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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00351910. Complaint IN00351910 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: 6/27, 6/28, 6/29, 6/30, 7/1 and 7/2/21 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 7 Medicaid: 69 Other: 7 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/7/21.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review and interview, the facility failed to ensure each resident's dignity was maintained related to wearing a hospital gown during the daytime for 2 of 3 residents reviewed for dignity. (Residents 4	F 0550	**The facility request paper compliance for this citation** *Submission of this plan of*	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and 23) Findings include: 1. On 6/27/21 at 11:40 a.m. and 1:52 p.m., Resident 4 was observed in bed wearing a hospital gown. On 6/28/21 at 9:37 a.m., and 1:55 p.m., the resident was observed in bed wearing a hospital gown. On 6/29/21 at 9:24 a.m., the resident was observed in bed wearing a hospital gown. The record for Resident 4 was reviewed on 6/28/21 at 2:40 p.m. Diagnoses included, but were not limited to, palliative care, dependence on supplemental oxygen, history of respiratory failure, schizoaffective disorder, type 2 diabetes mellitus, high blood pressure, major depressive disorder, and anxiety disorder. The Admission Minimum Data Set (MDS) assessment, dated 1/21/21, indicated it was very important for the resident to choose what clothes to wear. The Quarterly MDS assessment, dated 4/24/21, indicated the resident was moderately impaired for decision making. The resident had no behaviors including rejection of care. He was an extensive assist with a 2 person physical assist for bed mobility, dressing, personal hygiene, and the activity of bathing did not occur during the assessment reference period. There was no Care Plan indicating the resident preferred to wear a hospital gown in bed every day. Interview with the Director of Nursing on 6/30/21		*correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F 550 Resident's Rights Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · R4 was provided with appropriate clothing. R4 remains at his baseline for mood and behavior · R23 was provided with appropriate clothing. R23 remains at his baseline for mood and behavior 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at 3:00 p.m., indicated she did not know why the resident was not dressed in street clothes. 2. Interview with Resident 23 on 6/27/21 at 1:43 p.m., indicated he would like to be dressed in regular clothes. The resident stated, "This is what they tell me I have to wear" as he was pointing to the gown. On 6/28/21 at 10:00 a.m., and 1:57 p.m., the resident was observed in bed dressed in a hospital gown. On 6/29/21 at 9:26 a.m., 12:05 p.m., and 2:51 p.m., the resident was observed in bed dressed in a hospital gown. On 6/30/21 at 9:35 a.m., 10:24 a.m., and 1:27 p.m., the resident was observed in bed dressed in a hospital gown. On 07/01/21 at 9:45 a.m., CNA 3 and CNA 4 were providing morning care for the resident. When they had finished CNA 4 dressed the resident in a hospital gown, she did not ask the resident what he wanted to wear. Interview with CNA 3 at that time, indicated she usually offered the resident to get dressed, but he refused all the time, so she did not offer today. The record for Resident 23 was reviewed on 6/29/21 at 1:50 p.m. Diagnoses included, but were not limited to, stroke, acquired absence of right left above the knee, vascular dementia with behaviors, obstructive and reflux uropathy, peripheral vascular disease, epilepsy, heart failure, type 2 diabetes, high blood pressure, atherosclerotic heart disease		will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure residents are wearing appropriate clothing's. At least five random residents will be selected per audit. This will be completed three times weekly for 4 weeks the 2x weekly for 6 months. Any deficiencies will be corrected immediately. · Inservice will be provided on the following topic: o Resident rights and maintaining an environment that promotes enhancement of quality of life and recognizing each person's individuality 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Quarterly Minimum Data Set (MDS) assessment, dated 4/30/21, indicated the resident was alert and oriented. The resident needed extensive assist with 1 person physical assist for dressing, and extensive assist with 2 person physical assist for personal hygiene. The resident had no pressure ulcers, but was at risk for pressure ulcers. There was no Care Plan the resident preferred to be dressed in a hospital gown during the day. Interview with the Director of Nursing on 7/1/21 at 10:26 a.m., indicated the CNA should have offered the resident to get dressed. 3.1-3(t)		action will be completed: July 23, 2021	
F 0638 SS=E Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment timely for 5 of 38 residents whose MDS assessments were reviewed. (Residents 21, 18, 13, 24, and 17) Findings include: 1. The record for Resident 21 was reviewed on 7/2/21 at 9:00 a.m. There was a Quarterly Minimum Data Set (MDS) assessment completed on 2/10/21. Another Quarterly MDS assessment, was not completed until 6/29/21.	F 0638	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible*	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The record for Resident 18 was reviewed on 7/2/21 at 9:00 a.m. There was a Quarterly Minimum Data Set (MDS) assessment completed on 2/19/21 and then not again until 6/17/21. 3. The record for Resident 13 was reviewed on 7/2/21 at 9:00 a.m. A Quarterly Minimum Data Set (MDS) assessment was completed on 2/6/21 and then not again until 6/29/21. 4. The record for Resident 24 was reviewed on 7/2/21 at 9:00 a.m. A Quarterly Minimum Data Set (MDS) assessment was completed on 2/12/21 and then not again until 6/2/21. 5. The record for Resident 17 was reviewed on 7/2/21 at 9:00 a.m. A Quarterly Minimum Data Set (MDS) assessment was completed on 2/12/21. There was no other Quarterly assessment completed. Interview with the MDS Coordinator on 7/2/21 at 10:30 a.m., indicated she was aware the comprehensive assessments were not completed within 120 days. 3.1-31(d)(2)		*allegation of compliance. Please find enclosed this plan of correction for this survey.* F 638 Quarterly Assessment Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · R21's Minimum Data Set (MDS) is updated · R18's Minimum Data Set (MDS) is updated · R13's Minimum Data Set (MDS) is updated · R24's Minimum Data Set (MDS) is updated · R17's Minimum Data Set (MDS) is updated 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure resident's MDS are completed timely (every 3 months), transmitted and	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			approved by CMS. At least five random residents will be selected per audit. This will be completed three times weekly for 4 weeks then 2x weekly for 6 months. Any deficiencies will be corrected immediately. · Inservice will be provided with the MDS coordinators on the following topic: o Timely completion of comprehensive MDS assessments 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Update 4. Dates when corrective action will be completed: July 23, 2021	
F 0640 SS=B Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review.			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview, the facility failed to successfully export the Minimum Data Set (MDS) assessment in timely manner for 6 of 38 residents whose MDS assessments were reviewed. (Residents 20, 2, 14, 16, 22, and 24) Findings include: 1. The record for Resident 20 was reviewed on 7/2/21 at 9:00 a.m. The 5/18/21 Quarterly Minimum Data Set (MDS) assessment indicated it had been completed but was not exported or transmitted. 2. The record for Resident 2 was reviewed on 7/2/21 at 9:00 a.m. The 6/10/21 Significant Change Minimum Data Set (MDS) assessment was completed but was not exported or transmitted. 3. The record for Resident 14 was reviewed on 7/2/21 at 9:00 a.m. The 5/24/21 Quarterly Minimum Data Set (MDS) assessment was completed but was not exported or transmitted.	F 0640	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F640 Encoding/Transmittal Resident Assessment Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · R20's Minimum Data Set	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. The record for Resident 16 was reviewed on 7/2/21 at 9:00 a.m. The 5/20/21 Quarterly Minimum Data Set (MDS) assessment was completed but was not exported or transmitted. 5. The record for Resident 22 was reviewed on 7/2/21 at 9:00 a.m. The 5/24/21 Quarterly Minimum Data Set (MDS) assessment was completed but was not exported or transmitted. 6. The record for Resident 24 was reviewed on 7/2/21 at 9:00 a.m. The 6/2/21 Quarterly Minimum Data Set (MDS) assessment was completed but was not exported or transmitted. Interview with the MDS Coordinator on 7/2/21 at 10:45 a.m., indicated she was aware the comprehensive assessments were not exported timely.		(MDS) was transmitted · R2's Minimum Data Set (MDS) was transmitted · R14's Minimum Data Set (MDS) was transmitted · R16's Minimum Data Set (MDS) was transmitted · R22's Minimum Data Set (MDS) was transmitted · R24's Minimum Data Set (MDS) was transmitted 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure resident's MDS are completed timely (every 3 months), transmitted and approved by CMS. At least five random residents will be selected per audit. This will be completed three times weekly for 4 weeks then 2x weekly for 6 months. Any deficiencies will be corrected immediately. · Inservice will be provided with the MDS coordinators on the following topic:	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Ø Timely encoding and transmission of MDS assessments to the CMS system 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, record review and interview, the facility failed to ensure residents who needed limited assist with activities of daily living (ADLs) received help related to nail care for 1 of 5 residents reviewed for activities of daily living. (Resident 62) Finding includes: On 6/27/21 at 2:33 p.m., Resident 62 was observed in his room ambulating to the bathroom. His toe nails were very long and hanging over the front of his slippers.	F 0676	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of*	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record for Resident 62 was reviewed on 6/30/21 at 1:58 p.m. Diagnoses included, but were not limited to, lack of coordination, Alzheimer's, dysphagia, diabetes, mood disorder, hallucinations, and delusions. The Significant Change Minimum Data Set (MDS) assessment, dated 4/8/21, indicated he was severely cognitively impaired for decision making and required an extensive 1 person physical assist with personal hygiene. A revised Care Plan, dated 5/4/21, indicated he required assistance with ADL care such as personal hygiene and bathing. The interventions included, but were not limited to, provide assistance with ADLs as needed. Interview with the Director of Nursing (DON) in 7/1/21 at 10:25 a.m., indicated the resident was noncompliant with skin assessments and ADL care at times. He would not allow the staff to assess his toe nails. 3.1-38(a)(3)(E)		*correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F676 ADL's Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · R62's toenails were cut. Resident remains within baseline for mood and behavior. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure resident's nails are cut and ADL's provided. At least five random residents will be selected per audit. This will be completed three times weekly for 4 weeks the 2x weekly for 6 months. Any deficiencies will be corrected immediately. · Inservice will be provided on the following topic:	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			o Resident are being provided with the necessary services and receives assistance with activities of daily living. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADLs (activities of daily living) related to bathing, shaving, oral care, and nail care for 3 of 5	F 0677	**The facility request paper compliance for this citation** *Submission of this plan of*	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents reviewed for ADL's. (Residents C, 4, and 23) Findings include: 1. On 6/28/21 at 11:17 a.m., Resident C indicated he doesn't always get two showers a week. He also indicated he needed a shave. The resident had a growth of facial hair. On 6/29/21 at 9:41 a.m., 11:50 a.m., and 1:44 p.m., the resident continued to have a heavy growth of facial hair. On 6/30/21 at 10:07 a.m., the resident was observed being taken into the shower room. At 10:44 a.m., the resident indicated he received a shower but he still had not received a shave. He indicated he would like a shave if someone could give him one. The record for Resident C was reviewed on 7/1/21 at 10:56 a.m. Diagnoses included, but were not limited to, stroke, COVID-19, chronic pain, and left above the knee amputation. The Annual Minimum Data Set (MDS) assessment, dated 3/29/21, indicated the resident was cognitively intact for daily decision making and needed extensive assistance with bathing and personal hygiene. The Care Plan, dated 1/29/19 and reviewed on 3/29/21, indicated the resident required assistance of staff for ADL care such as locomotion, dressing, personal hygiene, and bathing. Interventions included, but were not limited to, provide assistance with ADL's as needed. The resident's scheduled shower days were		*correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F677 ADL provided for dependent residents Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · Resident C was shaven and provided ADL care · Resident 4 was provided a bath and bathing (bed bath) is scheduled 2x/week · Resident 23 was shaven, fingernails were cut, and oral care provided. ADL care is provided daily. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice.	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Wednesday and Saturday evening. Nurses' Notes, dated 6/9, 6/16, and 6/23/21, indicated the resident had received a shower. There was no documentation in the bathing task to determine if the resident received a complete bed bath or a shower for May and June 2021. The documentation in the bathing task, indicated the resident needed one person physical assistance for bathing on 5/5, 5/6, 5/14, 5/24, 5/26, 5/29, 6/3, 6/5, 6/8, 6/9, 6/12, 6/13, 6/14, 6/16, 6/17, 6/18, 6/19, 6/21, 6/22, 6/23, 6/26, 6/27, and 6/28/21. The resident required one person physical assist for personal hygiene on 6/26, 6/27, 6/28, 6/29, 6/30 and 7/1/21. There was no documentation indicating what type of personal hygiene was completed. Interview with the Director of Nursing on 7/1/21 at 10:26 a.m., indicated the bathing sheets did not indicate what type of bath was given and the resident should have received a shave as requested. 2. On 6/27/21 at 11:40 a.m. and 1:52 p.m., Resident 4 was observed in bed wearing a hospital gown. At those times, his nails were long and dirty and he was unshaven. On 6/28/21 at 9:37 a.m., and 1:55 p.m., the resident was observed in bed wearing a hospital gown. At those times, his nails were long and dirty and he was unshaven. On 6/29/21 at 9:24 a.m., the resident was observed in bed wearing a hospital gown. His nails were long and dirty and he was unshaven. On 6/30/21 at 9:38 a.m., the resident was observed		2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure resident ADL's provided for dependent residents. At least five random residents will be selected per audit. This will be completed three times weekly for 4 weeks the 2x weekly for 6 months. Any deficiencies will be corrected immediately. · Inservice will be provided on the following topic: o Dependent resident are being provided with the necessary services and receives assistance with activities of daily living. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained.	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in bed wearing a hospital gown. His nails were long and dirty. At 10:35 a.m., Activity Aide 1 was pushing a cart and providing nail care to residents. She was asked to provide nail care to Resident 4. The record for Resident 4 was reviewed on 6/28/21 at 2:40 p.m. Diagnoses included, but were not limited to, palliative care, dependence on supplemental oxygen, history of respiratory failure, schizoaffective disorder, type 2 diabetes mellitus, high blood pressure, major depressive disorder, and anxiety disorder. The resident received Hospice Services weekly from the nurse and CNAs. The Quarterly MDS assessment, dated 4/24/21, indicated the resident was moderately impaired for decision making. The resident had no behaviors including rejection of care. He was an extensive assist with a 2 person physical assist for bed mobility, dressing, personal hygiene, and the activity of bathing did not occur during the assessment reference period. The Care Plan, dated 1/21/21, indicated the resident required assistance from staff for ADL care such as locomotion, dressing, personal hygiene, and bathing. An approach was to provide assistance with ADLs as needed. Documentation in the task section indicated the resident was to receive a bath or a shower on Monday and Thursday during the evening shift. In 4/2021 the resident received a complete bed bath on 4/15, 4/26, 4/27, and 4/30/21. For the months of 5/2021 and 6/2021 there was no documentation the resident received a bath or a shower on Mondays and Thursdays.		4. Dates when corrective action will be completed: July 23, 2021	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Nurses' Notes, dated 6/9 and 6/21/21 indicated nail care was provided.

