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	09/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00387879 and IN00390783. Complaint IN00387879 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880 and F921. Complaint IN00390783 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F689. Survey dates: September 20, 21, 22, 23, 26, and 27, 2022 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 97 Total: 97 Census Payor Type: Medicare: 7 Medicaid: 72 Other: 18 Total: 97 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/30/22.	F 0000		
F 0554 SS=D	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp			

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

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Bldg. 00	§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Resident M) Finding includes: During a random observation on 9/21/22 at 10:43 a.m., Resident M was in her room in bed sleeping. At that time, two medication cups were observed on the over bed table. One medication cup contained multiple pills and the other cup had a liquid substance. The record for Resident M was reviewed on 9/26/22 at 2:01 p.m. Diagnoses included, but were not limited to, COVID-19, chronic obstructive pulmonary disease (COPD), and dementia without behavior disturbance. The Admission Minimum Data Set (MDS) assessment, dated 8/8/22, indicated the resident was moderately impaired for daily decision making. The resident had no Physician's Order for self administering medications and no Self-Administration of Medication assessment had been completed. Interview with the Director of Nursing on 9/26/22 at 4:00 p.m., indicated the medications should not have been left at the resident's bedside.	F 0554	F554 Resident Self-Admin Med-Clinically Approp The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified Licensed staff went in the room and assured that resident M had taken her medications 2) How the facility identified other residents: All residents who reside in the facility have the potential to be affected by this deficient practice 3) Measures put into place/ System changes: Licensed Staff will be re-educated proper medication pass to include staying with the resident until all medications are taken. 4) How the corrective actions will be monitored: Director of Nursing or designee will	10/16/2022

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	3.1-11(a)		complete 5 medication pass audits a week for 4 weeks to ensure that medications are given appropriately, then 3 medication pass audits thereafter until substantial compliance is met. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the			

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	facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on record review and interview, the facility failed to honor a resident's preference related to the number of showers per week for 1 of 1 residents reviewed for choices. (Resident 86) Finding includes: During an interview with Resident 86 on 9/20/22 at 10:18 a.m., he indicated he would like to take a shower every day. Currently, he was assigned to take a shower 2 times a week. The record for Resident 86 was reviewed on 9/22/22 at 3:52 p.m. Diagnoses included, but were not limited to, type 1 diabetes, ulcerative pancolitis, exocrine pancreatic insufficiency, bipolar disorder with psychotic features, and acute kidney failure. The 8/31/22 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The resident was totally dependent on staff for bathing. In the last 7 days, the resident had received 7 injections of Insulin. There was no Care Plan for preferences. An Activity Assessment, dated 5/26/22, indicated	F 0561	F561 Self Determination The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified Resident 86 was given a shower immediately and his shower preferences was updated in the system to reflect his preference. 2) How the facility identified other residents: All residents who reside in the facility have the potential to be affected by this deficient practice 3) Measures put into place/	10/16/2022

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	under the section of "bathing preference" the resident preferred a shower and would like to bathe daily. The shower log indicated the resident received a shower on 8/26, 8/27, 8/31, 9/1, 9/5, 9/8, 9/13, 9/16, 9/17, 9/18, 9/20, and 9/22/22. Interview with the Director of Nursing on 9/27/22 at 10:45 a.m., indicated the resident's preference was to be bathed every day. 3/1-3(u)(3)		System changes: Licensed Staff will be educated on honoring residents' preferences. 4) How the corrective actions will be monitored: Director of Nursing or designee will audit the compliance of resident showers 5 days a week during the clinical meeting for 4 weeks, then 3 days a week until substantial compliance is met. The Director of nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	
F 0638 SS=A 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 1 of 27 residents whose MDS assessments were reviewed. (Resident 1) Finding includes:	F 0638	F638 Qrtly Assessment at least every 3 months The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of	10/16/2022

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	The record for Resident 1 was reviewed on 9/27/22 at 7:30 a.m. The resident was admitted to the facility on 10/15/21. An Admission Minimum Data Set (MDS) assessment, dated 10/22/21 was completed on 11/2/21. A Quarterly MDS assessment, dated 3/24/22, was completed 3/30/22. A Quarterly MDS assessment, dated 6/4/22, was completed 7/11/22. A telephone interview with MDS Coordinator on 9/27/22 at 11:55 a.m., indicated she was unaware the 6/4/22 Quarterly MDS was not completed timely for the resident. 3.1-31(d)(2)		this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: The MDS for resident 1 was not able to be corrected 2) How the facility identified other residents: None of the resident who resides in the facility had the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: MDS coordinator will be in serviced on the importance of completing the MDS assessment timely. 4) How the corrective actions will be monitored: The MDS Coordinator will complete a weekly audit of assessment completed for timeliness. The administrator is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make	

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			recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately coded related to range of motion and enteral feeding for 2 of 27 MDS assessments reviewed. (Residents 6 and 83) Findings include: 1. During an interview with Resident 6 on 9/20/22 at 10:10 a.m., she indicated she was blind, however she was able to walk with her walking stick. At that time, she was observed moving all her extremities without any range of motion difficulty. She did not have any physical limitations. The record for Resident 6 was reviewed on 9/22/22 at 10:20 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia, major depressive disorder, and cortical blindness right side of brain. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/22 indicated the resident was cognitively intact and had no impairment in range of motion to both upper and lower extremities. The Quarterly MDS assessment, dated 6/9/22, indicated the resident had range of motion impairment to one side for both upper and lower	F 0641	F641 Accuracy of Assessments The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: The MDS for residents 6 and 83 were corrected 2) How the facility identified other residents: All resident who resides in the facility have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: MDS coordinator will be in serviced on the importance of coding the MDS assessment accurately	10/16/2022

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	extremities. The Annual MDS assessment, dated 9/9/22, indicated the resident had range of motion impairment to one side for both upper and lower extremities. A telephone interview with the MDS Coordinator on 9/27/22 at 11:55 a.m., indicated she had not physically been into the facility to look at or assess any of the residents. She made her assessments from the information provided by point click care. She was unaware the resident had no physical impairment from the diagnoses of hemiplegia. 2. On 9/20/22 at 1:37 p.m., Resident 83 was observed in bed. At that time and enteral feeding was infusing by the way of a peg tube (a tube inserted directly into the stomach for nutrition). The record for Resident 83 was reviewed on 9/26/22 at 4:05 p.m. Diagnoses included, but were not limited to, gastrostomy status. The Admission Minimum Data Set (MDS) assessment, dated 8/29/22, indicated the resident was receiving parental IV feedings. Physician's Orders, dated 8/24/22, indicated enteral feed Jevity 1.5 at 65 cubic centimeters (cc) per hour times 20 hours. There were no Physician's Orders for parental fluids. A telephone interview with the MDS Coordinator on 9/27/22 at 11:55 a.m., indicated a dietary staff member inaccurately coded the information regarding the enteral feeding.		4) How the corrective actions will be monitored: The MDS Coordinator will complete a weekly audit of assessment completed for accuracy. The administrator is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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	3.1-31(i)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to ensure a resident with a significant change in diagnoses and/or psychotropic medication received a new Level 1 PASARR (Preadmission Screening and Resident Review) for 1 of 1 residents reviewed for PASARR. (Resident 14) Finding includes: The record for Resident 14 was reviewed on 9/22/22 at 2:14 p.m. The resident was initially admitted to the facility on 3/8/16. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus,	F 0644	F644 Coordination of PASARR The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the	10/16/2022

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	non-Alzheimer's dementia, anxiety, depression, and psychotic disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/22, indicated the resident was not cognitively intact and needed extensive assistance with 1 person physical assist for dressing, toileting, personal hygiene. A Care Plan, revised on 9/8/22, indicated the resident received an antidepressant medication related to the diagnosis of major depression disorder. A Care Plan, revised on 9/8/22, indicated the resident had a diagnosis of major depressive disorder and anxiety disorder. A PASARR Level 1 screening was completed on 2/22/16 and indicated no level 2 was needed due to no diagnoses of major mental illness. Physician's Orders, dated 12/16/21, indicated Sertraline HCl (an antidepressant medication) tablet 25 milligrams (mg.) Give 1 tablet by mouth one time a day for depression. Physician's Orders, dated 12/16/21, indicated Olanzapine (an antipsychotic medication that is used to treat psychotic conditions) tablet 2.5 mg. Give one tablet by mouth two times a day for psychosis associated with dementia. Interview with the Director of Nursing on 9/23/22 at 10:18 a.m., indicated there was not an updated PASARR assessment completed for this resident since admission. The resident should have had an assessment completed with a change in diagnoses and addition of antipsychotic medications.		provisions of federal and state law. 1) Immediate actions taken for those residents identified A level 1PASARR was completed for resident 14 2) How the facility identified other residents: All residents who receive antipsychotic medications in the facility have the potential to be affected by this deficient practice 3) Measures put into place/ System changes: SSD will be educated on the PASARR process. 4) How the corrective actions will be monitored: The SSD will review residents who have change in antipsychotic medications 5 days a week in the clinical meeting to validate if a Level 1 PASARR is needed. The Administrator is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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	Interview with the Social Service Director on 9/26/22 at 1:34 p.m., indicated she was aware the resident needed an updated PASARR assessment completed because of the change in diagnoses and current medications. 3.1-16(d)(1)(A)			
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 were provided assistance with activities of daily living (ADL's) related to nail care and shaving for 2 of 5 residents reviewed for ADL's. (Residents 6 and 29) Findings include: 1. On 9/20/22 at 10:08 a.m., Resident 6 was observed with facial hair on her chin and neck. Interview with the resident at that time, indicated she could not see to take care of it herself as she was blind. She would like it trimmed as she does not want facial hair and that should be something the CNAs look at while helping her every day. On 9/26/22 at 11:30 a.m., the resident was observed sitting in the dining room participating in activities. The facial hair was still visible on her chin and neck. The record for Resident 6 was reviewed on 9/22/22 at 10:20 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia, major depressive	F 0677	F 677 ADL Care for Dependent Resident The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate action taken for those residents identified. Resident 6 was shaved and resident 29 received nail care. How the facility identified other residents? All dependent residents residing in the facility have the potential to be	10/16/2022

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	disorder, and cortical blindness right side of brain. The Annual MDS assessment, dated 9/9/22, indicated the resident was cognitively intact and needed limited assist with 1 person physical assist with personal hygiene. A Care Plan, dated 4/5/22, indicated the resident required assistance with ADLs related to hemiplegia, stroke, and blindness. The approaches included, but were not limited to, assist with person hygiene including dressing/ grooming as needed. Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated personal hygiene was to be completed as needed. 2. On 9/20/22 at 1:33 p.m., Resident 29 was observed sitting in a wheelchair in his room. He was unshaven with dried food on his face. He had very long and dirty nails to both hands. On 9/21/22 8:43 a.m. and 10:48 a.m., the resident was observed sitting in a wheelchair. He was unshaven with dried food on his face. He had very long and dirty nails to both hands. There was a black substance under his fingernails on the left hand. On 9/22/22 at 10:08 a.m., and 1:10 p.m., the resident was observed sitting in a wheelchair. He had very long and dirty nails to both hands. There was a black substance under his fingernails on the left hand. The record for Resident 29 was reviewed on 9/22/22 at 2:20 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia, dysphagia, major depressive disorder, high blood pressure,		affected by this alleged deficient practice. What measures put into place/ Systemic changes? Staff was re-educated on the importance of providing ADL care to include shaving and nail care as needed to residents. How will the corrected action be monitored? Director of Nursing or Designee will complete observation on 5 residents once a day, 5 times weekly for 4 weeks, and 5 residents 2x weekly thereafter to ensure ADL care compliance. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Completion: 10/16/2022	

