STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	07/02/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00435972, IN00437067, IN00437072, IN00437100, IN00437119, IN00437347, IN00437524, and IN437564. Complaint IN00435972 - No deficiencies related to the allegations are cited. Complaint IN00437067 - Federal/State deficiencies related to the allegations are cited at F609. Complaint IN00437072 - No deficiencies related to the allegations are cited. Complaint IN00437100 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00437119 - Federal/State deficiencies related to the allegations are cited at F609. Complaint IN00437347 - No deficiencies related to the allegations are cited. Complaint IN00437524 - Federal/State deficiencies related to the allegations are cited at F690. Complaint IN00437564 - Federal/State deficiencies related to the allegations are cited at F609 and F689. Unrelated deficiency is cited. Survey dates: July 1 & 2, 2024 Facility number: 000366 Provider number: 155469 AIM number: 100288900	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dilane Knights	Administrator	07/26/2024

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

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	Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 2 Medicaid: 73 Other: 17 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 5, 2024.			
F 0609 SS=E Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure employees (Confidential Interview 2 and Terminated Employee 6) reported allegations of abuse by an employee (Employee 7) toward residents of the Memory Care Unit to the Administrator. This had the potential to affect 18 residents who resided on the Memory Care Unit. Finding includes: During an interview, Confidential Interview 5 indicated Employee 7 would make fun of the residents and would call the residents by derogatory names. They had never seen physical harm done to the residents. They indicated this had been going on but it had not been reported. They felt when abuse was reported nothing was ever done and the facility didn't care. The Administrator was immediately notified and indicated this was the first time she had been made aware of this allegation. During an interview on 7/2/24 at 11:51 a.m., Terminated Employee 6 indicated Employee 7 had told her she would hit the resident when no one could see her. Terminated Employee 6 was unable to provide names of residents. Employee 7 would threaten other staff if they reported her, she would get them all fired. Terminated Employee 6 indicated Employee 7 would use foul language,	F 0609	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F609- Reporting of Alleged Violations It is the policy of Harbor Healthcare to ensure that all allegations of abuse are Reported and investigated Timely. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Employee 7 no longer works for the facility, the current residents on the dementia unit remain free from abuse. How the facility will identify other residents having the potential to be affected by the same deficient	07/25/2024

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	call residents names and tell them their family members did not like them. She would cuss in front of the residents and would refuse to provide care to the residents. Terminated Employee 6 indicated she reported this to the DON, her hours were cut and the facility took away her holiday pay. She indicated when she attempted to tell the Administrator she was told to report it to the DON. During an interview with the DON on 7/2/24 at 1:53 p.m., she indicated Terminated Employee 6 had never reported allegations of abuse and her hours had never been decreased. She indicated when abuse was reported to her, the allegations would have been reported to the Administrator, the Indiana Department of Health and an investigation would have been initiated. During an interview with the Administrator on 7/2/24 at 2:24 p.m., she indicated Terminated Employee 6 had just reported the allegation and a full investigation had been initiated. She had not been informed of the allegation at any prior time from the employee. The Corporate Regional Vice President and Corporate Nurse Consultant were made aware of the allegations from Terminated Employee 6 on 7/2/24 at 2:56 p.m. The facility abuse policy, dated 9/1/20, and received as current from the Administrator, indicated employees were required to report any incident, allegation or suspicion of abuse to the administrator immediately. The employees, without fear of retaliation, may also independently report the abuse to the state survey agency. This citation relates to Complaints IN00437067,		practice and what corrective action will be taken. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. p paraid="1780200193" paraeid="{ae987e24-37bb-4082-84d4-e0868883b568}{36}" > All Staff were in-serviced on: 7/25/2024 Immediately reporting suspected, verbalized threats, or witnessed abuse to the administrator. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The Administrator /designee will interview 5 staff and 5 residents/families to confirm knowledge of the process for reporting abuse. This will be completed for 5x/ week x2 weeks then weekly for 6 months.	

