OF A STATE OF STREET AND STREET OF STREET OF STREET					0.125 1.0.0,000 307		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155469	B. WING		01/29/2025		
		1	STREET	T ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	2		W 49TH AVE			
CASA OF	HOBART		HOBART, IN 46342				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
F 0000							
Bldg. 00							
	This visit was for a Recertification and State		F 0000	Casa of Hobart ("the provider	")		
	Licensure Survey.	This visit included the		submits this Plan of Correctio	n		
	Investigation of Co	mplaints IN00450254,		("POC") in accordance with			
	IN00450652, and II	N00451800.		specific regulatory requiremen	nts. It		
				shall not be construed as an			
	Complaint IN00450	0254 - Federal/State deficiencies		admission of any alleged			
		ations are cited at F677, F686		deficiency cited. The Provider			
	and F921.	,		submits this POC with the			
				intention that it be inadmissible	le by		
	Complaint IN00450652 - Federal/State deficiencies related to the allegations are cited at F689.			any third party in any civil or			
				criminal action against the			
	related to the allega	ations are cited at 1 00%.		Provider or any employee, ag	ont		
	Complaint INO0451	1800 - Federal/State deficiencies		officer, director, or shareholde			
	_	ations are cited at F677 and					
	F921.	tions are cited at Fo// and		the Provider. The Provider he	·		
	F921.			reserves the right to challenge			
	G 1.4 I	21 22 22 24 27 28 120		findings of this survey if at any	•		
	· ·	ary 21, 22, 23, 24, 27, 28, and 29,		time the Provider determines			
	2025			the disputed findings: (1)are r			
				upon to adversely influence o			
	Facility number: 00			serve as a basis, in any way,			
	Provider number:			the selection and/or impositio	n of		
	AIM number: 1002	288900		future remedies, or for any			
				increase in future remedies,			
	Census Bed Type:			whether such remedies are			
	SNF/NF: 92			imposed by the Centers for			
	Total: 92			Medicare and Medicaid Servi	ces		
				("CMS"), the state of Indiana	or		
	Census Payor Type	:		any other entity; or (2) to serv	e, in		
	Medicare: 4			any way to facilitate or promo	te		
	Medicaid: 67			action by any third party agair			
	Other: 18			the Provider. Any changes to			
	Private: 3			Provider policy or procedures			
	Total: 92			should be considered to be			
				subsequent remedial measure	es as		
	These deficiencies	reflect State Findings cited in		that concept is employed in R			
	accordance with 41	C		407 of the Federal Rules			
	accordance with 41	0 110 10.2 3.1.		of Evidence and should be			
			1	or Evidence and should be			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Falon Wendel RN, DON 02/16/2025

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB N						IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155469	B. WI	NG		01/29	/2025
NAME OF I	PROVIDER OR SUPPLIE	D.	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	-KOVIDER OR SUFFEIE	X.		4410 W	/ 49TH AVE		
CASA OF	FHOBART			HOBAF	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Quality review completed on 2/5/25.				inadmissible in any proceeding	g on	
					that basis.		
					The provider offers its respons		
					credible allegations of complia	nce	
					and plan of correction as part	of its	
					ongoing efforts to provide qua	lity of	
					care to residents. The provide	r	
					respectfully requests a desk		
					review of the following plans of	of	
					correction.		
F 0554	483.10(c)(7)						
SS=D	Resident Self-Adr	min Meds-Clinically Approp					
Bldg. 00	.						
		on, record review, and	F 05	554	Please accept the following		02/25/2025
		ity failed to ensure a resident			the facility's credible allegati	on	
		f-administer medications and			of compliance. This plan of	_	
	<u>-</u>	ders to self-administer for 1 of 1			correction does not constitu		
		For self-administration of			an admission of guilt or liabi	_	
	medication. (Resid	lent G)			by the facility and is submitt	ed	
	Finding includes				only in response to the		
	Finding includes:				regulatory requirement.		
	During random abo	servations on 1/21/25 at 11:28			F554 Resident Self Admin		
	_	on 1/22/25 at 9:45 a.m., 1:31 p.m.			Meds-Clinically Appropriate		
	-	on 1/23/25 at 5:45 a.m., an			What corrective action(s) will be		
	_	d inhaler was observed on			accomplished for those reside		
	Resident G's over b				found to have been affected b	y uie	
	Resident G S over t	bed table.			deficient practice. A self-administration		
	During an interview	w on 1/21/25 at 11:30 a.m., the				for	
		she used the inhaler for rescue			assessment was completed Resident G, she was deemed		
	breathing at least d				I		
	oreauming at least 0	any.			appropriate to self administe medications. MD was notified		
	The record for Desi	ident G was reviewed on			and an order was received to		
		n. Diagnoses included, but were			self-administer PRN albutero		
	_	D (Chronic Obstructive				"	
	I not infined to COP.	D (CHIOIIIC OOSH HCHVC			inhaler. Care plan was		1

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Pulmonary Disease), acute respiratory failure,

Alzheimer's disease, anxiety disorder, high blood

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updated.

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How the facility will identify other

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155469	B. WING		01/29/2025	
		<u> </u>	(MD E)	ADDRESS CITY OF THE TIP OF		
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
CASA 01	F HOBART			/ 49TH AVE		
CASA OI	T NUDAK I		HOBAF	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	pressure, and bipol	ar disorder.		residents having the potential		
				be affected by the same defic		
		terly Minimum Data Set (MDS)		practice and what corrective a	action	
		ed the resident was cognitively		will be taken;		
	_	ision making. The resident's		All facility residents with		
	vision was adequat	e and she wore glasses.		medication orders have the		
				potential to be affected by the	ne	
		ed on 5/14/24, indicated the		same alleged deficient		
		for complications including		practice.		
		experienced while lying flat		What measures will be put int		
	and upon exertion secondary to COPD. The			place or what systemic chang		
	approaches were to administer aerosol or			will be made to ensure that the	=	
	bronchodilators as ordered.			deficient practice does not rec	cur;	
		1 . 10/10/04		Staff were educated on		
	· ·	r, dated 8/19/24, indicated		self-administration of		
		IFA Inhalation Aerosol		medications policy, with		
		nister inhale one puff orally		emphasis on not to leave		
	every 6 hours as ne	eded for wheezing.		medications at the residents		
	Thomas versions and C	administration assessment or a		bedside unless an assessme	ent	
				and order for		
	physician's order for self-administer her			self-administration have bee	en	
	sen-administer her	own innaier.		completed.	wad	
	During an interview	v on 1/23/25 at 10:05 a.m., the		Respiratory Therapist review residents with PRN rescue	veu	
	_	g had no additional information		inhalers and assessed if		
	to provide.	5 nau no auditional illiorillation		self-administration is		
	to provide.			appropriate.		
	The current 2/15/2	l "Self-Administration of		How the corrective action(s) w	vill he	
		ally Appropriate" policy,		monitored to ensure the defici		
		Consultant 1 on 1/23/25 at		practice will not recur, i.e., wh		
		ed a resident may only		quality assurance programs w		
	· ·	dications after the IDT has		put into place;	50	
		medications may be		Facility Angel's will audit 5		
		The IDT will determine at a		residents 2 days per week fo	or 6	
		ident had the capacity to follow		months to ensure no	•	
		lent's cognitive status was		medication is improperly		
		resident's ability to understand		stored at the bedside and an	ıv	
	and store medication			medication noted at bedside		
		,		has an assessment and orde		

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3.1-11(a)

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for self-administration.

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	F OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/29/2025
	ROVIDER OR SUPPLIE	R	4410 V	ADDRESS, CITY, STATE, ZIP CO V 49TH AVE RT, IN 46342	OD.
(X4) ID PREFIX TAG	(EACH DEFICIE	TSTATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5) DULD BE PROPRIATE DATE
				The Director of Nursing/designee will summary of the audits Quality Assurance commonthly for 6 months at the facility maintains 9 compliance. Thereafter determined by the Quaternined by the Quaternined by the Quaternined by the Quaternined will be quarterly and present at the QA meeting.	to the nmittee and until 15% r, if ality auditing done quarterly min priate dit 5 reek for 6 rly and any edside d order . dication thave a essment r for an for

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/29/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE				
CASA OF	F HOBART		HOBA	RT, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F 0583 SS=D Bldg. 00	Based on observation failed to ensure a remaintained related to completing an assessinserted directly into	on and interview, the facility sident's privacy was to a Nurse Practitioner (NP) asment of a peg tube (a tube to the stomach for nutrition) in 1 of 1 resident reviewed for	F 0583	Reviewed by:Date	ute oility		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/29/2025 155469 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART **HOBART. IN 46342** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE During a random observation on 1/28/25 at 11:34 Privacy/Confidentiality of a.m., a CNA removed Resident C from the dining Records room when the lunch trays had arrived, due to the What corrective action(s) will be resident being NPO (nothing my mouth). The accomplished for those residents resident was placed in the hallway right outside of found to have been affected by the the room. At that time, an NP entered the memory deficient practice. care unit and asked the Infection Prevention Resident C remains in the Nurse for a pair of gloves. The NP donned the pair facility, privacy has been of gloves and lifted up the resident's shirt to maintained during care and observe the peg tube (a tube inserted directly into assessments. No signs of the stomach for nutrition) in the middle of the psychosocial distress have hallway. She did not take the resident to a private been noted due to this alleged area to make her assessments. The resident's deficient practice. stomach and peg tube were exposed for all to see. How the facility will identify other residents having the potential to The record for Resident C was reviewed on be affected by the same deficient 1/27/25 at 2:03 p.m.. Diagnoses included, but were practice and what corrective action not limited to, peg tube, falls, dysphagia (difficulty will be taken. swallowing), type 2 diabetes, palliative care, All facility residents have the Parkinson's disease, psychotic disorder, severe potential to be affected by the dementia with agitation, high blood pressure, same alleged deficient restlessness and agitation. practice. What measures will be put into The 12/24/25 Significant Change Minimum Data place or what systemic changes Set (MDS) assessment indicated the resident was will be made to ensure that the not cognitively intact for daily decision making deficient practice does not recur. and was dependent on staff for most of his Staff and contracted providers activities of daily living, including bathing. The were educated to not provide resident had a feeding tube and received 51% or care, assessment and services more of his nutrition through the tube and 501 in common areas to ensure cubic centimeters (cc) of fluids through the tube. that residents' privacy is maintained. During an interview on 1/28/25 at 11:50 a.m., the How the corrective action(s) will be NP had no additional information to provide. monitored to ensure that the deficient practice will not recur, During an interview on 1/28/25 at 4:15 p.m., the i.e., what quality assurance

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provide.

Director of Nursing indicated she had called the

concerns. She had no additional information to

NP's physician supervisor and informed him of her

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programs will be put into place.

staff and contracted providers

DON/Designee will observe

in 3 common areas/unit

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUILDING B. WING	00	COMPLETED 01/29/2025	
	PROVIDER OR SUPPLIEF F HOBART	₹	STREET 4410 W HOBAF			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION	
	3.1-3(p)(4)			hallways twice weekly x 6 months to ensure resident privacy is maintained durt assessment and care. The Director of Nursing/designee will presummary of the audits to Quality Assurance commitmenthly for 6 months and the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, aut and monitoring will be do quarterly and present quatat the QA meeting.	sent a the ittee I until diting ne arterly ve iders it's ing	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00			COMPLETED 01/29/2025	
		155469	B. WIN	B. WING			2025	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
CASA OF	F HOBART			4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	ı	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	P	PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROP		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)		15	DATE	
					Y/N			
					Were vendors, contracted st providers, providing care ar services in common areas? Y/N Comments			
					- - -			
					- - -			
					-			
					-			
					Reviewed by:			
					Date_			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances				_			
	failed to file a griev investigate, and res personal items that	view, and interview, the facility vance form, thoroughly olve grievances for missing were reported to staff for 1 of 1 for grievances. (Resident 23)	F 058	35	Please accept the following a the facility's credible allegati of compliance. This plan of correction does not constitu an admission of guilt or liabi by the facility and is submitt	on te lity	02/25/2025	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLETED	
		155469	B. W	ING		01/29/2025	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			V 49TH AVE		
CASAO	F HOBART				RT, IN 46342		
CASA O	TIODANI			HOBAI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORI		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE	
	Finding includes:				only in response to the		
					regulatory requirement.		
	1	w on 1/21/25 at 9:52 a.m.,			-		
		ted she was missing a teal blue			F585 Grievances		
		many people about the issue.			-		
		n missing for over 2 months			What corrective action(s) will I		
	and nothing was do	one about it.			accomplished for those reside		
					found to have been affected b	y the	
		3 a.m., The resident was			deficient practice.		
		neelchair watching she			Resident 23 remains in the		
		icated she had not filed a			facility, grievance have been		
	grievance for the missing clothing. She indicated				filed and follow-up resolution		
	she spoke with laundry staff and she had no				have been discussed with th	·e	
	follow up.				son and resident.		
	The man and for Dea	ident 23 was reviewed on			How the facility will identify oth		
		m. Diagnoses included, but were			residents having the potential		
		niplegia (paralysis on one side of			be affected by the same defici		
		nsion (high blood pressure),			practice and what corrective a will be taken.	Cuon	
		a (low iron), and stroke.			All facility residents have the		
	depression, anemia	i (low non), and stroke.			potential to be affected by the		
	The Quarterly Min	imum Data Set (MDS)			same alleged deficient		
		10/27/24, indicated the resident			practice.		
		tact. The resident had			What measures will be put into	0	
		side of the upper and lower			place or what systemic chang		
	extremity and used				will be made to ensure that the		
	1				deficient practice does not rec		
	There was no griev	vance/concern form filed for the			All staff was held, reviewed		
	resident's first miss				policy on the grievance		
					process, ensuring that all		
	During an interview	w on 1/27/25 at 2:48 p.m.,			verbal grievances have been	ı	
	Laundry Aide 1 inc	dicated she was aware of the			filed in writing so it can be		
	missing teal outfit.	She indicated she had			investigated and resolved		
	personally labeled	the outfit and knew exactly			accordingly.		
	what was missing.	She had not been able to locate			Resident council was held,		
	the clothing for a v	while and had not filed a			residents were made aware	of	
	grievance to replac	ee the resident's personal			the grievance process. Posti	ing	
	belongings.				is available in prominent		
					locations on how to file a		
During an interview on 1/28/25 at 9:51 a.m., the				grievance and who the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 01/20/2025				
		155469	B. WING 01/29/2025				2025
	PROVIDER OR SUPPLIER F HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Director of Nursing	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION (DON) indicated she nce should have been filed for		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) grievance officer is. Director of Customer Experience visited cognitivel intact residents and ensured that any outstanding grievan had been filed and resolved. Facility Angels will discuss a grievance that has been brought to their attention	y ce	(X5) COMPLETION DATE
					brought to their attention during rounds at the morning meetings. How the corrective action(s) we 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 quarte at the QA meeting.	ill be	