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	09/27/2022

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

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	aphasia, reduced mobility, and vascular dementia. The Annual Minimum Data Set (MDS) assessment, dated 7/16/22, indicated the resident was not cognitively intact. The resident was an extensive assist with a 1 person physical assist for personal hygiene. He had a limitation in range of motion impairment on one side for both upper and lower extremities. The resident had no oral problems and weighed 142 pounds with no significant weight loss. A Care Plan, revised on 9/7/22, indicated the resident was limited in ADLs. The approaches were to assist as needed. Interview with CNA 1 on 9/26/22 at 9:10 a.m., indicated nail care and shaving were to be done when needed. Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated personal hygiene was to be done as needed, and not necessarily waiting for shower days. The resident's fingernails should have been trimmed and cleaned and he should have been shaved. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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	comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents were sent out for evaluation timely after a fall and fall follow up was completed for 2 of 4 residents reviewed for falls. The facility also failed to ensure areas of bruising and excoriation were assessed and monitored, treatments were completed as ordered, treatment orders were obtained, and weekly skin assessments with measurements were completed for 6 of 7 residents reviewed for skin conditions, non-pressure related. (Residents E, F, C, J, G, H, and K) Findings include: 1. On 9/20/22 at 11:40 a.m., Resident E was observed in his room seated on the side of his bed. The resident had a sling in place to his right arm. He indicated he had fallen and broken his arm. The resident proceeded to remove the sling and remove his tee shirt. A large area of yellow/greenish bruising was observed to the resident's right upper arm and chest area. The record for Resident E was reviewed on 9/22/22 at 2:49 p.m. Diagnoses included, but were not limited to, hemiplegia (muscle weakness) following a stroke and vascular dementia without behavior disturbance. The Admission Minimum Data Set (MDS) assessment, dated 8/4/22, indicated the resident was moderately impaired for daily decision making and he required limited assistance with bed mobility and transfers. The resident had one fall since admission or the prior assessment with no injury.	F 0684	F684 Quality of Care The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: 1. Area of bruising was assessed, and an order put in place to monitor for Resident E 2. Scratches to bilateral calves were assessed and treatment obtained. 3. Resident C no longer in facility 4. Wounds were assessed for Resident J and appropriate treatments were obtained. 5. Treatment to resident G's forehead and abdomen was completed. 6. Areas to resident H's right foot was assessed and appropriate treatments were obtained. 7. Area of bruising was assessed, and an order put in place to monitor for Resident K 2) How the facility identified other	10/16/2022

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	Nurses' Notes, dated 9/11/22 at 9:41 p.m., indicated the resident was found on the floor in his room in front of his wheelchair next to his bed. No changes in range of motion (ROM) were noted. The resident indicated he hit his shoulder when he landed. No redness or discoloration was noted. The resident indicated he lost his balance and fell when he was trying to get into his chair. A Post Fall Observation assessment had been completed on 9/11/22. There were no additional Post Fall Observation assessments available for review. A Physician's Order, dated 9/12/22, indicated the resident was to have an x-ray of his right shoulder due to shoulder pain post fall. Nurses' Notes, dated 9/12/22 at 2:27 p.m., indicated the resident had an acute distal fracture to the right shoulder. The Physician was notified and orders were received to send the resident to the hospital for further evaluation and treatment. A Fall Interdisciplinary Team (IDT) progress note was completed on 9/12/22 at 3:36 p.m. Nurses' Notes, dated 9/12/22 at 9:22 p.m., indicated the resident returned from the hospital with a right clavicle (collarbone) fracture. The next entry in the Nurses' Notes related to the resident's fall/fracture was dated 9/16/22 at 6:00 a.m., and indicated the resident had a quiet night and he slept without any issues. He had a sling in place with no swelling noted to the extremity and no complaints of pain. The next entry related to the resident's fall/fracture was a Physician's Progress Note, dated 9/19/22 at		residents: All residents who reside in the facility have the potential to be affected by this deficient practice 3) Measures put into place/ System changes: Staff will be re-educated on assessing and monitoring non pressure and pressure areas, the importance of completing treatments per physicians' orders and completing post-fall follow up assessments. 4) How the corrective actions will be monitored: Director of Nursing or designee will complete 5 wound care audits a week to ensure that the treatments are completed as ordered and ensure that 3 residents with bruising have been monitored weekly. Also post fall assessments will be audited 5 days a week during the clinical meeting. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16//2022	

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	6:48 p.m., which indicated the resident had a closed non-displaced fracture of the right clavicle due to a recent fall and he had a sling. The next entry in the Nurses' Notes related to the resident's fall/fracture was dated 9/21/22 at 5:13 p.m., and indicated the resident had a pained look to his face. He pointed to his right shoulder and indicated it bothered him when he was asked. The resident was given a pain pill. He was wearing a sling at that time and bruises to his right shoulder were still visible but healing. This was the first documented entry about the bruising. The resident had no order to monitor the bruising and his last weekly skin observation assessment was dated 9/1/22. The resident had no Care Plan related to the fracture and bruising. Interview with the Director of Nursing on 9/27/22 at 11:10 a.m., indicated the area of bruising to the resident's right upper arm and chest area should have been monitored and follow up documentation should have been completed after the resident's fall. 2. On 9/22/22 at 1:20 p.m., Resident F was observed in her room in bed. Dried blood was observed on the sheet next to the resident's right leg. Areas of scratch marks were noted on both of the resident's calves. At 2:55 p.m., the Wound Nurse completed a skin assessment. An undated gauze dressing was in place to the back of the resident's right calf. The dressing was soiled with areas of dried blood. Both legs had areas of redness and scratch marks. Interview with the Wound Nurse at that time, indicated she did not know who applied the			

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	dressing. On 9/26/22 at 10:30 a.m., the resident did not have a dressing in place to the back of the right calf. The record for Resident F was reviewed on 9/22/22 at 1:08 p.m. Diagnoses included, but were not limited to, cellulitis of the left and right lower limbs and pressure ulcer of the left heel stage 3. The Admission Minimum Data Set (MDS) assessment, dated 8/1/22, indicated the resident was cognitively intact for daily decision making and required extensive assistance for bed mobility. A Care Plan, dated 9/15/22, indicated the resident had a potential for impaired skin integrity. Interventions included, but were not limited to, avoid scratching and keep hands and body parts from excessive moisture and keep fingernails short. The Weekly Skin Observation assessment, dated 9/19/22, indicated the resident had pruritis (itching) to her bilateral legs. The rear left thigh and the front of the right thigh had scratch marks. The right lower leg (rear) was identified but no description was provided. The September 2022 Physician's Order Summary (POS), indicated there was no order for any treatment to the back of the resident's right calf. Interview with the Director of Nursing on 9/27/22 at 11:10 a.m., indicated a treatment order for the right calf area would be clarified. 3. On 9/22/22 at 9:00 a.m., Resident C was observed lying in bed and wearing a hard cervical neck collar.			

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	155469	A. BUILDING 00 B. WING	09/27/2022

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	The record for Resident C was reviewed on 9/26/22 at 10:05 a.m. Diagnoses included, but were not limited to, COPD, chronic kidney disease, dependence on renal dialysis, high blood pressure, altered mental status, right femur fracture, history of falling and dementia. The resident was admitted to the facility on 4/22/22. The resident was admitted to the hospital on 9/14/22 and returned to the facility on 9/17/22. The Quarterly Minimum Data Set (MDS) assessment, dated 8/12/22, indicated the resident was not alert and oriented. The resident needed extensive assist with 1 person physical assist for bed mobility, and extensive assist with 2 person physical assist for transfers and required supervision with 1 person assist for eating. There was no history of falls since the last assessment. The resident weighed 118 pounds with a weight gain. A Care Plan, revised on 5/6/22, indicated the resident was at risk for falls. A Post Fall Observation, dated 9/7/22 at 5:47 p.m., indicated the resident had an unwitnessed fall in the resident's room. The resident was sitting in a wheelchair prior to the fall. Nurses' Notes, dated 9/8/22 at 3:43 p.m., indicated the resident was alert to name and moved all extremities. A Fall Interdisciplinary Team (IDT) Progress Note, dated 9/9/22 at 11:33 a.m., indicated the team met to discuss the resident's fall and strategies to reuse for future falls. The resident was noted on the floor in the bedroom by staff. The resident was unable to give a description of the fall. No			

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	injury noted upon observation reported by the nurse. The resident was assessed by the nurse and a non-slip liner was placed in the seat of the wheelchair. Nurses' Note, dated 9/13/22 at 2:35 p.m., indicated new orders received to x-ray neck for complaints of pain to neck by the resident. Physician's Orders, dated 9/13/22, indicated x-ray of neck for pain. A Nurses' Note, dated 9/13/22 at 2:41 p.m., indicated all stat called for x-ray to neck. The cervical spine x-ray, dated 9/13/22 at 5:34 p.m. and reported back to the facility at 9:09 p.m., indicated the exam was limited to a single view. There was mild motion artifact. The bones were osteopenic. An acute cervical compression fracture was not excluded. Moderate multilevel degenerative changes were seen. No foreign bodies were identified. A Nurses' Note, dated 9/14/22 at 2:03 p.m.(17 hours after the results had been received), indicated x-ray of spine, cervical 2-3 was conducted as ordered. The results were scanned to the attending Physician and awaiting response. A Nurse's Note, dated 9/14/22 at 2:25 p.m., indicated orders were received to send the resident to the hospital for a Cat Scan (CT) without contrast to the cervical spine to rule out a fracture. Transportation has been arranged and estimated arrival was 30-40 minutes. A Nurse's Note, dated 9/15/22 at 11:29 a.m., indicated the resident had been admitted to the hospital for a cervical neck fracture.			

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	155469	A. BUILDING 00 B. WING	09/27/2022

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A CT scan report, dated 9/15/22, indicated the resident had a traumatic type 2 odontoid fracture following a mechanical trip with resultant closed neck injury.

The Fall Follow Up Assessment indicated the following:
- 9/8/22 at 2:47 a.m., vital signs obtained on 9/8/22 at 10:16 p.m. and a pain assessment was obtained on 9/8/22 at 10:18 p.m.
- 9/8/22 at 10:47 a.m., vital signs obtained on 9/9/22 at 7 a.m.
- 9/8/22 at 6:47 p.m., vital signs obtained on 9/8/22 at 3:30 p.m.
- 9/9/22 at 2:47 a.m., vital signs obtained on 9/9/22 at 2:14 a.m.
- 9/9/22 at 10:47 a.m. vital signs obtained on 9/9/22 at 7 a.m.
- 9/9/22 at 6:47 p.m., vital signs obtained on 9/9/22 at 7 a.m. and a pain assessment completed on 9/9/22 at 7:58 a.m.
- 9/10/22 at 2:47 a.m. vita signs obtained on 9/10/22 at 10:43 p.m. and a pain assessment completed on 9/10/22 at 10:44 p.m.
- 9/10/22 at 10:47 a.m., vital signs obtained on 9/12/22 at 8 a.m. and a pain assessment completed on 9/13/22 at 10:00 p.m.
- 9/10/22 at 6:47 p.m. and vital signs obtained on 9/12/22 at 8 a.m. and a pain assessment completed on 9/13/22 at 10:00 p.m.

All of the above assessments were competed by the same nurse and the vital signs and pain assessment had been completed on different days other than the assessment day.

Interview with the Director of Nursing (DON) on 9/26/22 at 2:40 p.m., indicated the nurse who worked that evening probably did not see or look

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	09/27/2022

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for the final report of the cervical spine x-ray. The report was read and sent to the Physician the next day.

Interview with the DON on 9/27/22 at 10:45 a.m., indicated she reviewed the x-ray the next morning. The fall follow up assessments were completed by the same person and at the same time of the day. The vital signs and pain assessments on the fall follow up were not obtained on the day of the actual assessments.

4. During an interview with Resident J on 9/21/22 at 8:10 a.m., indicated the areas to the left and right legs were not being treated. There was a bandage observed to the left inner lower leg with no date noted on the bandage. The resident's lower left leg was dry with a large scaly patch area with very dry and flaking skin in the center. There were no bandages except for the small one on left inner leg.

On 9/21/22 at 3:30 p.m., and on 9/22/22 at 10:08 a.m., there were no bandages observed to either leg.

The record for Resident J was reviewed on 9/21/22 at 4:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes, high blood pressure, congestive heart failure, peripheral vascular disease, anxiety, and major depressive disorder.

The Annual Minimum Data Set (MDS) assessment, dated 8/22/22, indicated the resident was cognitively intact. The resident had 1 arterial ulcer.