Interview with the Director of Nursing (DON) on 6/30/21 at 3:00 p.m., indicated the facility had changed computer programs in 5/2021. The package the company purchased was not allowing the staff to document when residents received a shower, and if nail care had been provided. The staff were to provide a shower or bath for the resident two times a week even if the Hospice CNA was coming that day.

Interview with the DON on 7/1/21 at 10:26 a.m., indicated the only documentation they have regarding bathing was when the CNA documented in the task section under bathing, the resident required total dependence for bathing. The documentation did not indicate if the resident actually received a shower or bed bath.

3. Interview with Resident 23 on 6/27/21 at 1:49 indicated he had not been shaved in a while, and his fingernails were long and could be cleaned. He also indicated staff do not always help him to brush his teeth. He would prefer the swabs and not a toothbrush.

On 6/28/21 at 10:00 a.m., and 1:57 p.m., the resident was observed in bed dressed in a hospital gown. At those times the resident was unshaven and his nails were long and dirty.

On 6/29/21 at 9:26 a.m., 12:05 p.m., and 2:51 p.m., the resident was observed in bed dressed in a hospital gown. At those times, the resident was unshaven and his nails were long and dirty.

On 6/30/21 at 9:35 a.m., the resident was observed

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

in bed. Activity Aide #1 was in the room and indicated she was going to provide nail care to the resident. The resident was unshaven at that time as well.

On 6/30/21 at 1:27 p.m., the resident was observed in bed. CNA 5 had just finished shaving the resident. Interview with CNA 5 at the time, indicated she was on light duty was providing shaves to all of the male residents.

