PRINTED: 09/18/2024
FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC				ON	1B NO. 0938-039	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 155469	A. BUILDING B. WING	00	COMPLETED 08/15/2024		
		.50100		ADDRESS, CITY, STATE, ZIP COD	1 30,10	.,	
NAME OF P	ROVIDER OR SUPPLIEF	₹		49TH AVE			
CASA OF	HOBART		HOBART, IN 46342				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
F 0000							
Bldg. 00							
Diag. 00	This visit was for th	ne Investigation of Complaints	F 0000				
		438757, IN00438809, IN00439721,	1 0000				
		440433, and IN00440984.					
	G 1 : , D100426	2020 F 1 1/G (1 C ' '					
		8030 - Federal/State deficiencies ations are cited at F677.					
	related to the allega	tilons are cited at 1 0//.					
	Complaint IN00438	8757 - Federal/State deficiencies					
	related to the allega	tions are cited at F677 and					
	F684.						
	Complaint INIO0429	2000. No definiencies related to					
	the allegations are	8809 - No deficiencies related to					
	ane unegations are c	oned.					
		9721 - No deficiencies related to					
	the allegations are o	eited.					
	Complaint INION/30	9881 - Federal/State deficiencies					
		ations are cited at F842.					
		0433 - Federal/State deficiencies					
	related to the allega	tions are cited at F689.					
	Complaint IN00440	0984 - No deficiencies related to					
	the allegations are of	,, , , , , , , , , , , , , , , , , , , ,					
	_						
	Unrelated deficience	eies are cited.					
	Survey dates Augu	sst 13, 14, and 15, 2024					
	Survey dates. Augu	ist 13, 14, and 13, 2024					
	Facility number: 00	00366					
	Provider number: 1	55469					
	AIM number: 1002	88900					
	Census Type:						
	SNF/NF: 93						
	Total: 93						
	- Juli / J					1	

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

TITLE (X6) DATE

Alisha Boler RN BSN RNC 09/10/2024

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

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING				
CASA OF	ROVIDER OR SUPPLIER HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0550 SS=D Bldg. 00	Quality review com 483.10(a)(1)(2)(b) Resident Rights/E Based on observation interview, the facility resident's dignity was catheter drainage base 2 residents with uring Finding includes: On 8/13/24 at 11:55 Resident H was observed in the doorway. On 8/14/24 at 8:30 at the resident's foley contained yellow ur from the doorway. On 8/15/24 at 8:29 awas observed in the foley catheter drainage.	reflect State Findings cited in 0 IAC 16.2-3.1. pleted on 8/20/24. (1)(2)	F 0550	Casa of Hobart Complaint Survey: 08/15/202 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only it response to the regulatory requirement. F550 Residents Rights/Exerci of Rights What corrective action(s) will accomplished for those reside found to have Resident H drainage bag was immediately covered with a dibag and drainage bag was emptied	an y the n	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155469	B. WING 08/15/2024			2024	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
04040	LIODADT		4410 W 49TH AVE				
CASA OF	HOBART			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	The record for Resident H was reviewed on				How the facility will identify oth	ner	
	8/14/24 at 10:21 a.m. Diagnoses included, but				residents having the potential		
	were not limited to, chronic kidney disease and				be affected by the same defici		
	pressure ulcer of the sacrum (a triangular bone at		practice and what corrective action				
	the base of the spine).				will be taken;		
	The Quarterly Mini	mum Data Set (MDS)			All residents at risk that have f	olev	
	assessment, dated 6/1/24, indicated the resident				catheters have the potential to	•	
		paired for daily decision making			affected will be monitored dail		
	and had an indwelling catheter.				6 months and thereafter	,	
	and had an marroning carretor.						
	A Care Plan, dated 5/9/24, indicated the resident				What measures will be put in		
	was at risk for complications secondary to				place or what systemic change	es	
	-	a foley catheter related to			will be made to ensure that the		
	having a pressure u				deficient practice does not rec		
					denoter product deed not rec	ω,	
	A Physician's Order	c, dated 7/6/24, indicated the			Staff were in serviced on: 8/28	1/24	
		ench/10 cubic centimeter (cm)			Stan Were in 661 Vieta 511: 6/26	<i>,,</i>	
	urinary catheter.	chem to energ commission (em)			• Ensuring dignity measures a	re in	
					place when residents have fold		
	On 8/15/24 at 8:30	a.m., Nurse Consultant 1 was			catheters	o y	
		e resident's foley catheter			Ensure residents with foley		
		ng an interview at that time,			catheters are covered		
		indicated the resident's foley			Ensuring drainage bags are		
		ag should have been covered		emptied and output documented			
		a bag that covers the drainage				ou .	
	bag so the urine wo				How the corrective action(s) w	ill be	
	- ag so the time wo				monitored to ensure the deficience		
	3.1-3(t)				practice will not recur, i.e., who		
	3.1 3(6)				quality assurance programs w		
					put in place;	III DE	
			1		Pat III Place, 		
					The DON /designee will audit		
					residents with foley bags at lea	ast	
					3x/week at varied times to ens		
					dignity is maintained, including		
						•	
					not limited to providing ADL's		
					residents with impaired cogniti	ive	
					status, resident's needing		
					extensive assistance for bed		

