| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00421764 and IN00422865. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy.<br><br>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and a PSR to the Investigation of Complaints IN00415423 and IN00417794 completed on 11/2/23.<br><br>Complaint IN00421764 - Federal/State deficiencies related to the allegations are cited at F693.<br><br>Complaint IN00422865 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00415423 - Corrected.<br><br>Complaint IN00417794 - Corrected.<br><br>Survey dates: December 11 and 12, 2023<br><br>Facility number: 000366<br>Provider number: 155469<br>AIM number: 100288900<br><br>Census Bed Type:<br>SNF/NF: 85<br>Total: 85<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 63<br>Other: 18<br>Total: 85 | F 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Rosa McGowen | VPO | 12/29/2023 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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 |
|---|---|---|---|---|
| | This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 12/13/23. | | | |
| F 0693 SS=J Bldg. 00 | 483.25(g)(4)(5)<br>Tube Feeding Mgmt/Restore Eating Skills<br>§483.25(g)(4)-(5) Enteral Nutrition (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-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>Based on record review and interview, the facility failed to implement measures to ensure a moderately impaired dependent resident was not lying flat in bed while an enteral (administered into the gastrointestinal tract) tube feeding was infusing, which led to labored breathing, audible crackle lung sounds, projectile vomiting, unresponsiveness, intubation, and ultimately death for 1 of 3 residents reviewed for tube feeding. (Resident B) | F 0693 | 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.<br>**F693 Tube Feeding** | 12/13/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The immediate jeopardy began on November 11, 2023 when the resident was observed several times by staff during the early and late morning hours with the head of bed flat and the enteral tube feeding infusing. Later that day at 11:15 a.m., the resident was observed with labored breathing, crackles upon auscultation (listening with stethoscope), gurgling and severe projectile vomiting which required suctioning. The resident became unresponsive, was intubated, and transported to the Emergency Room (ER) where she died. The Administrator, Vice President of Operations, and both Nurse Consultants were notified of the immediate jeopardy at 2:30 p.m. on December 11, 2023. The immediate jeopardy was removed on December 12, 2023, but noncompliance remained at the lower scope and severity level of actual harm that is not immediate jeopardy.<br><br>Finding includes:<br><br>During a phone interview on 12/11/23 at 10:58 a.m. with Resident B's mother, she indicated her daughter had just come back from the hospital the day before. The family member indicated she visited her daughter every day and arrived at the facility between 10:30 a.m. and 11:00 a.m. She entered her daughter's room and observed her "breathing very hard and loud" the bed was completely flat. The mother indicated she even knew the head of the bed could not be flat when someone had a feeding tube running. She immediately turned the call light on, and kept calling her daughter's name, but she was not responding. She knew her daughter was "gone" "dead." She went out into the hall to get help, but could not find anyone, so she called for help, and CNA 1 came towards her. She told the CNA the | | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>Resident B no longer resides in the facility.<br>**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;**<br>All residents with enteral feeding have the potential to be affected by the same alleged deficient practice.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;**<br>Staff were educated on:<br>Proper elevation of the Resident's head will be maintained according to resident's condition unless medically contraindicated. Position head of the bed at 30-45 degrees. All clinical staff need to ensure that head of bed is elevated at all times when enteral feeding is on, providing water flushes and medication.<br>Check the Enteral Administration Record or EMAR for specific order. Be sure to start and stop tube feeding per physician's orders.<br>Verify placement of tube prior to administering medications, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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 |
|---|---|---|---|---|