On 7/1/21 at 9:45 a.m. the resident was observed in bed. CNA 3 and CNA 4 were going to provide morning care to the resident. After the resident received his partial bath, CNA 4 rubbed lotion on his upper body and put deodorant under his arms. He was dressed in a hospital gown and incontinence care was provided. The CNAs gathered the dirty linen, removed their gloves and washed their hands with soap and water and left the room. Neither CNA offered or rendered oral care to the resident.

Interview with both CNAs at that time, indicated they did not offer or provide oral care to the resident.

The record for Resident 23 was reviewed on 6/29/21 at 1:50 p.m. Diagnoses included, but were not limited to, stroke, acquired absence of right left above the knee, vascular dementia with behaviors, obstructive and reflux uropathy, peripheral vascular disease, epilepsy, heart failure, type 2 diabetes, high blood pressure, atherosclerotic heart disease

The Quarterly Minimum Data Set (MDS) assessment, dated 4/30/21, indicated the resident was alert and oriented. The resident needed extensive assist with 1 person physical assist for

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dressing, and extensive assist with 2 person physical assist for personal hygiene. The resident had no pressure ulcers, but was at risk for pressure ulcers. Interview with the Director of Nursing (DON) on 6/30/21 at 3:00 p.m., indicated the resident's nails should have been trimmed and cleaned as needed and he should have been shaved with morning care. Interview with the DON on 7/1/21 at 10:26 a.m., indicated oral care should have been provided with morning care. 3.1-38(a)(2)(A) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure areas of bruising were assessed and monitored and treatments were completed as ordered for 2 of 2 residents reviewed for skin conditions (non-pressure related). (Residents C and D) Findings include:	F 0684	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts*	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. On 6/27/21 at 3:16 p.m., Resident C had a white 4 x 4 bandage to his right lateral forearm. The dressing was not dated and the resident indicated he didn't get his dressing changed as ordered. The record for Resident C was reviewed on 7/1/21 at 10:56 a.m. Diagnoses included, but were not limited to, stroke, COVID-19, chronic pain, and left above the knee amputation. The Annual Minimum Data Set (MDS) assessment, dated 3/29/21, indicated the resident was cognitively intact for daily decision making and needed extensive assistance with bed mobility, bathing and personal hygiene. The resident was totally dependent on staff for transfers. Nurses' Notes, dated 5/21/21 at 4:06 p.m., indicated the resident came to the writer that afternoon and stated his right arm was bleeding and he didn't know how he did it. A 0.7 centimeter (cm) x 1 cm open area to the right lateral arm was observed. The area was red in color. He had no complaints of pain. New orders were received. A Physician's Order, dated 5/21/21, indicated the right lateral arm was to be cleansed with normal saline and oil emulsion was to be applied. The area was to be covered with a dry dressing on Monday, Wednesday and Friday, day shift. The dressing could be changed for soilage or removal as needed every shift. The treatment order was not listed on the May and June 2021 Treatment Administration Records (TARs). Nurses' Notes, dated 5/28/21 at 4:47 a.m., indicated		*alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F684 Quality of Care Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · Resident C's wound on the right lateral arm was treated and now is healed. · Resident D's skin discoloration on the on upper are lower extremities were monitored and are now fading. No signs and symptoms of discomfort noted. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident continued with a dressing clean, dry, and intact to the right arm and sacrum without any active bleeding or drainage noted. Interview with the Director of Nursing on 7/1/21 at 10:26 a.m., indicated the resident's dressing should have been dated and the treatment orders put on the TAR. Interview with the Wound Nurse on 7/2/21 at 10:20 a.m., indicated she was not aware the resident had an area to his right lateral arm. She indicated staff were to notify her when a skin issue was found. 2. On 6/28/21 at 11:19 a.m., Resident D was observed in the dining room seated in her geri chair. She had multiple areas of discoloration to her upper and lower extremities. On 6/29/21 at 9:53 a.m., the resident was observed in the dining room seated in her geri chair. The areas of discolorations remained. On 6/30/21 at 9:56 a.m., she was observed in the activity room seated in her geri chair. The areas of discolorations remained to her upper and lower extremities. The record for the resident was reviewed on 6/28/21 at 2:09 p.m. Diagnoses included, but were not limited to, cerebral infarct, falls, anxiety, depression, and dementia. The Significant Change Minimum Data Set (MDS) assessment, dated 5/5/21, indicated the resident was severely cognitively impaired and required extensive physical assistance with bed mobility and transfers. A Care Plan, dated 5/28/21, indicated the resident was at risk for alterations in skin integrity. The		· An audit tool will be developed to ensure that a weekly skin assessment is performed on all residents. This will be completed two times weekly for 4 weeks the 1x weekly for 6 months. Any deficiencies will be corrected immediately. · Nursing staff were in serviced on the following topic: o Perform resident weekly skin assessment, MD notification of any observed alteration in skin integrity and treatment and monitoring in place. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interventions included, but were not limited to, monitor skin during daily ADL (activities of daily living) care. The 6/24/21 Skin Assessment indicated the resident had no skin impairments. A Nursing Note, dated 6/30/21 at 3:00 p.m., indicated the resident was noted with bruises to her bilateral arms and legs. There was a purple/black area to her right lower calf measuring 1 centimeter (cm) x (by) 3 cm, a purple area to her right upper calf measuring 3 cm x 1 cm, a purple/black area to her right upper inner arm measuring 1.5 cm x 1 cm. A cluster of purple/red bruises were noted to her right lower arm measuring 6 cm x 2 cm, and a cluster of purple/red bruises to her left lower arm measuring 7 cm x 2.5 cm. Interview with the Director of Nursing (DON) on 7/1/21 at 10:35 a.m., indicated the areas of discolorations should have been identified, assessed, and monitored. The "Skin Condition Assessment & Monitoring-Pressure and Non-Pressure" policy, dated 9/1/20, provided by the Administrator on 7/1/21 at 3:32 p.m., indicated when bruises are healing without complications the nurse will monitor the site weekly. This Federal tag relates to Complaint IN00351910. 3.1-37(a)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure relieving devices were in place and the resident's foot was repositioned from against the foot board which resulted in an acquired deep tissue injury pressure ulcer to the bottom of the left lateral foot for 1 of 3 residents reviewed for pressure ulcers. (Resident 23) Finding includes: On 6/27/21 1:45 p.m., Resident 23 was observed in bed. At that time, his left foot was pressed against the foot board of the bed and was laying directly on the mattress. His foot was not elevated, nor was there any pressure relieving devices under the foot. The resident had a specialty air mattress on his bed. On 6/28/21 at 10:00 a.m., the resident was observed in bed. At that time, his left foot was pressed against the foot board of the bed and was laying directly on the mattress. His foot was not elevated, nor was there any pressure relieving devices under the foot.	F 0686	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F 686 Treatment/Prevent PU Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/29/21 at 9:26 a.m., 12:05 p.m., and 2:51 p.m., the resident was observed in bed. At those times, his left foot was pressed against the foot board of the bed and was laying directly on the mattress. His foot was not elevated, nor was there any pressure relieving devices under the foot. On 6/30/21 at 9:35 a.m., the resident was observed in bed. At that time, his left foot was pressed against the foot board of the bed and was laying directly on the mattress. His foot was not elevated, nor was there any pressure relieving devices under the foot. On 6/30/21 at 1:27 p.m., the resident was observed in bed. At that time, his left foot was laying directly on the mattress and was not elevated, nor was there any pressure relieving devices under the foot. 7/1/21 at 9:45 a.m., CNA 3 and CNA 4 were going to provide morning care to the resident. The resident was wearing a sock to his left and it was elevated on a pillow. CNA 3 removed his sock and the resident's great toenail was observed with dried blood. There was a small open area noted in the corner of his toe. There was a large dark red/maroon unopened area on the bottom of the left lateral foot. The resident's foot was very dry and had a large amount of dried scaly skin. There was dried skin flakes observed all over the mattress. After morning care, the Wound Nurse was informed of the open areas on the resident's body. Interview with the Wound Nurse on 7/1/21 at 10:30 a.m., indicated the resident had no open areas currently at the present time. She indicated she would assess the open areas immediately.		· R23's skin assessment was completed. R23 was provided with heel lift boots for pressure relief. Open area on the corner of his left toe is being treated and R23's received daily skin care and inspection. Pressure area to the left lateral foot remained stable and treatment and monitoring is in place. 1. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure that weekly skin assessment of residents is in place. At least five random residents will be selected per audit. This will be completed three times weekly for 4 weeks the 2x weekly for 6 months. Any deficiencies will be corrected immediately. · Inservice will be provided on the following topic: o Weekly monitoring of resident's skin condition during routine care and skin check schedule. Any abnormalities noted	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record for Resident 23 was reviewed on 6/29/21 at 1:50 p.m. Diagnoses included, but were not limited to, stroke, acquired absence of right left above the knee, vascular dementia with behaviors, obstructive and reflux uropathy, peripheral vascular disease, epilepsy, heart failure, type 2 diabetes, high blood pressure, atherosclerotic heart disease The Quarterly Minimum Data Set (MDS) assessment, dated 4/30/21, indicated the resident was alert and oriented. The resident needed extensive assist with 1 person physical assist for dressing, and extensive assist with 2 person physical assist for personal hygiene. The resident had no pressure ulcers, but was at risk for pressure ulcers. The Care Plan, dated 5/3/21, indicated the resident had limited functional status in regards to the ability to independently change positions in bed. The Care Plan, dated 5/3/21, indicated the resident had potential for impairment to skin integrity related to immobility, incontinence, and a history of pressure ulcers. Physician's Orders, dated 5/3/21, indicated to suspend or offload heels when in bed. The last documented weekly skin assessment was dated 6/24/21 which indicated the resident had no open areas or new skin issues. Nurses' Notes, dated 7/1/21 at 10:50 a.m., indicated the resident had current skin issues. A Deep Tissue Injury (DTI) to the left lateral foot which measured 3.5 centimeters (cm) by 3.0 cm. The wound bed was necrotic with no drainage. A skin		will be assessed, referred to MD/NP for interventions. o Pressure Ulcer prevention protocol which includes but not limited to: turning and repositioning and offloading; use of pressure relieving devices, daily skin care using skin barrier creams and skin protectants 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tear was observed to the left great toe, which measured 1 cm by 0.5 cm. There was granulation to the wound bed with some drainage. The Physician was notified and new orders were obtained. The Wound Physician would see the resident on the next rounding day. Physician's Orders, dated 7/1/21, indicated to cleanse the left lateral foot with normal saline and pat dry. Apply skin prep daily until resolved. May apply as needed every shift for DTI. Bacitracin ointment to left great toe topically every day shift for skin tear until resolved. Interview with Wound Nurse on 7/1/21 at 11:30 a.m., indicated she had completed the skin assessment for the resident. She observed a Deep Tissue Injury (DTI) to the bottom of the left lateral foot and a skin tear which looked like an ingrown toenail to the left great toe. She notified the Physician and orders were received for skin prep every shift for the DTI and for the wound Doctor to see the resident on his next visit which was next week. She indicated his heel boot was not in the room, so a new one was obtained. Her last skin assessment was completed on 6/24/21 approximately 1 week ago and the resident had no open areas. The resident's foot was to be offloaded while in bed and should not be touching or pressed against the foot board. The current 3/13/21, "Wound Prevention" policy, provided by the Director of Nursing on 7/1/21 at 11:45 a.m., indicated weekly skin checks will be conducted by the licensed nurse and will be documented in the resident's electronic medical record. Daily, during routine care, the CNA will observe the resident's skin. When abnormalities were noted this will be communicated to the licensed nurse and the licensed nurse will proceed			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and complete a wound or skin event. All residents will have the following nursing care procedures as recommended and indicated. Pressure relief: As needed position and reposition the resident with pillows and other supportive devices. Skin hygiene: Daily with care lubricant the skin with lotion, to keep it soft. During care inspect the skin for signs and symptoms of skin breakdown. 3.1-40(a)(1)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review and interview, the facility failed to ensure restorative therapy was being performed as ordered by the Physician related application of splints (an anti-contracture device) for 1 of 5 residents reviewed for limited range of motion. (Resident D)	F 0688	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute*	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding includes: On 6/28/21 at 11:19 a.m., Resident D was observed in the dining room seated in her geri chair. She did not have her anti-contracture device in her left hand. On 6/29/21 at 9:53 a.m., the resident was observed seated in the dining room in her geri chair. Her anti-contracture device was observed in her right hand. The record for the resident was reviewed on 6/28/21 at 2:09 p.m. Diagnoses included, but were not limited to, cerebral infarct, falls, anxiety, depression, and dementia. The Significant Change Minimum Data Set (MDS) assessment, dated 5/5/21, indicated the resident was severely cognitively impaired and required extensive physical assistance with bed mobility and transfers. A Physician's Order, dated 6/4/21, indicated restorative splint, apply to left hand to prevent further contraction. A Care Plan, dated 6/4/21, indicated the resident was at risk for skin breakdown due to contraction of the hand. The interventions included, but were not limited to, apply splint to palm of hand daily. There was no documentation to indicate the staff were donning the splint daily as ordered. Interview with the Director of Nursing (DON) on 7/1/21 at 10:35 a.m., the resident was to have her anti-contracture device applied to her left hand daily as per the Physician's Order.		*admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F688 Increase/Prevent decrease in ROM/mobility Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · Resident D's anti-contracture device is applied on her left hand and is being monitored as ordered. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-42(a)(2)		developed to ensure resident's splint devices are applied and monitored appropriately. At least five random residents will be selected per audit. This will be completed weekly for 4 weeks the 2x weekly for 6 months. Any deficiencies will be corrected immediately. · Inservice will be provided on proper applications of splints and other anti-contracture devices. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed for residents who were nutritionally at risk for 2 of 2 residents reviewed for nutrition. (Residents 2 and 63) Findings include: 1. On 6/29/21 at 11:55 a.m., CNA 1 took Resident 2's lunch tray into his room. The CNA left the room with the resident's lunch tray. He indicated the resident refused his lunch. The record for Resident 2 was reviewed on 6/29/21 at 12:13 p.m. Diagnoses included, but were not limited to, hemiplegia (muscle weakness) following a stroke, type 2 diabetes, dysphagia (difficulty swallowing), and orthostatic hypotension (low	F 0692	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F692 Nutrition/Hydration Status	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	blood pressure). The Medicare 5 day Minimum Data Set (MDS) assessment, dated 6/4/21, indicated the resident was moderately impaired for daily decision making and he needed supervision with eating. The resident had sustained a significant weight loss of 5% or more within the past month. The Care Plan, dated 6/10/21, indicated the resident received a general regular diet. The resident had a history of weight loss. Interventions included, but were not limited to, encourage oral intake of food and fluids if not contraindicated and provide, serve diet as ordered and monitor intake and record every meal. On 5/10/21, the resident weighed 150 pounds. On 6/14/21, the resident weighed 137 pounds, an 8.6% weight loss in one month. The May 2021 Food Consumption log, indicated meals were not documented on the following dates: Dinner: 5/31/21 The June 2021 Food Consumption log, indicated meals were not documented on the following dates: Breakfast: 6/14 and 6/22/21 Lunch: 6/7, 6/14, and 6/22/21 Dinner: 6/1, 6/2, 6/7, 6/11, 6/13, 6/20, 6/26, 6/27, and 6/29/21 Interview with the Director of Nursing on 7/1/21 at 10:26 a.m., indicated the food consumption logs		Maintenance Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · R2's meal/nutritional consumption is being monitored and documented appropriately. R2 was admitted under hospice care on 7/14/2021 · R63's meal/nutritional consumption is being monitored and documented appropriately. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure resident's nutritional/meal intake is monitored and documented appropriately and any significant weight changes are addressed as appropriate. At least five random residents will be selected per audit. This will be completed weekly for 4 weeks the 2x weekly	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	should have been completed. 2. On 6/29/21 at 12:10 p.m., Resident 63 was observed sitting up in bed. Her lunch tray had been placed on the over bed table in front of her. The nurse had set her up to eat, however, the resident was not eating and just staring at her food. She was served a pureed meal and a health shake. On 7/1/21 at 8:03 a.m., the resident was sitting in her wheelchair in the main dining room. Her breakfast tray was placed in front of her and CNA 6 sat down to assist and cue the resident to eat. She needed cueing to eat and drink her fluids. She was served a pureed meal, which included super cereal and milk. She did not have a health shake on her tray. The record for Resident 63 was reviewed on 6/29/21 at 10:35 a.m. Diagnoses included, but were not limited to, major depressive disorder, dysphagia, acute kidney failure, pain, anxiety, high blood pressure, osteoarthritis, repeated falls, syncope, and dementia. The 3/3/21 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was not alert and oriented and needed supervision with set up help for eating. The resident weighed 144 pounds with a significant weight loss. The Care Plan, dated 5/11/21, indicated the resident required a mechanically altered diet. The resident has a history of weight loss. An approach was to monitor intake and record every meal. The resident weighed 145 pounds on 5/11/21 and 126 pounds on 6/11/21. The last documented weight was on 6/28/21 which was 129 pounds.		