7/2023 at 11:59 a.m., indicated the writer was waiting to hear back from the Oral Surgeon regarding the resident's appointment. During an interview on 1/23/25 at 3:18 p.m., the Social Service Director indicated she did not find any documentation that the resident had seen the dentist or had a follow up appointment with the oral surgeon for 2024. During an interview on 1/23/25 at 3:48 p.m., the Director of Nursing indicated she understood the concern and had no additional information to provide. 3.1-24(a)(1)		accomplished for those residents found to have been affected by the deficient practice. **Resident 73 remains in the facility, and tooth extraction have been performed on 2/7/25. Dental care plan have been initiated. MDS with ARD of 12/24/24 have been modified.** 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 residents residing in the facility have the potential to be affected by the alleged 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; **MDS and social service staff were educated in:** **Performing residents' oral assessments quarterly and as needed; initiating appropriate dental referrals; and reviewing dental visit reports timely.** **Ensuring that care plans are in place for dental concerns.** **Social services performed an audit on residents with dental consents, date when last dental care was performed and initiated referral as needed.** How the corrective action(s) will be	

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			monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place. **Social Service Director/designee will audit 5 residents, once weekly for 6 months, to ensure that dental services have been received.** **Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance.** **Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.** - - - - - - **F791 Dental** - **Social Service Director/designee will audit 5 residents, once weekly for 6 months, to ensure that dental services have been received.** - - **Resident Identifier** **MDS ARD** **Sect L coded accurately**	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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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			Y/N **Last Dental Visit** **Follow up needed?** **Y/N/NA** **Dental Care Plan in place** **Y/N/NA** - **Reviewed by:** ______________________________ ________________**Date**_________ _____	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to a Nurse Practitioner (NP) failing to perform hand hygiene after glove removal, enhanced barrier precautions (EBP) not followed while emptying an indwelling Foley catheter and for a resident with a peripherally inserted central catheter (PICC), disposal of a lancet in the garbage can, and glove use in the hallway during random infection control observations. (Residents 82, C, 12, and F) Findings include: 1. During a random observation on 1/22/25 at 1:25 p.m., Resident 82 was observed in his room getting dressed. At 1:30 p.m., an Intravenous (IV) nurse entered the room to insert a PICC line so the resident could start his IV antibiotic therapy for an Urinary Tract Infection. At 1:33 p.m., the IV nurse walked out of the room wearing gloves to both of his hands and continued to walk all the way down the hallway to the nurses' station. At 1:35 p.m., he walked back into the room wearing the same gloves to both hands. At 2:03 p.m., the IV nurse walked out of the room wearing soiled bloody gloves to both hands. He walked all the way down to the nurses' station and then he removed his gloves and threw them away in the garbage can. During an interview on 1/22/25 at 2:04 p.m., Restorative CNA 1 indicated, "He can't do that," referring to the gloves in the hallway, and she was going to let the Unit Manager know right away.	F 0880	**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.** **F880 Infection Prevention and Control** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents 12, F and C remain in the facility without any adverse effects.** **Resident 82 returned to the hospital, hospital admission is not related to alleged deficient practice.** 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 facility residents have the potential to be affected by the same alleged deficient practice.** What measures will be put into	02/25/2025

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	155469	A. BUILDING 00 B. WING	01/29/2025