| | head of the bed was flat and her daughter was breathing very hard and she needed help. The CNA entered the room and raised the head of the bed. The resident's mother indicated after her head was raised, all the fluid came out, she threw up everything and "it had been built up in there for a long time." There was no suction machine in the room to help her daughter. The nurse RN 1 came into the room and asked her to leave the room so they could "work on her." The mother was not aware if her daughter was suctioned or not, but did see the nurses bring in a machine to do that. She was also not aware if they initiated CPR while at the facility in her room. The paramedics came into the room and when they took her out, they worked on her for a long time in the parking lot. She said they pronounced her dead in the ER.<br><br>The closed record for Resident B was reviewed on 12/11/23 at 10:40 am. The resident was admitted to the facility on 10/28/22. Diagnoses included, but not were not limited to, dementia, stroke, bipolar disorder, high blood pressure, multiple sclerosis, schizophrenia, dysphagia, pressure sore, peg tube (a tube in the stomach which was used for nutrition), hemiplegia, type 2 dm, and Candida sepsis.<br><br>The resident was discharged to the hospital on 10/31/23 and readmitted back to the facility on 11/10/23.<br><br>The Modification of the Admission Minimum Data Set (MDS) assessment, dated 9/26/23, indicated the resident was moderately impaired for decision making and was an extensive assist with a 2 person physical assist for bed mobility. The resident had swallowing issues such as food running out of her mouth and holding food in her | | feeding and water flushes. Document the resident's medical record to include any complication and notify the physician as needed.<br>Signs of enteral feeding complications: coughing, vomiting, respiratory distress, aspiration<br>**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;**<br>DON/designee will audit all residents with enteral feeding, to ensure that head of bed is positioned properly at all times and enteral feeding is administered per physician orders. Audit will be done 5x/weekly x 4 months, including off shift hours. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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.<br>**Date by which systemic corrections will be completed: 12/13/2023**<br="" p=""> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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 |
|---|---|---|---|---|
| | mouth. She received 51% of her nutrition through enteral feedings.<br><br>A Care Plan, dated 8/4/23, indicated the resident was at risk for complications secondary to requiring a tube feeding. The approaches were the head of the bed was to elevated to 30 to 45 degrees.<br><br>A Care Plan, dated 9/21/22 and revised on 11/13/23, indicated the resident was at risk for impaired nutritional status due to being NPO, peg tube feedings and weight loss. The approaches were to ensure all staff were informed of the resident's special dietary and safety needs.<br><br>Physician's Orders, dated 11/10/23, indicated NPO (Nothing By Mouth) and Jevity 1.5 (enteral feed)via the peg tube at 50 cubic centimeters (cc) per hour. The resident was also in isolation for Candida Auris.<br><br>The Medication Administration Record for the month of 11/2023 indicated the enteral feeding was signed out as being turned on and infusing on the midnight shift on 11/10 and the day shift for 11/11/23.<br><br>Nurses' Notes, dated 11/10/23 at 11:09 p.m., indicated the resident was alert and oriented with some confusion. She returned to the facility tonight with a picc line to the left upper arm, a foley (urinary)catheter, and was to be in isolation for Candida Auris. The resident also had a wound to the sacral area. The Physician and family were notified.<br><br>Nurses' Notes, dated 11/11/23 at 11:51 a.m., indicated, "Resident sent to ER due to unresponsive to stimuli vigorous shake on | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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 |
|---|---|---|---|---|
| | multiple attempts, crackle noted on auscultation. feeding paused, resident was suctioned. HOB [head of bed] elevated. POA [power of attorney] at bedside, MD notified."<br><br>Nurses' Notes, dated 11/11/23 at 3:26 p.m., indicated the hospital had called to let the facility know the resident was deceased.<br><br>A Hospital Note, dated 11/11/23 at 11:59 a.m., indicated the patient presented with cardiac arrest and EMS was called to the nursing home for difficulty breathing. EMS reported the patient was supine with agonal breathing, and went into pulseless electrical activity upon arrival to ER and ACLS (advanced cardiac life support) therapy was initiated. EMS intubated the patient in the field, however, no life saving medications were administered. A physical exam indicated the patient was ill and toxic appearing and her pupils were dilated at 6 millimeter bilaterally. There was no palpable pulse or heart sounds heard with auscultation and breath sounds were heard with bagging bilaterally. The patient's critical condition was discussed with the mother and the decision was made to take her off life support. The patient was pronounced dead at 12:11 p.m.<br><br>A written time line of events, provided by Nurse Consultant 2, indicated on Friday 11/10/23 the resident was readmitted to the facility at 7:00 p.m. At 10:00 p.m., 2 staff members indicated the head of the bed was elevated. On Saturday 11/11/23 at 12:00 a.m., LPN 1 indicated the resident was lying flat in bed, but the peg tube was not running. The head of the bed was elevated and the peg tube was infusing again. At 5:00 a.m., LPN 1 indicated she had checked on the resident but did not recall if the bed was flat or elevated. On 11/11/23 at 9:00 a.m., the Admissions Director was the manager on | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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 |