for 6 months. Any deficiencies will be corrected immediately. · Inservice nursing staff on proper monitoring and documentation of resident's nutritional intake and timely notification of MD and dietitian of resident's significant weight changes for interventions 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Registered Dietitian's (RD) progress note, dated 6/8/21 at 1:32 p.m., indicated the resident has a 12.2% weight loss over the last 30 days. The resident had poor oral intake per food consumption records, with 0-25% at most meals. Recommend to increase ready care shakes to all meals and weekly weight next week. Physician's Orders, dated 6/8/21 indicated health shakes at all meals. The meal consumption intake logs for the months of 5/2021 and 6/2021 indicated breakfast was not documented on 5/7, 5/8, 5/9, 5/18, 5/21, 6/1, 6/13, 6/17, and 6/18/21. The lunch meal was not documented on 5/7, 5/8, 5/9, 5/18, 5/21, 5/24, 6/1, 6/7, 6/13, 6/17, and 6/18/21. The dinner meal was not documented on 5/3, 5/5, 5/7, 5/8, 5/16, 5/19, 5/20, 5/21, 5/31, 6/1, 6/3, 6/9, 6/11, 6/13, 6/21, 6/26, and 6/28/21. Interview with the Director of Nursing on 6/30/21 at 3:00 p.m., indicated the meal consumption logs should have been completed and the resident was to receive a health shake at all meals. 3.1-46(a)(1)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	483.65 of this subpart. Based on observation, record review, and interview, the facility failed to provide proper respiratory care and services related to oxygen at the correct flow rate, physician orders for oxygen, monitoring of humidification bottles, and changing and dating the oxygen tubing for 4 of 4 residents reviewed for oxygen. (Residents 46, 148, 4, and 18) Findings include: 1. On 6/27/21 at 10:00 a.m. and 2:28 p.m., Resident 46 was observed in bed. The nasal cannula was not in her nares (nostrils) and the oxygen concentrator was set at 5 liters. On 6/28/21 at 9:42 a.m. and 11:36 a.m., the resident's oxygen concentrator was set at 4 1/2 liters. The oxygen tubing was not dated. At 2:57 p.m., the resident was holding the oxygen cannula in her hand and the concentrator was set at 4 1/2 liters. The oxygen tubing was not dated. On 6/29/21 at 9:40 a.m., 11:43 a.m., 1:44 p.m., and 3:05 p.m., the resident's oxygen was not in her nares. The oxygen concentrator was set at 2 1/2 liters and the tubing was not dated. On 6/30/21 at 9:34 a.m. and 11:15 a.m., the resident's oxygen was not in her nares. The oxygen concentrator was set at 2 1/2 liters and the oxygen tubing was not dated. The record for Resident 46 was reviewed on 6/30/21 at 3:06 p.m. Diagnoses included, but were not limited to, stroke, anoxic brain damage, dementia without behavior disturbance, heart failure, and oxygen dependent.	F 0695	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F 695 Respiratory/Tracheostomy Care and Suctioning Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · R46's oxygen set-up and settings are corrected and is now set per md order, O2 tubing is dated and changed per policy, O2 cannula placed on nostrils appropriately, R46's O2 saturation remains within baseline. No signs of distress noted. · R148's oxygen set-up and settings are corrected and is now set per md order, O2 tubing is dated and changed per policy, O2	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Quarterly Minimum Data Set (MDS) assessment, dated 6/14/21, indicated the resident was moderately impaired for daily decision making and she had used oxygen during the assessment reference period. The Care Plan, dated 6/21/21, indicated the resident required oxygen therapy to relieve hypoxia (lack of oxygen) related to the diagnosis of shortness of breath. The resident at times would remove her oxygen tubing. Interventions included, but were not limited to, administer oxygen as ordered. A Physician's Order, dated 4/30/21, indicated the resident was to receive oxygen by the way of a nasal cannula. Administer at 3 liters per minute as needed (prn) for shortness of breath or oxygen saturations below 90. The oxygen tubing, mask, or cannula were to be changed weekly on Wednesday. A Physician's Order, dated 5/9/21, indicated the resident's pulse oximeter (oxygen saturation) and temperature were to be monitored every shift. The June 2021 Treatment Administration Record (TAR), indicated the prn oxygen had not been signed out as being applied. The June 2021 Medication Administration Record (MAR), indicated the resident's oxygen saturation was monitored each shift. Her oxygen saturation was above 90% each shift. Interview with the Director of Nursing on 7/1/21 at 10:26 a.m., indicated the resident would pull her oxygen off and the oxygen should have been administered as ordered. She also indicated the tubing should have been dated.		cannula placed on nostrils appropriately, R148's O2 saturation remains within baseline. No signs of distress noted. · R4's oxygen set-up and settings are corrected and is now set per md order, O2 tubing is dated and changed per policy, R4's O2 saturation remains within baseline. No signs of distress noted. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. · 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure that resident's oxygen therapy is administered correctly per doctor's order and ensure that the O2 tubing's and humidifiers are checked and dated appropriately per policy. At least five random residents will be selected per audit. This will be completed three times weekly for 4 weeks the 2x weekly for 6 months. Any deficiencies will be corrected immediately. · Nursing staff has been	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. On 6/27/21 at 3:16 p.m., Resident 148 was observed in his room in bed. The oxygen nasal cannula was not in his nares and the oxygen concentrator was set at 2 1/2 liters. On 6/28/21 at 11:44 a.m., 2:05 p.m., and 2:55 p.m., the resident's oxygen concentrator was set at 2 1/2 liters and the tubing was not dated. On 6/29/21 at 11:37 a.m. and 1:44 p.m., the resident's oxygen concentrator was set at 2 1/2 liters and the tubing was not dated. The record for Resident 148 was reviewed on 6/30/21 at 10:00 a.m. Diagnoses included, but were not limited to, COVID-19, oxygen dependent, hypoxemia, and dementia without behavior disturbance. The Admission/Medicare 5 day Minimum Data Set (MDS) assessment, dated 5/24/21, indicated the resident was severely impaired for daily decision making and he had used oxygen during the assessment reference period. The Care Plan, dated 5/20/21, indicated the resident required oxygen therapy to relieve hypoxia related to the diagnosis of hypoxemia. Interventions included, but were not limited to, administer oxygen as ordered. A Physician's Order, dated 5/18/21, indicated the resident was to receive oxygen by the way of a nasal cannula at 3 liters per minute continuously. Interview with the Director of Nursing on 7/1/21 at 10:26 a.m., indicated the resident's oxygen concentrator should have been set at the correct rate and the tubing should have been dated. 3.		in-serviced on proper oxygen set-up: O2 rate, correct concentrator set-up, checking the functionality of humidification bottles, proper dating of oxygen tubing and proper documentation of respiratory services provided on the resident's medical record. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/27/21 at 11:34 a.m., and 1:53 p.m., Resident 4 was observed in bed. He had a nasal cannula in both nares and his oxygen rate was set at 4 liters per minute. The humidification bottle on the oxygen concentrator was dated 6/16/21. His oxygen tubing was not dated. On 6/28/21 at 9:52 a.m., and 1:55 p.m., the resident was observed in bed with a nasal cannula for oxygen in both nares. The humidification bottle was now dated 6/27/21, however, there was no date on the oxygen tubing. The oxygen rate was set at 4 liters per minute. On 6/29/21 at 9:24 a.m., the resident was observed in bed with a nasal cannula for oxygen in both nares. The humidification bottle was now dated 6/27/21, however, there was no date on the oxygen tubing. The record for Resident 4 was reviewed on 6/28/21 at 2:40 p.m. Diagnoses included, but were not limited to, palliative care, dependence on supplemental oxygen, history of respiratory failure, schizoaffective disorder, type 2 diabetes mellitus, high blood pressure, major depressive disorder, and anxiety disorder. The Quarterly MDS assessment, dated 4/24/21, indicated the resident was moderately impaired for decision making. The resident had no behaviors including rejection of care. He was an extensive assist with a 2 person physical assist for bed mobility, dressing, personal hygiene, and the activity of bathing did not occur during the assessment reference period. The Care Plan, dated 1/21/21, indicated the resident was at risk for adverse consequences related to respiratory failure. An approach was to			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administer oxygen as ordered. The Care Plan, dated 1/9/21, indicated the resident had an order for prn oxygen therapy related to history of shortness of breath and history of respiratory distress. Nursing approaches were to administer oxygen as ordered and explain the importance of keeping oxygen at the prescribed setting. Stress more oxygen may not be better. Physician's Orders, dated 6/8/21, indicated to change oxygen tubing and mask or cannula, (label) every night shift on Wednesdays and as needed. Physician's Orders, dated 5/3/21, indicated may apply nasal cannula oxygen at 4 liters per minute as needed for shortness of breath or if oxygen saturation was less than 92%. The Treatment Administration Record (TAR), for the month of 6/2021, indicated the oxygen tubing change had been signed out on 6/19/21. The resident's oxygen saturation was documented as being in the high 90's. Interview with the Director of Nursing on 6/30/21 at 3:00 p.m., indicated oxygen tubing and humidification bottles were to be changed weekly and dated. She was unsure why the resident had a prn order for oxygen.4. On 6/27/21 at 10:29 a.m., Resident 18 was observed in bed with her eyes closed. Her oxygen rate was set at 3 liters via nasal cannula. Her oxygen tubing was not dated and her humidification bottle was dated 6/16/21. On 6/28/21 at 11:07 a.m., the resident was observed in bed with her oxygen infusing at 3 liters. Her tubing remained undated and her humidification bottle was dated 6/16/21.			