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	T OF HEALTH AND H				FO	TED: 02/18/20 RM APPROVED IB NO. 0938-039
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/29/2025	
	PROVIDER OR SUPPLI HOBART	ER	STREET A 4410 W HOBAF			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	N E RIATE	(X5) COMPLETION DATE
				- - -		
				- - -		
				- - -		
				- - -		
				- - -		
				- - -		
				- - -		
				- - -		
				- - -		
				-		

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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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155469	B. WING	_	01/29/2025	
NAME OF D	DROWINED OR CLINDLIED		STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER		4410 W	/ 49TH AVE		
CASA OF	HOBART		HOBAF	RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG			
				Resident identifier Did the residents verbalize a	nv	
				concern/grievance?	'' ^y	
				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		
			1	1		

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i i i i i i i i i i i i i i i i i i i		X1) PROVIDER/SUPPLIER/CLIA				ì	3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155469		B. WING 01/29/2				
						0 17 2 07		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE					
CASA OF	HOBART				RT, IN 46342			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION DATE	
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requireme Transfer/Discharg Based on record rev failed to ensure the was notified in writi hospital for 1 of 3 re hospitalization. (Re Finding includes: Resident 20's record 3:00 p.m. Diagnoses to, dementia, respira schizophrenia, and o bone infection) of le The Significant Cha assessment, dated 1: was moderately imp making. The Change in Cone 11/6/24, indicated the resident and ordered out to the hospital. Physicians' Notes, de resident was sent out	nts Before e riew and interview, the facility resident's Responsible Party ing related to a transfer to the esidents reviewed for esident 20) I was reviewed on 1/27/25 at as included, but were not limited atory failure, muscle weakness, esteomyelitis (muscle and	F 06		Please accept the following at the facility's credible allegatiof compliance. This plan of correction does not constitute an admission of guilt or liabil 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 reside found to have been affected by 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 acopy of the facility will identify oth residents having the potential be affected by the same deficipractice and what corrective active	on te lity ed oe nts y the to ent ction	02/25/2025	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155469	B. WI	NG		01/29/	2025
				CTD FFT A	ADDRESS OF A STATE TIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
040401	LIODADT			l	49TH AVE		
CASA OF	F HOBART			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE
	The resident was ac	lmitted to the hospital with a			potential to be affected by th	е	
	toe infection on 11/	6/24 and returned to the			same alleged deficient		
	facility on 11/25/24	. The resident was admitted to			practice.		
	the hospital on 1/7/2	25 with septic shock and			What measures will be put into	5	
	returned to the facil	-			place or what systemic changes		
					will be made to ensure that the		
	There was no indica	ation the State transfer form			deficient practice does not rec		
		esident's responsible party for			Nursing Staff members and		
	either admission.				medical records dept. were		
					educated on the process to		
	During an interview	v on 1/28/25 at 11:45 a.m., the			ensure that notification of th	е	
	_	(DON) indicated she had no			facilities bed hold notice		
	additional information to provide and understood				occurs.		
	the concern.				How the corrective action(s) w	/ill be	
					monitored to ensure that the		
	3.1-12(a)(6)(A)(ii)				deficient practice will not recu	·,	
					i.e., what quality assurance	<i>,</i>	
					programs will be put into place	e.	
					All discharges and transferre		
					out residents reviewed daily		
					the clinical meeting will be		
					audited for proof of notificati	ion	
					of the facility bed hold policy		
			This process will occur daily for				
					all discharges and transfers		
					out.		
					The Director of		
					Nursing/designee will preser	nt a	
					summary of the audits to the		
					Quality Assurance committe		
					monthly for 6 months and ur	ıtil	
					the facility maintains 95%		
					compliance. Thereafter, if		
					determined by the Quality		
					Assurance committee, auditi	ng	
					and monitoring will be done	-	
					quarterly and present quarte	rly	
					at the QA meeting.		
					<u> </u>		
					_		
	I		1		İ	,	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIF A. BUILDII B. WING	PLE CONSTRUCTION NG <u>00</u>	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF P	ROVIDER OR SUPPLIEF	3		REET ADDRESS, CITY, STATE, ZIP CO. 10 W 49TH AVE	D
CASA OF	HOBART		НС	DBART, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	ULD BE COMPLETION
				- F623 Notice requirements Be Transfers /Discharge - All discharges and tran out residents will be autor proof of notification facility bed hold policy process will occur daily discharges and transfer This includes the week Manager on duty/Nursi supervisor - Resident Identifier Did the resident discharge notice? Y/N If yes, did the resident the discharge notice? Y/N If yes, was the signed of uploaded to the EHR If not, Was the Bed hold policy is Mail to the Resp. Pare P.O.A.? Y/N If yes, Was a copy of the stame envelope uploaded to the stame envelope uploaded to the residents.	nsferred udited n of the . This y for all ers out. eend ng urge or ity? receive copy cy sent arty or

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
CASA OF	HOBART			RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	(EACH DEFICIEN			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Y/N If no, Comment here	(X5) COMPLETION DATE
				 - -	
				ReviewerDate	
				Date	

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	PROVIDER OR SUPPLIER HOBART			4410 W	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing Based on record reversal factories about their them of new medicareviewed for particity (Resident D) Finding includes: During an interview Resident D indicate or inform him of ne physician's orders. The record for Resident D indicate or inform him of ne physician's orders. The record for Resident D indicate or inform him of ne physician's orders. The record for Resident D indicate or inform him of ne physician's orders. The record for Resident D indicate or inform him of ne physician's orders. The 12/2/25 at 4:10 p.m. not limited to, acute (Chronic Obstructive diabetes mellitus (Dipressure, chronic kin and depression. The 12/2/24 Quarter assessment indicate intact for daily decises ubstantial to maxim and/or showering. A Physician's Order Amlodipine 10 mill the morning for high Physician's Orders,	and Revision riew and interview, the facility dents were involved in reare related to informing ations for 1 of 7 residents pation in care planning. on 1/21/25 at 2:49 p.m., destinated the staff did not always tell were destinated as included, but were the respiratory failure, COPD are Pulmonary Disease) type 2 pM), heart failure, high blood deney disease, osteoarthritis, rly Minimum Data Set (MDS) destinated the resident was cognitively sion making and needed mal assistance with bathing r, dated 12/4/24, indicated igrams (mg), give one tablet in	F 06	557	Please accept the following the facility's credible allegat of compliance. This plan of correction does not constitute an admission of guilt or liable by the facility and is submit only in response to the regulatory requirement. F657 Care Plan Timing and Revision What corrective action(s) will accomplished for those reside found to have been affected by deficient practice. Resident D remains in the facility, a care plan meeting was held, including but not limited to his current medication list was discuss Care plans on hypertension have been updated, care plan on ABT use has been resolved How the facility will identify of residents having the potential be affected by the same deficient practice and what corrective awill be taken. All facility residents have the potential to be affected by the same alleged deficient practice. What measures will be put in	be ents by the lt to cient action	02/25/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/29/2025	
	PROVIDER OR SUPPLIER F HOBART		4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
CASA OI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR tablet in the mornin Tamiflu Oral Capsu time a day for 14 d There was no docur the resident was ma medication regime for the flu. During an interview Unit Manager indic made aware of new During an interview Director of Nursing	on 1/28/25 at 4:00 p.m., the indicated there was no resident was made aware of			ges he ecur. d on ing t the II g e. will be ur, ce. t to ent a ne tee until

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155469	B. WI			01/29/	
		100.00				0 17 2 07	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
01 1	No vident on sort eith			4410 W 49TH AVE			
CASA OF	HOBART		HOBART, IN 46342				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					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.		
					about their care.		
					Resident Identifier		
					New medication		
					Resident notified of new		
					medication?		
					Y/N		
					Documentation of notificatio	n	
					in the medical records?		
					Y/N		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ,	ILTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPI	
ANDILAN	OI CORRECTION	155469	B. WI		<u></u>	01/29	
		.55100				0 1/20	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD V 49TH AVE		
CASA OF	HOBART				RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
5 0077					- Reviewed by: ————————————————————————————————————		
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provide	d 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.		F 06	77	Please accept the following a the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability 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 resided found to have been affected be deficient practice. Resident E remains in the fact and assistance with feeding is provided. Residents C and D are received showers as per preference. How the facility will identify offer residents having the potential be affected by the same deficit practice and what corrective a will be taken. All residents requiring assistance with Activities of Daily Living have the potential to be affected by the same	te ility ed Dee ents y the ility, ing ner to ient ient iction	02/25/2025
	The resident did not receive a shower at least two times a week for the months of 10/2024, 11/2024,				alleged deficient practice. What measures will be put into	0	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155469	B. W	ING		01/29/	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	₹			/ 49TH AVE		
CASA O	F HOBART				RT, IN 46342		
	1		1		, 100 12 I		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		was no shower or completed			place or what systemic chang		
		ed on 10/1/24, 11/20/24, 1/4/25,			will be made to ensure that th		
	1/8/25, 1/15/25, and	d 1/25/25.			deficient practice does not red	cur;	
					Staff were re-educated on:		
		v on 1/28/25 at 4:15 p.m., the			Providing residents		
		eated the resident should have			with assistance with their		
	a shower at least tw	vo times a week.			activities of daily living (ADL	•	
					per plan of care/preferences		
					with a special focus on		
		esident C was reviewed on			assistance with eating and		
	_	Diagnoses included, but were			showers.		
		tube, falls, dysphagia (difficulty			Dining room staff		
	swallowing), type 2 diabetes, palliative care,				assignments every meal as		
	Parkinson's disease, psychotic disorder, severe				shown in daily nursing		
	dementia with agitation, high blood pressure,				schedule.		
	restlessness and ag	itation.			Use of quick entry		
					group in point of care (POC)		
	1	ficant Change Minimum Data			identify showers assigned for	or	
	` ′	ent indicated the resident was			the shift.		
		ect for daily decision making			Restorative Nurse reassesse		
	_	on staff for most of his			residents to identify who ne		
	activities of daily li	ving, including bathing.			supervision and assistance	with	
					feeding.		
	· ·	ed on 1/14/25, indicated the			Clinical managers reviewed		
	-	ssistance with ADLs due to			residents shower preference		
	dementia.				and schedule to ensure that		
					staff will provide and docum		
		receive a shower on			shower tasks. Clinical meeti	ng	
	-	aturdays evenings. There was			agenda to include review of	_	
		nted at least 2 times a week on			documentation compliance	Of	
	11/2, 11/9, 11/13, a	and 1/22/25			POC charting.		
	D						
	_	v on 1/28/25 at 4:15 p.m., the					
		of Nursing indicated the			11	201.15	
		re least two showers a week.			How the corrective action(s) v		
	3. On 1/23/25 at 8:30 a.m. and 8:48 a.m., Resident E				monitored to ensure the defici		
	was observed sitting up in bed and eating a bowl				practice will not recur, i.e., wh		
		was tipped in the opposite			quality assurance programs w	/III be	
		dent and milk was dripping out			put into place;	_	
	of the bowl onto he	r gown. The resident had a	1		DON/Designee will observe	5	I

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155469	B. W	ING		01/29/2	2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	₹			/ 49TH AVE		
C484 O	F HOBART				RT, IN 46342		
CASA OI	FINDBAKT			ПОВАР	(1, IN 40342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	plastic spoon positi	oned backwards in her mouth			residents that require		
	and was making a g	gagging noise. The restorative			assistance with feeding, twic	e	
	nursing aide was wa	alking by the resident's room			weekly for 6 months, to ensu	re	
	and was immediate	ly notified.			that staff is providing		
					assistance during meals.		
		v at the time, Restorative CNA			DON/Designee will audit and		
		dent was normally a "set up"			interview 5 residents, twice		
		omething must be wrong with			weekly for 6 months, to ensu	ire	
	the resident.				that residents are receiving		
					showers as scheduled.		
		iewed for Resident E on			Director of Nursing/designed		
		m. Diagnoses included but were			will present a summary of th		
	_	ession, muscle weakness, age			audits to the Quality Assurar	nce	
	related cataract, and encephalopathy.				committee monthly for 6		
					months and until the facility		
		um Data Set (MDS)			maintains 95% compliance.		
		0/20/24, indicated the resident			Thereafter, if determined by		
		act for daily decision making.			the Quality Assurance		
	_	ed supervision/touching			committee, auditing and		
		g . Oral hygiene required			monitoring will be done		
	_	assistance, and toileting			quarterly and present quarte	rly	
		thing, upper and lower body			at the QA meeting.		
	assistance.	ıbstantial/maximum			-		
	assistance.				-		
	A Core Plan ravisa	d on 1/20/24, indicated the			-		
		ed visual function related to			-		
	cataracts and glauce				-		
	cataracts and graded	onia.			-		
	A Care Plan revise	d on 1/20/24, indicated the			-		
		sistance with Activities of			-		
	_	s) including bed mobility,			-		
		ileting and bathing related to			-		
		nosis of osteoarthritis.			-		
	Interventions were				-		
		g and drinking as needed, and			-		
		personal hygiene as needed.			-		
		1 70			-		
	A Physician's Order	r, dated 1/22/25, indicated to			-		
		of Ceftriaxone (antibiotic)			-		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COM	ie survey ipleted 29/2025
	PROVIDER OR SUPPLIEI F HOBART	₹	4410 V	ADDRESS, CITY, STATE, ZIP C V 49TH AVE RT, IN 46342	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF intravenously (IV) Infection (UTI) for Nurses' Notes, date	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION daily for a Urinary Tract 10 days. d 1/22/2025 at 10:08 a.m., nt was experiencing increased	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Nurses' Notes, date indicated the reside had been yelling an and refused care. T new orders were re (intravenous) access During an interview Director of Nursing have had supervise	d 1/21/2025 at 9:00 p.m., and had spit out medication, discreaming, refused meals, the Physician was notified and ceived for a midline IV and IV antibiotic. If you on 1/24/25 at 11:12 a.m., the grandicated the resident should dimeal consumption. If to Complaints IN00450254		Ef677 ADL Care Provided Dependent Residents DON/Designee will obteresidents that require assistance with feeding weekly for 6 months, that staff is providing assistance during meresident Identifier Resident Invited to the room for supervision Y/N Staff provided assistated during meals? Y/N Name of staff providing assistance	pserve 5 ng, twice to ensure eals. e dining ?	