Physician's Orders, dated 7/25/22, indicated left lateral shin, left lower calf, and right lower medial shin: cleanse with normal saline, pat dry, apply

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	09/27/2022

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	xeroform, and cover with dry dressing every day shift on Monday, Wednesday, and Friday and prn. The Treatment Administration Record (TAR) for the month of 8/2022, indicated the left lateral shin treatment was not signed out as being completed on 8/8, 8/12, 8/15, 8/17, and 8/19/22. The left lower lateral calf was not signed out as being completed on 8/5, 8/8, 8/12, 8/15, 8/17, and 8/19/22. The right lower medial shin was not signed out as being completed on 8/5, 8/8, 8/12, 8/15, 8/17, and 8/19/22. The 9/2022 TAR indicated all the treatments were signed out as being completed through 9/22/22 The last documented wound assessment, completed by the Wound Physician, was dated 8/8/22. The venous wound to the left lower calf was resolved. The wound to the left lateral shin measured 4.5 centimeters (cm) by 1.7 cm. The xeroform was to be discontinued and Hydrofera Blue Foam with gauze bandage was to begin three times a week. There were no Physician's Orders for the Hydrofera Blue Foam to begin on 8/8/22. There were no more weekly wound measurements after 8/8/22. Interview with the Wound Nurse on 9/26/22 at 9:30 a.m., indicated she had just finished a skin assessment to both of his lower extremities. She took a picture of the resident's areas to the legs and sent it to the Wound Doctor who was still sick and was not coming in today to assess the resident. She had not completed any of the treatments to either leg last week.			

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	155469	A. BUILDING 00 B. WING	09/27/2022

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Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated the treatments should have been done as ordered by the Physician.

Interview with the Wound Nurse on 9/26/22 at 3:30 p.m., indicated the Wound Doctor had given new treatment orders for the resident's legs.

5. Interview with Resident G on 9/20/22 at 10:30 a.m., indicated the bandages to the forehead and abdomen were not always changed. At that time, there was a bandage on the left forehead that was dated 9/18/22. There was also an open area to the abdomen. Agency LPN 1 entered the room and pulled back the bed linens and removed the resident's brief. At that time, she lifted up the resident's abdomen and there was a bloody open area observed. The wound was not treated or covered.

On 9/21/22 at 8:15 a.m., the resident was observed in bed. There was a bandage on the forehead dated 9/18/22.

The record for the Resident G was reviewed on 9/22/22 at 11:08 a.m. Diagnoses included, but were not limited to, dementia without behaviors, heart failure, type 2 diabetes, high blood pressure, and dysphagia.

The Annual Minimum Data Set (MDS) assessment, dated 8/27/22, indicated the resident was cognitively intact and needed supervision with set up help only for eating. The resident weighed 168 pounds with a significant weight loss. There were no open areas identified.

The Care Plan, revised on 5/26/22, indicated the resident has impairment to skin integrity. The

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	155469	A. BUILDING 00 B. WING	09/27/2022

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approaches were to provide the treatment as ordered.

Physician's Orders, dated 9/12/22, indicated to cleanse area to lower abdomen with normal saline and pat dry. Cut Hydrofera Blue Foam dressing to size and cover with dry dressing every Monday, Wednesday, and Friday.

There were no Physician's Orders for the wound on the forehead.

Wound Physician Progress Notes, dated 9/12/22, indicated the wound of the lower abdomen was full thickness and measured 0.8 centimeters (cm) by 1.5 cm by 0.3 cm and was 100% granulation tissue. Continue the treatment of Hydrofera Blue Foam apply three times per week for 9 days.

A post surgical wound to upper face was full thickness and measured 1.4 cm by 1.1 cm by 0.3 cm and was thick adherent devitalized necrotic tissue of 30%, 20% slough, and 50% granulation tissue. The treatment plan was Hydrofera Blue Foam apply three times per week for 30 days. Discontinue the skin prep treatment.

The Treatment Administration Record (TAR) for the month of 9/2022 indicated there was no documentation of any of the treatments being completed.

There was no treatment order for the skin prep that was to be applied to the forehead lesion before the Hydrofera Blue Foam treatment.

Interview with the Wound Nurse on 9/22/22 at 11:30 a.m., indicated she had been working on the floor and tried to make sure the treatments were being done. She was unaware the treatment 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	09/27/2022

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

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the forehead was not on the treatment sheet.

Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated the treatments should be done as ordered by the Physician. All treatments should be documented as completed on the TAR.

6. The record for Resident H was reviewed on 9/22/22 at 3:00 p.m. The resident was admitted to the facility on 9/12/22. Diagnoses included, but were not limited to, myocardial infarction, Parkinson's disease, adult failure to thrive, cystitis, and urine retention.

The Minimum Data Set (MDS) assessment was still in progress.

There was no Care Plan for the open areas on the resident's feet.

An Admission Clinical Observation, dated 9/12/22, indicated there was no documentation regarding any impairment to the feet.

Physician's Orders, dated 9/13/22, indicated Triple Antibiotic Ointment (Neomycin-Bacitracin-Polymyxin). Apply to left anterior and right anterior 2nd toes topically every day shift for pressure area and cover with a bandaid.

A Skin Assessment, dated 9/12/22, indicated the resident had open lesions on both feet on the 2nd toe.

A Skin Assessment, dated 9/16/22, indicated open sores on the left anterior 2nd toe and right anterior 2nd toe.

A Skin Assessment, dated 9/18/22, indicated left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	and right anterior 2nd toe pressure sore from left and right great toenails. The Skin and Wound Evaluation, dated 9/23/22 and was still in progress and not completed, indicated the right foot second toe measured 0.8 cm by 0.5 cm. There was no description of the open area. There was no measurement or assessment of the left anterior 2nd toe. Interview with the Director of Nursing on 9/27/22 at 1:55 p.m., indicated the right foot was the only open area that was measured. She indicated both open areas should have been measured at the time of observation and weekly thereafter.7. During an observation of Resident K on 9/20/22 at 1:28 p.m., the resident was in a wheelchair in her room and there were two quarter sized bruises noted to her right forearm. The resident was unable to explain how she obtained the bruises and indicated staff had not been monitoring them. On 9/22/22 at 10:08 a.m., two bruises were still noted to the resident's right forearm. Resident K's record was reviewed on 9/22/22 at 1:09 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia affecting the right side (muscle weakness on one side), high blood pressure, non-Alzheimer's dementia, anxiety disorder, bipolar disorder, and psychotic disorder. A Physician's Order, dated 11/10/21, indicated skin assessment weekly. Document new skin issues per protocol every Wednesday on the evening shift. The September 2022 Medication and Treatment			

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	155469	A. BUILDING 00 B. WING	09/27/2022

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

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	Administration Record, indicated the skin assessment on 9/14/22 and 9/21/22 were not completed as ordered. There was no documentation related to the bruises on the right forearm. Interview with the Director of Nursing on 9/27/22 at 11:45 a.m., indicated the staff should have assessed the resident weekly for new skin conditions as per the Physician's order. This Federal tag relates to Complaint IN00390783. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure treatments were completed as ordered and weekly measurements were obtained for 2 of 2 residents reviewed for pressure ulcers. (Residents F and 10)	F 0686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of	10/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Findings include: 1. On 9/22/22 at 11:44 a.m., Resident F was observed in her room in bed. There was no visible dressing to her left foot and her foot was resting directly on the fitted sheet. At 1:20 p.m., there was no visible dressing to the resident's left foot and her foot was resting directly on the fitted sheet. At 2:55 p.m., the Wound Nurse completed a skin assessment. The resident had no dressing in place to the left foot and her foot was resting directly on the fitted sheet. The resident was observed with an open area to her left heel and some drainage was noted. The Wound Nurse indicated the resident had a pressure area, she had attempted to change the dressing yesterday as ordered but the resident refused. On 9/26/22 at 10:30 a.m., the resident was again observed in bed with no dressing to her left foot and her foot was resting directly on the fitted sheet. The record for Resident F was reviewed on 9/22/22 at 1:08 p.m. Diagnoses included, but were not limited to, cellulitis of the left and right lower limbs and pressure ulcer of the left heel stage 3. The Admission Minimum Data Set (MDS) assessment, dated 8/1/22, indicated the resident was cognitively intact for daily decision making and required extensive assistance for bed mobility. No pressure ulcers were identified. A Care Plan, dated 9/15/22, indicated the resident had skin breakdown to her left heel. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness as well as weekly treatment documentation to include measurement of each		compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: 1. Treatment was completed to resident F's left foot. 2. Treatment was completed to resident 10's right thigh. 2) How the facility identified other residents: All residents who have pressure areas have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: Licensed Staff will be re-educated on the importance of ensuring that residents have dressings in place to pressure ulcers. 4) How the corrective actions will be monitored: Director of Nursing or designee will complete 5 observations on residents with pressure ulcers to ensure that the dressing is clean, dry and intact, then 3 observations a week until substantial compliance is met. The Director of Nursing is responsible for compliance. The results of these audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	area of skin breakdown's width, length, depth, type of tissue and exudate. A Physician's Order, dated 9/12/22, indicated to cleanse the left heel with normal saline, pat dry, cut Hydrofera blue foam dressing to size, and cover with a dry dressing one time a day on Monday, Wednesday, and Friday and as needed (prn) for wound care. Nurses' Notes, dated 9/21/22 at 12:03 p.m., indicated the Wound Nurse attempted to provide wound care and the resident refused and started being combative. The September 2022 Treatment Administration Record (TAR) indicated the treatment was signed out as being completed on 9/21 and 9/23/22. Interview with the Wound Care Nurse on 9/26/22 at 11:00 a.m., indicated the treatment had been signed out by an Agency Nurse even though it had not been completed on 9/21 and 9/23/22. Interview with the Director of Nursing on 9/27/22 at 11:10 a.m., indicated documentation should not have been completed by the Agency Nurse if the treatment had not been completed. She also indicated attempts should have made to cover the resident's heel or place something underneath her feet. Interview with the Nurse Consultant on 9/27/22 at 11:59 a.m., indicated if the resident refused weekly measurements, it should have been documented in the progress notes. 2. During an interview with Resident 10 on 9/20/22 at 11:16 a.m., she indicated her bandages for the pressure sore were not getting changed as ordered.		reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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	09/27/2022

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

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	On 9/20/22 at 2:31 p.m., the resident was observed on the toilet. CNA 2 was present and assisted the resident to a standing position with the sit to stand lift. At that time, there was 1 pressure sore observed to the back of the resident's right thigh The area was beefy red and there was no bandage observed on the wound. On 9/26/22 at 9:42 a.m., the Wound Nurse was going to change the resident's bandage to the right thigh. CNA 1 assisted the resident to a standing position with the sit to stand lift and pulled down her pants. There was no bandage on the pressure sore. The open area was beefy red and clean. There was no bandage observed in her pants that might had fallen off. Interview with the Wound Nurse at that time, indicated she was unaware the bandage was not on pressure ulcer. The record for Resident 10 was reviewed on 9/21/22 at 3:40 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia, muscle spasm, and, high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 6/23/22, indicated the resident was moderately impaired for cognition. She had a range of motion impairment on one side for both upper and lower extremities. The resident had 1 stage 3 pressure ulcer. A Care Plan, dated 9/15/22, indicated the resident had a Stage 3 pressure ulcer to the right posterior thigh. The approaches were to provide wound care per treatment order. Physician's Orders, dated 6/27/22, indicated right posterior thigh, cleanse with normal saline, pat			

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

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	dry, apply collagen powder, Anasept gel, and cover with dry dressing every Monday, Wednesday and Friday and prn. Physician's Orders. dated 9/12/22, indicated to cleanse right posterior lower thigh with normal saline and pat dry. Cut Hydrofera blue dressing to size and place to area and cover with dry dressing one time a day and prn. The Treatment Administration Record (TAR) for the month of 8/2022, indicated the treatment to the right thigh was blank and not signed out as completed on 8/5, 8/12, 8/15, 8/17, 8/19, 8/24, 8/26, and 8/29/22. The TAR for the month of 9/2022, indicated the treatment dated 6/27/22 was never discontinued when the new treatment of the Hydrofera blue was ordered, therefore staff were signing out both treatments as being completed and there was only 1 pressure ulcer to the right thigh. The Wound Physician Progress Note, dated 9/12/22, indicated the right thigh ulcer was a Stage 3 measuring .5 centimeters (cm) by 1.2 cm by 0.2 cm with a 100% granulation. The treatment was to continue Hydrofera Blue Foam three times a week. Interview with the Wound Nurse on 9/22/22 at 11:30 a.m., indicated she had been working the floor the last couple of days and was unaware there was no bandage on the resident's pressure sore on 9/20/22. The resident was being seen the Wound Doctor on Mondays, however, he was ill and did not come in this past Monday. Resident 10 had 2 treatment orders for the same area and the order from June 2022 should have been			