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/29/21 at 12:00 p.m., the resident was observed in bed with her oxygen infusing at 3 liters. Her tubing remained undated and her humidification bottle was dated 6/16/21. The record for the resident was reviewed on 6/29/21 at 10:40 a.m. Diagnoses included, but were not limited to, diabetes, acute respiratory failure, dementia, delirium, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 6/3/21, indicated the resident was never/rarely understood, she was totally dependent on staff for care, and she required oxygen. A Physician's Order, dated 6/8/21, indicated change oxygen tubing and mask or cannula. Clean the concentrator with approved wipe with each tubing change every Wednesday and as needed, and label the tubing. A Care Plan, dated 5/12/21, indicated the resident had a history of respiratory failure and required oxygen therapy. The interventions included, but were not limited to, administer oxygen as ordered and change oxygen tubing weekly or as ordered. Interview with the Director of Nursing on 6/30/21 at 1:45 p.m., indicated the resident's oxygen tubing and humidification should be changed weekly and dated. The "Oxygen Administration" policy, dated 3/2004, provided by the Administrator on 7/1/21 at 3:32 p.m., indicated make sure the oxygen humidifier jar was labeled properly.			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to provide the necessary care and services for residents who received Hemodialysis related to not assessing or monitoring the access site for 1 of 1 residents reviewed for dialysis. (Resident 50) Finding includes: The record for Resident 50 was reviewed on 6/29/21 at 2:45 p.m. Diagnoses included, but were not limited to, Encephalopathy, arteriovenous fistula, acquired absence of left leg above the knee, vascular dementia with behavioral disturbance, type 2 diabetes mellitus, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, acute kidney failure, stroke, end stage renal disease, and dependence on renal dialysis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/25/21, indicated the resident was alert and oriented, and received dialysis as resident. There was no Care Plan for dialysis. Physician's Orders, dated 4/30/21, indicated Hemodialysis every Monday, Wednesday, and	F 0698	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F 698 Dialysis Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · R50's pre-dialysis assessment and access site are assessed and documented daily	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Friday. Physician's Orders, dated 5/3/21, indicated Pre-dialysis vital signs and assessment every day shift on Monday, Wednesday and Friday. Document if shunt or fistula has bruit and thrill (+). Use (-) if not present. Assess access site and document any adverse signs in progress note. Assess dialysis access site for redness, swelling, pain, drainage and notify physician with any symptoms and document in progress note. Assess for bruit and thrill, document (+) for present, (-) for absent every shift. The Medication Administration Record (MAR) dated 5/2021 and 6/2021 indicated the pre-dialysis assessment was not completed on 5/12, 5/17, 6/21, 6/23, and 6/28/21. The MAR for the months of 5/2021 and 6/2021 indicated the access site, including the assessment of the fistula and bruit every shift, was not signed out as being completed for the day shift on 5/12, 5/17, 5/27, 6/19, 6/23, and 6/24/21, the evening shift on 6/10 6/14, and 6/15/21, and on 6/20/21 for the night shift. Interview with the Director of Nursing on 7/2/21 at 10:35 a.m., indicated the pre-dialysis assessment and the access site assessment was to be completed as ordered by the physician. 3.1-37(a)		as ordered. R50 remains at his baseline functioning and is receiving dialysis as scheduled. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure that residents receiving dialysis treatment are assessed daily and access site are checked and documented. This will be completed three times weekly for 4 weeks the 2x weekly for 6 months. Any deficiencies will be corrected immediately. · Nursing staff has been in-serviced on proper care of dialysis- monitoring, observation, and documentation 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: July 23, 2021	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure medications were held per blood	F 0757	**The facility request paper compliance for this**	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pressure parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 6/29/21 at 12:13 p.m. Diagnoses included, but were not limited to, hemiplegia (muscle weakness) following a stroke, type 2 diabetes, dysphagia (difficulty swallowing), and orthostatic hypotension (low blood pressure). The Medicare 5 day Minimum Data Set (MDS) assessment, dated 6/4/21, indicated the resident was moderately impaired for daily decision making. A Physician's Order, dated 5/3/21, indicated the resident was to receive Midodrine (a medication to treat low blood pressure) HCl 10 milligrams (mg), give 1 tablet by mouth three times a day for hypotension (low blood pressure). The medication was to be held if the resident's systolic blood pressure (top number) was over 100. The May 2021 Medication Administration Record (MAR), indicated the resident's systolic blood pressure was greater than 100 on the following dates and the medication was given: 6:00 a.m.: 5/4-5/19 and 5/21-5/25/21 2:00 p.m.: 5/3-5/19 and 5/21-5/24/21 10:00 p.m.: 5/3-5/16, 5/19, and 5/21-5/24/21 Interview with the Director of Nursing on 7/1/21 at 10:26 a.m., indicated the Midodrine should have been held per the blood pressure parameters ordered by the physician.		**citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 757 Drug Regimen is Free from Unnecessary Drugs** It is the facility policy to ensure that each resident's drug regimen is free from unnecessary drugs. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** · R 2's Midodrine order was discontinued on 5/28/21. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-48(a)(3)		will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure that all medications are administered and signed off in EMAR. At least five random residents will be selected. This will be completed three a week for 2 weeks then 2x a week for 6 months · Inservice will be provided on the following topic: o All medications with parameters are monitored and documented. Notification of attending physician if results are outside the parameters. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure psychotropic medications were monitored for side effects and effectiveness for 1 of 5 residents reviewed for unnecessary medications. (Resident 62) Finding includes: The record for Resident 62 was reviewed on 6/30/21 at 1:58 p.m. Diagnoses included, but were not limited to, lack of coordination, Alzheimer's, dysphagia, diabetes, mood disorder, hallucinations, and delusions. The Significant Change Minimum Data Set (MDS) assessment, dated 4/8/21, indicated he was severely cognitively impaired for decision making and required an extensive 1 person physical assist with personal hygiene. His medications received in the past 7 days included, but were not limited to, antipsychotics, antidepressants, and anti-anxiety medications. The June 2021 Physician Order Summary indicated Lorazepam (an anti-anxiety medication) 0.5 mg (milligrams) and 0.25 mg daily, Zyprexa (an antipsychotic medication) 10 mg twice daily, and Zoloft (an antidepressant medication) 50 mg	F 0758	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 758 Free from unnecessary Psychotropic Meds** It is the facility policy to ensure that each resident's drug regimen is free from unnecessary drugs. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient**	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	before bedtime. There was no documentation to indicate the resident was being monitored for side effects and/or effectiveness for the use of the above psychotropic medications. Interview with the Director of Nursing on 7/1/21 at 10:25 a.m., indicated the resident should have been monitored every shift for side effects and effectiveness for the use of his psychotropic medications. The "Psychoactive Medication Management" policy, dated 3/21/21, provided by the Administrator on 7/1/21 at 3:32 p.m., indicated the management of psychoactive medications will consist of evaluating effectiveness and monitoring for any adverse side effects. 3.1-48(a)(3)		**practice:** · R 62's medications were reviewed. Psychotropic medications were monitored for side effects and effectiveness and is now properly documented on the eMAR. R62 remains at baseline of functioning. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure that all medications that requires monitoring (i.e psychotropic medications) are administered and signed off in EMAR. At least five random residents will be selected per audit. This will be completed three a week for 2 weeks then 2x a week for 6 months · Inservice will be provided on the following topic: o All medications that requires monitoring are monitored for side effects and effectiveness and documented properly on eMAR 3. Quality Assurance Plans to	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications were not left at the bedside in the residents' rooms for 1 of 1 residents reviewed for medication storage. (Resident 23) Finding includes: On 6/28/21 at 10:00 a.m., Resident 23 was observed laying in bed. At that time, there were 2 pink tablets in a medication cup on his over bed table. The resident asked for the surveyor to give the medication to him. The medication was removed from the over bed table and taken to the nurses' station. Interview with LPN 1 at 10:15 a.m. indicated she had left the pills on the over bed table and the resident had told her he was going to take them after he had finished eating. The record for Resident 23 was reviewed on 6/29/21 at 1:50 p.m. Diagnoses included, but were not limited to, stroke, acquired absence of right left above the knee, vascular dementia with behaviors, obstructive and reflux uropathy, peripheral vascular disease, epilepsy, heart failure, type 2 diabetes, high blood pressure, atherosclerotic heart disease	F 0761	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 761 Label/store biologicals Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** · R 23's medications were reviewed. R23 was educated that all medications received will not be left at the bedside. R23 remains	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Quarterly Minimum Data Set (MDS) assessment, dated 4/30/21, indicated the resident was alert and oriented. The resident needed extensive assist with 1 person physical assist for dressing, and extensive assist with 2 person physical assist for personal hygiene. The resident had no pressure ulcers, but was at risk for pressure ulcers. Physician's Orders, dated 4/29/21, indicated Calcium Antacid Tablet Chewable 500 milligrams (mg) 1 tablet by mouth two times a day. There was no order or an assessment for the resident to self administer his own medications. Interview with the Director of Nursing on 6/30/21 at 3:00 p.m., indicated the nurse should not have left the medication at the bedside. 3.1-25(b)		within baseline of functioning. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure that residents take their medications during medication pass and are not to be left with the resident at the bedside. At least five random residents will be selected per audit. This will be completed three a week for 2 weeks then 2x a week for 6 months · Inservice will be provided on the following topic: o All residents will be observed when taking medications and medications are not to be left at the bedside. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	
F 0804 SS=F Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review and interview, the facility failed to ensure food was prepared by methods that conserved nutritive value. This had the potential to affect the 80 residents who received food from the kitchen. Finding includes: On 6/27/21 at 8:50 a.m., Dietary Cook 1 was observed placing a pan of mashed potatoes on the steam table.	F 0804	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and*	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with Dietary Cook 1 on 6/27/21 at 9:19 a.m., indicated the pureed food preparation for lunch had already been completed and placed in the steam table. She also indicated the greens and mashed potatoes were on the steam table as well. All she still needed to prepare for lunch was the chicken. She indicated lunch started at 11:30 a.m. Interview with the Dietary Food Manager (DFM) on 6/30/21 at 11:03 a.m., indicated the food for lunch on 6/27/21 should not have been placed on the steam table at 9:00 a.m. She indicated that was too early. The "Pureed Food Preparation" policy provided by the DFM on 6/30/21 at 1:52 p.m., indicated pureed foods would be heated to a minimum of 165 degrees Fahrenheit before serving and used or discarded within two hours. 3.1-21(a)(1)		*submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 804 Nutritive Value/Appear, Palatable/Prefer Temp** Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · Facility's dietary menu was reviewed to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor and appearance. Food and drink are palatable, attractive, and at a safe and appetizing temperature 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents have the potential to be affected of the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			· Anthen 2x a week for 6 months · A 1:1 in-service will be provided to Dietary Manager on nutritive value/appearance, palatability and preferred temperature of food · In-service will be provided to all dietary and nursing staff who prepares and serve meal trays to ensure that food temperature is maintained when it is served and food is presentable and palatable when served. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. . · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	
F 0812 SS=F	483.60(i)(1)(2) Food			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure food was stored, prepared, and served under sanitary conditions related to an accumulation of dust and debris on food equipment as well as food debris, an accumulation of dust on fans in the dish area and walk in refrigerator, food not labeled and dated, and food exposed in the walk in freezer in 1 of 1 kitchen areas and 2 of 2 unit pantries. This had the potential to affect the 80 residents who received food from the kitchen. (The Main Kitchen, Bakersfield pantry, and Main Unit pantry) Findings include: 1. During the Initial Tour of the kitchen with Dietary Cook 1 on 6/27/21 at 9:00 a.m., the	F 0812	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of*	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	following was observed: a. The top of the convection oven had an accumulation of dust and grease. b. There were food crumbs and debris on the counter where the toaster was located. The toaster was covered with plastic. c. The top of the steamer had an accumulation of dust and grease. d. There was dried spillage on the juice machine. e. The top of the dishwasher had an accumulation of dust and debris. The large fan in the dishwashing area had an accumulation of dust on the fan blades and fan cover. The fan was running at the time of the observation. f. The walk in cooler had dust on the ceiling and around the fan vents. g. The plastic lid on a container of cream of mushroom soup was not secured and the soup was exposed. A plastic container of bean and chicken soup was covered with aluminum foil. The foil was torn in sections and the soup was exposed. Both items were located in the walk in freezer. h. Two sandwiches in the reach in cooler were wrapped in plastic wrap. The sandwiches were not dated and the bread was hard to touch. 2. During the Full kitchen tour with the Dietary Food Manager (DFM) and Administrator on 6/30/21 at 9:00 a.m., the following was observed: a. The top of the convection oven had an		*correction for this survey.* **F 812 Food procurement, Store/Prepare serve sanitary** Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · Facility's kitchen was cleaned thoroughly to ensure that dusts, grease, crumbs, and debris were removed on all areas in the kitchen. Food areas appropriately covered, labeled, and dated appropriately 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents have the potential to be affected of the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · In-services were provided to dietary staff, including dietary manager on food safety requirements that include procurement of food from approved sources, proper storage, preparation, distribution, and sanitation of kitchen. · Dietary consultant	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accumulation of dust and grease. b. The top of the steamer had an accumulation of dust and grease. c. The large fan in the dishwashing area had an accumulation of dust on the fan blades and fan cover. d. The lid on a plastic container of food in the walk in freezer was not fastened and the food was exposed. Interview with the DFM at that time, indicated all of the above were in need of cleaning or had already been cleaned. She also indicated the food should have been sealed and the sandwiches dated. 3. On 7/2/21 at 9:16 a.m., the following was observed in the Bakersfield pantry: a. Three cups of vanilla pudding covered with plastic wrap, located in the refrigerator, were not dated. b. A plastic bakery container in the refrigerator was observed with 3 cupcakes. The plastic container was not dated. c. Food wrapped in paper from a local pizza restaurant was observed on the shelf in the refrigerator. The paper was not dated. Interview with CNA 2 at that time, indicated the pudding was delivered to the unit that morning and the cupcakes were from yesterday. She indicated both items needed to be dated and the left over food on the shelf needed to be discarded.		and or Administrator will conduct observation of the kitchen to cover sanitation and proper storage of food at least three times weekly for two weeks then 2x weekly for 6 months. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. . · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. On 7/2/21 at 9:31 a.m., the following was observed in the Main Unit pantry: a. A styrofoam container with left over food was dated 6/26/21. The container was located in the refrigerator. b. A plastic bag containing left over food was dated 6/27/21. The bag was located in the refrigerator. Interview with the Assistant Administrator at that time, indicated the food was to be discarded after 72 hours. The "Food Storage (Dry, Refrigerated, and Frozen)" policy was provided by the DFM on 7/2/21 at 9:36 a.m. The policy indicated all food items would be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. Leftover contents of cans and prepared food would be stored in covered, labeled, and dated containers in refrigerators and/or freezers. 3.1-21(i)(3)			
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			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 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			