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Facility ID: 000366

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155469	A. BUILDING B. WING	00	COMPLETED 01/29/2025		
		100408			01/28/2020		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD / 49TH AVE			
CASA OF	F HOBART		HOBART, IN 46342				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION		
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	DON/Designee will audit and interview 5 residents, twice weekly for 6 months, to ensuthat 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/29/2025	
	PROVIDER OR SUPPLIER HOBART			4410 W	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					Reviewed by:		
F 0679 SS=C Bldg. 00	483.24(c)(1) Activities Meet Inte	erest/Needs Each Resident			_ Date:		
Blag. UU	interview, the facili personalized activit impaired and depen ongoing stimulation for 1 of 1 resident re (Resident 81) Finding includes: On 1/21/25 at 10:13 observed sitting in 1 and rocking herself There was no televit On 1/21/25 at 3:50 awake in her wheelet television was not of the resident's niece her aunt was screan indicated the televis there. On 1/22/25 at 1:35 was observed lying was not on and ther	erview on 1/22/24 at 9:49 a.m., indicated she walked in and hing and hollering out. She tion was not on when she got p.m. and 2:51 p.m., the resident awake in bed. The television e was no music playing. a.m. and at 8:48 a.m., the ed sitting up in bed, the	F 06	79	Please accept the following the facility's credible allegat of compliance. This plan of correction does not constitute an admission of guilt or liability the facility and is submitted only in response to the regulatory requirement. F679 Activities Meet Interest/Needs of Each Resident of those resident found to have been affected be 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 our residents having the potential be affected by the same deficient practice and what corrective a will be taken. All residents in the facility has the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recommend.	ion Ite Illity Ite Int Ite Int Ite Int Ite Ite Ite Ite Ite Ite Ite Ite Ite It	02/25/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED			
		155469	B. WI	B. WING		01/29/20)25
NAME OF F	PROVIDER OR SUPPLIER	•	•		ADDRESS, CITY, STATE, ZIP COD		
		•	4410 W 49TH AVE				
CASA OF	F HOBART			HOBAF	RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		a.m., the resident was observed			Activity Director was		
		as awake lying in bed staring			in-serviced on:		
	_	e television. The television			Performing activity		
	was on and there w	as no music playing.			assessment upon admission	١,	
	On 1/24/25 at 0:00	a.m., the Activity Director was			quarterly and as needed Providing activities the		
		the daily chronicle to the			meet the needs and	iat	
		the chronicle on her bedside			preferences of each resident	.	
	table and walked ba				Documenting activities		
	and warked ba	on out.			provided, including 1:1		
	During an interview	at the time, the Activity			activities		
	_	indicated the resident receives			Initiating and reviewi	ng	
		dicated she had had only been			activity care plans	'' ⁹	
		nth and would try and locate			Activity team was in-service	۱ ا	
	documentation.	and would try and rocate			on how to provide and	"	
	documentation.				document 1:1 activities per		
	On 1/24/25 at 9:03	a.m., the Activity Director went			plan of care.		
		ent had her television on, and			Activity team conducted		
		f she would like the daily			re-assessment of residents'		
		er, or if she wanted music			activity needs and preference	es.	
	played.	,			and reviewed activity care	,	
					plans.		
	The record for Resi	dent 81 was reviewed on			How the corrective action(s) w	/ill be	
	1/23/25 at 10:04 a.r.	n. Diagnoses included, but were			monitored to ensure the defici		
	not limited to, depre	ession, muscle weakness, age			practice will not recur, i.e., wh	at	
	related cataract, and				quality assurance programs w		
					put into place;		
		um Data Set (MDS)			Administrator/Designee will		
		0/20/24, indicated the resident			audit and observe 5 resident	s	
	was cognitively inta	net for daily decision making.			twice weekly for 6 months, to	o	
	_	ed supervision/touching			ensure that residents are		
	1	g . Oral hygiene required			offered and participating in		
	1 -	assistance, and toileting			activities that meet their nee	ds	
		thing, upper and lower body			and preferences.		
	dressing required su	ıbstantial/maximum			The administrator/designee		
	assistance.				will present a summary of th		
					audits to the Quality Assura	nce	
		d on 1/20/24, indicated the			committee monthly for 6		
	1	ed visual function related to			months and until the facility		
	cataracts and glauce	oma.			maintains 95% compliance.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/29/2025
	PROVIDER OR SUPPLIE F HOBART	2	4410 V	ADDRESS, CITY, STATE, ZIP COI V 49TH AVE RT, IN 46342)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREGE (EACH CORRECTIVE ACTION SHOUNDS SHOUNDED TO THE APPOPER OF THE APPOPE	JLD BE COMPLETION DATE
	1	ity care plan. e documentation indicated the it for the resident was on		Thereafter, if determine the Quality Assurance committee, auditing and monitoring will be done quarterly and present q at the QA meeting.	d
	During an interview	v on 1/27/25 at 2:11 p.m., the g indicated she understood the or the television should have dent.		F679 Activities Meet Interest/Needs of Each Administrator/Designee audit and observe 5 res twice weekly for 6 mont ensure that residents a offered and participatin activities that meet thei and preferences. Resident Identifier Activity Need/Preference (Group/Independent/1:1 Activity Performed Documented in medical records Y/N Activity care plan in pla	e will idents ths, to re g in r needs

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUILDING 00 COMPLETED 01/29/2025					
	ROVIDER OR SUPPLIER HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0684 SS=D Bldg. 00	interview, the facilit non-pressure areas v bandages were chan reviewed for skin co blood pressure parar resident reviewed for assessed and monitor	were monitored, assessed, and ged for 1 of 1 resident onditions non-pressure related, meters were followed for 1 of 1 or dialysis, and a resident was bred post cataract surgery for wed for vision and hearing.	F 0684	Reviewed by:	te lity ed		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155469	B. W	ING _		01/29/	2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			/ 49TH AVE		
CASA OF	F HOBART				RT, IN 46342		
0/10/101	TIODATT			110B/ (I			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		. 1/01/05 . 11 00			deficient practice.		
	_	riew 1/21/25 at 11:28 a.m.,			Resident G remains in the		
		ed her double vision was back			facility, cataract post operati	ive	
		e staff about it. She indicated			report was obtained and		
		gery a couple of months prior			reviewed on 1/28/25,		
	and was airaid som	ething else was wrong.			plan/recommendation is to		
	The record for Desi	dent G was reviewed on			return to clinic as needed.	.	
		. Diagnoses included, but were			Vision care plan was initiate	u,	
	_	D (Chronic Obstructive			and an appointment to the optometrist was scheduled of	ا ۱۰۰۰	
), acute respiratory failure,			to complaints of double vision		
	-	e, anxiety disorder, high blood			Resident 82 returned to the	JII.	
	pressure, and bipola	-			hospital on 2/7/25, hospital		
	pressure, and orpora	ar disorder.			admission is not related to		
	The 11/14/24 Quart	terly Minimum Data Set (MDS)			alleged deficient practice.		
		ed the resident was cognitively	How the facility will identify other				
		sion making. The resident's			residents having the potential		
	-	e and she wore glasses.			be affected by the same defic		
	, isisii was aasqaas	and she were glasses.			practice and what corrective a		
	There was no Care	Plan for vision.			will be taken.	.0011	
					All residents in the facility ha	ave	
	A referral, dated 7/	11/24, indicated the resident			the potential to be affected by		
		cataract surgery. The			the alleged deficient practice	-	
		made for the right eye on			What measures will be put int		
		m. and the left eye on 9/17/24 at			place or what systemic chang		
	10:30 a.m.				will be made to ensure that the		
					deficient practice does not red	cur;	
	There was no docur	mentation in the clinical record			Nursing team members were		
	the resident had the	cataract surgery.			educated on:		
					Change in condition		
	1	an's Orders, dated 9/11/24, for			assessment policy, including	g	
		ps and for Polytrim antibiotic			documentation of performed	ı	
	eye drops post cata	ract surgery.			procedures/surgery;		
					assessment and monitoring	of	
		sment or monitoring of the			resident post		
		d after she returned from			procedure/surgery		
	having cataract eye	surgery on 9/11/24.			Medication		
					administration of medication	ns	
		dated 9/18/24, indicated orders			with parameters		
	for Prednisone and	Polytrim eye drops again for			Procedure with return	ı	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 01/29/2025
	PROVIDER OR SUPPLIER HOBART		4410 W	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	There was no docur the resident left the surgery for the other assessment or any k resident returned. During an interview Unit Manager, indicestaff to document in resident left for an a assessment after the having cataract surged Unit Manager had reprovide The current 10/1/20 Assessment" policy Nursing (DON) on resident assessment admission, re-admission, re-adm	mentation in the clinical record facility to have cataract reye, nor was there an find of monitoring when the cated she would expect nursing a the clinical record when a appointment and compete an eresident returned from gery. To on 1/28/25 at 4:15 p.m., the to additional information to 20 "Change in Condition provided by the Director of 1/29/25 at 10:45 a.m., indicated was to be completed upon ssion, and with change in change in resident condition RN/LPN must complete an g vital signs and any Resident assessment was to resident's medical record. ation on 1/23/25 at 6:52 a.m., ting on the side of the bed with was a soiled, foul smelling his lower back. The bandage tinage noted and was crinkled there was also another clear	TAG	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, folloup and documentation are in place. How the corrective action(s) with 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 drasite, once weekly x 6 months to ensure that assessment, output monitoring and dressichanges are performed as ordered.	ill be
		ze observed just above the as a drainage bag filled with		Director of Nursing/Designee will audit 5 residents with	

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liquid coming from a drain under the foul smelling

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medication parameters, once

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 01/29/2025				
		155469	B. W	ING		01/29/	2025
	PROVIDER OR SUPPLIER		•	4410 W	ADDRESS, CITY, STATE, ZIP COD 49TH AVE RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
TAG	and soiled bandage. On 1/23/25 at 2:40 posserved in the reside look at the bandage with area. There was a vectoming from the bandage was dirty a coming from it. She ever been changed strain. At 2:45 p.m., the Webandage from the drain. At 2:45 p.m., the Webandage from the drain. At 2:45 p.m., the Webandage from the drain. The several normal salir remove the substantial flange and drain. The several normal salir remove the substantial flange and drainage was rank and had a drainage noted. The attempted to remove several attempts becomes attempts becomes desired in the bandages prior the scheduled pring (as not list to do.) The record for Residulty on 10/26 to 10/26 t	p.m., the Unit Manager was dent's room and was asked to son his back. She was able to the the drain and observed the ery strong, foul smelling odor indage. If at that time, she indicated the and there was a strong odor was unsure if the bandage had since he had returned with the If ound Nurse removed the rain site. At that time, there and drain observed. There was ried brown drainage on the ne Wound Nurse had to use the pouches and gauze pads to be that was adhered to the tube. The soiled gauze pad large amount of dried brown would wound Nurse then the clear bandage and it took cause it was adhered to the		TAG	weekly x 6 months, to ensure that medications are administered according to ordered parameters. Director of Nursing/Designed will audit 3 residents who has scheduled appointments/procedures, oweekly x 6 months, to ensure assessment, monitoring, foll 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 ur the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, auditi and monitoring will be done quarterly and present quarte at the QA meeting.	e d nce e ow	DATE
	renal and perinephri	ic abscess, renal dialysis,	1		l _		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u> COMPLETED			ETED
		155469	B. W	'ING		01/29/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
04040	LIODADT				/ 49TH AVE		
CASA OF	F HOBART			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
	anemia, chronic kid	ney disease, depression, and,					
	end stage renal dise	ase.					
	The 12/24/24 Quart	erly Minimum Data Set (MDS)			<u> </u>		
	assessment, indicate	ed the resident was			<u> </u>		
	moderately impaire	d for daily decision making and			1_		
	had an indwelling F	Foley catheter.			F684 Quality of Care		
					Director of Nursing/Designed	e	
	A Care Plan, dated	12/9/24, indicated the resident			will audit 3 residents with dra		
	had a drain in place	due to a renal abscess.			site, once weekly x 6 months	s,	
					to ensure that assessment,		
	A Physician's Order	r, dated 1/7/25, indicated to			output monitoring and dress	ing	
	monitor the renal ab	oscess drain site (right			changes are performed as		
	accordion drain site	e) every shift and report any			ordered.		
	abnormalities to the	doctor. May cleanse with			Resident Identifier		
	wound cleanser or r	normal saline and cover the			Assessment of drain site		
	drainage site with g	auze island with border. May			weekly		
	change if soiled or i	may be removed as needed.			Y/N		
					Output documented as order	red	
		ministration Records (MAR),			Y/N		
		1/2025, indicated the right			Dressing changed performed	d	
		(renal abscess) was not			as scheduled		
	-	monitored on the following			Y/N		
	days:						
		nd 12/27, 1/1, 1/4, 1/5, 1/6, 1/8,					
	1/9, 1/10, 1/12, 1/13						
	_	27 and 12/29, 1/7, 1/8, 1/10,					
	1/16, 1/18, 1/21, 1/2	22/25					
	7E1 ' 1 / 1'	1 2 9 1 1 2 1					
	_	drain site bandage to be					
		ot signed out at all on the					
	1/2025 MAR/TAR.						
	A Dhygigian's Onder	r, dated 12/10/24, indicated					
		eation to raise the blood					
	,	rams (mg), give two tablets by			Director of Nursing/Designer	_	
		day for hypotension. Hold if			Director of Nursing/Designed will audit 5 residents with	-	
		r) blood pressure was greater				_	
		ic (bottom number) blood			medication parameters, once		
					weekly x 6 months, to ensure	ㅂ	
	pressure was greate	ı man 80.			that medications are		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155469	B. WING 01/29/2025				2025
			1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.	4410 W 49TH AVE				
CASA OF	HOBART				RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
TAG	The 1/2025 MAR in administered on the 1/2/25 a.m. dose and 128/87 1/2/25 mid day dose 145/76 1/2/25 hs (bedtime) was 113/83 1/18/25 hs dose and 127/89 1/20/25 a.m. dose and 122/81 During an interview Director of Nursing condition of the four renal abscess area. During an interview Unit Manager had in provide regarding the administration. The current 9/1/202 and Monitoring Prepolicy, provided by at 5:00 p.m., indicate conditions will be a and signs of complitions of the skin tears, wounds, include the date of the performed the process.	d the blood pressure was e and the blood pressure was dose and the blood pressure I the blood pressure was and the blood pressure		TAG	administered according to ordered parameters. Resident Identifier Medication with Parameter Parameters followed as ordered Y/N Comments Director of Nursing/Designed will audit 3 residents who has scheduled appointments/procedures, oweekly x 6 months, to ensure assessment, monitoring, followed.	e d nce e low	DATE
	signs and symptoms	acement, cleanliness, and s of infection.			up and documentation are in place.	ı	
	3.1-37(a)				Resident Identifier Date of Appointment/Proced Documentation that resident left and returned to/from		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION C	completed 01/29/2025
	PROVIDER OR SUPPLIEF F HOBART	8	4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R 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
				procedure Y/N Assessment and monitoring post procedure Y/N Comments	
				Reviewed by: Date	_
F 0686 SS=D Bldg. 00	Ulcer	o Prevent/Heal Pressure			
	failed to ensure pre completed as order antibiotics for a wo administered as ord reviewed for pressu Finding includes:	view and interview, the facility source ulcer treatments were ed and IV (intravenous) und infection were ered for 1 of 1 resident are ulcers. (Resident F)	F 0686	Please accept the following as the facility's credible allegatio of compliance. This plan of correction does not constitute an admission of guilt or liabili by the facility and is submitted only in response to the regulatory requirement. F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers	n e ty