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	IN00437119, and IN00437564. 3.1-28(c)		The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly. Compliance Date:7/25/2024	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure care planned interventions to prevent falls were in place, related to anti-roll brakes not initiated in a timely manner for 1 of 4 residents reviewed for falls and accidents. (Resident D) Finding includes: During an observation on 7/1/24 at 3 p.m., Resident D was sitting in her wheelchair in	F 0689	p="" paraid="1066850204" paraeid="{e1692ae4-9d23-420b-8f7c-d184d9634e50}{187}">Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F689 - Free of	07/25/2024

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	activities. There were no anti-roll back brakes on the wheelchair. During an observation on 7/2/24 at 5:04 a.m., the resident was in bed. The wheelchair was beside the bed and there were no anti-roll back brakes on the wheelchair. During an observation on 7/2/24 at 6:13 a.m., there were no anti-roll back brakes on the wheelchair. RN 8 was in the room and acknowledged the anti-roll back brakes were not on the wheelchair. During an interview on 7/2/24 at 6:15 a.m., the Director of Nursing (DON) indicated the Fall Care Plan indicated the anti-roll back brakes would be used when available and they had been ordered. She presented an e-mail, dated 6/26/24 that indicated the brakes had been requested. The e-mail, dated 7/1/24 indicated the facility was to call the Supplier. The invoice had not indicated the anti-roll back brakes had been ordered. Resident D's record was reviewed on 7/1/24 at 1:14 p.m. The diagnoses included, but were not limited to, fracture of the left femur. An Annual Minimum Data Set assessment, dated 5/28/24, indicated an intact cognitive status, no impairment of the upper and lower extremities, was independent with wheelchair mobility, required moderate assistance with bed mobility and transfers, and had no falls. A Nurse's Progress Note, dated 6/14/24 at 7:32 a.m., indicated the resident was found on the floor between the two nightstands in the room. She was unsure how she had ended up on the floor. She denied pain or injury and was assisted into the wheelchair.		Accidents Hazards /Supervision /devices It is the policy of Casa of Hobart to ensure that care planned interventions are in place for residents who experience falls and incidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.¿ ¿ Resident D's anti roll backs are in place as of 7/2/2024 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.¿ ¿ ¿ What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.¿ Staff were in-serviced on:¿¿ Ensuring care planned fall interventions are in place.¿ How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.¿ The DON /designee During the IDT meeting will ensure fall interventions are available prior to placing the intervention on the care plan. Audits for compliance will be completed per occurrence this process will be indefinite. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months.¿ Thereafter, if determined by the Quality	

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	A Nurse's Progress Note, dated 6/14/24 at 6:09 p.m., indicated the resident complained of left hip and leg pain. The Nurse Practitioner was notified and an X-ray of the left hip was ordered. The X-ray of the left hip and pelvis, dated 6/14/24 at 10:06 p.m., indicated the bones were osteopenic with degenerative changes of the lower lumbar spine and sacroiliac joint. No acute fractures or dislocations seen. The left leg X-ray indicated mildly osteopenic bones and no fractures were seen. A Care Plan, dated 8/25/2, indicated the resident was a risk for falls. The interventions included a fall occurred on 6/14/24 and the intervention of anti-roll back brakes would be applied when available was added on 6/15/24. An Interdisciplinary Team Progress Note,dated 6/17/24 at 10:41 a.m., indicated the wheelchair not locked prior to a transfer was the root cause of the fall. The intervention and care plan updated, indicated anti-roll back brakes were put into place. A Nurse's Progress Note, dated 6/18/24 at 9:21 a.m., indicated the resident continued to complain of pain to the left hip. A Nurse's Progress Note, dated 6/18/24 at 9:38 a.m., indicated a Physician's Order to transfer the resident to the Emergency Room was obtained. A hospital X-ray of the left hip, dated 6/18/24, indicated a left femoral neck fracture. A Nurse's Progress Note, dated 6/25/24 at 6:51 p.m., indicated the resident returned to the facility post surgical repair of the left femoral neck		Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.¿ Monitoring will be on going.¿ Compliance Date: 7/25/2024	