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 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, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to transport staff not wearing the appropriate face coverings, gloves worn in the hallway, hand hygiene not completed prior to meals, and water not changed during a bed bath for 3 of 3 meal observations and 1 of 1 observations of a bed bath. (Residents 14 and 23) Findings include: 1. During a random observation, on 6/29/21 at 10:49 a.m., a transport staff member was walking down the Blueberry hallway with a neck gaiter face covering. At 10:54 a.m., he was transporting a resident in the hallway and continued to wear the neck gaiter face covering.	F 0880	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F880 Infection Prevention and Control	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with the Infection Preventionist on 7/1/21 at 2:45 p.m., indicated the transport staff member should have been wearing a surgical mask. The COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated 6/22/21, indicated universal use of facemasks should continue for all HCP, residents, and visitors that come into the facility. 2. During a random observation on 7/2/21 at 10:33 a.m., Hospice CNA 1 was observed walking out of a resident's room with disposable gloves in use. The CNA proceeded to get the linen barrel which was located in the hallway. Interview with the Hospice CNA at that time, indicated the gloves shouldn't have been worn in the hallway. Interview with the Director of Nursing on 7/2/21 at 1:50 p.m., indicated gloves were not to be worn in the hallway. The COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated 6/22/21, indicated to remove and discard gloves when leaving the resident room or care area.3. During a meal observation on 6/27/21 at 11:58 a.m., there were 12 residents seated in the main dining room waiting on lunch. A CNA was observed passing beverages to the residents. The meal trays were brought into the dining room by the kitchen staff and were ready to be passed at 12:03 p.m. There were 5 facility staff members passing trays and at no time did a staff member offer to provide hand hygiene to the residents before they ate their food. Ten of the 12 residents		Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · The transport staff was in-serviced on the correct PPE face covering to utilize per policy. · Hospice nurse was educated on proper use of gloves. · All residents including R14 in the dining room were offered to do hand hygiene every mealtime. · R23 was checked for wellbeing. No signs and symptoms of infection noted · Proper Hand hygiene in service with staff was completed for every patient-staff encounter · Staff were re-educated on proper infection control practices, donning, and doffing of PPE and Hand Hygiene 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents may have the potential to be affected by the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · An audit tool will be developed to ensure that proper	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were able to feed themselves. On 6/28/21 at 11:45 a.m., 12 residents were observed in the dining room waiting for lunch. At 11:50 a.m., the lunch trays were served. At no time, did facility staff offer or provide hand hygiene to the residents before they ate their food. Ten of the 12 residents were able to feed themselves. On 6/29/21 at 11:37 a.m., 7 residents were observed in the dining room feeding themselves the lunch meal. No staff was observed to offer or provide hand hygiene to them before eating. At at 11:38 a.m., Activity Aide 2 was holding Resident 14's hand and walked her over to obtain a clothing protector. The two walked hand in hand and the aide assisted the resident to sit down and placed the clothing protector over her clothes. The resident was served her lunch tray and started to eat. No staff provided hand hygiene to the resident prior to eating. Interview with LPN 2 on 6/29/21 at 11:40 a.m., indicated she did not physically provide hand hygiene to the residents before lunch was served, however, they were supposed to do it in their rooms before they come down, but she could not be assured all residents performed hand hygiene before they entered the dining room. Interview with the Director of Nursing on 6/29/21 at 11:42 a.m. indicated she was aware hand hygiene must be performed on all residents prior to their meals. 4. On 7/1/21 at 9:45 a.m., CNA 3 and CNA 4 were preparing to provide morning care to Resident 23. Both CNAs performed hand hygiene and donned clean gloves to both hands. CNA 3 washed the		infection control practices, proper PPE use and handwashing is always observed. DON/designee will randomly observe staff 3 staff 3x weekly for 4 weeks then 2 staff weekly for 6 months. Any deficiencies will be corrected immediately. · Nursing staff were in serviced on proper infection control practices, proper PPE donning and doffing including but not limited to mask, respirator devices, gloves, gown and eye protection, with return demonstration. · Nursing staff were in serviced on proper handwashing and ABHS use during every patient care and every resident encounter including but not limited to serving meal trays, when providing ADL care. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's face, under arms, and abdomen and dried him off. She gave a soapy wash cloth to CNA 4 who was standing on the other side of the bed and she provided peri care and cleaned under his scrotum. CNA 3 removed her gloves and performed hand hygiene and obtained a cylinder to empty the Foley catheter. She donned a pair of clean gloves to both hands and emptied the urine from the catheter. The CNA took the cylinder into the bathroom and flushed the urine down the toilet. The CNA came back to the bedside, removed her gloves and donned a clean pair of clean gloves to both hands. She did not perform hand hygiene. CNA 4 had finished with the peri care and indicated to CNA 3 to roll the resident over so she could wash his back side. The resident was rolled over onto his left side and CNA 3 washed his back and buttocks with the same water that had been used to wash his front side. After the resident was washed, they dried him off and rolled him onto to his back. CNA 3 obtained a wash cloth from the basin and proceeded to wash his left leg and foot with the same water used to wash the rest of his body. The CNAs removed their gloves and washed their hands with soap and water when the morning care was completed. Interview with both CNAs at the end of morning care indicated there were aware hand hygiene must be performed after glove removal. CNA 3 was unaware of the need to change the water after providing peri care and then washing the resident's back side. Interview with the Director of Nursing on 7/1/21 at 10:26 a.m., indicated the CNAs should have emptied the water from the basin after washing the resident's peri area and before washing his back.		Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The 12/31/20 current "Hand Hygiene" policy, provided by the Director of Nursing on 7/1/21 at 11:45 a.m., indicated hand hygiene was to be performed immediately after glove removal. 3.1-18(b)			
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a functional and sanitary environment was maintained related to lime build up on faucets, dried food spillage on walls and sinks, dirty floors, and food spillage on pipes in 1 of 1 kitchen areas. This had the potential to affect the 80 residents who received food from the kitchen. (The Main Kitchen) Finding includes: During the Initial Tour of the kitchen with Dietary Cook 1 on 6/27/21 at 9:00 a.m., the following was observed: a. The faucet on the hand washing sink had an accumulation of lime build up. Food stains were observed inside of the sink. b. The wall located behind the steamer had an accumulation of dried food spillage. c. Dried food spillage was observed on the counter legs. d. The vent on the window air conditioning unit had an accumulation of dust. There was also an	F 0921	**The facility request paper compliance for this citation** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 921 Safe/Functional/Sanitary comfortable Environment** Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: · Facility's kitchen was	07/23/2021

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accumulation of dust and debris on the window ledge housing the air conditioning unit. e. The floor tile behind the steamer and underneath the 3 compartment sink had an accumulation of a black substance along the wall. f. An accumulation of lime build up was on the floor tile underneath the dishwasher and in the dishwashing area, the white PVC pipe in the dishwashing area was soiled with dried food debris. Interview with the Dietary Food Manager (DFM) on 6/30/21 at 9:15 a.m., indicated all of the above areas were in need of cleaning or had already been cleaned. 3.1-19(f)		cleaned thoroughly to ensure that there is no lime build up, no food stains, no dried food, no dust, no debris on all areas in the kitchen. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents have the potential to be affected of the same deficient practice. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · In-services were provided to dietary staff, including dietary manager on food safety requirements that include procurement of food from approved sources, proper storage, preparation, distribution, and sanitation of kitchen. · Dietary consultant and or Administrator will conduct environmental rounds and observation of the kitchen to ensure proper sanitation in the kitchen least three times weekly for two weeks then 2x weekly for 6 months. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.	

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	07/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			. · All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: July 23, 2021	