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	155469	A. BUILDING 00 B. WING	09/27/2022

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

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	discontinued. The Hydrofera Blue treatment was not entered correctly in the computer. The treatment was to be completed three times a week not daily. Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated the treatments should have been completed as ordered by the Physician. 3.1-40(a)(2)			
F 0688 SS=E 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 residents were monitored and assessed for the development of contractures and splints were applied as ordered for 4 of 6 residents reviewed for limited range of motion (ROM). (Residents 4, 10, 29, and K)	F 0688	F688 Increase Prevent Decrease in ROM Mobility The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	10/16/2022

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	155469	A. BUILDING 00 B. WING	09/27/2022

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	Findings include: 1. On 9/21/22 at 8:25 a.m., Resident 4 was observed in her room seated in a recliner. The resident's ring finger on her left hand was in a bent position. When asked, she was able to extend all of her fingers except for her ring finger. The resident did not have a splint or any other type of anti-contracture device in use. On 9/22/22 at 10:25 a.m., the resident was seated in her recliner in her room. There were no anti-contracture devices in place to the left hand. At 11:44 a.m., the resident remained in the recliner and she was feeding herself using her right hand. There were no anti-contracture devices in place to the left hand. On 9/26/22 at 8:25 a.m., the resident was in her room eating breakfast. The resident was feeding herself with her right hand. There were no anti-contracture devices in place to the left hand. The record for Resident 4 was reviewed on 9/22/22 at 10:37 a.m. Diagnoses included, but were not limited to, memory deficit following a stroke and stiffness of unspecified joint. The Quarterly Minimum Data Set (MDS) assessment, dated 9/8/22, indicated the resident was cognitively impaired for daily decision making and she required extensive assistance with bed mobility. The resident had no functional limitation in her range of motion (ROM) to her upper and lower extremities. No physical or occupational therapy as well as restorative services were received during the assessment reference period. A Care Plan, dated 5/4/21, indicated the resident		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: 1. Resident 4 left ring finger was assessed, Physician notified, and orders put in place for anti-contracture device. 2. Resident 10 right hand was assessed, Physician notified, and orders put in place for anti-contracture device. 3. Resident 29 right hand was assessed, Physician notified, and orders put in place for anti-contracture device. 4. Resident K right hand was assessed, Physician notified, and orders put in place for anti-contracture device. 2) How the facility identified other residents: All residents who reside in the facility have the potential to be affected by this deficient practice 3) Measures put into place/ System changes: Staff will be re-educated on monitoring residents for change in ROM and reporting to physician for orders for contracture prevention.	

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	155469	A. BUILDING 00 B. WING	09/27/2022

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	needed some encouragement at times to engage in structured programs, related to the resident having limited use of her hands at that time due to her health. There were no other Care Plans related to limited ROM. There was no documentation of ROM exercises being provided by staff in the "Task" section of the record. A Physician's Order, dated 3/18/22, indicated the resident was to continue skilled Occupational Therapy (OT) services 3-5 times a week for 4 weeks for therapeutic exercises, therapeutic activities, and self-care retraining. OT services were discontinued on 4/8/22. The OT discharge summary, dated 4/8/22, did not indicate the resident had a limited range of motion to the ring finger on her left hand. There were no discharge orders for ROM or splinting. Interview with the Director of Nursing on 9/27/22 at 1:55 p.m., indicated OT staff stated the resident did not have a contracture when she was on their previous case load. The contracture to the finger was new and the resident was going to be evaluated. Nurses' Notes, dated 9/27/22 at 1:39 p.m., indicated OT to screen due to contracted finger noted to the resident's left hand. Physician made aware. A Physician's Order, dated 9/27/22, indicated OT to screen due to contracted finger to left hand. 2. On 9/20/22 at 11:24 a.m., Resident 10 was		4) How the corrective actions will be monitored: Director of Nursing or designee will complete 5 resident observations a week to ensure that there are no ROM concerns that are not noted then 3 residents a week thereafter until substantial compliance is met. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

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observed in the wheelchair. The right hand was flaccid and contracted, and the resident had to use the left hand to open it. Interview with the resident at that time, indicated there was no restorative therapy anymore and her splint does not get put on every day. There was no hand splint observed on her right hand.

On 9/21/22 at 3:27 p.m., the resident was observed in the wheelchair. There was no hand splint in her right hand. The right hand was flaccid and contracted.

On 9/22/22 at 9:20 a.m., and 4:40 p.m., and on 9/26/22 at 9:02 a.m., and 9:42 a.m., the resident was observed in the wheelchair. There was no hand splint in her right hand.

On 9/26/22 at 9:12 a.m., CNA 1 entered the resident's room and the resident informed the CNA the splint was in the closet. The CNA opened the doors and the splint was located exactly where the resident indicated it was. The hand splint was donned to the right hand at that time.

The record for Resident 10 was reviewed on 9/21/22 at 3:40 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia, muscle spasm, and, high blood pressure.

The Quarterly Minimum Data Set (MDS) assessment, dated 6/23/22, indicated the resident was moderately impaired for cognition. She had a range of motion impairment on one side for both upper and lower extremities.

The Care Plan, revised on 9/8/22, indicated the resident had a splint to the right hand due to hemiplegia. The approaches were to apply the

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	splint per Physician's Orders. Physician's Orders, dated 9/9/21, indicate nursing to apply resting hand splint to right hand daily. Put on in the morning and off in the evening. Under the task section, there was no documentation in the last 30 days of the splint being applied. There was no documentation on the 9/2022 Treatment Administration Record (TAR) or Medication Administration Record (MAR) for the hand splint whether it had been donned and doffed. Interview with CNA 1 on 9/26/22 at 9:12 a.m., indicated she had thought the resident wore a hand splint but not all the time. Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated the splint should have been on as ordered by the Doctor. 3. On 9/20/22 at 1:33 p.m., Resident 29 was observed sitting in a wheelchair. His right hand was in the shape of fist and there was no hand splint or any device noted to the hand. On 9/21/22 at 8:43 a.m., 10:48 a.m., and 3:28 a.m., the resident's right hand was in the shape of fist and there was no hand splint or any device noted to the hand. On 9/22/22 at 10:08 a.m., and 1:10 p.m., on 9/23/22 at 3:04 p.m., and on 9/26/22 at 9:00 a.m., and 12:10 p.m., the resident's right hand was in the shape of fist and there was no hand splint or any device noted to the hand.			

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	155469	A. BUILDING 00 B. WING	09/27/2022

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

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	The record for Resident 29 was reviewed on 9/22/22 at 2:20 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia, dysphagia, major depressive disorder, high blood pressure, aphasia, reduced mobility, and vascular dementia. The Annual Minimum Data Set (MDS) assessment, dated 7/16/22, indicated the resident was not cognitively intact. The resident was an extensive assist with a 1 person physical assist for personal hygiene. He had a limitation in range of motion impairment on one side for both upper and lower extremities. The resident had no oral problems and weighed 142 pounds with no significant weight loss. The Care Plan, revised on 9/27/21, indicated the resident has a splint to the right arm related to hemiplegia. The approaches were for the splint to be on in the a.m. and off in the p.m. daily. Physician's Orders, dated 9/24/21, indicated splint to be on in the a.m. and off in the p.m. daily. There was no documentation on the 9/2022 Treatment Administration Record (TAR) or Medication Administration Record (MAR) regarding the hand splint whether it had been donned and doffed. Interview with CNA 1 on 9/26/22 at 9:10 a.m., indicated she was unaware the resident was to wear a splint to his right hand. Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated if there were orders for the splint, then the resident should have been wearing the hand splint.4. During an observation of Resident K on 9/20/22 at 1:28 p.m., the resident was in her wheelchair in her room and there was			

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	no splint noted on her right hand. On 9/22/22 at 10:08 a.m., the resident was not wearing a splint to her right hand. On 9/23/22 at 9:06 a.m., the resident was not wearing a splint to her right hand. On 9/26/22 at 2:20 p.m., the resident was not wearing a splint to her right hand. Resident K's record was reviewed on 9/22/22 at 1:09 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia affecting the right side (muscle weakness on one side), high blood pressure, non-Alzheimer's dementia, anxiety disorder, bipolar disorder, and psychotic disorder. The Quarterly Minimum Data Set assessment, dated 7/29/22, indicated the resident was moderately cognitively impaired. The resident required extensive assistance with one person physical assist for toilet use and personal hygiene. The resident had a functional limitation in range of motion the upper and lower extremity on one side. A Physician's order, dated 9/30/21, indicated nursing staff to apply splint to right hand every day in the morning, and remove at night. Assess skin/circulation before and after application two times a day for prevention of a contracture. A Care Plan, dated 6/28/21, indicated the resident had a splint to the right hand related to hemiplegia and required a restorative splint/brace program. Interventions included, but were not limited to, application of splint to the right hand and assess skin and circulation under the splint.			

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	Interview with QMA 2 on 9/26/22 at 10:52 a.m., indicated she had never seen the resident wear a hand splint and was unsure if she was supposed to have one on. The record had no documentation related to the splint being applied and skin assessments being completed twice a day. Interview with the Director of Nursing on 9/27/22 at 1:58 p.m., indicated the resident was being screened again by therapy to determine if the splint was needed at this time. 3.1-42(a)(1) 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for residents who were at risk for falls for 1 of 4 residents reviewed for falls. (Resident L) Finding includes: On 09/20/22 at 9:54 a.m., Resident L was observed in bed. The resident's upper body was on the bed while the lower body was on a mattress on the	F 0689	F689 Free of Accident Hazards/Supervision Devices The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	10/16/2022

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	floor next to the bed. The mattress was not affixed to the floor to prevent sliding. There was a bright orange sign posted on the wall to remind the resident to use the call light for assistance before getting out of bed. On 9/20/22 at 1:56 p.m., the resident was observed sitting on the floor at the door in the room. On 9/21/22 at 9:51 a.m., the resident was observed standing by and rummaging in a wardrobe closet in the room. No staff were in the room at that time. Moments later a loud, smacking noise was heard, and the resident was observed lying on the floor with her head near the roommate's bed. The resident indicated she had hit her head by making hand motions around the right side of their face. A red area was noted to their head. On 9/27/22 at 9:32 a.m., the resident was observed on the floor in the dining room. Another resident informed staff that the resident hit her head when she fell. There was no staff observed in the dining room during the fall. There was no non-slip liner on the seat of the wheelchair. On 9/27/22 at 2:15 p.m., the resident was observed in bed. There was no non-slip liner in the seat of the wheelchair. At 3:00 p.m., a staff member found the non-slip liner in the drawer. The record for Resident L was reviewed on 9/22/22 at 2:30 p.m. Diagnoses included, but were not limited to, Stroke (CVA), schizophrenia, non-Alzheimer's dementia,and psychotic disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 7/6/22, indicated the resident was not cognitively intact and was unsteady but can stabilize without staff assist.		facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified Resident L was reassessed, and interventions were updated in attempt to decrease falls. 2) How the facility identified other residents: All residents who reside in the facility have the potential to be affected by the allege deficiency. 3) Measures put into place/ System changes: Staff will be re-educated on falls, fall interventions and prevention. 4) How the corrective actions will be monitored: Director of Nursing or designee will complete rounds on 3 residents at least once a day 5 times per week to ensure that residents have their fall interventions in place. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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A Care Plan, revised on 11/29/21, indicated the resident had a history of falls prior to admission and was at further risk for future falls related to impaired balance during transition and cognitive impairment with fluctuating cognitive status resulting in poor safety awareness.

A Fall Risk Assessment, dated 8/29/21, indicated the resident was a fall risk.