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155469	B. WING		01/29/2025	
			OTDEET	ADDDECC CITY CTATE ZIB COD		
NAME OF P	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD		
	- HOBART		4410 W 49TH AVE HOBART, IN 46342			
UASA UI	HODANT		HOBAR			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		t time, he was observed with a		What corrective action(s) will l		
		inserted central catheter) in his		accomplished for those reside		
		nere were no IV antibiotics		found to have been affected b	y the	
	-	e. From 10:15 a.m. until 11:40		deficient practice;		
		IV antibiotic administered to the		Resident F's treatments are b	•	
	resident.			rendered and documented pe	r	
	0 1/22/25 : 0 45	4 11 4 1		physician orders.		
		.a.m., the resident was observed		Resident F is receiving all	:	
		t, there was an IV antibiotic bag		medications including antibiot	ics	
		e that had already infused. The		per physician orders.		
		eropenem with 1/22/25 at 5:00		How the facility will identify oth		
	a.m. handwritten or	i inc label.		residents having the potential	• • • • • • • • • • • • • • • • • • •	
	During a random of	heartration on 1/22/25 at 6:55		be affected by the same defic	• • • • • • • • • • • • • • • • • • •	
	-	bservation on 1/23/25 at 6:55 ion room on the main station,		practice and what corrective a	ICHOH	
		ibiotic bags of Vancomycin in		will be taken;		
		had arrived to the facility on		All residents with pressure ulcers have the potential to I	20	
	1/21/25.	and arrived to the facility on		affected by the same alleged		
	1,21,23.			deficient practice.	'	
	The record for Resi	ident F was reviewed on		What measures will be put into	n	
		a. Diagnoses included, but were		place or what systemic chang	• • • • • • • • • • • • • • • • • • •	
		is, osteomyelitis, arthritis,		will be made to ensure that the		
	-	ressive disorder, pressure ulcer,		deficient practice does not rec		
		hrenia, and neuromuscular of		Nurses were re-educated on	·	
	the bladder.	•		the following:		
				Rendering wound car	re	
	The 10/10/24 Quar	terly Minimum Data Set (MDS)		per physician orders and		
	assessment indicate	ed the resident was cognitively		documenting the care in the		
	intact for daily deci	sion making and had a Foley		Treatment Administration		
	(urinary) catheter.	Γhe resident had one stage 3		Record (TAR)		
	*	loss where the underlying		Administering all		
		aneous fat) was visible within		medications including		
		bone, tendon, or muscle was		antibiotics per physician ord	lers	
		are ulcer and one stage 4		and documenting the		
	pressure ulcer that	were present on admission.		administration in the		
				Medication Administration		
		sed on 1/22/25, indicated the		Record (MAR)		
		skin impairments to the right		How the corrective action(s) w	• • • • • • • • • • • • • • • • • • •	
	and left hips and the	and left hips and the right ischium. The		monitored to ensure the defici	ent	

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approaches were to administer treatments as

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practice will not recur, i.e., what

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLE	ETED
		155469	B. W	ING _		01/29/2	2025
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			49TH AVE		
CASA OF	F HOBART				RT, IN 46342		
	1100/1111			11007	1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
	ordered and monitor for effectiveness.				quality assurance programs w	ill be	
					put into place;		
		ed 1/22/25, indicated the			Wound nurse/designee will		
	_	/ medication and had a PICC			randomly audit 5 residents		
		es were to administer IV			requiring wound care weekly	'	
	antibiotics as order	ed by the physician.			for 6 months, with a special		
	The Wound Dhygie	ian Notes, dated 1/20/25,			focus on residents receiving antibiotics for treatment of		
		nt had a Stage 3 pressure ulcer			wounds to ensure treatment	_	
		measured 7.5 centimeters (cm)			are rendered and documente	_	
		in width by 0.6 in depth that			per orders and antibiotics ar		
		ion tissue (a new, pink or red,			administered and document		
	_	rms at the site of a wound as it			per orders.		
		ining (a condition where tissue			Director of Nursing/designed	, 	
		ocket under the wound			will present a summary of th		
		wound appear larger than it			audits to the Quality Assurar		
	_	m at 3 o'clock. There was			committee monthly for 6		
		ssure ulcer to the left hip that			months and until the facility		
		n length by 6.2 cm in width by			maintains 95% compliance.		
	4.5 cm depth with 1	00% granulation tissue. There			Thereafter, if determined by		
	was undermining of	f 2.5 cm at 9 o'clock. There was			the Quality Assurance		
	a Stage 3 pressure t	lcer to the right ischium that			committee, auditing and		
	measured 5.5 cm in	length by 5.7 cm in width by 1			monitoring will be done		
	•	re was 100% granulation tissue			quarterly and present quarte	rly	
	with undermining a	t 3 o'clock.			at the QA meeting.		
					_		
		ere present on admission but			-		
	just had not healed.				_		
					F686 Treatment/Svcs to		
		lmitted to the hospital on			Prevent/Heal Pressure Ulcers	<u>s</u>	
	_	c shock and returned back to			Wound nurse/designee will		
	-	5 with IV antibiotics for a			randomly audit 5 residents		
	wound infection.				requiring wound care weekly	<i>'</i>	
	Dhygioigala Ond	dated 11/24/24 indicated to			for 6 months, with a special		
	1 .	dated 11/24/24, indicated to			focus on residents receiving		
	_	d left hips with normal saline,			antibiotics for treatment of		
		n's moistened kerlix to the vith an ABD pad and secure			wounds to ensure treatments are rendered and documente	·	
		a day every a.m. and hs			per order and antibiotics are		
	(bedtime).	a day every a.m. and no			administered and document		
	(ocumine).		1		i auministereu anu uocumenti	- u	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/29/2025	
	PROVIDER OR SUPPLIER	·	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE	
TAG	The Treatment Adr the month of 11/20 the right and left hi on 11/1, 11/2, 11/4. Physician's Orders, cleanse the right an pat dry, apply gauz saline to the wound sliver, cover with A every day and even was to be cleansed apply gauze roll ke gel (anasept) to the ABD pad and secur evening shift. The 12/2024 TAR is left and right hips v completed for the e and 12/30/24. The 12/2024 TAR is treatment was not so n 12/26 and 12/27	ninistration Record (TAR) for 24 indicated the treatment for ps were blank for the hs shift .11/6, 11/17, 11/18, and 11/24/24. dated 12/23/24, indicated to d left hips with normal saline, e roll kerlix moistened with 0.9 bed with alginate calcium with .BD pad and secure with tape ing shifts. The right ischium with normal saline, pat dry, rlix with sodium hypochlorite wound bed, cover with an e with tape every day and and cover with an ere with tape every day and and cated the treatment for the evere not signed out as being vening shift on 12/26, 12/27 andicated the right ischium igned out as being completed /24 for the evening shift.	TAG	per orders. - Resident Identifier Does the residents have wounds requiring treatment Y/N If yes, Are the treatment orders be signed on the TAR? Y/N - Is the resident receiving antibiotic therapy? Y/N - If yes, Is the administration signe on MAR? Y/N	nt?	
	cleanse the left and pat dry, and apply § 0.9 saline to the wo	dated 1/9/25, indicated to right hips with normal saline, gauze roll kerlix moistened with und bed with alginate calcium with an ABD pad and secure and evening shift.		- - - -		
	left and right hips v completed on 1/10/ 1/10, and 1/11/25 fo	dicated the treatments for the were not signed out as being 25 for the day shift and on 1/9, or the evening shift.		- - - -		
	A Physician's Orde	r, dated 1/10/24, indicated	1	1 -		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155469	B. WING		01/29/2025	
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE	
		ntravenous Solution				
		m infuse two times a day every		-		
	a.m., and hs.			-		
				1		
	The Medication Administration Record (MAR) for			1		
	1/2025 indicated the	e Vancomycin was not signed		_		
	_	stered on 1/10/25 for both a.m.		_		
	and hs, and on 1/12	/25 for the hs dose.		-		
	A DI CONTRACTOR	1 . 11/12/25 * 12 1		-		
		r, dated 1/13/25, indicated ntravenous Solution		-		
				-		
	Reconstituted 1 gram, infuse two times a day at			- Poviowor		
	8:00 a.m. and 8:00 p.m.			ReviewerDate_		
	A Physician's Order	r, dated 1/13/25, indicated		Bate		
	1	enous Solution Reconstituted 1				
	gram infuse three ti					
	8					
	The 1/2025 MAR in	ndicated the Vancomycin was				
	not signed out as be	eing administered on 1/18/25				
	for the 8:00 p.m. do	ose and 1/20/25 for the 8:00 a.m.				
	dose. The Meropen	em was not signed out as				
	_	on 1/13 at 5 a.m., 1/17 and 1/18				
	_	t 1:00 p.m. and 9:00 p.m., and				
	1/21/24 at 5:00 a.m	. and 9:00 p.m.				
	A Disersist 1 O 1	4-4-4 1/20/25 :. 1: 4 1				
	1	r, dated 1/20/25, indicated				
		ntravenous Solution				
	hours for wound int	750 mg intravenously every 12				
	nours for would in	iccuoil.				
	The 1/2025 MAR in	ndicated the Vancomycin was				
		eing administered on 1/20 and				
	1/21/25 for the 9:00					
		•				
	During an interview	y on 1/23/25 10:37 a.m., the				
	Wound Nurse indic	ated treatments were to be				
	completed as ordere	ed by the doctor. He worked				
		1 3:00 p.m., and was not in the				
	facility during the e	evening times.				

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/29/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
F 0687 SS=D Bldg. 00	Unit Manager, indiccompleted as ordered be administered as of the current 9/1/202 and Monitoring Prespolicy, provided by at 5:00 p.m., indicate treatments shall be in electronic TAR after. This citation relates 3.1-40(a)(2) 483.25(b)(2)(i)(ii) Foot Care Based on observation interview, the facility received the necessarelated to podiatry were viewed for podiatry were viewed for podiatry was at 2:37 grant wanted his toe nails long. He had told exhis room this request was going unot senile, his mind he needed and wanted to the complete of the complete	on 1/27/25 at 3:30 p.m., the cated the treatments were to od and IV antibiotics were to ordered by the physician. O "Skin Condition Assessment source and Non-Pressure" the DON as current on 1/28/25 and physician-ordered initialed by the staff on the reach administration. to Complaint IN00450254. On, record review, and the failed to ensure the resident any treatment and foot care disits for 1 of 1 resident any treatment and foot care disits for 1 of 1 resident any care. (Resident 69) On, Resident 69 indicated he could down and they were too deep staff member who entered at multiple times. On, Resident 69 was observed and the total cut and felt his inheard. He indicated he was was sharp, and he knew what ed. Resident 69's toe nails to long and unkempt looking.	F 0687	Please accept the following the facility's credible allega of compliance. This plan of correction does not constit an admission of guilt or lial by the facility and is submit only in response to the regulatory requirement. F687 Foot Care What corrective action(s) will accomplished for those reside found to have been affected deficient practice; Resident 69 remains in the facility and has had foot carendered including trimmin toenails on 1/25/25 without signs and symptoms of advireactions. How the facility will identify of	ute pility tted be lents by the re g of		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/29/2025	
NAME OF P	PROVIDER OR SUPPLIER	.			ESS, CITY, STATE, ZIP COD	-	
				10 W 49T			
CASA OF	F HOBART		HC	BART, IN	N 4034Z		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREF	IX CF	(EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROI	BE PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	ì	DEFICIENCY)		DATE
		diatrist had not cut his nails in			sidents having the potent		
		f would not cut his toe nails			affected by the same de		
	either.				actice and what corrective	e action	
	TI 1CD.	1 460 : 1			l be taken;		
		dent 69 was reviewed on			residents residing in th		
	not limited to, end s	. Diagnoses included, but were			cility have the potential	to be	
		al dialysis, and type 2 diabetes			ected by the alleged ficient practice		
	mellitus with diabet				nat measures will be put	into	
	memus with diabet	не першорашу.			ice or what systemic cha		
	The Quarterly Mini	mum Data Set (MDS)			I be made to ensure that	-	
assessment, dated 1/4/25, indicated the resident					ficient practice does not		
was cognitively intact for daily decision making.				rsing staff were educat			
			ı	garding providing foot of			
	The Care Plan, date	ed 1/4/25, indicated to avoid		_	d trimming nails for		
		hands and body parts from			n-diabetic residents and	d	
		Keep fingernails short.		I	lowing up with podiatry		
					betic residents that rec		
	The last Podiatry A	ssessment, dated 9/20/24		ı	ail trim.		
	indicated Resident's	s 69's toenail length was 2 mm		So	cial services performed	l an	
	(millimeters). The p	oodiatrist performed a		aud	dit on residents with po	diatry	
		al exam, reviewed the medical		coı	nsents, date when last	foot	
		ed and debrided the toe nails to		car	re was performed and		
		nce. There were no signs of			erral as needed.		
		ote indicated non-professional			ound care nurse perforr		
		hazardous to the patient.			in sweep to identify res	idents	
		necessary, but no sooner than			th long toenails.		
	60 days.			I	w the corrective action(s	,	
	and the	0 1 1 1 1 1 1 1			nitored to ensure that th		
		s from the podiatrist in January		ı	ficient practice will not re		
	2025 for Resident 6)) .			, what quality assurance		
	During on interview	on 1/24/25 at 9:56 a.m., the			ograms will be put into pl		
	-	sultant indicated she had no			ound nurse/designee wi		
		missed podiatry appointment		ı	ndomly assess 5 reside ily x 2 weeks then 2x/wo		
		or a rescheduled appointment			sure that foot care is be		
	-	make sure to rescheduled the			ndered, and nails are be	-	
	-	y services for 2/4/25.		ı	nmed per facility proto	-	
	1051delli 101 podiati	, services for 21 1123.		ı	ector of Nursing/design		
	3.1-47(a)(7)			ı	I proceed a summary of		