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	fracture. During an interview on 7/2/24 at 2 p.m., the DON indicated the facility was able to get the anti-roll back brakes from another facility and they were now on the resident's wheelchair. This citation relates to Complaints IN00437100 and IN00437564. 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to			

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	restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure a resident who was admitted with a urinary catheter had a correct assessment of the catheter, physician orders for the catheter, and a documented reason for the catheter. The facility failed to ensure urinary catheter care was completed and the urinary catheter was monitored, for 1 of 2 residents reviewed for urinary catheter care. (Resident G) Finding includes: Resident G's closed record was reviewed on 7/1/24 at 3:12 p.m. The diagnoses included, but were not limited to, cellulitis of the left lower limb and benign prostatic hyperplasia (BPH). A Hospital Discharge Summary, dated 6/5/24, indicated the resident would be discharged with a urinary catheter. An Admission Nursing Assessment, dated 6/5/24 at 10:55 p.m., completed by LPN 1, indicated the resident was continent of urine and a toilet and incontinent briefs were used. The resident's urine was clear and the resident did not have a urinary catheter. The Baseline Care Plan, dated 6/5/24, indicated one person assistance was required for toileting.	F 0690	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F690 Bowel/Bladder Incontinence, Catheter, UTI It is the policy of Casa Hobart Healthcare to ensure that residents admitted with urinary catheters have an assessment, physician orders for use and care with documented reason. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident G No longer resides in the facility. How the facility will identify other residents having the potential to	07/19/2024

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	There was no care plan that indicated the resident had an urinary catheter. The Admission Nurse's Progress Note, dated 6/5/24 at 5:29 p.m., and completed by LPN 1 indicated the Physician had been notified of the admission and the medication orders from the hospital were to be continued. There was no documentation that indicated the resident had a urinary catheter. The Physician's Orders, dated 6/5/24 through 6/11/24, indicated there were no Physician's Orders for the urinary catheter, the reason for the urinary catheter, or the care of the urinary catheter. There were no Nursing Progress Notes from 6/5/24 to 6/11/24 at 1:27 p.m., that indicated the resident had a urinary catheter or the urine and catheter was being monitored. A Nurse's Progress Note, dated 6/11/24 at 1:27 p.m., indicated a family member requested the resident be transferred to the hospital due to blood being present in the urine on 6/10/24. The Nurse indicated the urine was yellow and without blood on 6/11/24. There was no documentation that indicated a urinary catheter was present. A Physician's Order, dated 6/11/24, indicated the resident was to be transferred to the Hospital Emergency Room for an evaluation and treatment. The CNA urinary status documentation indicated: On 6/6/24 the day and night shift indicated there was a urinary catheter present On 6/7/24, the night shift indicated a urinary catheter was present. On day shift the resident was incontinent and on evening shift the resident		be affected by the same deficient practice and what corrective action will be taken. All residents with an indwelling Catheter have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Staff were in serviced on: 7/17/2024 Nursing Staff will Obtain orders for use and monitoring upon admission. Nursing aides will Report/document of urinary output Q shift. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The DON /designee will audit 5 residents who have indwelling foley catheters 3x/week for 2 weeks then weekly for 6 months to ensure assessment, orders for usage, monitoring as well as	