A Fall IDT (Interdisciplinary Team) Progress Note, dated 9/22/22 at 3:18 p.m., indicated they met to discuss the resident's fall on 9/18/22 and strategies to reduce future falls. The resident was noted sitting on floor in hallway. No injury was noted and Hospice was made aware for a medication review. Signs were posted in the bedroom to request assistance before transferring. A non-slip liner was put in place to the resident's wheelchair.

Interview with the resident's sister on 9/22/22 at 2:00 p.m., indicated a concern with how often the resident had fallen since Sunday 9/18/22. The sister indicated she had purchased a rolling walker for the resident to use while in the room.

Interview with the Assistant Director of Nursing (ADON) on 9/26/22 at 2:00 p.m., indicated the facility had implemented fall precautions such as a mattress on the floor next to the bed, rubber soled shoes, and reminders posted in the room to use the call light, but the resident often would get out of bed without calling for help.

This Federal tag relates to Complaint IN00390783.

3.1-45(a)(2)

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure indwelling foley catheter tubing was kept off the floor and	F 0690	F690 Bowel/Bladder Incontinence, Catheter, UTI The facility requests paper	10/16/2022

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	catheter care was signed out as completed for a resident with an urinary tract infection (UTI) for 1 of 1 residents reviewed for catheters. (Resident H) Finding includes: On 9/20/22 at 1:55 p.m. Resident H was observed sitting in a wheelchair. The indwelling foley catheter tubing was observed on the ground under the chair. At 2:36 p.m., a member from the therapy department was pushing the resident in the wheelchair with the catheter tubing dragging on the ground. On 9/21/22 at 11:10 a.m., and 9/22/22 at 1:58 p.m., the resident was observed sitting in the wheelchair and the foley catheter tubing was on the floor. The record for the resident was reviewed on 9/22/22 at 3:00 p.m. The resident was admitted to the facility on 9/12/22. Diagnoses included, but were not limited to, myocardial infarction, Parkinson's disease, adult failure to thrive, cystitis, and urine retention. The Minimum Data Set (MDS) assessment was still in progress. Physician's Orders, dated 9/12/22, indicated to change urinary drainage bag and may irrigate foley catheter with 30- 50 milliliters of water for blockage. Complete catheter care every shift. Physician's Orders, dated 9/14/22, indicated Augmentin (an antibiotic) Tablet 875-125 milligrams (mg). Give 1 tablet by mouth two times a day for Cystitis for 8 Days until 9/22/22.		compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident H catheter tubing was got off the floor and orders for the catheter care was reinstated to allow for documentation 2) How the facility identified other residents: All residents who a foley catheter or urostomy have the potential to be affected by this deficient practice. An audit was conducted for all residents who have a foley or urostomy to ensure that all appropriate physician orders are in place. 3) Measures put into place/ System changes: Licensed staff will be re-educated on assuring that residents have the appropriate orders for foley catheter or urostomy care. 4) How the corrective actions will be monitored: Director of Nursing or designee will	

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	Physician's Orders, dated 9/20/22, indicated foley catheter size 16 french with a balloon size of 10 ml. Change the catheter as needed for dislodgement, leaking or blockage. The 9/2022 Medication Administration (MAR), indicated the Augmentin was blank and not signed out as being administered on 9/14 at 8 p.m., 9/15 at 8 a.m., and coded with a "9" (see nurses' notes) on 9/15 at 8 p.m. The antibiotic was discontinued on 9/22/22. The 9/2022 Treatment Administration Record (TAR), indicated catheter care was not signed out as being completed for the evening shift on 9/13, 9/17, and 9/19/22 and on the midnight shift on 9/12, 9/14, 9/15, 9/16, and 9/20/22. An Infectious Disease Nurse Practitioner Note, dated 9/14/22 at 10:13 a.m., indicated the resident had cystitis and was placed on the antibiotic of Augmentin to be completed at the long term care facility. A Nurse's Note, dated 9/15/22 at 7:28 p.m., indicated the facility was waiting delivery of the Augmentin. There was no Care Plan for the indwelling foley catheter or the UTI. Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated the antibiotic Augmentin was in the EDK (Emergency Drug Kit) and could have been accessed to administer to the resident. The foley catheter tubing should not have been on the floor and catheter care was to be done every shift as ordered by the Physician. 3.1-41(a)		complete an audit 5 times a week to ensure that appropriate orders for catheter care are in place and being documented on. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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F 0692 SS=E Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake 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 supplements were provided as ordered and meal consumption was monitored for residents with a history of weight loss and/or were at nutritional risk for 5 of 8 residents reviewed for nutrition. (Residents F, M, 29, C and G) Findings include:: 1. On 9/26/22 at 8:30 a.m., Resident F was in her room eating breakfast. She did not receive a health shake with her meal. The record for Resident F was reviewed on 9/22/22 at 1:08 p.m. Diagnoses included, but were	F 0692	F692 Nutrition/Hydration Status Maintenance The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the	10/16/2022

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	not limited to, cellulitis of the left and right lower limbs and pressure ulcer of the left heel stage 3. The Admission Minimum Data Set (MDS) assessment, dated 8/1/22, indicated the resident was cognitively intact for daily decision making and required supervision with eating. A Care Plan, dated 9/13/22, indicated the resident was at risk for impaired nutritional status due to therapeutic diet, class 3 obesity, refusal of meals, and was at risk for malnutrition. Interventions included, but were not limited to, offer substitute if less than 50% of meal consumed and provide nutritional supplements as ordered. A Physician's Order, dated 9/9/22, indicated the resident was to receive a NAS (No Added Salt) diet, regular texture, regular (thin) consistency and a 4 ounce house shake at breakfast and lunch. A Physician's Order, dated 9/14/22, indicated the resident was to receive a house shake two times a day for a supplement, 4 ounce house shake at breakfast and lunch, provided by dietary. The Registered Dietitian (RD) Progress Note, dated 9/13/22 at 4:51 p.m., indicated the resident's estimated nutritional needs were " ... based on adjusted body weight to preserve lean body mass without over feeding less active adipose tissue. Resident with poor-fair oral intake, resident will refuse meals. Resident was previously receiving double protein at meals, however, will not recommend to add back due to poor intake of meals. Resident received therapeutic diet due to prior medical history. Resident received multivitamin that would aid in healing. Resident is at risk for malnutrition due to impaired skin integrity as well as refusal of meals. Resident may		provisions of federal and state law. 1) Immediate actions taken for those residents identified: 1. Resident F received a health shake, no negative outcome noted 2. Resident M was assessed by the Registered Dietician with no negative outcome noted 3. Resident 29 had a Cookie swallow and diet was upgraded. 4. Resident C no longer resides in the facility. 5. Resident G received a health shake, no negative outcome noted. 2) How the facility identified other residents: All resident who resides in the facility have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: Staff will be in serviced on the importance of documenting resident meal consumptions and providing supplements as ordered. 4) How the corrective actions will be monitored: The DON or designee will audit documentation for meal consumption and supplements 5 days a week to ensure that it is completed and accurate. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved	

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	benefit from adding additional protein for nutritional support. Recommend 30 cubic centimeters (cc's) Prostat (a protein supplement) twice a day (BID) and a 4 ounce house shake BID. Will continue to follow as needed." On 7/26/22 the resident weighed 352 pounds and on 9/19/22, the resident weighed 322 pounds. The Food Consumption log from 9/9 - 9/26/22, indicated the following: - No breakfast or lunch was documented on 9/10 and 9/25/22 - No lunch was documented on 9/11/22 - No dinner was documented on 9/17, 9/18, and 9/23/22 - No meal consumption was documented on 9/13, 9/16, 9/21, and 9/22/22 Interview with the Director of Nursing on 9/27/22 at 11:10 a.m., indicated the resident's food consumption logs should have been completed and she should have received her health shakes. 2. The record for Resident M was reviewed on 9/26/22 at 2:01 p.m. Diagnoses included, but were not limited to, COVID-19, chronic obstructive pulmonary disease (COPD), and dementia without behavior disturbance. The Admission Minimum Data Set (MDS) assessment, dated 8/8/22, indicated the resident was moderately impaired for daily decision making. The resident required supervision with eating and received a mechanically altered/ therapeutic diet. A Care Plan, dated 9/20/22, indicated the resident was at risk for impaired nutritional status due to new admission to facility, mechanically altered		x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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	155469	A. BUILDING 00 B. WING	09/27/2022

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

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	diet, body mass index (BMI) <22.0, history of weight gain and at risk for malnutrition. Interventions included, but were not limited to, offer substitute if less than 50% of meal is consumed. The September 2022 Physician's Order Summary (POS), indicated the resident received a Consistent Carbohydrate (CCHO) and No added Salt (NAS) diet, Mechanical Soft texture, Regular (thin) consistency. No tomato, potato, banana, oranges, or orange juice. The Food Consumption log from 9/1 - 9/26/22, indicated the following: - No breakfast or lunch documented on 9/1, 9/20, and 9/24/22. - No lunch or dinner documented on 9/8/22. - No dinner documented on 9/2, 9/17, 9/18, 9/19, and 9/23/22. - No meal consumption documented on 9/6, 9/7, 9/16, 9/21, 9/22, and 9/25/22. Interview with the Director of Nursing on 9/26/22 at 4:00 p.m., indicated the resident's food consumption should have been monitored and documented. 3. The record for Resident 29 was reviewed on 9/22/22 at 2:20 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia, dysphagia, major depressive disorder, high blood pressure, aphasia, reduced mobility, and vascular dementia. The Annual Minimum Data Set (MDS) assessment, dated 7/16/22, indicated the resident was not cognitively intact. The resident was an extensive assist with a 1 person physical assist for personal hygiene. He had a limitation in range of motion impairment on one side for both upper and lower extremities. The resident had no oral			

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	problems and weighed 142 pounds with no significant weight loss. A Care Plan, revised on 9/7/22, indicated the resident was limited in functional status in regards to eating. The approaches included, but were not limited to, monitor and record intake of food. A Care Plan, revised 9/7/22, indicated the resident was nutritionally at risk for weight loss. The approaches included, but were not limited to, monitor intake and record every meal. The resident's most recent weights were as follows: 8/9/22 152 pounds 9/2 136 pounds 9/8 133 pounds 9/19 135 pounds A Registered Dietitian's (RD) Progress Note, dated 9/6/22 at 7:21 p.m., indicated the resident's weight was 136 pounds which was a 11.1% weight loss in the last 30 days. Physician's Orders, dated 9/8/22, indicated house shake daily and regular pureed texture diet with nectar consistency fluids. Double portions at all meals and a 4 ounce house shake at breakfast. The meal consumption logs for the month of 9/2022, indicated breakfast was not documented on 9/3, 9/16, 9/19, 9/20. Lunch was not documented on 9/3, 9/7, 9/10, 9/19, 9/20 and dinner was not documented on 9/2, 9/6, 9/7, 9/13, 9/16, 9/20, and 9/21/22. Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated food consumption should be completed after every meal.			

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4. On 9/22/22 at 11:52 a.m., Resident C was observed in bed wearing a cervical collar. At that time, lunch was served and the resident received a pureed diet with thickened liquids. The CNA stayed in the room to feed the resident.

The record for Resident C was reviewed on 9/26/22 at 10:05 a.m. Diagnoses included, but were not limited to, COPD, chronic kidney disease, dependence on renal dialysis, high blood pressure, altered mental status, right femur fracture, history of falling and dementia. The resident was admitted to the facility on 4/22/22.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/12/22, indicated the resident was not alert and oriented. The resident needed extensive assist with 1 person physical assist for bed mobility, and extensive assist with 2 person physical assist for transfers. They required supervision with 1 person assist for eating. There was no history of falls since the last assessment. The resident weighed 118 pounds with a weight gain.

A Care Plan, revised on 9/20/22, indicated the resident was at risk for malnutrition.

The resident weighed 130 pounds on 8/1/22 and 118 pounds on 9/2/22. The most recent weight, obtained on 9/17/22, indicated the resident weighed 116 pounds.

A Registered Dietitian's (RD) Progress Note, dated 9/20/22 at 1:39 p.m., indicated the resident had a 7.6% weight loss in the last 30 days.

Physician's Orders, dated 7/6/22, indicated renal liquid supplement two times a day for supplement.