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/15/2024		
	ROVIDER OR SUPPLIER HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0554 SS=D Bldg. 00		nin Meds-Clinically Approp		mobility, resident's needing assistance with hygiene and bathing and resident's needin assistance with transfers. The DON /designee will prese summary of the audits to the Quality Assurance committee monthly for 6 months. Therea if determined by the Quality Assurance committee, auditin and monitoring will be done quarterly and present quarterl the QA meeting. Monitoring whe on going. Date of compliance: 8/28/24	ent a after, g y at vill		
	interview, the facili Order for self admin an assessment to se completed, for 1 of self-administration. Finding include: On 8/13/24 at 1:16 pleaving a medicine on the bedside table LPN 1 walked out of B began to administration an interview indicated the pills with the self-administration of the self-administration o	p.m., LPN 1 was observed cup with 14 white circular pills in the room with Resident B. of Resident B's room. Resident ter their own medications.	F 0554	Casa of Hobart Complaint Survey: 8.15.24 Please accept the following at facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability b facility and is submitted only it response to the regulatory requirement. F554 Resident Self Admin Meds-Clinically Appropriate What corrective action(s) will accomplished for those reside found to have been affected by deficient practice:	an y the n be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/15/2024			
NAME OF F	PROVIDER OR SUPPLIEF	<u>.</u> :		ADDRESS, CITY, STATE, ZIP COD	1		
CASA OF	HOBART		4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
				Resident B- Medication was			
	_	v on 8/13/24 at 1:19 p.m., LPN 1		immediately removed from th	e		
		ed away from the resident while		bedside and stored properly.			
	1	nedication, she had no reason		How the facility will identify of	I		
		resident did not have a self		residents having the potentia			
	administration orde	r		be affected by the same defic	I		
				practice and what corrective	action		
		was reviewed on 8/13/24 at		will be taken;			
	_	s included, but were not limited		All facility residents with			
	to, end stage renal of			medication orders have the			
	hypertension, and r	enal dialysis.		potential to be affected by the			
				same alleged deficient praction	I		
	The Admission Minimum Data Set (MDS)			What measures will be put in	I		
	l '	5/5/24, indicated the resident		place or what systemic chang	•		
	was cognitively into	act.		will be made to ensure that the	ne		
				deficient practice does not re	I		
	1	r, dated 7/10/24, indicated to		Staff re-educated on not leav			
	1 -	Cl (narcotic pain medication)		medications at resident beds	ide		
	_	(milligrams) - Controlled Drug,		unless there is an order for			
	1 -	olets) by mouth in the morning		self-administration and a			
	for pain.			self-administration assessme	nt		
				completed.			
		rs for self-administration of the		How the corrective action(s)	I		
	medications.			monitored to ensure the deficient			
		112		practice will not recur, i.e., wh	I		
		ssments completed for		quality assurance programs v	vill be		
	self-administration	of the medications.		put into place;			
	A C '11' 11' 11'	1 1 10 16 4 1 1 1 4 2 6		DON/Designee will audit 5			
		tled, "Self -Administration of		residents 3 days per week to			
		ded by the Director of Nursing		ensure no medication is	:		
		o.m. as current, indicated, " A		improperly stored at the beds	side		
	1	elf administer medications		and any medication noted at			
	_	disciplinary Team] has		bedside has orders for			
	determined which r self-administered			self-administration.			
	sen-administered	··		DON/Designee will present a			
	2.1.11(-)			summary of the audits to the			
	3.1-11(a)			Quality Assurance committee	I		
				monthly for 6 months. There	aπer,		
				if determined by the Quality			
	l		1	Assurance committee, auditir	ng I		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155469	B. WI	B. WING		08/15/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER			l	49TH AVE		
CASA OF	HOBART				RT, IN 46342		
0/10/101	TIOD/IIII			1100/11	1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					and monitoring will be done		
					quarterly and present quarterly		
					the QA meeting. Monitoring w	rill	
					be on going.		
					Date by which systemic		
					corrections will be completed:		