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	The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on 10/26/24. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis, anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and had an indwelling Foley (urinary) catheter. A Care Plan, dated 1/22/25, indicated the resident required contact isolation precautions due to ESBL (Extended-Spectrum Beta-Lactamase) in the urine. The approaches were to provide proper PPE and maintain contact isolation precautions. A Physician Order, dated 1/22/25, indicated contact isolation related to ESBL in the urine. An urinalysis with a culture and sensitivity, dated 1/22/25, indicated the resident had an urinary tract infection with Klebsiella Pneumoniae (ESBL) that was greater than 100,000 colonies. During an interview on 1/28/25 at 10:00 a.m., the Director of Nursing indicated she was made aware from her staff of the nurse leaving the resident's room with the soiled gloves. The current 9/1/2020 "Infection Prevention and Control Program" provided by Nurse Consultant 2 on 1/23/25 at 1:30 p.m., indicated personal protective equipment was appropriately discarded after resident care prior to leaving the room.		place or what systemic changes will be made to ensure that the deficient practice does not recur; **All facility staff, contracted staff and vendors were re-educated on:** **Enhanced Barrier Precautions** **Syringe and Needle Disposal Policy** **Hand Hygiene** **Doffing PPE prior to moving to clean area of care.** **Proper disposal of biohazard waste i.e. bloody gloves and sharps** **Infection Control Nurse performed return demonstrations and skills validation on hand hygiene, PPE donning and doffing.** 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; **IP nurse/designee will observe 5 facility staff including contracted staff and vendors twice weekly for 6 months, to ensure infection control practices are in place and implemented.** **The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee**	

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	2. During a random observation on 1/28/25 at 11:34 a.m., a CNA removed Resident C from the dining room when the lunch trays had arrived, due to the resident was NPO (nothing my mouth). The resident was placed in the hallway right outside of the room. At that time, an NP entered the memory care unit and asked the Infection Prevention Nurse for a pair of gloves. The NP donned the pair of gloves, without performing hand hygiene, and lifted up the resident's shirt to observe the peg tube (a tube inserted directly into the stomach for nutrition). She touched the peg tube with her gloved hands and then pulled down his shirt, removed the gloves and threw them away on the side of the medication cart. She then asked the Infection Prevention Nurse some questions about the resident as well as other residents. She did not perform hand hygiene after glove removal. During an interview at that time, the NP indicated she could not find any hand sanitizer to perform hand hygiene and had no additional information to provide. During an interview on 1/28/25 at 3:30 p.m., the Director of Nursing had no additional information to provide. The current 9/1/2020 "Infection Prevention and Control Program" policy, provided by Nurse Consultant 2 on 1/23/25 at 1:30 p.m., indicated gloves were to be changed and hand hygiene performed before moving from a contaminated body site to a clean site. 3. During medication pass on 1/23/25 at 11:34 a.m., LPN 1 was preparing to check Resident 12's blood sugar with a glucometer. The LPN gathered the supplies and entered the resident's room. She		**monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.** **F880 Infection prevention and control** **IP nurse/designee will observe 5 facility staff including contracted staff and vendors twice weekly for 6 months, to ensure infection control practices are in place and implemented.** **Staff/Contracted Staff Name** **Task Observed** **Hand Hygiene performed?** **Y/N** **EBP maintained?** **Y/N/NA** **Needles disposed properly?** **Y/N/NA**	

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	washed her hands with soap and water, donned a pair of gloves to both hands, and wiped the resident's finger with an alcohol pad. She pricked the resident's finger with a blue lancet, obtained the blood and placed it on the strip that was inside the glucometer. After checking the blood sugar level, she placed the used lancet, the alcohol pad and the used bloody test strip into one of her gloved hands and removed the glove with all of the supplies inside, removed the other glove and rolled them into a ball and threw everything away into the garbage can inside the resident's room. She walked out of the room and performed hand hygiene at the medication cart. She drew up the resident's scheduled insulin and administered it in her abdomen. Before leaving the room, the LPN was asked where she disposed of the used lancet, she indicated she put it in the sharp's container on the side of the medication. She was then asked to look into the garbage can in the resident's room, where the blue lancet could be visibly seen inside the rolled glove in the trash can. During an interview at that time, the LPN indicated she was aware used lancets should be disposed of into the sharp's container. During an interview on 1/23/25 at 11:45 a.m., the Director of Nursing (DON) indicated the used lancet should have been disposed of in the sharp's container. The current 10/25/2014 "Syringe and Needle Disposal" policy provided by the DON on 1/28/25 at 2:00 p.m., indicated, immediately after use, syringes and needles will be placed into a puncture resistant one way container (sharps) specifically designed for that purpose.		**Gloves removed in the hallway?** **Y/N/NA** - **Reviewed by:** ______________________________ _______________**Date**__________ ______	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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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	4. During a random observation on 1/23/25 at 6:39 a.m., LPN 2 entered Resident F's room to disconnect the intravenous (IV) antibiotic from the resident's PICC line. The LPN donned clean gloves to both hands and did not perform hand hygiene first, disconnected the IV from the PICC line, and flushed the port of the PICC line with a saline flush. The LPN removed his gloves and left the room. CNA 1 entered the room shortly thereafter to empty the resident's Foley catheter. She donned a clean mask over her mouth and gloves to both hands. She did not put on an isolation gown. She removed the urinal from the bathroom and emptied the urine from the catheter bag into the urinal. Afterwards she poured the urine into the toilet, removed her gloves and performed hand hygiene. The record for Resident F was reviewed on 1/22/25 at 1:35 p.m. Diagnoses included, but were not limited to, sepsis, osteomyelitis, arthritis, anxiety, major depressive disorder, pressure ulcer, paraplegia, schizophrenia, and neuromuscular of the bladder. The 10/10/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a Foley (urinary) catheter. The resident had no oral problems, weighed 118 pounds with no significant weight loss. The resident had one stage 3 pressure ulcer and one stage 4 pressure ulcer that were present on admission. A Care Plan, dated 1/22/25, indicated the resident was in contact isolation. A Care Plan, dated 1/22/25, indicated the resident required IV medication and had a PICC line.			