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

PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/29/2025	
	ROVIDER OR SUPPLIE	R	4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
CASA OF (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			rly ATE

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PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED 01/29/2025	
	PROVIDER OR SUPPLIE	₹	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0689 SS=D Bldg. 00	interview, the facil materials were lock residents' rooms fo smoking and halos ordered for 1 of 1 r (Residents G, F and Findings include:	on, record review, and ity failed to ensure smoking sed in a safe place and not in the r 2 of 2 residents reviewed for were on a resident's bed as esident reviewed for falls.	F 0689	Please accept the following the facility's credible allegat of compliance. This plan of correction does not constitu an admission of guilt or liability the facility and is submitted only in response to the regulatory requirement. F689 - Free of Accidents Hazards /Supervision /device	ion te ility ed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETE				
		155469	B. W	ING		01/29/	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			/ 49TH AVE		
CASA OF	F HOBART			HOBART, IN 46342			
(X4) ID	CLIMMADV	STATEMENT OF DEFICIENCIE	1	ID	I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(A3) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG		at G was sitting on the side of		IAG	It is the policy of Casa of		DAIL
		e, there was a vape (electronic			Hobart to ensure that care		
		the bed next to her. During an			planned interventions are in		
		ne, the resident indicated she			place for residents who		
		ner at all times, but only used it			experience falls and incident	te	
	when she went outs				What corrective action(s) will		
					be accomplished for those		
	The record for Resi	dent G was reviewed on			residents found to have been	n	
		. Diagnoses included, but were			affected by the deficient		
		O (Chronic Obstructive			practice.		
), acute respiratory failure,			Resident G- Smoking materia	ıls	
	Alzheimer's disease	e, anxiety disorder, high blood			have been removed from the		
	pressure, and bipola	ar disorder.			bedside for safety and monito	ring	
					Resident F - Smoking materia	-	
	The 11/14/24 Quart	erly Minimum Data Set (MDS)			have been removed from the		
	assessment indicate	d the resident was cognitively			bedside for safety and monito	ring.	
	intact for daily deci-	sion making.			Smoking care plan initiated.		
					Resident H – Halos are in pla	ce	
		d on 10/23/23, indicated the			as ordered and care planned		
		xer. The approaches were to					
		ences outlined in the policy			How the facility will identify		
	for smoking and no	ncompliance.			other residents having the		
					potential to be affected by the	ie	
		ng Risk Assessment indicated	same deficient practice and				
		smoked and preferred to			what corrective action will be	е	
		ty needed to store the			taken.		
	resident's cigarettes	and lighter.			All residents who smoke and		
	Duning on intermi	y on 1/22/25 at 0:45 a tha			those at risk of falls have the		
	_	on 1/23/25 at 9:45 a.m., the ated the vape should not be in			potential to be affected by the		
	the resident's room	ated the vape should not be in			same alleged deficient practic	ᠸ.	
	the restuent's room				What measures will be put ir	nto	
	During an interview	on 1/23/24 at 10:30 a.m., the			place or what systemic	11.0	
		had no further information to			changes will be made to		
	provide.	, and no result information to			ensure that the deficient		
	provide.				practice does not recur.		
					An emergency smoking meeti	na	
	2. During random of	bservations on 1/21/25 at 10:47			was held on 1/23/25 with all	…ອ	
	_	3:10 p.m., Resident F was			smokers attending to discuss		
	_	those times, the top drawer to			smoking policy and contracts		

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	PROVIDER OR SUPPLIER		STREET 4410 V HOBA		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	three packs of cigar the drawer. During an interview indicated he was no was too cold outside. The record for Resi 1/22/25 at 1:35 p.m not limited to, sepsi anxiety, major depr paraplegia, schizopl the bladder. The 10/10/24 Quart	open. There were two vapes, ettes and two lighters inside v at that time, the resident t currently smoking because it e. dent F was reviewed on . Diagnoses included, but were s, osteomyelitis, arthritis, essive disorder, pressure ulcer, hrenia, and neuromuscular of erly Minimum Data Set (MDS) d the resident was cognitively		were obtained. Staff were in-serviced on: Ensuring care planned interventions are in place at time of care planning. Ensuring that all residence are aware of the facilities sate smoking protocol and residence are not allowed to keep their smoking materials i.e. lighted cigarettes, tobacco or Vapes Clinical team and IDT review care plan interventions of rewho had a fall in the last 30	the idents ife ents r own rs, s wed fall sidents
	A 10/4/24 Smoking resident actively smoontinue. The reside the lighter and cigar A 10/30/24 Smokin	Plan regarding smoking. Risk Assessment indicated the tooked and preferred to the total reded the facility to store		How the corrective action(swill be monitored to ensure	·
	continue. The reside the lighter and cigar A 1/9/25 Smoking I resident did not smo During an interview Unit Manager indic and vapes should no room.	ent needed the facility to store rettes. Risk Assessment indicated the		that the deficient practice of not recur, i.e., what quality assurance programs will be into place. Facility Angel's will audit 5 residents 2 days per week for months to ensure no smoking materials are kept at bedside. The Director of Nursing /des will review 5 residents with fincidents, once weekly x 6	e put or 6 ng e.

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Event ID:

633F11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155469	B. W	ING		01/29/	2025
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
04040	LIODADT		4410 W 49TH AVE				
CASA OF	F HOBART			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Director of Nursing	had no further information to			months, to ensure that fall		
provide.				interventions are in place			
					according to care plan.		
	The current 9/2022	"Resident Smoking" policy,			Director of Nursing/designed)	
	provided by Nurse	Consultant 1, indicated			will present a summary of th	е	
	possessing, carrying	g, or holding materials used to			audits to the Quality Assura	nce	
	smoke (including, b	out not limited to, cigarettes,			committee monthly for 6		
	cigars, loose tobacc	o, pipes, lighters, and			months and until the facility		
	matches) by residen	its who required supervision			maintains 95% compliance.		
	was prohibited insid	le the building. Residents			Thereafter, if determined by		
	must give smoking	materials to staff when they			the Quality Assurance		
	enter the building e	ven if the resident has been			committee, auditing and		
	assessed to be indep	pendent in carrying such			monitoring will be done		
	materials when off	the premises. 3. On 1/22/25 at			quarterly and present quarte	rly	
	2:42 p.m., Resident	H was in the bathroom. The			at the QA meeting.		
	resident's bed was o	bserved in the low position					
	and there were no h	alos (bed mobility assist			_		
	device) on the resid	ent's bed.			_		
					_		
		a.m., Resident H was lying in			_		
		sion. The bed was in the low			_		
		los were observed on the			-		
		resident indicated he had slid			-		
	out of the bed sever	al times.			-		
					-		
		was reviewed on 1/22/25 at			-		
		s included, but were not limited			-		
	_	ascular dementia, moderate			-		
	without behavioral				-		
	disturbance, mood	disturbance, and anxiety.			-		
					<u>F689 -</u> Free of Accidents		
		imum Data Set (MDS)			Hazards /Supervision /device	es	
		2/17/24, indicated the resident			Facility Angel's will audit 5		
	was cognitively inta	act.			residents 2 days per week for		
		11/00/05			months to ensure no smoking		
	_	ated 1/22/25, indicated the			materials are kept at bedside.		
		am (IDT) met to review the					
		ed on 1/2/2025. The root cause			The Director of Nursing /desig		
		esident slid out of the bed.			will review 5 residents with fal		
	Interventions and th	e care plan were updated. All			incidents, once weekly x 6		

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

PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/29/2025	
	PROVIDER OR SUPPLIE F HOBART	R	4410 V	ADDRESS, CITY, STATE, ZIP COD N 49TH AVE RT, IN 46342		
CASA OI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O care planned intervithe incident. New included implement During an Intervite on 1/24/25 at 11:2 intervention of hal in place for the res	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Ventions were in place at time of interventions, dated 1/22/25, atting halos bilaterally. We with the Director of Nursing 5 a.m., she indicated the cost to the bed should have been ident to prevent falls. Is to Complaint IN00450652.			DATE	
F 0690 SS=D Bldg. 00	Based on observat	continence, Catheter, UTI ion, record review, and ity failed to ensure Foley	F 0690	ReviewerD Please accept the following the facility's credible allega		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLET			ETED	
		155469	B. W	ING		01/29/	/2025
		l		CTREET	ADDRESS CITY STATE 710 COD		
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
04040	LIODADT				49TH AVE		
LASA OF	F HOBART			HORAK	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	catheter bags and to	ibing were kept off of the			of compliance. This plan of		
	floor, Enhanced Ba	rrier Precautions (EBP) were			correction does not constitu	te	
	maintained and sup	rapubic catheter site care was			an admission of guilt or liabi	lity	
	completed for 2 of 2	2 residents reviewed for			by the facility and is submitte	ed	
	catheters. (Residen	ts 82 and 49)			only in response to the		
					regulatory requirement.		
	Findings include:				F690 Bowel/Bladder		
					Incontinence, Catheter, UTI		
	1. During random o	bservations on 1/22/25 at 9:44			What corrective action(s) will be	эе	
	_	12:06 p.m., and on 1/27/25 at			accomplished for those reside	ents	
	9:49 a.m., Resident	82 was observed sitting in his			found to have been affected b	y the	
	wheelchair with a F	oley catheter bag hooked on			deficient practice.		
	the arm of the wheelchair, making the bag above				Resident 82 returned to the		
	the resident's waist.				hospital, hospital admission w	as	
					not related to the alleged defic	cient	
	During a random o	bservation on 1/23/25 at 6:52			practice.		
	a.m., the resident w	as sitting on the side of the			Resident 49 - received cathete	er	
	bed, and the indwel	ling Foley catheter tubing was			care without adverse reaction.		
	on the floor and the	drainage bag was hanging on			Suprapubic catheter change o	order	
	the trash can. CNA	1 was in the resident's room			have been updated and clarific	ed.	
	and was going to er	npty the Foley catheter. The			Suprapubic catheter have bee	en	
	_	of clean gloves to both hands			irrigated as ordered.		
		for the urinal to empty the			How the facility will identify oth	ner	
		find one, so she removed the			residents having the potential	to	
		room. She came back to the			be affected by the same defici	ient	
	1	ash basin, and indicated she			practice and what corrective a	ction	
	could not find anyn	nore urinals so she grabbed the			will be taken;		
	1	g to empty the urine into it.			All residents with indwelling		
	1	of clean gloves to both hands,			catheters have the potential	to	
		hand hygiene and placed a			be affected by the same		
	1	floor and put the pink wash			alleged deficient practice and	d	
	_	towel. She picked up the			reviewed orders for care		
		heter and emptied the urine			What measures will be put into		
		took the basin into the			place or what systemic change		
	_	ied the contents into the toilet.			will be made to ensure that the		
		pasin in the sink and with a			deficient practice does not rec	:ur;	
		gun to dry the inside. After			Staff were re-educated on:		
	1	e opened the resident's drawer			Ensuring catheter care	is	
		to the closet. She removed her			rendered as per orders.		
	gloves and left the	oom.	1		Ensuring catheter are irrigate	ed	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING 00 COMI			ETED
		155469	B. W	'ING		01/29/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	S.			/ 49TH AVE		
CASA OF	HOBART				RT, IN 46342		
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE		ID	<u> </u>		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LISC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	DATE	
1110	REGUERITORT OR	EBE BENTI TING IN GRAINTIGN		1110	as ordered.		Ditte
	During an interview	at that time, CNA 1 indicated			Ensuring catheter		
	•	the was supposed to wear an			drainage bag/tubing are		
		n emptying the urinal.			positioned off the floor		
					Staff to don proper PPE		
	The record for Resi	dent 82 was reviewed on			when emptying and	-	
		The resident was admitted to			maintaining catheter.		
		6/24. Diagnoses included, but			Infection Control nurse		
	-	acute myocardial infarction,			identified all residents with		
	·	ic abscess, renal dialysis,			catheter, reviewed and		
		ney disease, depression, and,			updated catheter orders.		
	end stage renal dise	-					
	C						
	The 12/24/24 Quart	erly Minimum Data Set (MDS)					
	assessment, indicate	ed the resident was					
	moderately impaire	d for daily decision making and					
	had an indwelling F	oley catheter.			How the corrective action(s) v	vill be	
			monitored to ensure the deficient				
	A Care Plan, dated	1/22/25, indicated the resident			practice will not recur, i.e., wh	at	
	required contact iso	lation precautions due to			quality assurance programs w	/ill be	
	ESBL (Extended-Sp	pectrum Beta-Lactamase) in the			put into place;		
	urine. The approach	nes were to provide proper PPE			Nurse managers/designee w	rill	
	and maintain contac	et isolation precautions.			audit 3 residents with cathet	ers	
			2 times per week for 6 months,				
		d on 1/12/25, indicated the	to ensure catheter care and				
		for complications secondary			irrigation is rendered per		
	•	The resident preferred to			orders and catheter is		
	•	lrainage bag on wheelchair arm			positioned off the floor and t	to	
	-	oproaches were to maintain			ensure that EBP are		
	_	ecautions, and educate the			maintained.		
		s of not following the catheter			The Director of		
		mendations related to the			Nursing/designee will presen		
	positioning.				summary of the audits to the		
		1 . 110/0/04 . 1			Quality Assurance committe		
		dated 12/9/24, indicated Foley			monthly for 6 months and u	ntil	
	·	ench with a balloon size of 10			the facility maintains 95%		
	milliliters (ml) for n	neurogenic bladder.			compliance. Thereafter, if		
	A PM 11 O 1	1 . 10/10/04 : 1: 1			determined by the Quality	_	
		date 12/18/24, indicated			Assurance committee, audit	_	
	Enhanced Barrier P	recautions (EBP) for infection			and monitoring will be done		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155469	B. W	ING		01/29/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
CA CA O	LIODADT				49TH AVE		
CASA OI	F HOBART			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	control intervention	to reduce transmission of			quarterly and present quarte	rly	
	multi drug resistant	organisms (MDROs).			at the QA meeting.		
	Enhanced barrier pr	recautions involve gown and			_		
	glove use during hi	gh-contact resident care			_		
	activities for residen	nts known to be colonized or			_		
	infected with MDR	O as well as those at increased			_		
	risk of MDRO acqu	nisition (e.g., residents with			_		
	wounds or indwelli	ng medical devices.).			_		
					_		
	-	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				_		
		siella Pneumoniae (ESBL) that			_		
	was greater than 10	0,000 colonies.			F690 - Bowel/Bladder		
					Incontinence, Catheter, UTI		
		dated 1/22/25, indicated			Nurse managers/designee w		
	-	ution reconstituted 1 gram.			audit 3 residents with cathete		
	_	s (mg) intravenously every			2 times per week for 6 month	ıs,	
	evening shift for an	UTI for 10 days.			to ensure catheter care and		
					irrigation is rendered per		
	_	on 1/23/25 at 7:09 a.m., the			orders and catheter is		
	_	indicated an isolation gown			positioned off the floor and t	0	
		to the resident being in			ensure that EBP are		
		cause he had ESBL in the			maintained.		
	urine.				Resident Name		
		1/07/07			Catheter care and irrigation		
	_	y on 1/27/25 at 3:30 p.m., the			provided		
		cated the resident had a care			(observation/interview)		
		ed the Foley catheter on the					
		elchair. The catheter bag and			Y/N		
	tubing should not h	ave been on the floor.					
	Th + 0/1/202	00 I I I i i i i i i i i i i i i i i i			Catheter drainage bag is off		
		20 "Urinary Catheter Care"			the floor		
		Nurse Consultant 2, indicated			WAI		
	_	ositioned to maintain a			Y/N		
		ine to prevent back flow of			Oteff mediately: FDD /		
		er or tubing, during transfer,			Staff maintaining EBP during	·	
	ambulation and bod	ly positioning. Urinary			catheter care, emptying and		

