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	08/15/2024

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 the Investigation of Complaints IN00438030, IN00438757, IN00438809, IN00439721, IN00439881, IN00440433, and IN00440984. Complaint IN00438030 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00438757 - Federal/State deficiencies related to the allegations are cited at F677 and F684. Complaint IN00438809 - No deficiencies related to the allegations are cited. Complaint IN00439721 - No deficiencies related to the allegations are cited. Complaint IN00439881 - Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00440433 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00440984 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: August 13, 14, and 15, 2024 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Type: SNF/NF: 93 Total: 93	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alisha Boler	RN BSN RNC	09/10/2024

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

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	Census Payor Type: Medicare: 4 Medicaid: 71 Other: 8 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/20/24.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to foley catheter drainage bags not being covered for 1 of 2 residents with urinary catheters. (Resident H) Finding includes: On 8/13/24 at 11:55 a.m., 2:00 p.m., and 4:25 p.m., Resident H was observed in their room in bed. The resident's foley catheter drainage bag contained yellow urine and the bag was visible from the doorway. On 8/14/24 at 8:30 a.m., 9:37 a.m., and 10:38 a.m., the resident was observed in their room in bed. The resident's foley catheter drainage bag contained yellow urine and the bag was visible from the doorway. On 8/15/24 at 8:29 a.m. and 11:03 a.m., the resident was observed in their room in bed. The resident's foley catheter drainage bag contained yellow urine and the bag was visible from the doorway.	F 0550	Casa of Hobart Complaint Survey: 08/15/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F550 Residents Rights/Exercise of Rights What corrective action(s) will be accomplished for those residents found to have Resident H drainage bag was immediately covered with a dignity bag and drainage bag was emptied	08/28/2024

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	The record for Resident H was reviewed on 8/14/24 at 10:21 a.m. Diagnoses included, but were not limited to, chronic kidney disease and pressure ulcer of the sacrum (a triangular bone at the base of the spine). The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/24, indicated the resident was moderately impaired for daily decision making and had an indwelling catheter. A Care Plan, dated 5/9/24, indicated the resident was at risk for complications secondary to requiring the use of a foley catheter related to having a pressure ulcer to the sacrum. A Physician's Order, dated 7/6/24, indicated the resident had a 16 french/10 cubic centimeter (cm) urinary catheter. On 8/15/24 at 8:30 a.m., Nurse Consultant 1 was asked to observe the resident's foley catheter drainage bag. During an interview at that time, Nurse Consultant 1 indicated the resident's foley catheter drainage bag should have been covered with a dignity bag (a bag that covers the drainage bag so the urine would not be visible). 3.1-3(t)		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents at risk that have foley catheters have the potential to be affected will be monitored daily for 6 months and thereafter What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were in serviced on: 8/28/24 • Ensuring dignity measures are in place when residents have foley catheters • Ensure residents with foley catheters are covered • Ensuring drainage bags are emptied and output documented How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place; The DON /designee will audit residents with foley bags at least 3x/week at varied times to ensure dignity is maintained, including but not limited to providing ADL's for residents with impaired cognitive status, resident's needing extensive assistance for bed	

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			mobility, resident's needing assistance with hygiene and bathing and resident's needing assistance with transfers. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date of compliance: 8/28/24	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure a Physician's Order for self administration of medications and an assessment to self-administer medications was completed, for 1 of 1 resident reviewed for self-administration of medications. (Resident B) Finding include: On 8/13/24 at 1:16 p.m., LPN 1 was observed leaving a medicine cup with 14 white circular pills on the bedside table in the room with Resident B. LPN 1 walked out of Resident B's room. Resident B began to administer their own medications. During an interview at that time, the resident indicated the pills were Methadone and they always took the medication independently.	F 0554	Casa of Hobart Complaint Survey: 8.15.24 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F554 Resident Self Admin Meds-Clinically Appropriate What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	08/28/2024