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	155469	A. BUILDING 00 B. WING	01/29/2025

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

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	A Physician Order, dated 1/9/25, indicated Enhanced Barrier Precautions (EBP) for infection control intervention to reduce transmission of multi drug resistant organisms (MDROs). Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices.). A Physician Order, dated 1/2025, indicated Vancomycin 750 milligrams (mg) IV for a wound infection. During an interview on 1/23/25 at 7:09 a.m., the Director of Nursing indicated an isolation gown was to be worn due to the resident being on EBP for the wounds, PICC line and Foley catheter. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager indicated the resident was in EBP and proper precautions should be followed. 3.1-18(b)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to keep the resident's environment clean and in good repair related to marred walls, marred and dirty floors, marred and dirty heat registers, missing toilet paper holders, feces on bed linen, feces on a shared room divider, cracked ceiling tile, a call light not working, and hot water temperatures above 120 degrees on 5 of 5 units throughout the facility. (Cherry Lane, Cherry Court, Blueberry Lane, Apple Lane and	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.** **F921 Safe/Functional/Sanitary/Comf**	02/25/2025

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	01/29/2025

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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	Bakersfield Lane). Findings include: During the Environmental tour with the Maintenence Director on 1/29/25, the following was observed: 1. Cherry Lane a. Room 7: The room divider between the resident beds had smeared feces on it. The divider was shared between 2 residents. b. Room 13-2: The residents bed linen had visible feces stains on them. The resident asked multiple times for clean bed linen and was not granted clean bed linen. Two residents shared this room. c. Room 17-2: The room had marred walls along the bed. 2. Cherry Court a. Room 29-1: The wardrobe closet was marred and the bathroom walls were marred. 3. Apple Lane a. Room 21: On 1/21/25 at 2:53 p.m., the hot water temperature was checked by the Maintenence Director and registered 122 degrees in the resident's bathroom. b. Room 24: On 1/21/25 at 2:53 p.m., the hot water temperature was checked by the Maintenence Director and registered 122 degrees in the resident's bathroom.		**ortable Environment** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Room 7: The room divider between the resident beds had been replaced, no smeared feces.** **Room 13-2: The residents bed linen had been changed.** **Room 17-2: The room that had marred walls along the bed was painted.** **Room 29-1: The wardrobe closet that was marred and the bathroom walls that were marred was painted.** **Room 21: The hot water temperature in the residents bathroom was checked by the Maintenence Director and within normal range.** **Room 24: The hot water temperature in the residents bathroom was checked by the Maintenence Director and within normal range.** **Room 33: The hot water temperature in the residents bathroom was checked by the Maintenence Director and**	

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	155469	A. BUILDING 00 B. WING	01/29/2025