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

PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155469	A. BUILDING B. WING	00	COMP	E SURVEY PLETED 9/2025
	PROVIDER OR SUPPLIER F HOBART		4410 W	ADDRESS, CITY, STATE, ZIP COI / 49TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR drainage bags and to	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ubing shall be positioned to touching the floor directly.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) maintenance (observation)	JLD BE	(X5) COMPLETION DATE
	The current 9/1/202 Control Program" p on 1/23/25 at 1:30 p followed CDC proto precautions (TBP). suspected infections TBP.2. During an ir Resident 49 indicate catheter bag all night get his catheter exclor clean his catheter. On 1/21/25 at 3:39 p shirt to show his sto catheter was dirty an insertion site.	0 "Infection Prevention and rovided by Nurse Consultant 2 o.m., indicated the facility ocols for transmission based Residents with known or a were placed on appropriate atterview on 1/21/25 at 2:23 p.m., and the staff does not drain his at or day, he had to call 911 to hanged, and they do not flush on., the resident had lifted his omas site and catheter. The and dried crusted blood around		Y/N		
	one had cleaned his did not flush his cat his shirt to show his dirty and dried crust insertion site. The record was revi 1/22/24 at 2:11 p.m. not limited to, depre pulmonary disease (wasting and anxiety The Quarterly (MDi indicated the resider daily decision making catheter. The resider	S) assessment, dated 12/18/24, nt was cognitively intact for ng. Resident had an indwelling nt required supervision or with toileting hygiene and		Reviewed by:	_Date	

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	of correction identification number 155469	A. BUILDING B. WING	00	COMPLETED 01/29/2025
	PROVIDER OR SUPPLIER HOBART	4410 W	ADDRESS, CITY, STATE, ZIP COD 7 49TH AVE RT, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	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.	TAG	DEFICIENCY)	
	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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	X1) PROVIDER/SUPPLIER/CLIA	l` ′			(X3) DATE	
N				00		
	155469	B. WI	NG		01/29/	2025
UPPLIER			4410 W	49TH AVE		
MARY S	TATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
EFICIENO	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
ORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
nange. N	No further information was					
	Status Maintenance					
le facility in logs and or reside 3 reside 4 and 82 lude: lude: intervie indicated bosed to 6, but bro received that motor Reside 35 p.m. o, sepsis or depreschizoph 4 Quarte indicated ily decisheter. The reside of 1 and of 1 a	y failed to ensure food and supplements were ents with a history of weight ents reviewed for nutrition. The word 1/21/25 at 10:51 a.m., and he had lost a lot of weight. The receive double portions for eakfast was "skimpy" at times. and a serving of scrambled eggs borning. The word of the weight is a serving of scra	F 06	592	the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liabid by the facility and is submitted only in response to the regulatory requirement. F692 Nutrition/Hydration State Maintenance What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice. Resident F remains in the facility, and is receiving doult portions as ordered, daily documentation of meal consumption and supplement with ongoing monitoring. Resident 82 returned to the hospital, hospital admission we not related to the alleged deficient. How the facility will identify other residents having the potential be affected by the same deficient practice and what corrective a will be taken. All residents residing in the	te llity ed tus oe ents y the ble tus oient oient ient ient ient oction	02/25/2025
	JUPPLIER MMARY S EFICIENCE ORY OR hange. N 1-(3) /dration servation servat	IDENTIFICATION NUMBER 155469 UPPLIER MMARY STATEMENT OF DEFICIENCIE EFFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION thange. No further information was 1)-(3) Adration Status Maintenance servation, record review and the facility failed to ensure food the logs and supplements were for residents with a history of weight 3 residents reviewed for nutrition. Fand 82)	IDENTIFICATION NUMBER 155469 IDENTIFICATION NUMBER 165469 IDENTIFICATION NUMBER 165669 IDENTIFICATION NUMBER 166669 IDENTIFICATION NUMBER 155469 STREET / 4410 W HOBAF MARRY STATEMENT OF DEFICIENCIE EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION hange. No further information was D-(3) //dration Status Maintenance servation, record review and the facility failed to ensure food an logs and supplements were for residents with a history of weight 3 residents reviewed for nutrition. I and 82) Indee: Interview on 1/21/25 at 10:51 a.m., Indicated he had lost a lot of weight. Soed to receive double portions for is, but breakfast was "skimpy" at times. The received 1 serving of scrambled eggs to that morning. For Resident F was reviewed on Sp. Diagnoses included, but were o, sepsis, osteomyelitis, arthritis, or depressive disorder, pressure ulcer, schizophrenia, and neuromuscular of 4 Quarterly Minimum Data Set (MDS) indicated the resident was cognitively ity decision making and had a Foley heter. The resident had no oral eighed 118 pounds with no significant The resident had one stage 3 er and one stage 4 pressure ulcer that	IDENTIFICATION NUMBER 155469 DUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342 IMARY STATEMENT OF DEFICIENCIE EFFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION hange. No further information was per facility failed to ensure food at logs and supplements were for residents with a history of weight 3 residents reviewed for nutrition. and 82) Jude: Interview on 1/21/25 at 10:51 a.m., addicated he had lost a lot of weight. Socied to receive double portions for so, but breakfast was "skimpy" at times. received 1 serving of scrambled eggs that morning. The trailent was cognitively or depressive disorder, pressure ulcer, schizophrenia, and neuromuscular of the consumption and supplement with ongoing monitoring. Resident 82 returned to the hospital, hospital admission will decigned 118 pounds with no significant The resident had no oral eighed 118 pounds with no significant The resident had one stage 3 ger and one stage 4 pressure ulcer that	DENTIFICATION NUMBER 155469 IDENTIFICATION NUMBER 155469 IDENTIF	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155469	B. Wl	ING		01/29/	2025
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF P	ROVIDER OR SUPPLIEF	₹			49TH AVE		
CV6V U	- HOBART				491H AVE RT, IN 46342		
UASA UI	HODANI			HODAR			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	·	sed on 1/14/25, indicated the			deficient practice.		
		for impaired nutritional status.			What measures will be put into)	
	The approaches we	re to provide diet and			place or what systemic change	es	
	supplements as orde	ered.			will be made to ensure that the	Э	
					deficient practice does not rec	ur.	
	The Care Plan, revi	sed on 1/22/25, indicated the			Nursing staff were reeducate	d	
	resident had actual	resident had actual skin impairments to the right			regarding the process for		
	and left hips and the right ischium. The				assuring that documentation	of	
	approaches were to	monitor nutritional status,			daily meal consumptions and	d	
	serve diet as ordere	d, monitor intake and record.			supplements are completed		
					each. Nutritional Monitoring		
	The resident weighed 112 pounds on 12/2/24 and				policy was reviewed with		
	weighed 92 pounds on 1/20/25.				nursing staff.		
					Dietary staff was educated o	n	
	A Physician Order,	dated 1/15/25, indicated			ensuring that meals are		
	double portions at r	neals.			prepared following the		
					prescribed diet order.		
	The meal consumpt	tion logs indicated there was			Nutrition at Risk meeting was	s	
	no breakfast docum	nented on 11/12, 11/28, 12/7,			held on 2/4/25, audit of		
	12/8, 12/29/24, 1/12	2, and 1/14/25. There was no			supplements was performed	,	
	lunch documented	on 10/6, 12/29, 10/9, 10/11,			orders reviewed and updated	d.	
	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.			How the corrective action(s) w	ill be	
					monitored to ensure that the		
	During an interview	on 1/27/25 at 3:30 p.m., the			deficient practice will not recur	-,	
	_	ated meal consumptions			i.e., what quality assurance		
	should be documen	ted after every meal.			programs will be put into place	Э.	
					The Director of Nursing		
					/designee will audit 5		
	_	vation on 1/23/25 at 2:10 p.m.,			residents, twice weekly for 6		
	Resident 82 was ob	served in his room. At that			months, to ensure food		
	time, his lunch tray	was observed on the dresser			consumption logs and		
	covered and untouc	hed. He was served meat,			supplements are documente	d	
	potatoes, vegetable	and dessert.			and completed.		
			I		Director of Nursing/designed		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155469	B. W	ING		01/29/	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIEF	8			49TH AVE		
CASA OF	HOBART				RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	SHOULD BE COMPLETIC APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		dent 82 was reviewed on			will present a summary of th		
		. The resident was admitted to			audits to the Quality Assurar	nce	
	-	6/24. Diagnoses included, but			committee monthly for 6		
		acute myocardial infarction,			months and until the facility		
		ic abscess, renal dialysis,			maintains 95% compliance.		
	anemia, chronic kidney disease, depression, and,				Thereafter, if determined by		
	end stage renal disease.				the Quality Assurance		
	TI 10/04/04 0 1 . M				committee, auditing and		
	The 12/24/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately				monitoring will be done		
		2			quarterly and present quarte	rly	
	impaired for daily decision making and weighed				at the QA meeting.		
	161 pounds. The resident received a therapeutic				-		
	diet.				-		
	A C DI	1 10/10/04 : 1: . 1.1			-		
		d on 12/10/24, indicated the			-		
		for impaired nutritional status			-		
		approaches were to provide			-		
	the diet and suppler	ments as ordered.			-		
	A Physician Order,	dated 12/11/24, indicated					
	liberal renal diet an	d a renal liquid supplement in					
	the morning, give o	ne can of Nepro every day.			_		
					_		
		ed 160 pounds on 12/9/24 and			_		
	163 pounds on 1/7/2	25.			-		
	The meal consumpt	ion logs indicated there was			- F692 Nutrition/Hydration Sta	tus	
		ented on 12/7, 12/8/24, 1/12,			Maintenance		
		was no lunch documented on			The Director of Nursing		
		2/28, 12/31/24, 1/1, 1/12, 1/14,			/designee will audit 5		
		3/25. There was no dinner			residents, twice weekly for 6		
		1, 11/4, 11/6, 12/18, 12/28/24,			months, to ensure food and		
		8, 1/25, and 1/27/25			supplement consumption log	as	
	1.2, 1.12, 1/11, 1/10, 1/20, und 1/2//20				are documented and	- د	
	The Medication Administration Record (MAR) for				completed.		
	12/2024 and 1/2025 indicated the renal liquid				Resident Identifier		
	supplement was signed out as being administered,				Meal trays are prepared as		
		ntation of how much was			ordered		
	consumed by the re						
	.,				V/N		