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	Give 1 can/carton of Nepro twice a day. Physician's Orders, dated 8/21/22, indicated liberal renal diet with pureed texture and nectar thick consistency for liquids. Double portions at all meals. The meal consumption logs for 9/2022 indicated breakfast was not documented on 9/24 and 9/25/22. Lunch was not documented on 9/12, 9/24, and 9/25/22 and dinner was not documented on 9/1, 9/3, 9/7, 9/12, 9/13, 9/17, 9/18, 9/20, 9/21, 9/24, and 9/25/22. Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated meal consumption logs were to be completed after each meal. 5. During an interview with Resident G on 9/20/22 at 10:40 a.m., they indicated they did not always receive supplements with meals. On 9/26/22 at 8:55 a.m., the resident was observed in bed, with their eyes closed. The breakfast meal was untouched and there was no health shake on the tray. The record for the Resident G was reviewed on 9/22/22 at 11:08 a.m. Diagnoses included, but were not limited to, dementia without behaviors, heart failure, type 2 diabetes, high blood pressure, and dysphagia. The Annual Minimum Data Set (MDS) assessment, dated 8/27/22, indicated the resident was cognitively intact and needed supervision with set up help only for eating. The resident weighed 168 pounds with a significant weight loss. There were no open areas identified.			

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	A Care Plan, revised on 5/26/22, indicated the resident was limited in functional status with eating and drinking. The approaches were to monitor and record intake of food. The resident weighed 185 pounds on 7/5/22 and 167 pounds on 9/2/22. A Registered Dietician (RD) Progress Note, dated 8/9/22 at 10:49 p.m., indicated the resident had a cancerous lesion to the forehead and a lesion to the lower abdomen. A weight gain was noted in the last 30 days. The RD recommended adding a 4 ounce health shake daily and weekly weights. A RD Progress Note, dated 8/23/22 at 12:41 p.m., indicated the resident was noted with a 11.6% weight loss in the last 30 days. The RD recommended to increase 4 ounce health shake twice a day. Physician's Orders, dated 4/21/22, indicated regular diet and double portions with breakfast. Physician's Orders, dated 8/10/22, indicated house shake one time a day for supplement, to be provided by dietary. Physician's Orders, dated 8/24/22, health shake increase to 2 times a day for supplement at breakfast and lunch, to be provided by dietary. The meal consumption logs for the month of 9/2022, indicated breakfast not documented on 9/7, 9/20, and 9/21/22. Lunch was not documented on 9/7, 9/12, 9/20, and 9/21/22 and dinner was not documented on 9/1, 9/3, 9/7, 9/12, and 9/13/22. Interview with the Nurse Consultant on 9/27/22 at 8:40 a.m., indicated the resident's food			

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	consumption was to be completed after every meal and health shakes were to be given to the resident as ordered by the Physician. The "Food and Nutrition Services" policy, provided by the Nurse Consultant on 9/27/22 at 10:00 a.m., indicated nursing personnel, with the assistance of the food and nutrition service staff, will evaluate and document food and fluid intake of residents with or at risk for significant nutritional problems. 3.1-46(a)(1)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 ensure a resident with complaints of pain received scheduled medication to relieve the pain for 1 of 1 residents reviewed for pain. (Resident 90) Finding includes: Interview with Resident 90 on 9/20/22 at 10:30 a.m., indicated she was having a lot of back pain and the medications they had given her were not helping. The record for Resident 90 was reviewed on 9/22/22 at 3:06 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, fibromyalgia (widespread musculoskeletal pain),	F 0697	F697 Pain Management The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for	10/16/2022

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	scoliosis (a sideways curvature of the spine), myalgia (muscle pain), tremor, thyroid disorder, and depression. The Admission Minimum Data Set (MDS) assessment, dated 9/2/22, indicated the resident was moderately cognitively impaired for daily decision making. The resident was on a scheduled pain medication regimen and had received opioids in the last 7 days. The Care Plan, dated 8/25/22, indicated the resident was at risk for pain. Interventions included, but were not limited to, administer analgesia as per orders. A Physician's Order, dated 8/24/22, indicated Norco (a pain medication) 7.5-325 milligrams (mg) four times a day for severe pain. A Nurse's Note, dated 9/2/22 at 3:52 p.m., indicated the resident needed a new prescription for the Norco tablets and the Physician was notified. The Director of Nursing (DON) provided the Controlled Drug Receipt/Record/Disposition Form on 9/23/22 at 12:18 p.m. The form indicated the Norco tablets were dispensed as ordered on 8/24/22 to 8/31/22 and 9/14/22 to 9/22/22. The DON was unable to produce the record for the medication being dispensed from 9/1/22-9/13/22. Interview with the DON on 9/26/22 at 2:15 p.m., indicated there was a problem with the pharmacy getting medications to the facility timely and there should have been documentation of a follow up with the pharmacy. 3.1-37(a)		those residents identified: Resident 90 received pain medication as ordered. 2) How the facility identified other residents: All residents receiving pain medications have the potential to be affected by this alleged deficient practice. An audit was completed on all residents with pain medication to ensure that medications were available. 3) Measures put into place/ System changes: Licensed Staff was educated on the importance of monitoring, assessing, documenting, and providing pain medication according to physician's order and resident plan of care. 4) How the corrective actions will be monitored: Director of Nursing or designee will review documentation 5 days a week to ensure that pain medications were given and available. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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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 ensure a fluid restriction was monitored and a dialysis access site was assessed for 2 of 3 residents reviewed for dialysis. (Residents M and 67) Findings include: 1. The record for Resident M was reviewed on 9/26/22 at 2:01 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and end stage renal disease. The Admission Minimum Data Set (MDS) assessment, dated 8/8/22, indicated the resident was moderately impaired for daily decision making. The resident required supervision with eating and received a mechanically altered/ therapeutic diet. A Physician's Order, dated 9/16/22, indicated the resident had a 1200 cubic centimeter (cc) daily fluid restriction. The resident also received in house dialysis every Monday, Wednesday, and Friday. There was no documentation related to the fluid restriction on the September 2022 Medication or Treatment Administration Records. The Monitor Intake section in the "Task" portion	F 0698	F 698 Dialysis The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate action taken for those residents identified. 1. Resident M's order for his Fluid restriction was corrected to allow documentation. 2. Resident 67's order for assessment of the dialysis site was updated to allow documentation. How facility identified other residents? All facility residents who utilize dialysis services have the potential to be affected by the same alleged deficient practice.	10/16/2022

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	of the resident's record indicated the following: - No documentation of fluid intake on 9/16, 9/21, 9/22, and 9/25/22. - On 9/17/22 at 9:30 a.m., a "4" was coded. No other entries had been completed. - On 9/18/22 at 10:48 a.m., a "24" was coded. No other entries had been completed. - On 9/19/22 at 11:12 a.m., 240 cc's was coded. No other entries had been completed. - On 9/20/22 at 8:03 p.m., 240 cc's was coded. No other entries had been completed. - On 9/23/22 at 2:59 p.m., 240 cc's was coded. No other entries had been completed. - On 9/24/22 at 10:55 p.m., 320 cc's was coded. No other entries had been completed. Interview with the Director of Nursing on 9/27/22 at 11:10 a.m., indicated the resident's fluid intake should have been monitored and documented. 2. Interview with Resident 67 on 9/20/22 at 9:50 a.m., indicated the staff did not assess or monitor his dialysis access site. Resident 67's record was reviewed on 9/23/22 at 9:39 a.m. Diagnoses included, but were not limited to, stroke, renal insufficiency, high blood pressure, and hemiplegia (muscle weakness affecting one side). The Admission Minimum Data Set (MDS) assessment, dated 8/11/22, indicated the resident was cognitively impaired for daily decision making. He required supervision for bed mobility, transfers, dressing, toilet use, and personal hygiene. He had functional limitation in range of motion affecting upper and lower extremities on one side. The resident was dependent on renal dialysis. A Physician's order, dated 9/6/22, indicated		An audit was completed on all residents who receive dialysis to ensure that dialysis access site assessments were completed. Measures put in place/System Changes: Licensed staff were re-educated on ensuring that dialysis site access assessment is completed on all resident receiving dialysis services and fluid restriction documentation is being followed. How the corrected actions will be monitored: Director of Nursing or Designee will audit all dialysis residents' documentation weekly for 4 weeks, and 2x weekly thereafter to ensure that dialysis site access and fluid restriction documentation is in the clinical record. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Compliance: 10/16/2022	

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	assess for arteriovenous fistula (a connection made between an artery and a vein for dialysis access) bruit/thrill every shift. If either was absent, notify the Physician. The record lacked documentation of the access site being monitored per the Physician's Order. Interview with the Director of Nursing (DON) on 9/26/22 at 1:14 p.m., indicated the order was entered incorrectly so it did not show up on the Medication Administration Record (MAR) for nursing to document their assessment of the fistula. 3.1-37(a)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			

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	§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on record review, and interview, the facility failed to ensure a QMA's (Qualified Medication Aide) record of annual inservice training was available for review for 1 of 10 employee records reviewed. (QMA 1) Finding includes: QMA 1's employee record was reviewed on 9/22/22 at 1:30 p.m. QMA 1 was hired on 7/14/16. The file lacked any record of annual inservice training completed for 2021. Interview with the Administrative Consultant on 9/22/22 at 2:10 p.m., indicated there was no documentation of the QMA's annual training. 3.1-14(j)	F 0726	F726 Competent Nursing Staff The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: QMA 1 annual in servicing was completed. 2) How the facility identified other residents: All residents who reside in the facility had the potential to be affected by this deficient practice. 3) Measures put into place/ System changes HR Director was educated on the	10/16/2022

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			importance of monitoring and auditing employee records to ensure compliance with yearly required in-servicing and training. 4) How the corrective actions will be monitored: The HR Director will complete log to include names of all QMA's employed by the facility. The log will be audited monthly to ensure that staff has the needed in servicing until substantial compliance is met. The administrator is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.			

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	(B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post in a timely manner the daily staffing sheet which indicated how many staff were working in the facility and the facility census. This had the potential to affect the 97 residents who resided in the facility. Finding includes: On 9/20/22 at 8:35 a.m., the daily staffing sheet located in the foyer was dated 9/16/22. At 9:43 a.m., the daily staffing sheet was still dated 9/16/22.	F 0732	F732 Posted Nurse Staffing Information The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	10/16/2022

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	09/27/2022

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	On 9/26/22 at 8:21 a.m., the daily staffing sheet located in the foyer was dated 9/24/22. Interview with the Administrator on 9/27/22 at 3:00 p.m., indicated the staffing sheets were to be updated daily at the beginning of the day shift.		deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Daily staffing sheet posted with all licensed staff working immediately 2) How the facility identified other residents: No residents were affected by this alleged deficient practice 3) Measures put into place/ System changes: IDT were re-educated on the importance of posting the daily staffing. 4) How the corrective actions will be monitored: The administrator will audit the placement of the daily staffing 5 days a week and the manager on duty will audit on the weekends to ensure that it is posted. The administrator is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	
F 0740 SS=D	483.40 Behavioral Health Services			

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Bldg. 00	§483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to ensure behavioral health services were obtained for 1 of 3 residents reviewed for mood and behavior. (Resident F) Finding includes: On 9/21/22 at 8:43 a.m., Resident F denied entry to her room. On 9/22/22 at 11:44 a.m., 1:20 p.m., and 2:55 p.m., the resident was observed in her room in bed. She was awake and staring straight ahead. She would not speak when spoken to. On 9/26/22 at 8:30 a.m., 10:30 a.m., and 12:10 p.m., the resident was observed in her room in bed. She was awake and staring straight ahead. She would not speak when spoken to. The record for Resident F was reviewed on 9/22/22 at 1:08 p.m. Diagnoses included, but were not limited to, major depressive disorder and schizophrenia. The Admission Minimum Data Set (MDS) assessment, dated 8/1/22, indicated the resident was cognitively intact for daily decision making	F 0740	F 740 Behavioral Health Services The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for residents identified. Referral was sent for resident F for behavioral health services. How facility identified other residents? All facility residents who have the need for behavioral health services have the potential to be affected by the alleged deficient practice. Measure put in place/System Changes:	10/16/2022