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	During an interview on 8/13/24 at 1:19 p.m., LPN 1 indicated she walked away from the resident while administering her medication, she had no reason and was aware the resident did not have a self administration order. . Resident B's record was reviewed on 8/13/24 at 9:45 a.m. Diagnoses included, but were not limited to, end stage renal disease, diabetes, hypertension, and renal dialysis. The Admission Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident was cognitively intact. A Physician's Order, dated 7/10/24, indicated to give Methadone HCl (narcotic pain medication) Oral Tablet 10 mg (milligrams) - Controlled Drug, give 140 mg (14 tablets) by mouth in the morning for pain. There were no orders for self-administration of the medications. There were no assessments completed for self-administration of the medications. A facility policy, titled, "Self -Administration of Medication", provided by the Director of Nursing on 8/15/24 at 3:05 p.m. as current, indicated, "... A resident may only self administer medications after the IDT [Interdisciplinary Team] has determined which medications may be self-administered ...." 3.1-11(a)		Resident B- Medication was immediately removed from the bedside and stored properly. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents with medication orders have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff re-educated on not leaving medications at resident bedside unless there is an order for self-administration and a self-administration assessment completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside and any medication noted at bedside has orders for self-administration. DON/Designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing	

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			and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/28/2024	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL's) received assistance with incontinence care in a timely manner for 1 of 3 residents reviewed for ADL's. (Resident G) Finding includes: During an interview on 8/13/24 at 1:19 p.m., Resident G indicated they were not checked or changed every 2 hours and they had not been changed all day. LPN 2 and CNA 1 entered the resident's room on 8/13/24 at 1:35 p.m. to provide incontinence care. CNA 1 indicated the resident's assigned CNA was giving a bed bath so she was going to provide care. The resident's brief was saturated with urine and the bath blanket underneath the resident was wet as well. At the completion of incontinence care, the resident indicated that was the first time they were changed for the day and the last time was around 2:00 a.m. During an interview on 8/13/24 at 1:56 p.m., CNA 3, who was assigned to the resident, indicated she	F 0677	**Casa of Hobart** **Complaint Survey: 8.15.24** **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident G was assisted with incontinence care. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	08/28/2024

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	had not provided incontinence care for the resident because the resident would tell her when they needed to be changed. During an interview on 8/13/24 at 2:25 p.m., CNA 1 indicated the resident's brief was soiled with urine and the bath blanket underneath the resident was also wet. The record for Resident G was reviewed on 8/14/24 at 8:55 a.m. Diagnoses included, but were not limited to, morbid obesity, cellulitis (a bacterial skin infection), and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 7/2/24, indicated the resident was cognitively intact. The resident was dependent on staff for toilet transfers and was frequently incontinent of bladder and bowel. A Care Plan, dated 3/18/24 and reviewed on 6/13/24, indicated the resident required assistance with ADL's including bed mobility, eating, transfers, toileting, and bathing related to weakness and decreased mobility. Interventions included, but were not limited to, assist with toileting care as needed. During an interview on 8/15/24 at 1:58 p.m., the Director of Nursing (DON) indicated the resident should have been provided incontinence care in a more timely manner. The facility policy titled, "Activities of Daily Living (ADL's)/Maintain Abilities" was provided as current by the DON on 8/15/24 at 3:15 p.m. The policy indicated a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The		**what corrective action will be taken;** All residents requiring assistance with Activities of Daily Living have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff re-educated on providing residents with assistance with Activities of Daily Living (ADL's) per plan of care/preferences. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will Audit 5 residents weekly, to ensure assistance with ADL's is being provided with a focus on incontinence care/toileting for 6 months. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic**	

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	facility would also provide care and services for toileting/elimination. This citation relates to Complaints IN00438030 and IN00438757. 3.1-38(a)(3)(A)		**corrections will be completed: 8/28/2024**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure treatments were completed as ordered for non-pressure skin conditions for 1 of 3 residents reviewed for non-pressure skin conditions. (Resident G) Finding includes: During an observation of incontinence care on 8/13/24 at 1:35 p.m., Resident G had a hydrocolloid (a bandage used to treat uninfected wounds) bandage in place to the left ischial area (the lower hip bone area). During an interview at that time, CNA 1 indicated the dressing was dated 8/12/24. LPN 2, who was also in the room, indicated the dressing was a hydrocolloid dressing and it was dated 8/12/24. The record for Resident G was reviewed on 8/14/24 at 8:55 a.m. Diagnoses included, but were not limited to, morbid obesity, cellulitis (a bacterial skin infection), and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 7/2/24, indicated the resident was cognitively intact. The resident was dependent on staff for toilet transfers and was frequently incontinent of bladder and bowel.	F 0684	Casa of Hobart Complaint Survey: 8.15.24 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident (G) Remains in the facility without further incident and received dressing change per the physician order. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents that have treatment	09/04/2024