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PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155469	A. BUILDING B. WING	00 00	COMPLETED 01/29/2025
NAME OF I	PROVIDER OR SUPPLIEI	R		r address, city, state, zip cod W 49TH AVE	
CASA O	F HOBART			RT, IN 46342	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF During an interview Unit Manager indictory to be documented a amount of renal supplication of the transfer of the current and rev Monitoring" policy Consultant 2 on 1/2 monitor each meal hydration, and supplice intake as follow	rised 1/13/25 "Nutritional r, provided by Nurse 29/25 at 9:35 a.m., indicated intake to include food, blement consumption. Record rs on the medical records: e, between 50-75%, between	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) (CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPROPRIATE OF THE APPROPRIATE OF THE	RIATE COMPLETION DATE
	i		1	-	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155469	B. W	ING		01/29/	/2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				/ 49TH AVE		
CASA OF	HOBART				RT, IN 46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0698	483.25(I)						
SS=D	Dialysis						
Bldg. 00	,						
-	Based on record rev	riew and interview, the facility	F 0	598	Please accept the following as the facility's credible allegation		02/25/2025
	failed to monitor a f	luid restriction for 1 of 1					
resident reviewed for dialysis. (Resident 82)				of compliance. This plan of			
					correction does not constitu	te	
	Finding includes:				an admission of guilt or liab	-	
The record for Resident 82 was reviewed on				by the facility and is submitt	ed		
				only in response to the			
	1/23/25 at 6:17 a.m. The resident was admitted to				regulatory requirement.		
	the facility on 10/26/24. Diagnoses included, but				F698 Dialysis		
	were not limited to, acute myocardial infarction,				What corrective action(s) will		
	renal and perinephric abscess, renal dialysis,				accomplished for those reside		
		ney disease, depression, and,			found to have been affected b	y the	
	end stage renal dise	ase.			deficient practice;		
	FFI 10/01/01 0	1.15			Resident 82 returned to the		
	·	erly Minimum Data Set (MDS)			hospital; hospital admission w		
	assessment, indicate				not related to the alleged defid	cient	
		d for daily decision making. He			practice.	ı	
	_	oley catheter and received			How the facility will identify oth		
	dialysis on admissic	on and while a resident.			residents having the potential		
	A Cara Plan raviga	d on 12/19/24 indicated the			be affected by the same defic		
		d on 12/18/24, indicated the for altered fluid balance			practice and what corrective a will be taken;	ICHOH	
	related to dialysis at				All residents requiring dialys	eie	
	Totaled to diarysis at	na maia restriction.			services with fluid restriction		
	A Physician Order	dated 12/8/24, indicated for the			have the potential to be	113	
	-	e 1200 cubic centimeters (cc)			affected by the same alleged	ı	
	-	chronic kidney disease:			deficient practice.	•	
	•	nursing 420 cc every shift.			What measures will be put int	0	
	<i>y</i> , 55 55 and 1	<i>G</i>			place or what systemic chang		
	There was no docum	nentation on the 12/2024 and			will be made to ensure that th		
		Administration or Treatment			deficient practice does not rec		
		ords to indicate the fluid			Nursing staff were re-educat		
	restriction was being	g monitored or accounted for			to ensure that fluid restriction		
	by nursing staff.	-			per the physician orders are		
					maintained. Fluid Restriction		
	During an interview	on 1/29/25 at 10:45 a.m., the			policy was reviewed with		
		indicated there was no			nursing and dietary staff.		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155469	B. W	ING		01/29/	2025
	PROVIDER OR SUPPLIER HOBART		•	4410 W	ADDRESS, CITY, STATE, ZIP COD 7 49TH AVE RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	documentation in th	ne clinical record regarding for			Dietary staff was educated o	n	
	any monitoring of the	he fluid restriction.			ensuring fluid restriction ord	ers	
					are reflected in dietary ticket	s	
		id Restriction" policy indicated			and followed per order. Dieta	ıry	
	management of fluid intake was critical to specific				tickets updated accordingly.		
	residents, therefore a physician order for fluid				Nutrition at Risk meeting was	S	
	restriction would be maintained. Dietary and other				held on 2/4/25, audit of		
	departments would be notified of the fluid				residents on fluid restriction		
		an communicate any fluid			was performed, orders		
	given.				reviewed and updated.		
					How the corrective action(s) w		
	3.1-37(a)				monitored to ensure the defici-		
					practice will not recur, i.e., who		
					quality assurance programs w	ill be	
					put into place;		
					Director of Nursing/designee		
					will audit 3 residents on fluid		
					restriction, once weekly x 6		
					months, to ensure monitorin	_	
					of fluid restriction is ensured	l.	
					The Director of		
					Nursing/designee will preser		
					summary of the audits to the		
					Quality Assurance committee	e	
					monthly for 6 months.		
					Thereafter, if determined by the Quality Assurance		
					committee, auditing and		
					monitoring will be done		
					quarterly and present quarte	rlv	
					at the QA meeting. Monitorin	-	
					will be on going.	ອ	
					20 011 901119.		
					-		
					-		
					-		
					-		
					F698 Dialysis		
					- Director of Nursing/designee	;	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/29/2025
	ROVIDER OR SUPPLIER		4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	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 d ng d.
				-	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs	and Biologicals		-	
	Based on observation	on, record review and	F 0761	Please accept the following	as 02/25/2025

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155469	B. W	ING		01/29/	2025
		L		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			49TH AVE		
CASA OF	- HOBART				RT, IN 46342		
	1.00/11(1				I TOUTE		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ity failed to ensure proper			the facility's credible allega	tion	
	_	related to medications			of compliance. This plan of		
		e, pre-filled saline syringes			correction does not constitu		
		(peripherally inserted central			an admission of guilt or liab	-	
		not stored securely,			by the facility and is submit	ted	
		eys left unattended, insulin			only in response to the		
	-	hen opened, and loose pills			regulatory requirement.		
		dication carts for 1 of 2 units			F761 Label/Store Drugs &		
	(The Main Station Unit) This had the potential to				<u>Biologicals</u>		
	affect all residents receiving medications from						
	LPN 2.				What corrective action(s) will		
	F' 1' ' 1 1				accomplished for those resid		
	Findings include:				found to have been affected	by the	
	1 5 ' 1	1 1/22/25 4.5.20			deficient practice:		
	_	n observation on 1/23/25 at 5:29			Medications were immediat	eıy	
	· · · · · · · · · · · · · · · · · · ·	l medication cart was observed n unit. There were seven			secured appropriately.		
					Medication cart keys were		
		tions in plastic cups on the top eart with the resident's first			secured. Loose pills were		
		e cups. The medication cart			removed from the cart and		
		f the cart, as well as a box of			opened medications were		
		drops, and two bingo (punch			labeled appropriately.	avith.	
		ls each of Losartan (a			LPN 2 have been provided value 1:1 education and counseling		
		lower the blood pressure) and				_	
		ication used for prostate			on proper medication storage How the facility will identify or	_	
	enlargement).	reactor asoca for prostate			residents having the potentia		
	Timi gomoni,				be affected by the same defice		
	During an interview	w on 1/23/25 at 5:34 a.m., LPN 2			practice and what corrective		
	_	the bathroom and left the			will be taken;		
		cart because he was going to			All residents have the poter	ntial	
	-	i just had not done that yet.			to be affected by the same	- *	
		know better not to pre-pour			alleged deficient practice. A	JI	
	the resident's medic				Med carts and med rooms h		
					been audited and concerns	-	
	During an interview	w on 1/23/25 at 10:00 a.m., the			corrected		
	_	g indicated the nurse was not			What measures will be put in	to I	
		r resident medication.			place or what systemic chang		
					will be made to ensure that the	-	
					deficient practice does not re		
	2. During random of	observations on 1/21/25 at 10:57			Nurses were re-educated or		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE COMPL 01/29/	ETED		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
CASA O	F HOBART			4410 W 49TH AVE HOBART, IN 46342			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		, on 1/22/25 at 9:45 a.m., 1:23			Medication Storage policy,		
		., and on 1/23/24 at 6:39 a.m.,			including:		
	_	l of pre-filled saline syringes			Preparing medication		
	hanging on the IV	pole in Resident F's room.			at the time of administration	l	
	During an interview	w on 1/23/25 at 9:10 a.m., the			only Ensuring medication		
	_	g indicated the pre-filled saline			bottles, containers, eye drop		
	syringes should not have been stored in the				insulins are appropriately	J 3,	
	resident's room.				labeled and stored properly		
					Medication cart keys		
	The current 9/1/2020 "Medication Storage" policy				are kept always secured		
	provided by Nurse	Consultant 1 on 1/23/25 at			No medications are I	eft	
	11:45 a.m., indicate	ed the facility should ensure all			unattended on the medication	on	
	medications were stored in a locked cart.				cart and resident bedside.		
					All Medication carts and		
					medication rooms have bee	n	
		vation of the medication cart for			audited and concerns		
		8/25 at 9:10 a.m. with the			corrected.		
		following was observed:			How the corrective action(s) v		
	_	oills in a medication cup with a			monitored to ensure the defic		
	first name written o	on it.			practice will not recur, i.e., wh		
	A I arraman armin	ge with no resident label was			quality assurance programs v	vIII be	
	loose in the top dra				put into place. DON/designee will audit 2		
	loose in the top tha	twei.			medication carts once a wee	nk	
	- There were 2 Lan	itus Insulin pens with no			for 6 months, to ensure	ZK.	
	resident label or da	-			medications are labeled		
		1			appropriately and stored		
	- There was a Basa	glar insulin pen that was			properly.		
	opened with no dat	-			The Director of		
					Nursing/designee will prese	nt a	
	- There were seven	loose pills in the second			summary of the audits to the	е	
		se pills as well as two plastic			Quality Assurance committee	ee	
	-	e drops that had no resident			monthly for 6 months and u	ntil	
	name on it in the th	nird drawer.			the facility maintains 95%		
					compliance. Thereafter, if		
	_	w on 1/28/25 at 9:20 a.m., the			determined by the Quality		
		g (DON) indicated all loose			Assurance committee, audit	-	
		ectables found needed to be			and monitoring will be done		
	disposed of. Insuli	in pens should be labeled with	I		quarterly and present quarte	eriv	I

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PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155469	A. BUILDING B. WING	00	COMPLETED 01/29/2025
	PROVIDER OR SUPPLIER		4410 W	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE	
CASA OPPREFIX TAG	(EACH DEFICIEN REGULATORY OR the resident name at The current 9/1/202 provided by Nurse 0 11:45 a.m., indicate opened, the facility guidelines with resp Facility staff should the medication contensure that all medications.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION and date opened. 0 "Medication Storage" policy Consultant 1 on 1/23/25 at d once a medication was should follow manufacture sect to expiration dates. I record the date opened on ainer. The facility should cations were each resident ontainers in which they were		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) at the QA meeting.	ek

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PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE (A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/29/2025		
	PROVIDER OR SUPPLIE F HOBART	R	4410 \	FADDRESS, CITY, STATE, ZIP COD W 49TH AVE IRT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emerger Based on observati interview, the facil received routine de decayed and broke reviewed for denta Finding includes: During an interview	ncy Dental Srvcs in NFs ion, record review, and ity failed to ensure a resident ental services related to in teeth for 1 of 3 residents I services. (Resident 73) w on 1/21/25 at 2:57 p.m., ted the facility was supposed to	F 0791	Please accept the following the facility's credible allegat of compliance. This plan of correction does not constituan admission of guilt or liab by the facility and is submit only in response to the regulatory requirement. F791 Dental What corrective action(s) will	as 02/25/2025 tion ate tility ted

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>			COMPL	ETED
		155469	B. W	NG		01/29/	2025
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			49TH AVE		
CASA OI	F HOBART				RT, IN 46342		
CASA OI	TIODANI			HODAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		dentist after she cracked her			accomplished for those reside		
		a dentist over a year ago and			found to have been affected b	y the	
		eded an extraction. There had			deficient practice.		
	been no follow up s	since.			Resident 73 remains in the		
					facility, and tooth extraction		
		ident 73 was reviewed on			have been performed on		
	_	. Diagnoses included, but were			2/7/25. Dental care plan have	!	
		ety disorder, depression, kidney			been initiated. MDS with ARI)	
	failure, and hyperte	ension (high blood pressure).			of 12/24/24 have been		
					modified.		
		imum Data Set (MDS)			How the facility will identify oth		
	assessment, dated 12/24/24, indicated the resident				residents having the potential	to	
	was cognitively intact. The resident had no				be affected by the same defici	ent	
	cracked, loosed, or chipped teeth.				practice and what corrective a	ction	
					will be taken;		
	There was no denta	ll care plan.			All residents residing in the		
					facility have the potential to	be	
		ed 11/22/23, indicated the			affected by the alleged		
		oral surgeon for extraction of			deficient practice		
	#14 and #16 root ti	ps.			What measures will be put into		
					place or what systemic change	es	
		ote, dated 12/7/2023 at 11:59			will be made to ensure that the		
		writer was waiting to hear back			deficient practice does not rec		
	_	eon regarding the resident's			MDS and social service staff		
	appointment.				were educated in:		
					Performing residents		
		v on 1/23/25 at 3:18 p.m., the			oral assessments quarterly a	ind	
		ector indicated she did not find			as needed; initiating		
	I	that the resident had seen the			appropriate dental referrals;		
		ow up appointment with the			and reviewing dental visit		
	oral surgeon for 20	24.			reports timely.		
					Ensuring that care		
		v on 1/23/25 at 3:48 p.m., the			plans are in place for dental		
	_	g indicated she understood the			concerns.		
		additional information to			Social services performed ar		
	provide.				audit on residents with denta		
					consents, date when last der	ntal	
	3.1-24(a)(1)				care was performed and		
					initiated referral as needed.		
					How the corrective action(s) w	ill be	

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

PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/29/2025
	ROVIDER OR SUPPLIE	R	4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
`	SUMMARY (EACH DEFICIE)	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			DATE T, e. final l. e. e. e. nce
				at the QA meeting.	al

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

PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/29/2025		
	ROVIDER OR SUPPLIEI HOBART	R	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) Y/N Last Dental Visit Follow up needed? Y/N/NA Dental Care Plan in place Y/N/NA	ATE COMPLETION DATE		
				Reviewed by:Date	_		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155469 B. WING 01/29/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART **HOBART. IN 46342** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE F 0880 483.80(a)(1)(2)(4)(e)(f) SS=E Infection Prevention & Control Bldg. 00 Based on observation, record review and 02/25/2025 F 0880 Please accept the following as interview, the facility failed to ensure infection the facility's credible allegation control practices were in place and implemented of compliance. This plan of related to a Nurse Practitioner (NP) failing to correction does not constitute perform hand hygiene after glove removal, an admission of guilt or liability enhanced barrier precautions (EBP) not followed by the facility and is submitted while emptying an indwelling Foley catheter and only in response to the for a resident with a peripherally inserted central regulatory requirement. catheter (PICC), disposal of a lancet in the F880 Infection Prevention and garbage can, and glove use in the hallway during **Control** random infection control observations. (Residents 82, C, 12, and F) What corrective action(s) will be accomplished for those residents Findings include: found to have been affected by the deficient practice; 1. During a random observation on 1/22/25 at 1:25 Residents 12, F and C remain p.m., Resident 82 was observed in his room in the facility without any getting dressed. At 1:30 p.m., an Intravenous (IV) adverse effects. nurse entered the room to insert a PICC line so the resident could start his IV antibiotic therapy for an Resident 82 returned to the Urinary Tract Infection. At 1:33 p.m., the IV nurse hospital, hospital admission is walked out of the room wearing gloves to both of not related to alleged deficient his hands and continued to walk all the way down practice. the hallway to the nurses' station. At 1:35 p.m., he walked back into the room wearing the same How the facility will identify other gloves to both hands. At 2:03 p.m., the IV nurse residents having the potential to walked out of the room wearing soiled bloody be affected by the same deficient gloves to both hands. He walked all the way down practice and what corrective action to the nurses' station and then he removed his will be taken; gloves and threw them away in the garbage can. All facility residents have the potential to be affected by the During an interview on 1/22/25 at 2:04 p.m., same alleged deficient Restorative CNA 1 indicated, "He can't do that," practice. referring to the gloves in the hallway, and she was going to let the Unit Manager know right away. What measures will be put into