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	The Maintenence Director indicated at that time, the hot water heater was set at 118 and he was going to turn it down now. The day before, a pipe burst in the kitchen and they had turned up the boosters. 4. Blueberry Lane a. Room 33: On 1/21/25 at 2:30 p.m., the hot water temperature was checked by the Maintenence Director and registered 123 degrees in the resident's bathroom. b. Room 34-1: There were marred walls in the resident's room. c. Room 38 -2: There were marred walls in the resident's bathroom. d. Room 42-1-2: The wall behind the head of beds 1 and 2 were scratched and marred, the front of the heat register was discolored with a black substance at the base, the walls were marred in the room and the bathroom. 5. Bakersfield Lane a. Room 60: The heat register was marred in the bathroom. b. Room 64-2: There were marred walls and cracked ceiling tile outside of the bathroom door. The bathroom walls were marred and there was no toilet paper holder. One resident use this bathroom. c. Room 66-2: The heat register was marred, the		**within normal range.** **Room 34-1: The marred walls in the resident's room was painted.** **Room 38 -2: The marred walls in the resident's bathroom was painted.** **Room 42-1-2: The wall behind the head of beds 1 and 2 that were scratched and marred was painted, the front of the heat register that was discolored with a black substance at the base, the walls that were marred in the room and the bathroom were fixed.** **Room 60: The heat register that was marred in the bathroom was painted.** **Room 64-2: There marred walls and cracked ceiling tile outside of the bathroom door was fixed. The bathroom walls that were marred was painted and a toilet paper holder was placed.** **Room 66-2: The heat register that was marred was painted, the wall behind the head of the bed that was marred was painted, and toilet paper holder in the bathroom was placed.**	

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	01/29/2025

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

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	wall behind the head of the bed was marred, and there was no toilet paper holder in the bathroom. Two residents shared the room and four residents used the bathroom. d. Room 69-1: The walls were marred next to the bed. The call light was not working. The heat register was marred. There were no toilet paper holder in the bathroom. The wall underneath the mirror by sink was marred. One resident resided in the room and used the bathroom. e. Room 71-1: The toilet paper holder was broken in the bathroom. The nuns cap (urine collection cup) laying on the heat register in bathroom was not contained. There was debris behind the bed and dirt against the wall behind the bed. Three residents shared the bathroom. During an interview with the Maintenance Director on 1/29/25 at 9:31 a.m., he indicated the areas of concern should have been cleaned and/or repaired and he would take care of it. This citation tag relates to Complaint IN00450254 and IN00451800. 3.1-19(f)		**Room 69-1: The walls that were marred next to thebed was painted . The call light was replaced immediately and is now working. The heat register that was marred was painted. Toilet paper holder in the bathroom was placed. The wall underneath the mirror by sink that was marred was painted.** **Room 71-1: The toilet paper holder was replaced in the bathroom. The nuns cap (urine collection cup) laying on the heat register in bathroom was discarded. The debris behind the bed were sweept and dirt against the wall behind the bed was cleaned.** 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 facility residents have the potential to be affected by the same alleged 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; **All staff meeting was held and reviewed:**	

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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			Process notifying maintenance/environmental services of any necessary repairs or cleaning needed. **Completed full house walk through and environmental assessment and in progress** **Work orders been tracked and logged** 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; **The Maintenance Director and housekeeping director will audit 10 rooms weekly for 6 months for maintenance and housekeeping issues. Identified issues will be corrected timely.** **The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months and until the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.** - -	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			F921 **Safe/Functional/Sanitary/Comfortable Environment** **The Maintenance Director and housekeeping director will audit 10 rooms weekly for 6 months for maintenance and housekeeping issues. Identified issues will be corrected timely.** **Room #** **Maintenance/ Housekeeping issues identified?** **Yes/No** **Was a work order completed?** **Yes/No/NA** **Was the issue corrected?** **Yes/No** **Any Follow up comments**	

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	01/29/2025

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			Maintenance: marred walls & floors, toilet paper holders, cracked ceiling tiles, Call lights,ETC. **Auditor Name :** _____	

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	01/29/2025

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

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			_ **Date:**	