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	A Physician's Order, dated 8/7/24, indicated the resident's left ischium was to be cleansed with normal saline or wound cleanser, pat dry, apply betadine (a topical antiseptic), and leave open to air daily. The August 2024 Treatment Administration Record (TAR), indicated the treatment to the left ischium had been signed out as being completed on 8/12/24. There was no treatment order for the hydrocolloid dressing. A Wound Physician Progress Note, dated 8/7/24, indicated the wound to the left ischium was non-pressure and resulted from trauma or injury. The wound measured 1 centimeter (cm) by 1 cm by 0.1 cm. Betadine was to be applied to the wound once daily. During an interview on 8/14/24 at 9:15 a.m., the Wound Nurse indicated the resident was seen by the Wound Physician that morning and he was waiting to see if any orders had changed. A Wound Physician Progress Note, dated 8/14/24, indicated a new treatment order for hydrocolloid, apply 3 times per week for 30 days. During an interview on 8/15/24 at 1:58 p.m., the Director of Nursing indicated the resident's treatment should have been completed as ordered on 8/12/24. This citation relates to Complaint IN00438757. 3.1-37(a)		orders have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Staff will be re-educated on the importance of ensuring that residents' treatment orders are followed as prescribed by the physician. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. DON or Designee will review wound care documentation 3 time per week during the clinical meeting for 6 months then two times a week thereafter to ensure that all wound care orders have been updated wound observations daily times 1 week then 3 X /week x 6 months for non-pressure wounds. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.	

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			Monitoring will be on going. Date by which systemic corrections will be completed: 9/4/24	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for a resident with a history of falls related to the bed being in a low position for 1 of 3 residents reviewed for falls. (Resident H) Finding includes: On 8/14/24 at 8:30 a.m., Resident H was observed in their room in bed eating a piece of toast. The bed was in a high position and a floor mat was present on the left side of the bed. At 9:37 a.m. and 10:38 a.m., the resident remained in bed. The bed was positioned at a medium height and was not low to the floor. On 8/15/24 at 8:29 a.m., the resident was in their room in bed. The resident's breakfast was on the over bed table and they were asking to be repositioned. The resident's bed was at a medium height at the time. CNA 2 entered the resident's room to provide assistance. During an interview at that time, CNA 2 indicated the resident's bed could go lower. She then demonstrated how low the bed could go, then indicated she didn't want to lower the bed all the way to the floor, otherwise the resident's foley catheter drainage bag would be touching the ground. The CNA also indicated	F 0689	**Casa of Hobart** **Complaint Survey: 08/15/2024** **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F689 Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by 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 the same deficient practice and what corrective action will be taken;** All residents at risk for falls have the potential to be affected by the	08/28/2024

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	the resident would adjust the height of the bed on their own. The record for Resident H was reviewed on 8/14/24 at 10:21 a.m. Diagnoses included, but were not limited to, cognitive communication deficit and schizophrenia. The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/24, indicated the resident was moderately impaired for daily decision making and was dependent on staff for transfers and bed mobility. A Care Plan, dated 1/22/24 and reviewed on 6/1/24, indicated the resident was at risk for falls with major injury. Interventions included, but were not limited to, place the bed in the lowest position. A Fall Risk assessment, dated 7/5/24, indicated the resident was a moderate risk for falls. An Interdisciplinary Team (IDT) Note, dated 7/29/24, indicated the resident was reaching for the trash can and fell out of bed. Nurses' Notes, dated 8/3/24 at 5:23 a.m., indicated the resident was found on the floor by the left side of the bed. A one inch laceration was found next to the left eyelid. The resident was sent to the emergency room for evaluation. The resident received 3 sutures while at the hospital. During an interview on 8/15/24 at 8:30 a.m., Nurse Consultant 1 indicated the resident's bed should be in a low position and the care plan would be updated to reflect the resident adjusting the bed height on their own.		same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff will be in-serviced on: An assessment is completed post fall and documented in the medical record. Ensuring fall interventions are in place as ordered. Ensure residents environment is free of accident hazards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON /designee will audit 5 residents with fall interventions weekly to ensure fall interventions are in place as ordered. Audits will be completed weekly for 6 months. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date of Completion: 8/28/2024**	