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155469	B. WING		01/29/2025		
		<u> </u>	<u> </u>	ADDDDGG OUTLY OF THE STREET			
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD			
00000	LIODADT		4410 W 49TH AVE				
LASA OI	F HOBART		HORAF	RT, IN 46342			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	(X5)			
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
				place or what systemic chang	es		
		ident 82 was reviewed on		will be made to ensure that th			
	1/23/25 at 6:17 a.m	a. The resident was admitted to		deficient practice does not red	cur;		
	-	6/24. Diagnoses included, but		All facility staff, contracted s	staff		
		, acute myocardial infarction,		and vendors were re-educat	ed		
		ric abscess, renal dialysis,		on:			
	·	lney disease, depression, and,		Enhanced Barrier			
	end stage renal dise	ease.		Precautions			
				Syringe and Needle			
		terly Minimum Data Set (MDS)		Disposal Policy			
		ed the resident was moderately		Hand Hygiene			
	impaired for daily decision making and had an			Doffing PPE prior to			
	indwelling Foley (u	urinary) catheter.		moving to clean area of care).		
				Proper disposal of			
		1/22/25, indicated the resident		biohazard waste i.e. bloody			
	_	plation precautions due to		gloves and sharps			
	·	pectrum Beta-Lactamase) in the					
		hes were to provide proper PPE		Infection Control Nurse			
	and maintain conta	ct isolation precautions.		performed return			
				demonstrations and skills			
	-	dated 1/22/25, indicated		validation on hand hygiene,			
	contact isolation re	lated to ESBL in the urine.		PPE donning and doffing.			
	An urinalysis with	a culture and sensitivity, dated		How the corrective action(s) v	vill be		
	-	the resident had an urinary tract		monitored to ensure the defici			
	·	osiella Pneumoniae (ESBL) that		practice will not recur, i.e., wh			
	was greater than 10	The state of the s		quality assurance programs w			
	grand man 10	-,		put into place;	50		
	During an interview	v on 1/28/25 at 10:00 a.m., the		IP nurse/designee will obser	ve		
	_	g indicated she was made aware		5 facility staff including			
	-	e nurse leaving the resident's		contracted staff and vendors	,		
	room with the soile	_		twice weekly for 6 months, t			
		6		ensure infection control	-		
	The current 9/1/202	20 "Infection Prevention and		practices are in place and			
	Control Program" provided by Nurse Consultant 2			implemented.			
		p.m., indicated personal					
		ent was appropriately discarded		The Director of			
		prior to leaving the room.		Nursing/designee will prese	nt a		
		5		summary of the audits to the			

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Quality Assurance committee

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/29/2025		
	OF PROVIDER OR SUPPLIE	R		4410 W	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION n observation on 1/28/25 at		ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) monthly for 6 months and until			(X5) COMPLETION DATE
	dining room when to the resident was resident was placed the room. At that the care unit and asked Nurse for a pair of of gloves, without lifted up the resident tube (a tube inserte nutrition). She toughoved hands and the removed the gloves side of the medicat Infection Prevention the resident as well perform hand hygien buring an interview she could not find a hand hygiene and hygiene and hand hygiene hygie	removed Resident C from the the lunch trays had arrived, due NPO (nothing my mouth). The d in the hallway right outside of me, an NP entered the memory of the Infection Prevention gloves. The NP donned the pair performing hand hygiene, and not's shirt to observe the peg d directly into the stomach for the the peg tube with her then pulled down his shirt, and threw them away on the ion cart. She then asked the non Nurse some questions about as other residents. She did not the after glove removal. We at that time, the NP indicated any hand sanitizer to perform the perform the performance of the p			monthly for 6 months and ur the facility maintains 95% compliance. Thereafter, if determined by the Quality Assurance committee, audit and monitoring will be done quarterly and present quarte at the QA meeting.	ing rly d ve	
	LPN 1 was prepari sugar with a glucor	on pass on 1/23/25 at 11:34 a.m., ng to check Resident 12's blood meter. The LPN gathered the d the resident's room. She			Y/N/NA Needles disposed properly? Y/N/NA		

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/29/2025
	PROVIDER OR SUPPLIER THOBART		4410 W	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	pair of gloves to bo resident's finger wit	rith soap and water, donned a th hands, and wiped the h an alcohol pad. She pricked		Gloves removed in the hallway?	
	the blood and place inside the glucomet	with a blue lancet, obtained d it on the strip that was er. After checking the blood		Y/N/NA - -	
	alcohol pad and the one of her gloved h	ced the used lancet, the used bloody test strip into ands and removed the glove lies inside, removed the other		- - -	
	glove and rolled the everything away int	em into a ball and threw to the garbage can inside the e walked out of the room and		- - -	
	performed hand hyg She drew up the res	giene at the medication cart. ident's scheduled insulin and er abdomen. Before leaving the		-	
	the used lancet, she sharp's container on	asked where she disposed of indicated she put it in the the side of the medication.		-	
	in the resident's roo be visibly seen inside	to look into the garbage can m, where the blue lancet could de the rolled glove in the trash		-	
	_	at that time, the LPN indicated lancets should be disposed		- - -	
	of into the sharp's c	-		- - -	
	Director of Nursing	(DON) indicated the used been disposed of in the		- - -	
	Disposal" policy pr	014 "Syringe and Needle ovided by the DON on 1/28/25 ted, immediately after use,		- - -	
	syringes and needle	s will be placed into a ne way container (sharps)		Reviewed by:	
	. , ,				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 29/2025	
	PROVIDER OR SUPPLIEF		4410 W	ADDRESS, CITY, STATE, ZIP / 49TH AVE RT, IN 46342	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	a.m., LPN 2 entered disconnect the intra the resident's PICC gloves to both hand hygiene first, discordine, and flushed the saline flush. The LI the room. CNA 1 et thereafter to empty She donned a clean gloves to both hand isolation gown. She bathroom and empt bag into the urinal. urine into the toilet, performed hand hygically the saline flush of the performed hand hygically the saline flush of the performed hand hygically the saline flush of the saline flush o	dent F was reviewed on . Diagnoses included, but were s, osteomyelitis, arthritis, essive disorder, pressure ulcer, hrenia, and neuromuscular of terly Minimum Data Set (MDS) d the resident was cognitively sion making and had a Foley The resident had no oral 118 pounds with no significant sident had one stage 3 one stage 4 pressure ulcer that mission. 1/22/25, indicated the resident				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/29/2025			
	ROVIDER OR SUPPLIER HOBART		4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Enhanced Barrier P control intervention multi drug resistant Enhanced barrier pr glove use during his activities for resider infected with MDR risk of MDRO acqu wounds or indwellin A Physician Order, Vancomycin 750 m infection. During an interview Director of Nursing was to be worn due for the wounds, PIC During an interview Unit Manager indic	dated 1/9/25, indicated recautions (EBP) for infection to reduce transmission of organisms (MDROs). recautions involve gown and gh-contact resident care at sknown to be colonized or O as well as those at increased disition (e.g., residents with an medical devices.). dated 1/2025, indicated dilligrams (mg) IV for a wound or on 1/23/25 at 7:09 a.m., the indicated an isolation gown to the resident being on EBP occ line and Foley catheter. or on 1/27/25 at 3:30 p.m., the ated the resident was in EBP ons should be followed.			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/S	anitary/Comfortable Environ			
-	failed to keep the re and in good repair r and dirty floors, ma missing toilet paper feces on a shared ro tile, a call light not temperatures above throughout the facil	on and interview, the facility esident's environment clean related to marred walls, marred rred and dirty heat registers, holders, feces on bed linen, som divider, cracked ceiling working, and hot water 120 degrees on 5 of 5 units ity. (Cherry Lane, Cherry ane, Apple Lane and	F 0921	Please accept the following the facility's credible allegat of compliance. This plan of correction does not constitu an admission of guilt or liable by the facility and is submitted only in response to the regulatory requirement. F921 Safe/Functional/Sanitary/Control	te lity ed

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155469	B. WIN	NG		01/29/	2025
NAME OF F	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP COD		
04040	- LIODADT				/ 49TH AVE		
CASA OF	F HOBART			HOBAF	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	I	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Bakersfield Lane).				ortable Environment		
	Findings include:				- What corrective action(s) will I	ne l	
	i mamga maraua.				accomplished for those reside		
	During the Environ	mental tour with the			found to have been affected b		
	Maintenence Direct	for on 1/29/25, the following			deficient practice;	,	
	was observed:						
					Room 7: The room divider		
	1. Cherry Lane				between the resident beds h	ad	
					been replaced, no smeared		
		m divider between the resident			feces.		
	beds had smeared feces on it. The divider was						
	shared between 2 residents.				Room 13-2: The residents be	∤ a	
	h Room 13-2: The	residents bed linen had visible			linen had been changed.		
		n. The resident asked multiple			Room 17-2: The room that ha	ad	
		linen and was not granted			marred walls along the bed	ıu	
		o residents shared this room.			was painted.		
					The painteen		
	c. Room 17-2: The	room had marred walls along			Room 29-1: The wardrobe		
	the bed.				closet that was marred and t	he	
					bathroom walls that were		
					marred was painted.		
	2. Cherry Court						
	D 20.1 T				Room 21: The hot water		
	a. Room 29-1: The and the bathroom w	wardrobe closet was marred			temperature in the residents		
	and the bathroom w	ans were marred.			bathroom was checked by the Maintenence Director and	ie	
	3. Apple Lane				within normal range.		
	T. T. P. P. Danie				Room 24: The hot water		
	a. Room 21: On 1/2	21/25 at 2:53 p.m., the hot water			temperature in the residents		
		ecked by the Maintenence			bathroom was checked by th		
		ered 122 degrees in the			Maintenence Director and		
	resident's bathroom	•			within normal range.		
		21/25 at 2:53 p.m., the hot water			Room 33: The hot water		
	_	ecked by the Maintenence			temperature in the residents		
		ered 122 degrees in the			bathroom was checked by th	ie	
I	resident's bathroom				Maintenence Director and		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 01/29/2025			LETED		
	PROVIDER OR SUPPLIEF HOBART	8	Ī	4410 W	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	The Maintenence D the hot water heater going to turn it dow	virector indicated at that time, was set at 118 and he was on now. The day before, a pipe and they had turned up the			within normal range. Room 34-1: The marred win the resident's room was painted. Room 38 -2: The marred win the resident's bathroon painted.	s valls	
	temperature was ch Director and registe resident's bathroom b. Room 34-1: The resident's room.	re were marred walls in the	Room 42-1-2: The w the Maintenence degrees in the marred walls in the Room 42-1-2: The w the head of beds 1 a were scratched and was painted, the fro heat register that wa discolored with a bla substance at the bas walls that were marr		Room 42-1-2: The wall be the head of beds 1 and 2 to were scratched and marrowas painted, the front of the tregister that was discolored with a black substance at the base, the walls that were marred in room and the bathroom we fixed.	that ed he e the	
	1 and 2 were scratc the heat register wa substance at the bas the room and the ba				Room 60: The heat register was marred in the bathroom was painted. Room 64-2: There marred and cracked ceiling tile or of the bathroom door was fixed. The bathroom walls were marred was painted a toilet paper holder was placed.	walls utside s	
	cracked ceiling tile The bathroom walls toilet paper holder. bathroom.	re were marred walls and outside of the bathroom door. s were marred and there was no One resident use this			Room 66-2: The heat regis that was marred was pain the wall behind the head of bed that was marred was painted, and toilet paper holder in the bathroom was	ted, of the	

STATEMENT OF DEFICIENCIES X1) PROVII		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155469		B. WING 01/29/2025			2025		
NAME OF PROVIDER OR SUPPLIER CASA OF HOBART			STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		d of the bed was marred, and					
	-	paper holder in the bathroom.			Room 69-1: The walls that we	ere	
		ed the room and four residents			marred next to thebed was painted . The call light was		
	used the bathroom.						
					replaced immediately and is		
		walls were marred next to the			now working. The heat regist		
	_	vas not working. The heat			that was marred was painted		
	_	. There were no toilet paper om. The wall underneath the			Toilet paper holder in the		
		marred. One resident resided in			bathroom was placed. The w underneath the mirror by sin		
	-				that was marred was painted		
	the room and used the bathroom.				tilat was marred was painted		
	e. Room 71-1: The toilet paper holder was broken				Room 71-1: The toilet paper		
	in the bathroom. The nuns cap (urine collection				holder was replaced in the		
		leat register in bathroom was			bathroom. The nuns cap (uri	ne	
		e was debris behind the bed			collection cup) laying on the		
		wall behind the bed. Three			heat register in bathroom wa		
	residents shared the				discarded. The debris behind		
					the bed were sweept and dire		
	During an interview	with the Maintenance			against the wall behind the		
	Director on 1/29/25 at 9:31 a.m., he indicated the				bed was cleaned.		
	areas of concern she	ould have been cleaned and/or					
	repaired and he wou	ıld take care of it.			How the facility will identify oth	ner	
					residents having the potential		
	This citation tag relates to Complaint IN00450254				be affected by the same defici		
	and IN00451800.				practice and what corrective a	ction	
	2.1.10/2				will be taken;		
	3.1-19(f)				An # 100		
					All facility residents have the		
					potential to be affected by th	e	
					same alleged deficient		
					practice.		
					What measures will be put into	、	
					place or what systemic change		
					will be made to ensure that the		
					deficient practice does not rec		
					as notonic practice account for	ω ,	
					All staff meeting was held an	ıd	
			1		reviewed:		

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Event ID:

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

PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	A. BUILDING <u>00</u>		X3) DATE SURVEY COMPLETED 01/29/2025	
	ROVIDER OR SUPPLIEF HOBART	R	4410 W	/ 49TH AVE RT, IN 46342		
CASA OF (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (RACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Process notifying maintenance/environmental services of any necessary repairs or cleaning needed. Completed full house walk through and environmental assessment a in progress Work orders been track and logged How the corrective action(s) w monitored to ensure the defici practice will not recur, i.e., wh quality assurance programs w put into place; The Maintenance Director ar housekeeping director will audit 10 rooms weekly for 6 months for maintenance and housekeeping issues. Identif issues will be corrected time The Administrator/designee will present a summary of th audits to the Quality Assuranc 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 quarte at the QA meeting.	and ed vill be sent at vill be defied ely.	
			1			

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

PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUILDING <u>00</u> B. WING		X3) DATE SURVEY COMPLETED 01/29/2025			
NAME OF P	ROVIDER OR SUPPLIER	ADDRESS, CITY, STATE, ZIP COD					
CASA OF	HOBART		4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
				F921 Safe/Functional/Sanitary/Co	omf .		
				ortable Environment The Maintenance Director ar housekeeping director will audit 10 rooms weekly for 6 months for maintenance and housekeeping issues. Identifies will be corrected time. 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	i fied ely.		

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/29/2025					
NAM	IE OF PF	ROVIDER OR SUPPLIEF	₹		ET ADDRESS, CITY, STATE, ZIP COD				
CASA OF HOBART				4410 W 49TH AVE HOBART, IN 46342					
(X4) PREI TA	FIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
					Maintenance: marred w & floors, toilet paper holde cracked ceiling tiles, Call lights,ETC. Auditor Name:	I			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	FICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
		155469	B. WING		01/29/2025			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE				
CASA OF HOBART			HOBART, IN 46342					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					_ Date:			
						_		
•			•		•		•	

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