|---|---|---|---|---|
| | duty and observed the resident's head of the bed flat and the enteral feeding was infusing. At that time, she notified RN 1 of the situation. At 10:00 a.m., RN 1 observed the resident's head of bed was flat and the tube feeding was infusing, he raised the head of the bed up at that time. At 11:15 a.m., the resident's mother alerted CNA 1 to come to the room due to the head of bed was flat again and the tube feeding was infusing. At 11:25 a.m., 911 was called and at 11:51 a.m., the resident was sent to the ER.<br><br>The following interviews were conducted as part of the facility investigation:<br><br>A statement from the Admissions Director on 11/14/23, indicated she was the manager on duty that day. She walked down to the resident's room at 9:00 a.m. She noticed there were no isolation gowns available so she told RN 1 about that and he filled the bin right away. She looked in the room and observed the resident lying flat in bed and could see she was breathing. She informed RN 1 the resident was a tube feeding and should not be lying flat in bed.<br><br>A telephone statement from CNA 1 on 11/14/23, indicated she was walking down Blueberry hall and noticed the resident's mother coming out of the room and wanting to know who her daughter's CNA was and stated "Anyone who knows anything about tube feeds knows they can't lie flat." She donned ppe and raised the head of the bed. CNA 1 went to wash her hands with soap and water and heard the resident's mother say "Oh my god, my baby is going to die!" She came out of the bathroom and observed the resident throwing up large amounts of her tube feeding. LPN 2 entered the room with the suction machine and started to suction her mouth. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A telephone statement from LPN 2 on 11/14/23, indicated she was at the nurses' station and overheard the resident's mother yelling. She saw CNA 1 enter the room and heard her say "help me!" When she arrived to the room the resident was throwing up and she listened to her breathing and knew she needed to be suctioned. RN 1 grabbed the suction machine and gave it to her and she started to suction immediately. The resident's mother was in the hallway and could be heard saying, "She shouldn't been laying flat. He don't know what he is doing." EMS arrived and continued to suction the resident and she was still breathing when she left the facility. She could hear the paramedics say, "Sounds like she has been like this for a couple of days."<br><br>A telephone statement from RN 1 on 11/17/23 indicated he was the day shift nurse assigned to the resident. He observed the resident lying flat in bed around 10:00 a.m. He raised the head of the bed at that time with no additional concerns. He indicated around 11:00 a.m., the resident had a change in condition and was sent to the ER.<br><br>There was no written statement from CNA 2 or any of the midnight shift CNAs who had worked the early morning hours on 11/11/23.<br><br>An inservice, (no date or time), indicated "Attention all Nurses, ensure the resident's head of bed is elevated (minimum of 30 degrees) when providing water flush, medication, and feeding via gastric tube. Check placement of gastric tube prior to administering feeding, medication, or water flush. Be sure to start and stop tube feeding per physician orders. Always administer tube feeding and water flush per physician orders...The inservice was signed by the Director of Nursing | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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 |
|---|---|---|---|---|
| | (DON), Assistant Director of Nursing, the Wound Care Nurse and a QMA. The next page indicated "Peg tube HOB elevated at least 30 degrees." The inservice was signed by 5 day shift CNAs, the DON, ADON, Wound Nurse, 3 day shift nurses, 1 day shift QMA, and 1 evening shift CNA.<br><br>During an interview on 12/11/23 at 11:30 a.m., RN 1 indicated he was the nurse on duty and was taking care of the resident. He arrived to work late around 7:30 a.m. and received report from the midnight nurse, The resident had come back from the hospital the night before and was now on IV antibiotics, and in isolation for Candida. He indicated her medications were not in from pharmacy so he had nothing to give her that morning. RN 1 indicated he started med pass and around 8:15 a.m., he had some blood sugars to do and other medications to give. He observed the resident sometime after that and the head of bed was flat while the enteral feeding was infusing, so he raised it up to 35 degrees and left the room, as he did not have her medications yet. Around 10:45 a.m., he was finished with med pass, and was seated at the nursing station, when the resident's mother came in and asked who her daughter's nurse was, he told her he was. She then walked down to her room and minutes later, CNA 1 came to nursing station and told him the resident was vomiting. LPN 2 and himself went to the room together to assess the situation and 911 was called. They could not get her to respond after shaking her. He also suctioned about 100 cc of tube feeding out of her mouth, and her breathing was very bad as he heard crackles. The paramedics arrived and she left to go to the hospital. He indicated he could not find the resident's CNA at that time, the one who was assigned to her. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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 |