					8/28/2024		
F 0677	483.24(a)(2)						
SS=D		d for Dependent Residents					
Bldg. 00	ADE Gale i Tovide	a for Dependent Residents					
2.49.00	Based on observation	on, record review, and	F 06	577	Casa of Hobart		08/28/2024
		ty failed to ensure residents	1 00	,,,	Complaint Survey: 8.15.24		00/20/2024
		t on staff for activities of daily					
	living (ADL's) rece				Please accept the following a	as	
		a timely manner for 1 of 3			the facility's credible allegati		
		for ADL's. (Resident G)			of compliance. This plan of		
		,			correction does not constitu	te	
	Finding includes:				an admission of guilt or liabi		
	C				by the facility and is submitte	-	
	During an interview	on 8/13/24 at 1:19 p.m.,			only in response to the		
	Resident G indicate	d they were not checked or			regulatory requirement.		
	changed every 2 ho	urs and they had not been					
	changed all day.				F677 ADL Care Provided for		
					Dependent Residents		
	LPN 2 and CNA 1	entered the resident's room on					
	8/13/24 at 1:35 p.m	to provide incontinence care.			What corrective action(s) wil	ı	
	CNA 1 indicated the	e resident's assigned CNA was			be accomplished for those		
		she was going to provide			residents found to have beer	1	
	care. The resident's	brief was saturated with urine			affected by the deficient		
	and the bath blanker	t underneath the resident was			practice;		
		completion of incontinence			Resident G was assisted with		
		dicated that was the first time			incontinence care.		
		for the day and the last time					
	was around 2:00 a.r.	n.			How the facility will identify		
					other residents having the		
		on 8/13/24 at 1:56 p.m., CNA			potential to be affected by th	е	
	3 who was assigned	d to the resident, indicated she	I		same deficient practice and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/15/2024 155469 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART **HOBART. IN 46342** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE had not provided incontinence care for the what corrective action will be resident because the resident would tell her when taken: they needed to be changed. All residents requiring assistance with Activities of Daily Living have During an interview on 8/13/24 at 2:25 p.m., CNA 1 the potential to be affected by the indicated the resident's brief was soiled with urine same alleged deficient practice. and the bath blanket underneath the resident was also wet. What measures will be put into place or what systemic The record for Resident G was reviewed on changes will be made to 8/14/24 at 8:55 a.m. Diagnoses included, but were ensure that the deficient not limited to, morbid obesity, cellulitis (a bacterial practice does not recur; skin infection), and heart failure. Staff re-educated on providing residents with assistance with The Quarterly Minimum Data Set (MDS) Activities of Daily Living (ADL's) assessment, dated 7/2/24, indicated the resident per plan of care/preferences. was cognitively intact. The resident was How the corrective action(s) dependent on staff for toilet transfers and was will be monitored to ensure the frequently incontinent of bladder and bowel. deficient practice will not recur, i.e., what quality A Care Plan, dated 3/18/24 and reviewed on assurance programs will be put 6/13/24, indicated the resident required assistance into place; with ADL's including bed mobility, eating, DON/Designee will Audit 5 transfers, toileting, and bathing related to residents weekly, to ensure weakness and decreased mobility. Interventions assistance with ADL's is being included, but were not limited to, assist with provided with a focus on toileting care as needed. incontinence care/toileting for 6 months. During an interview on 8/15/24 at 1:58 p.m., the Director of Nursing/designee will Director of Nursing (DON) indicated the resident present a summary of the audits should have been provided incontinence care in a to the Quality Assurance more timely manner. committee monthly for 6 months. Thereafter, if determined by the The facility policy titled, "Activities of Daily Quality Assurance committee, Living (ADL's)/Maintain Abilities" was provided auditing and monitoring will be as current by the DON on 8/15/24 at 3:15 p.m. The done quarterly and present policy indicated a resident who was unable to quarterly at the QA meeting. carry out activities of daily living would receive Monitoring will be on going.