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	and had episodes of feeling down, depressed, or hopeless. No behaviors had occurred during the assessment reference period. A Care Plan, dated 9/18/22, indicated the resident had the potential to be physically aggressive towards staff related to anger, dementia, and poor impulse control. She may become physically combative with other individuals. Interventions included, but were not limited to, administer medications as ordered and provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage seeking out of staff member when agitated. A Physician's Order, dated 7/29/22, indicated an order for psychiatric services to evaluate and treat. A Physician's Order, dated 9/9/22, indicated the resident was to receive Ziprasidone (an antipsychotic medication) 80 milligrams (mg) twice a day for mood and Zoloft (an antidepressant) 50 mg four times a day for depression. A Physician's Order, dated 9/22/22, indicated the resident was to receive Zoloft 50 mg daily. Nurse's Notes, dated 9/11/22 at 8:44 p.m., indicated the resident refused all of her medications and she refused to communicated. She was noted squeezing her eyes shut while the writer attempted to talk with her. Nurse's Notes, dated 9/12/22 at 3:27 p.m. and 8:44 p.m., indicated the resident was refusing her medications and meals.		Nursing staff, IDT and Social Services were in serviced on ensuring all referrals for behavioral health services are completed. How will the corrected actions be monitored? Social Services Director or Designee will audit behavior and mood documentation 5 times weekly for 4 weeks, and 2x weekly thereafter to ensure any referrals are completed for behavioral health services as ordered by the MD were completed to ensure compliance. The Administrator is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Completion: 10/16/2022	

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	Nurse's Notes, dated 9/13/22 at 5:06 p.m., indicated the resident was alert and refusing meals and medications at times. The resident was nonverbal during the room visit but she was aware of the writer's presence. The resident's Physician visited on 9/12/22 and was made aware of the changes. Nurse's Notes, dated 9/16/22 at 12:28 p.m., indicated the resident was aggressive, combative and attempting to hit staff, she refused all care and all medications and was now refusing to allow staff to keep her from falling off the edge of the bed. Orders were received from the Nurse Practitioner (NP) to send out for a psych evaluation. The resident returned to the facility at 9:24 p.m., with no new orders. Nurse's Notes on 9/17, 9/18, 9/19, and 9/20/22, indicated the resident continued to have episodes of refusing medications and meals. Nurse's Notes, dated 9/20/22 at 11:15 a.m., indicated while the writer was assisting a CNA with cleaning and changing the resident, the resident smiled at the nurse writer then unexpectedly used a closed fist and punched the nurse writer on the left side of the head. The writer redirected the resident and told her that hitting staff was not allowed and to please keep her hands to herself. The resident allowed the writer and the CNA to finish cleaning her and repositioning her with no further issues. A Physician's Order, dated 9/21/22, indicated it was okay to send the resident out for a Psychiatric evaluation. A Social Service Progress Note, dated 9/26/22 at 3:03 p.m., indicated a fax had been sent to the			

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	Neuro Psych hospital as requested by the Physician. Social Service was to continue to follow up with the referral. Interview with the Wound Nurse on 9/22/22 at 2:55 p.m., indicated the resident had changed since her readmission on 9/9/22. Prior to the resident going to the hospital, she would let staff do her treatments. Now she had been refusing her treatments at times along with having other behaviors. Interview with the Director of Nursing on 9/26/22 at 4:00 p.m., indicated she would have to follow up with Social Services to see if the initial order from July for Psych services was carried out. She also indicated when the resident was sent out for psych evaluations, she would be sent right back to the facility. Interview with the Social Service Director on 9/27/22 at 1:45 p.m., indicated when the resident was first admitted, she was alert and oriented and refused consent for psych services. She also indicated the resident had been sent out for psych evaluations but she kept getting sent right back to the facility despite having behaviors. The Social Service Director indicated since the resident's cognition had changed, she was going to reach out to the resident's husband for consent for psych services. She also indicated the resident's refusal for psych services should have been documented. 3.1-43(a)(1)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General.			

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	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 insulin was administered as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications. (Resident 86) Finding includes: During an interview with Resident 86, on 9/20/22 at 10:22 a.m., he indicated he does not always receive his insulin as ordered, which was 5 times a day. The record for Resident 86 was reviewed on 9/22/22 at 3:52 p.m. Diagnoses included, but were not limited to, type 1 diabetes, ulcerative pancolitis, exocrine pancreatic insufficiency, bipolar disorder with psychotic features, and	F 0757	F757 Drug Regimen is free from unnecessary Drugs The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for	10/16/2022

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	acute kidney failure. The 8/31/22 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The resident was totally dependent on staff for bathing. In the last 7 days, the resident had received 7 injections of insulin. There was no Care Plan for diabetes or the administration of insulin. Physician's Orders, dated 7/8/22, indicated check blood sugar four times a day with meals and at night. Use the transmitter to read the blood glucose level, stay near the resident and press the button. The resident has been educated as well and can use it on himself to read the blood glucose. Physician's Orders, dated 7/1/22, indicated Humalog Solution 100 unit/ml (milliliter) (Insulin Lispro. Inject as per sliding scale: if 0 - 150 = 0, 151 - 200 = 1 unit; 201 - 250 = 2 unit; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units. GIve subcutaneously three times a day. Physician's Orders, dated 6/23/22, indicated Insulin Glargine Solution 100 unit/ml. Inject 20 units subcutaneously two times a day. The Medication Administration Record (MAR), dated 9/2022, indicated the Humalog sliding scale insulin was to administered at 7:30 a.m., 11:30 a.m., and 5:30 p.m. The Glargine 20 units of insulin was to be administered at 7:30 a.m. and 8:00 p.m. The Glargine insulin was not signed out as being administered on 9/10, 9/13, 9/19, and 9/21/22 at 8:00 p.m. The Humalog sliding scale insulin was		those residents identified: The Physician was notified of Resident 86's current glucose readings and that insulin was not given as ordered. No negative outcome noted for Resident 86. 2) How the facility identified other residents: All residents who receive insulin have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: Licensed nurses will be educated on the importance of following physicians orders. 4) How the corrective actions will be monitored: The Director of Nursing or designee will complete a medication review audit 5 days a week to ensure that physician orders have been followed for medications with parameters. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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	not signed out as being administered on 9/13 and 9/19/22 at 5:30 p.m. Interview with the Director of Nursing on 9/27/22 at 10:45 a.m., indicated the insulin was not signed out as being administered. 3.1-48(a)(3)			
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			

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	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 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 a gradual dose reduction (GDR) was attempted for 1 of 7 residents reviewed for unnecessary medications. (Resident 14) Finding includes: The record for Resident 14 was reviewed on 9/22/22 at 2:14 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, non-Alzheimer's dementia, anxiety, depression, and psychotic disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/22, indicated the resident was not cognitively intact and needed extensive assistance with 1 person physical assist for dressing, toileting, personal hygiene. The resident received an antipsychotic medication and an antidepressant medication in the last 7 days.	F 0758	F758 Free from Unnec Psychotropic Meds The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: GDR was attempted for resident 14.	10/16/2022

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	Antipsychotic medications were given on a routine basis and there had not been any GDR attempts. A Care Plan, revised on 9/8/22, indicated the resident received an antidepressant medication related to the diagnosis of major depression disorder. A Care Plan, revised on 9/8/22, indicated the resident had a diagnosis of major depressive disorder and anxiety disorder. Interventions included, but were not limited to, administer medications as ordered by the Physician and monitor for side effects. Physician's Orders, dated 12/16/21, indicated Sertraline HCl (an antidepressant medication) tablet 25 milligrams (mg.) Give 1 tablet by mouth one time a day for depression. Physician's Orders, dated 12/16/21, indicated Olanzapine (an antipsychotic medication) tablet 2.5 mg. Give one tablet by mouth two times a day for psychosis associated with dementia. A Pharmacy Recommendation, dated 7/19/22, indicated to decrease the Olanzapine from 2.5 mg twice a day to 2.5 mg once a day. The record lacked documentation of the Physician's response with rationale for continuing the current dosage. Interview with the Director of Nursing on 9/27/22 at 4:31 p.m., indicated the resident should have had a GDR attempted as recommended by the consultant pharmacist. 3.1-48(b)(2)		2) How the facility identified other residents: All residents who receive antipsychotic medications have the potential to be affected by this deficient practice. An audit of all residents who receive psychiatric medications was completed to ensure that GDR's have been attempted timely. 3) Measures put into place/ System changes: SSD will be educated on the importance of attempting a gradual dose reduction for residents who receive psych medication. 4) How the corrective actions will be monitored: The SSD or designee will complete and audit weekly of residents who receive psych medication to ensure when a gradual dose reduction is needed. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food 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, record review, and interview, the facility failed to ensure food was served and stored under sanitary conditions related to dirty food equipment, uncovered food, and food not labeled and dated for 1 of 1 kitchens. This had the potential to affect the 96 residents who received food from the main kitchen or Main Units. (Main Kitchen, Main Unit) Findings include: 1. During the Initial Kitchen Sanitation tour on 9/20/22 at 8:57 a.m., with Dietary Cook 1, the following was observed:	F 0812	F812 Food Procurement/Store/Prepare Serve Sanitary The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction	10/16/2022

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	a. The food prep table had an accumulation of debris as well as a dried film on the surface. The shelf underneath the food prep table also had debris and a discoloration was noted. b. In the dry storage area, a plastic bin of raisin bran cereal was uncovered. Gnats were observed in the area. Interview with the Cook at that time, indicated the cereal should have been covered. c. A bag of sausage crumbles and a bag containing pita bread located in the walk in cooler was not dated. 2. During the Kitchen Sanitation tour, on 9/26/22 at 9:44 a.m., with the Dietary Food Manager (DFM) from a sister facility, the following was observed: a. The bottom shelf of the food prep table was discolored with a white residue. b. Three cups of chocolate pudding in the reach in cooler were not dated and the plastic lids were not secured. Interview with the DFM at that time, indicated the food should have labeled as well as the food items on the initial tour and the cereal bin covered. 3. Observation of the nutritional pantry on the Main Unit on 9/27/22 at 11:18 a.m., indicated the following: a. A plastic bag of food in the bottom drawer was dated "7/21". Facility staff in the pantry at that time, indicated the food had belonged to a resident that had passed away and it needed to be		is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: 1. The food prep table and shelf underneath were cleaned. 2. The Raisin Bran Cereal was discarded. 3. The Sausage crumbles and pita bread in the walk-in cooler were dated. 4. The chocolate pudding located in the reach in cooler was dated and the lids were secured. 5. Food noted to be in the refrigerator on the Main unit was discarded. 2) How the facility identified other residents: All resident who resides in the facility have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: Dietary staff was re-educated on kitchen sanitation and proper food storage. 4) How the corrective actions will be monitored: Dietary consultant and or Administrator will conduct observation of the kitchen to cover sanitation and proper storage of food at least three times weekly for 4 weeks. Then 2 times weekly for 3 months. Any deficiencies will be corrected immediately. The administrator is responsible for compliance.	