|---|---|---|---|---|
| | During an interview on 12/11/23 at 11:35 a.m., CNA 1 indicated she was working the other hall and stepped out of a room and heard the resident's mom yelling for help. She went to see what she needed and when she entered the room the resident was lying flat in bed and the tube feeding was infusing. The resident was breathing very hard and did not look like she was responding. She raised the head of the bed and started to leave the room to get the nurse and at that time, the resident's mom yelled, she turned around and the resident was vomiting tube feeding from her mouth, "like projectile vomiting." She got the nurse and they brought the suction machine in and started to suction her. CNA 1 indicated CNA 2 was her aide that day, but she thinks she might have been in another room taking care of someone else.<br><br>During an interview on 12/11/23 at 1:07 p.m., the Admissions Director indicated she was the manager on duty on 11/11/23 came in around 8:15 a.m., started doing her rounds in the facility, making sure staffing was ok and the residents were ok. At 9:00 a.m., she checked on the resident and observed her from the hallway, the head of the bed was flat and the tube feeding was infusing. She informed RN 1 right away, who was across the hall passing medications. She did not stay to make sure RN 1 raised the head of the bed immediately, she walked away.<br><br>During an interview on 12/11/23 at 1:20 p.m., the Director of Nursing (DON) indicated CNA 2 was interviewed and she had not even entered the resident's room from the start of her shift to when the resident left the facility with EMS.<br><br>During an interview on 12/11/23 at 1:30 p.m., the Vice President of Operations (VPO) indicated she | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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 |
|---|---|---|---|---|
| | was aware of the incident and was told by her clinical team the investigation was being taken care of. The Administrator who investigated the incident was no longer employed at the facility.<br><br>During an interview on 12/12/23 at 10:42 a.m., CNA 2 indicated she had asked RN 1 why the resident was in isolation and he threw his hands up in the air, suggesting he did not know. She told him she was uncomfortable taking care of the resident not knowing what kind of infection she had. She saw Restorative CNA and RN 1 talking about the care for the resident so she assumed the Restorative CNA would be taking care of the resident that day. She did not enter the resident's room at any point during the day on 11/11/23.<br><br>The American Nurse Association (ANA) website www.myamericannurse.com information, titled, "Tube Feeding Aspiration" and dated 3/12/19, indicated ..."Acute aspiration of tube feeding can result in a respiratory emergency ...."<br><br>A Memorial Sloan Kettering article found at "www.mskcc.org/cancer-care/patient-education/how-prevent-aspiration#section-1" and titled, "How to Prevent Aspiration," dated 12/12/22, indicated "....signs of aspiration include: coughing, choking, gagging, throat clearing, vomiting, trouble breathing, wheezing, painful breathing...."<br><br>A policy titled, "Enteral Tube Feeding via pump" dated 2/15/21, provided by Nurse Consultant 2, indicated it was the policy of the facility to provide enteral feeding via pump, as ordered by the physician, to ensure adequate nutrition for residents who were unable to maintain their nutrition orally. The head of the bed should be positioned to 30 to 45 degrees unless medically | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>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 |
|---|---|---|---|---|
| | contraindicated.<br><br>The immediate jeopardy that began on 11/11/23 was removed on 12/12/23 when the facility completed an all nursing staff inservice regarding feeding tubes, positioning of the resident in bed while the feeding tube was infusing, identifying signs and symptoms of aspiration, and educating nurses to make sure to find the root cause when the head of the bed was flat more than once, but the noncompliance remained at the lower scope and severity of actual harm that is not immediate jeopardy because the resident was lying flat in bed while the feeding was infusing through the peg tube which led to labored breathing, projectile vomiting, aspiration, unresponsiveness, intubation, pulseless, and ultimately death.<br><br>This citation relates to Complaint IN00421764.<br><br>3.1-44(a)(2) | | | |