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the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The

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Date by which systemic

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i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED 08/15/2024		
		155469	B. WI	NG		08/15/	/2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility would also p toileting/elimination	provide care and services for 1.			corrections will be completed 8/28/2024	d:	
	This citation relates to Complaints IN00438030 and IN00438757. 3.1-38(a)(3)(A)						
F 0684 SS=D Bldg. 00	483.25 Quality of Care						
Bidg. 00	interview, the facility were completed as a conditions for 1 of 3 non-pressure skin confirmation of 1	on, record review, and ty failed to ensure treatments ordered for non-pressure skin B residents reviewed for conditions. (Resident G) on of incontinence care on an	F 06	584	Casa of Hobart Complaint Survey: 8.15.24 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirement. F684 Quality of Care What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice. Resident (G) Remains in the facility without further incident received dressing change per physician order. How the facility will identify oth residents having the potential be affected by the same defici practice and what corrective a will be taken. All residents that have treatments.	an y the n oe onts y the and the ner to ent ction	09/04/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155469 B. WING 08/15/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART **HOBART. IN 46342** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE A Physician's Order, dated 8/7/24, indicated the orders have the potential to be resident's left ischium was to be cleansed with affected by the alleged deficient normal saline or wound cleanser, pat dry, apply practice. betadine (a topical antiseptic), and leave open to air daily. What measures will be put into place or what systemic changes The August 2024 Treatment Administration will be made to ensure that the Record (TAR), indicated the treatment to the left deficient practice does not recur. ischium had been signed out as being completed on 8/12/24. Staff will be re-educated on the importance of ensuring that There was no treatment order for the hydrocolloid residents' treatment orders are dressing. followed as prescribed by the physician. A Wound Physician Progress Note, dated 8/7/24, indicated the wound to the left ischium was How the corrective action(s) will be non-pressure and resulted from trauma or injury. monitored to ensure the deficient practice will not recur, i.e., what The wound measured 1 centimeter (cm) by 1 cm by 0.1 cm. Betadine was to be applied to the quality assurance programs will be wound once daily. put into place. During an interview on 8/14/24 at 9:15 a.m., the DON or Designee will review Wound Nurse indicated the resident was seen by wound care documentation 3 time the Wound Physician that morning and he was per week during the clinical waiting to see if any orders had changed. meeting for 6 months then two times a week thereafter to ensure A Wound Physician Progress Note, dated 8/14/24, that all wound care orders have indicated a new treatment order for hydrocolloid, been updated wound observations apply 3 times per week for 30 days. daily times 1 week then 3 X /week x 6 months for non-pressure During an interview on 8/15/24 at 1:58 p.m., the wounds. Director of Nursing indicated the resident's The Administrator/designee will treatment should have been completed as ordered present a summary of the audits on 8/12/24. to the Quality Assurance committee monthly for 6 months. This citation relates to Complaint IN00438757. Thereafter, if determined by the Quality Assurance committee, 3.1-37(a) auditing and monitoring will be done quarterly and present quarterly at the QA meeting.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/15/2024	
	PROVIDER OR SUPPLIE HOBART	R	4410 V	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
				Monitoring will be on going. Date by which systemic corrections will be completed 9/4/24	d:
F 0689 SS=D Bldg. 00	interview, the facili interventions were history of falls relaposition for 1 of 3 (Resident H) Finding includes: On 8/14/24 at 8:30 in their room in be bed was in a high present on the left and 10:38 a.m., the bed was positioned not low to the floor On 8/15/24 at 8:29 room in bed. The over bed table and repositioned. The height at the time. room to provide as that time, CNA 2 it could go lower. So the bed could go, to lower the bed all the resident's foley.	ity failed to ensure fall in place for a resident with a sted to the bed being in a low residents reviewed for falls. a.m., Resident H was observed deating a piece of toast. The position and a floor mat was side of the bed. At 9:37 a.m. eresident remained in bed. The dat a medium height and was	F 0689	Casa of Hobart Complaint Survey: 08/15/2 Please accept the following the facility's credible allega of compliance. This plan of correction does not constitute an admission of guilt or liated by the facility and is submit only in response to the regulatory requirement. F689 Free of Accident Hazards/Supervision/Device What corrective action(s) where the deficient practice; Fall interventions were immediately put in place for Resident H. How the facility will identify other residents having the potential to be affected by same deficient practice and what corrective action will taken; All residents at risk for falls if the potential to be affected by the potential to be affected by the potential to be affected by same deficient practice and what corrective action will taken;	g as ation of tute bility itted ces vill en the d be