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	continent. On 6/8/24 the day shift indicated a condom urinary catheter was used, the evening and night shift indicated the resident was continent. On 6/9/24 the day shift indicated a urinary catheter was present and on the night shift the resident was continent. On 6/10/24 the night and day shift indicated the resident was continent and the evening shift indicated a urinary catheter was present. On 6/11/24 the night and day shift indicated the resident had a urinary catheter. The resident was no longer in the facility on evening shift. During an interview on 7/2/24 at 11 a.m., the Director of Nursing (DON) indicated she was unable to determine if the resident had a urinary catheter. During an interview on 7/2/24 at 11:09 a.m., LPN 2 indicated he was "pretty sure" a urinary catheter was present. During an interview on 7/2/24 at 11:13 a.m., LPN 3 (discharging nurse) indicated she could not remember if a urinary catheter was present. During an interview on 7/2/24 at 11:15 a.m., LPN 4 indicated a urinary catheter was present and she had removed the leg bag due to the urine flowed back into the bladder and placed a regular drainage bag on the tubing. During an interview on 7/2/24 at 11:31 a.m., LPN 1 (admission nurse) indicated the resident had a urinary catheter. She acknowledged she had not documented the catheter on the Admission Assessment. She indicated the CNA's completed rounds every two hours and should know when they see the urinary catheter that the bag should		urinary output are reported and documented. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly. Completion Date 7/19/2024	

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	be emptied and catheter care needed completed. During an interview on 7/2/24 at 11:35 a.m., the DON indicated output is not completed on the residents with urinary catheters. A facility policy for urinary catheter care, dated 9/1/20, and received from the DON as current, indicated catheter drainage bags would be emptied one time on each shift or as needed. This citation relates to Complaint IN00437524. 3.1-41(a)(1)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and			

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	following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and			

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	155469	A. BUILDING 00 B. WING	07/02/2024

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	transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff members (RN 8), when providing care to a resident (Resident D) who was in Enhanced Barrier Precautions (EBP). This had the potential to affect 21 residents who reside on the Blueberry Lane Unit (1 of 5 Units) Finding includes: During an observation on 7/1/24 at 10:02 a.m., Resident D was observed lying in bed #2 in the room. The resident had an indwelling urinary catheter and the drainage bag was covered. There was a sign on the door that indicated the resident was in EBP and PPE was to be worn during care. There was PPE located next to the door outside of the room. Resident D's record was reviewed on 7/1/24 at 1:14 p.m. The diagnoses included, but were not limited to, fracture of the left femur. A Physician's Order, dated 6/28/24 at 4:24 p.m., indicated a urinary catheter was present and was to be changed every month and as needed for leakage or blockage. During an observation on 7/2/24 at 6:13 a.m., RN 8 was standing next to the resident's bed. She was holding a clear garbage bag. The bag contained the indwelling urinary catheter and drainage bag.	F 0880	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F880 - Infection prevention & Control It Is the policy of Casa of Hobart to ensure that staff use correct PPE when providing care to residents in enhanced barrier precautions. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;¿¿ ¿Staff donned the appropriate PPE for enhanced barrier precautions for resident D .¿ How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;¿	07/19/2024

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	RN 8 indicated she had just taken the urinary catheter out. She indicated she wore gloves but not a gown because the resident was not in isolation. RN 8 then acknowledged the EBP sign on the resident's door. A Physician's Order, dated 7/2/24, indicated the urinary catheter was to be discontinued. The facility policy for EBP, dated 3/20/24 and received from the Administrator as current, indicated EPB (gown and gloves) was to be used if the resident had an indwelling medical device (urinary catheters). 3.1-18(b)		All facility residents requiring enhance barrier precautions can be affected by the same alleged deficient practice.¿¿ deficient practice does not recur;¿ Staff were re-educated:¿ 7/2/2024 When/What Personal Protective Equipment (PPE) is to be used.¿ Donning PPE prior to moving to clean area of care.¿ Refer to the signage for clarity for appropriate PPE use How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.¿ DON/designee will observe 5 staff members per week providing care	

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			for a resident requiring Enhanced Barrier Precautions (EBP) to ensure PPE is donned and doffed, appropriately.¿¿¿ The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months.¿ Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.¿ Monitoring will be on going.¿ ¿ Compliance Date: 7/19/2024	