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	This citation relates to Complaint IN00440433. 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure urinary catheter drainage bags were not placed on the floor for a resident with a history of urinary tract infections for 1 of 2 residents reviewed for urinary catheters. (Resident F) Finding includes: On 8/14/24 at 8:28 a.m., Resident F was observed in their room in bed. During an interview at that time, the resident indicated to look at their urinary catheter drainage bag. The drainage bag was observed on the floor next to the bed and in need of emptying. The resident indicated the midnight shift did not empty the drainage bag or pick the bag up off of the floor. Resident B had requested a wash basin to put their drainage bag in so it wouldn't rest on the floor but was told that wasn't allowed. On 8/14/24 at 10:30 a.m., the resident's catheter drainage bag had been emptied but remained on the floor. On 8/15/24 at 8:27 a.m., the resident was again observed in bed. The catheter drainage bag was full and on the floor next to the bed. At 8:31 a.m., Nurse Consultant 1 was brought to Resident F's room and shown the catheter drainage bag on the floor. During an interview at that time, Nurse Consultant 1 indicated the resident's drainage bag would be emptied and removed from the floor.	F 0690	Casa of Hobart Complaint Survey: 8.15.24 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. F690 Bowel/Bladder Incontinence, Catheter, UTI What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Drainage for Resident F was immediately covered with a dignity bag and care plan updated with resident preference to have foley bag on the floor in wash basin. How the facility will identify other residents having the potential to be affected by the same deficient	09/04/2024

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	155469	A. BUILDING 00 B. WING	08/15/2024

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	The record for Resident F was reviewed on 8/15/24 at 10:51 a.m. Diagnoses included, but were not limited to, acute pyelonephritis (kidney infection), neuromuscular dysfunction of the bladder, and artificial opening of urinary tract status. The Admission Minimum Data Set (MDS) assessment, dated 7/16/24, indicated the resident was cognitively intact and had an indwelling catheter. A Care Plan, dated 7/11/24, indicated the resident was at risk for complications secondary to requiring the use of a suprapubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow). Interventions included, but were not limited to, position catheter bag and tubing below the level of the bladder and away from entrance room door. There was no care plan related to the resident placing the catheter drainage bag on the floor. A Physician's Order, dated 7/10/24, indicated the resident had a 16 french/10 cubic centimeter (cm) supra pubic catheter. A Physician's Order, dated 7/10/24, indicated the resident was to receive Meropenem (an antibiotic), use 1 gram intravenously (IV) three times a day for 6 days for an infection in the urine. Nurses' Notes, dated 8/15/24 at 10:58 a.m., indicated during rounds the resident's foley bag was observed on the floor, this was immediately after his bag had been drained and placed on his		practice and what corrective action will be taken; All residents who have foley bags have the potential to be affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff will be re-educated on the policy and procedures for assuring that residents' foley bags are covered and residents preferences are documented. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; During the clinical meeting the Director of Nursing or designee will review documentation and make observations 5 days a week for 6 months then two times a week thereafter to ensure that the residents with foley's have drainage bags that provide dignity, are emptied as needed, not kept on the floor and preferences are updated in the care plan. The Director of Nursing is responsible for compliance of this deficiency. The DON /designee will present a summary of the audits to the Quality Assurance committee	

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	bed. The resident was asked how it got on the floor and the resident stated he took it down and put it on the floor because he felt like it drained better. The resident was educated as to why being on the floor was improper. The resident then requested if his foley bag could be placed on the floor inside of wash basin. "Spoke with Clinical and his preference was granted and the care plan was updated." During an interview on 8/15/24 at 1:58 p.m., the Director of Nursing indicated there had been no documentation of the resident putting the foley bag on the floor and wanting a wash basin for the drainage bag prior to 8/15/24. 3.1-41(a)(2)		monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date of compliance: 9/4/2024	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to insulin administration for 1 of 3 residents reviewed for insulin use. (Resident L) Finding includes: The record for Resident L was reviewed on 8/15/24 at 10:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes and vascular dementia. The Annual Minimum Data Set (MDS) assessment, dated 7/20/24, indicated the resident was moderately impaired for daily decision making and was receiving insulin. A Care Plan, reviewed on 7/14/24, indicated the	F 0842	FOR Casa of Hobart Complaint Survey 8.15.24 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F842 Resident Records-Identifiable Information What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident L plan of care was updated. Resident had no adverse	09/04/2024

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	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 other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff will be re-educated on completing timely, complete, and accurate documentation in the resident's medical record. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/designee will audit 5 residents weekly for 2 weeks for 6 months to ensure that documentation related to insulin is 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. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic	

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			corrections will be completed: 9/4/24	