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SOWO11 Facility ID: 000366

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/15/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
(X4) ID	summary: (EACH DEFICIEN REGULATORY OR the resident would a their own. The record for Resi 8/14/24 at 10:21 a.r were not limited to, deficit and schizoph The Quarterly Mini assessment, dated 6 was moderately imp and was dependent mobility. A Care Plan, dated 6/1/24, indicated the with major injury. were not limited to, position. A Fall Risk assessm the resident was a n An Interdisciplinary 7/29/24, indicated the trash can and fe Nurses' Notes, dated the resident was for side of the bed. A c next to the left eyeli	dent H was reviewed on in. Diagnoses included, but cognitive communication in the paired for daily decision making on staff for transfers and bed in the lowest included, but place the bed in the lowest included, but place the bed in the lowest included in the lowest included in the lowest included in the lowest included inclu	ID	PROVIDER'S PLAN OF CORRECTION	eted che sare nment) the e put t 5 ns ntions its will ent a e after,
	Consultant 1 indica be in a low position	on 8/15/24 at 8:30 a.m., Nurse ted the resident's bed should and the care plan would be the resident adjusting the bed		quarterly and present quarter the QA meeting. Monitoring be on going. Date of Completion: 8/28/20	will
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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/15/2024	
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		to Complaint IN00440433.			
F 0690 SS=D Bldg. 00 Based on observation, record review, and					
	interview, the facilicatheter drainage bathoor for a resident vinfections for 1 of 2 catheters. (Resident Finding includes: On 8/14/24 at 8:28 in their room in beditime, the resident in catheter drainage bathooserved on the floof emptying. The reshift did not empty bag up off of the floa wash basin to put wouldn't rest on the allowed. On 8/14/24 at 10:30 drainage bag had be the floor. On 8/15/24 at 8:27 observed in bed. The full and on the floor Nurse Consultant 1 room and shown the floor. During an interview.	a.m., the resident B had requested their drainage bag in so it floor but was told that wasn't was to the bed. At 8:31 a.m., was brought to Resident F's e catheter drainage bag on the erview at that time, Nurse	F 0690	Casa of Hobart Complaint Survey: 8.15.24 Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions sof 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. F690 Bowel/Bladder Incontine Catheter, UTI What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; Drainage for Resident F was immediately covered with a diplag and care plan updated with resident preference to have for bag on the floor in wash basin. How the facility will identify other residents beging the petential.	ence, ence, gnity th bley cher
Consultant 1 indicated the resident's drainage bag would be emptied and removed from the floor.			residents having the potential be affected by the same defici		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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AND PLAN OF CORRECTION DESCRIPTION OF THE PROVIDER OR NIFPELER 156469 STREET ADDRESS, CITY, STATE, ZIP COD	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
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was observed on the floor, this was immediately summary of the audits to the		indicated during rou	ands the resident's foley bag			The DON /designee will prese	nt a	
		was observed on the	e floor, this was immediately			- ·		
		after his bag had be	en drained and placed on his			1 ·		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155469	B. W	B. WING			08/15/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER							
CASA OF	HOBART			4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	bed. The resident wa	as asked how it got on the			monthly for 6 months. Therea	fter,		
		nt stated he took it down and			if determined by the Quality			
put it on the floor because he felt like it drained				Assurance committee, auditing	3			
	better. The resident	was educated as to why			and monitoring will be done			
	being on the floor w	vas improper. The resident			quarterly and present quarterly	/ at		
	then requested if his	foley bag could be placed on			the QA meeting. Monitoring w	ill		
	the floor inside of w	ash basin. "Spoke with			be on going.			
	Clinical and his preference was granted and the							
	care plan was updated."							
					Date of compliance: 9/4/2024			
	During an interview on 8/15/24 at 1:58 p.m., the							
	Director of Nursing	indicated there had been no						
	documentation of th	documentation of the resident putting the foley						
	bag on the floor and	wanting a wash basin for the						
	drainage bag prior to	o 8/15/24.						
	3.1-41(a)(2)							
F 0842 SS=D	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information							
Bldg. 00								
	Based on record rev	iew and interview, the facility	F 0	342	FOR Casa of Hobart		09/04/2024	
	failed to ensure clin	ical records were complete and			Complaint Survey 8.15.24			
	accurately documen	ted related to insulin						
	administration for 1	of 3 residents reviewed for			Please accept the following as	the		
	insulin use. (Reside	ent L)			facility's credible allegation of			
					compliance. This plan of			
	Finding includes:				correction does not constitute	an		
					admission of guilt or liability by	the		
	The record for Resid	dent L was reviewed on			facility and is submitted only in	1		
	8/15/24 at 10:10 a.n	n. Diagnoses included, but			response to the regulatory			
	were not limited to,	type 2 diabetes and vascular			requirement.			
	dementia.				F842 Resident Records-			
					Identifiable Information			
	The Annual Minimu				What corrective action(s) will b	e		
	assessment, dated 7/	/20/24, indicated the resident			accomplished for those reside	nts		
		paired for daily decision making			found to have been affected by	y the	ļ	
	and was receiving in	nsulin.			deficient practice;			
					Resident L plan of care was			
	A Care Plan, reviewed on 7/14/24, indicated the				updated. Resident had no adv	erse		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SOWO11 Facility ID: 000366