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	155469	A. BUILDING 00 B. WING	09/27/2022

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	discarded. b. Two other plastic bags containing resident food items were not dated. The bags contained a sandwich from McDonald's and multiple food items wrapped in aluminum foil. The facility staff member indicated if the food wasn't dated, it needed to be discarded. Interview with the Administrative Consultant at 11:45 a.m., indicated the food should have been discarded since it wasn't dated. The facility policy titled, "Food Brought into the Facility by Family or Visitors" dated 3/21/21, indicated the following: "2. All food items that are already prepared by the family or visitor brought in will be labeled with name and dated. b. The prepared food must be consumed within 3 days. c. If not consumed within 3 days, food will be thrown away." 3.1-21(i)(3)		The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that			

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	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 disease; and			

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	(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 monitoring for COVID-19 signs and symptoms while COVID positive for 1 of 1 residents. The facility also failed to ensure hand hygiene was completed after glove removal for 1 of 2 treatments observed. The facility also failed to ensure personal protective equipment (PPE) was worn correctly in isolation rooms, masks were worn correctly, and wash basins, toothbrushes, and linens were stored correctly for random observations for infection control. (Residents C, N, G, and M) Findings include: 1. During a random observation on 9/21/22 at 8:43 a.m., CNA 3 was observed in Resident C's bathroom. She was wearing a face shield and surgical mask. The CNA was not wearing an	F 0880	F880 Infection Prevention Control The facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents/staff identified: 1. CNA C was re-educated on proper PPE usage. 2. LPN 1 was re-educated on proper PPE usage.	10/16/2022

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	isolation gown. The sign on the resident's door indicated he was in Contact/Droplet precautions. The sign on the door indicated prior to entering the room, a gown, gloves, N95 mask, and eye protection needed to be donned. At 11:43 a.m., CNA 4 entered the resident's room to deliver his lunch tray, she was wearing a gown, gloves, a face shield, and surgical mask. On 9/22/22 at 11:43 a.m., CNA 4 entered the resident's room. She was wearing a gown and an N95 mask. No eye protection was in use. Interview with the Director of Nursing on 9/26/22 at 4:00 p.m., indicated the CNA's should have donned the correct PPE (personal protective equipment) prior to entering the room. 2. During a random observation on 9/21/22 at 8:48 a.m., LPN 1 entered Room N's room to administer medications. No PPE was worn except for a surgical mask. The sign on the resident's door indicated she was in Contact/Droplet precautions. The sign on the door indicated prior to entering the room, a gown, gloves, N95 mask, and eye protection needed to be donned. Interview with the Director of Nursing on 9/26/22 at 4:00 p.m., indicated the LPN should have donned the correct PPE prior to entering the room. 3. During random observations on 9/21/22 at 3:34 p.m. and 3:44 p.m., a music/ singing activity was taking place in the main dining room. The Activity Director and the residents were positioned in a circle. The Activity Director had her mask pulled down below her chin at the above		3. Activity Director was re-educated on proper PPE usage. 4. Wound Nurse was re-educated on proper hand hygiene. 5. The dirty towels and cylinder in room 40 was discarded. 6. Wash basin on the floor in room 26 was discarded. 7. Wash clothes were discarded from the bathroom of room 42. 8. Resident M was assessed, and no negative outcome noted. 2) How the facility identified other residents: All residents who reside in the facility have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes Staff will be re-educated regarding infection control guidelines related to Covid-19, proper hand hygiene and proper storage of linens, wash basins and cylinders in the resident's bathrooms. 4) How the corrective actions will be monitored: The Director of Nursing or designee will audit covid monitoring 5 days a week to ensure that they were complete and accurate, 5 random hand hygiene observations a week and resident bathroom audits 5 days a week to ensure that infection control issues are not noted. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90%	

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	times. Interview with the Director of Nursing on 9/26/22 at 4:05 p.m., indicated the Activity Director should have been wearing her mask correctly. 4. On 9/26/22 at 10:20 a.m., Resident G was observed in bed. At that time, the Wound Nurse was going to change the resident's bandages to the abdomen and forehead lesions. The Wound Nurse performed hand hygiene and donned a clean pair of gloves to both hands. She removed the old bandage from the abdomen and threw it away. She cleaned the area with normal saline and patted it dry. The lesion was red with a moderate amount of bloody drainage. She removed the gloves and donned a clean pair of gloves to both hands and did not perform hand hygiene. The Wound Nurse cut the Hydrofera Blue to fit the wound and placed it in the center of the lesion and covered with a loose gauze bandage. She removed her gloves and performed hand hygiene and donned a clean pair of gloves to both hands. She removed the bandage from the resident's forehead and threw it away. She cleaned the area with normal saline and removed her gloves and donned a clean pair of gloves to both hands without performing hand hygiene. She completed the treatment and removed the gloves and performed hand hygiene. Interview with the Wound Nurse on 9/26/22 at 10:30 a.m., indicated she was aware she was supposed to perform hand hygiene after glove removal. Interview with the Director of Nursing on 9/26/22 at 2:40 p.m., indicated the Wound Nurse should have performed hand hygiene after doffing gloves.		compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/16/2022	

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	The current and updated 2/8/22, "COVID-19 Infection Control Guidance in Long-term Care Facilities", indicated hand hygiene [use of alcohol-based hand rub (ABHR) was preferred]: Adherence to strict hand hygiene must continue for all, particularly HCP, including when entering the facility and before and after resident care.5. During a random observation of Room 22 on 9/20/22 at 10:04 a.m., there was a toothbrush laying on the bathroom sink uncontained. Two residents resided in the room and shared the bathroom. 6. During a random observation of Room 40 on 9/20/22 at 10:17 a.m., there were two dirty towels and wash cloths on the hand rail and an uncontained plastic cylinder on the floor. Two residents resided in the room and shared the bathroom. 7. During a random observation of Room 26 on 9/20/22 at 11:04 a.m., there was a wash basin on the floor in the bathroom filled with a package of incontinent briefs and another mouth basin on the bathroom sink with a toothbrush inside it. Two residents resided in the room and shared the bathroom. 8. During a random observation of Room 42 on 9/20/22 at 1:23 p.m., there were six dirty washcloths and one towel on the hand rails in the bathroom. An uncontained plastic cylinder was found on the floor. Two residents resided in the room and shared the bathroom. 9. The record for Resident M was reviewed on 9/26/22 at 9:50 a.m. A Lab Note, dated 9/19/22 at 3:05 p.m., indicated the resident had tested positive for COVID-19.			

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	The 14 day isolation period had been started. A Physician's Order, dated 9/19/22, indicated isolation precautions: droplet/contact isolation related to positive COVID-19 status. Nursing assessment to be completed daily. A Physician's Order, dated 8/1/22, indicated to assess the resident's temperature and oxygen saturation every shift. A Physician's Order, dated 8/2/22, indicated to monitor for signs and symptoms of COVID-19 daily. The Treatment Administration Record (TAR), dated 9/2022, indicated the resident had her temperature and oxygen saturation assessed every shift. Interview with the Nurse Consultant on 9/26/22 at 3:30 p.m., indicated the resident should have had a respiratory assessment, vital signs, oxygen saturation, and assessment of symptoms completed every shift. The Indiana Department of Health Long-term Care COVID-19 Clinical Guidance, dated 2/8/22, indicated, " ... Assessment of residents. Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least three times daily to identify and quickly manage serious infection ..." This Federal tag relates to Complaint IN00387879. 3.1-18(b)			

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F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and			

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	(vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on record review and interview, the facility failed to ensure the residents' medical records included documentation the resident or resident representative was provided education on the benefits and potential risks associated with the COVID-19 vaccination and documentation why the vaccine was not administered, for 2 of 5 residents reviewed for COVID-19 vaccinations. (Residents F and E) Findings include: 1. Resident F's record was reviewed on 9/22/22 at 1:08 p.m. The diagnoses included, but were not	F 0887	F 887 Covid-19 Immunization The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely	10/16/2022

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	limited to, cellulitis of the right and left lower limb, hypothyroidism, atrial fibrillation (irregular heart beat), heart failure, major depressive disorder, and schizophrenia. The COVID-19 vaccination had not been documented as administered. There was no documentation education on the benefits and potential risks of the COVID-19 vaccine had been provided to the resident or the Representative. 2. Resident E's record was reviewed on 9/22/22 at 2:49 p.m. The diagnoses included, but were not limited to, hemiplegia (muscle weakness affecting one side of the body), traumatic brain injury, and dementia. The COVID-19 vaccination had not been documented as administered. There was no documentation education on the benefits and potential risks of the COVID-19 vaccine had been provided to the resident or the Representative. During an interview on 9/27/22 at 3:09 p.m., the Assistant Director of Nursing (ADON) indicated there was no proof of the vaccination offered upon admission and there was no declination form available in the records. The ADON and the Infection Preventionist were responsible for ensuring the residents were offered the COVID-19 vaccination.		because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Education was provided to Resident E and F on the benefits and risk associated with the Covid-19 vaccine. 2) How the facility identified other residents: All resident who resides in the facility that are not vaccinated have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: The infection preventionist was educated on the importance of offering unvaccinated residents the Covid-19 vaccination upon admission and periodically. 4) How the corrective actions will be monitored: The Infection Preventionist will audit resident vaccination status upon admission to ensure if a Covid-19 vaccination is wanted and if not, that education was provided. The Director of Nursing is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0921 SS=E 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 the residents' environment as well as the kitchen area was clean and in good repair related to dirty floors, marred walls and doors, food build up on the baseboards, lime build up on pipes, dirty floor tile, rusty hinges, dusty ceiling vents, and odors in 1 of 1 kitchen areas and on 4 of 4 Lanes. (The Main Kitchen and Cherry Lane, Apple Lane, Blueberry Lane, and Bakersfield) Findings include: 1. During the Initial Kitchen Sanitation tour on 9/20/22 at 8:57 a.m., with Dietary Cook 1, the following was observed: a. An accumulation of lime build up was observed on the pipes underneath the steam table as well as the bottom shelf. b. An accumulation of lime build up was observed on the pipes underneath the dishwasher. 2. During the Kitchen Sanitation tour, on 9/26/22 at 9:44 a.m., with the Dietary Food Manager (DFM) from a sister facility, the following was observed: a. The baseboard in the dish area had an accumulation of dried food spillage.	F 0921	5) Date of compliance: 10/16/2022 F921Safe Functional Environment The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: 1. Lime build up removed off pipes underneath the steam table, steam table bottom shelf and the dishwasher. 2. Dried food cleaned from the wall in the dish area in the kitchen. 3. The grout in the dishwasher area of the kitchen cleaned. 4. The dry storage area and steam table area floors were cleaned in the kitchen. 5. Pillow from room 10 discarded and replaced. 6. Room 13 was deep cleaned.	10/16/2022

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	b. The tile grout in the dish area was discolored as well as the tile. c. The floor tile in the dry storage room was dirty and discolored in sections. d. The floor tile near the steam table was discolored in sections. Interview with the DFM at that time, indicated all of the above needed to be cleaned. 3. During the environmental tour with the Director of Maintenance and the Director of Housekeeping on 9/27/22 at 1:40 p.m., the following was observed: a. Cherry Lane: - Room 10 had no pillow case on the pillow, the peach colored plastic cover on the pillow was torn in sections. The closet doors and drawers were scuffed and marred in places. - Room 13 had a malodorous smell. Two residents resided in the room. - Room 18-2 had a broken tray table. Two residents resided in the room. b. Apple Lane: - Room 21-1 had marred bedroom walls behind the bed. Two residents resided in the room. - Room 22 had marred walls by behind and near both beds. The flooring was scuffed and the bathroom ceiling vent was dusty and dirty. Two residents resided in the room and shared the bathroom.		7. The broken tray table in room 18 was removed. 8. Marred walls cleaned in room 21,22 and 26. 9. Floors in room 22 and 69 cleaned, buffed and waxed. 10. Ceiling vents in room 22 and 26 cleaned. 11. Room 38 deep cleaned. 12. The toilet seat in room 67 replaced. 13. The loose cable wire was removed from room 69. 2) How the facility identified other residents: All resident who resides in the facility have the potential to be affected by this deficient practice. 3) Measures put into place/ System changes: The housekeeping supervisor and Kitchen Supervisor was in serviced on daily cleaning schedules. Also, the Maintenance Director was in serviced on Preventative maintenance. 4) How the corrective actions will be monitored: The administrator or designee will do Kitchen sanitation audit 3 times a week to ensure that all areas are clean in the kitchen. The IDT will do Angel rounds on 10 rooms daily 5 times a week to ensure that rooms are clean, that all equipment functions properly and no hazards are present. Findings will be discussed during the IDT meeting and work orders will be completed as needed. 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	09/27/2022

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

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	- Room 26 had marred walls and a dirty/dusty bathroom ceiling vent. Two residents resided in the room and shared the bathroom. c. Blueberry Lane: - Room 38 had dirty and sticky flooring. The room had a malodorous smell. One resident resided in the room. d. Bakersfield: - Room 67 had a toilet seat that was rusted on the hinge. One resident resided in the room. - Room 69 had marred walls behind the chair and a loose cable wire lying across the floor. One resident resided in the room. Interview with the Director of Maintenance and the Director of Housekeeping indicated they were not aware of the conditions noted and would be cleaning and repairing them as soon as possible. This Federal tag relates to Complaint IN00387879. 3.1-19(f)		administrator is responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	