If continuation sheet Page 14 of 16

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/15/2024			
	PROVIDER OR SUPPLIER F HOBART	STREET ADDRESS, CITY, STATE, ZIP COD 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	(X5) COMPLETION DATE				
	resident was at risk for complications related to the diagnosis of diabetes mellitus. Interventions included, but were not limited to, diabetes medication as ordered by the physician. Monitor/document for side effects and effectiveness. A Physician's Order, dated 7/14/24, indicated the resident was to receive Lantus insulin 10 units at bedtime. The July 2024 Medication Administration Record (MAR) indicated the insulin was not signed out as being given on 7/14, 7/22, 7/27, and 7/31/24. During an interview on 8/15/24 at 2:30 p.m., the Director of Nursing (DON) indicated a QMA had been working the hall and she could not administer the insulin. The nurse on duty who administered the insulin for the above dates did not sign it out on the MAR. The facility policy, titled, "Medication Administration" was provided by the DON as current on 8/15/24 at 3:15 p.m. The policy indicated the individual administering the medication would initial the resident's MAR on the appropriate line after giving each medication and before administering the next one. This citation relates to Complaint IN00439881. 3.1-50(a)(1) 3.1-50(a)(2)		reaction. How the facility will identify off residents having the potential be affected by the same defici practice and what corrective a will be taken; All residents have the potential be affected by this alleged deficient practice. What measures will be put interplace or what systemic change will be made to ensure that the deficient practice does not recestaff will be re-educated on completing timely, complete, a accurate documentation in the resident's medical record. How the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., who quality assurance programs we put into place; DON/designee will audit 5 residents weekly for 2 weeks to months to ensure that documentation related to insurance accurately documented and clinical records are completed DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereat if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going. Date by which systemic	to ent ction If to Des es eur; and ef ill be ent at ill be for 6 in is ffter, g y at			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SOWO11 Facility ID: 000366

If continuation sheet

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

PRINTED: 09/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
	155469			B. WING			08/15/2024	
NAME OF PROVIDER OR SUPPLIER CASA OF HOBART				STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					corrections will be completed: 9/4/24			

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