STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa of Hobart	4410 W 49th Ave Hobart, IN 46342

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 20580 Based on observation, record review, and interview, the facility failed to ensure a resident was treated with respect and dignity related to not assisting the resident to the bathroom upon request, for 1 of 6 residents reviewed for respect and dignity. (Resident G) Finding includes: During an observation on 5/29/24 at 8:02 a.m., Resident G had activated the call light. On 5/29/24 at 8:09 the call light was observed not on. During an observation and interview on 5/29/24 at 8:12 a.m., Resident G had activated the call light. The resident was sitting on the side of the bed and the wheelchair was next to the bed. She indicated she needed to use the bathroom. Human Resources entered the room and asked the resident if she needed help and was informed by the resident she needed to use the bathroom. Human Resources left the call light on and informed the resident she would get a staff member to help her and left the room. The resident then indicated a man had came into her room earlier and she informed him she needed to use the bathroom. He had informed her she would have to wait because they were passing breakfast trays and turned the call light off. She indicated she had not wanted to make a mess in the bed and had tried to get into the chair by herself and fell back onto the bed. At 8:17 a.m., Restorative CNA 3 entered the room and assisted the resident to the wheelchair with minimal assistance and assisted the resident to the bathroom. During an interview on 5/29/24 at 8:22 a.m., the Director of Nursing indicated the resident should have been assisted to the bathroom when she first requested assistance. Resident G's record was reviewed on 5/29/24. The diagnoses included, but were not limited to, stroke. The Baseline Care Plan, dated 5/24/24, indicated one staff member was required for transfers and toilet use. The resident was alert and cognitively intact and was always continent of bowel and bladder. An Occupational Therapy Progress Note, dated 5/28/24, indicated moderate assistance was required for toileting and the sitting and standing balance was fair. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaint IN00432283. 3.1-3(t)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 20580 Based on observation, record review, and interview, the facility failed to ensure a resident who required maximum to dependent care received incontinent care in a timely manner, for 1 of 3 residents reviewed for incontinent care. (Resident D) Finding includes: During an observation and interview with Resident D on 5/28/24 at 8:27 a.m., she was lying on her back in bed wearing a hospital gown. The head of the bed was elevated. She indicated the facility staff checked her 2-3 times a day for incontinence of bowel and bladder. Resident D's record was reviewed on 5/28/24 at 12:19 p.m. The diagnoses included, but were not limited to, vascular dementia and bilateral above the knee amputations. A Quarterly Minimum Data Set (MDS) assessment, dated 4/8/24, indicated an intact cognition, no behaviors, impairment of the bilateral lower extremities, dependent for transfers, required maximum assistance for toileting, and was always incontinent of bowel and bladder. A Care Plan, revised on 1/22/24, indicated the resident had bowel and bladder incontinence. The interventions indicated the resident would be checked and incontinent care would be provided on care rounds and as needed. During an observation and interview on 5/28/24 at 1:25 p.m., the resident remained in bed, lying on her back. The head of the bed remained elevated. Resident D indicated no one had been in her room all day to check her for incontinence and she needed to go to the bathroom. She then activated the call light. The Wound Nurse entered the room and indicated he would need to find someone to assist him with here care, then turned the call light off and left the room. At 1:30 p.m., the facility staff had not returned to the room. A family member entered the room and the resident informed the family member she needed to go to the bathroom. The family member went to the door of the room and saw the Wound Nurse. He informed the family member he was still looking for someone to assist him. The Administrator was standing in the hallway outside the room and the family member informed her the Wound Nurse was looking for someone to help him with the resident's care. The Administrator indicated the CNA on the hallway was on break. The Wound Nurse and CNA 1 began the incontinent care at 1:33 p.m. Upon removing the cover sheet, there was dried bowel movement on the outside of the incontinent brief. There was dried yellow liquid on the bottom sheet, and on and under the cloth incontinent pad under the resident. The resident indicated again no one had been in to change her all day. After the incontinent care was completed, CNA 2 entered the room and identified herself as the resident's assigned CNA. She indicated she had checked the resident prior to the lunch being served. An Incontinence Policy, dated 2/12/21 and received from the Director of Nursing as current, indicated a resident who was incontinent would receive appropriate treatment and services. This citation relates to Complaint IN00432283. 3.1-38(a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 20580 Based record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, related to a fracture after a fall not investigated thoroughly for 1 of 6 residents reviewed for quality of care. (Resident E) Finding includes: Resident E's record was reviewed on 5/29/24 at 8:39 a.m. The diagnoses included, but were not limited to fractured left femur 4/11/24 and falls. A Significant Change MDS assessment, dated 4/18/24, indicated a severely impaired cognitive status, required moderate assistance with bed mobility and maximum assistance with transfers, and had no falls since re-admission into the facility. A Nurse's Progress Note, dated 4/4/24 at 10:30 p.m., indicated the resident was observed laying on the floor in front of the wheelchair. Emergency Medical Services (EMS) were notified. There were no obvious signs of injury. The level of consciousness was at baseline. The resident denied hitting her head. There was limited range of motion to the bilateral upper extremities and range of motion was tolerated to the bilateral lower extremities. The resident complained of pain to the left hip. There was no discoloration, bruising, swelling, shortening, rotation, or deformities observed. The Nurse Practitioner was notified and ordered diagnostic imaging of the left shoulder and hip. The resident refused to be transferred to the hospital. The X-Rays of the left shoulder and bilateral hips were completed on 4/5/24. There were no fractures observed. The Post Fall Follow-up assessments, dated 4/5/24 at 10:34 a.m. and 6:41 p.m., 4/6/24 at 10:01 a.m. and 8:02 p.m., 4/7/24 at 4:02 a.m. and 8:03 p.m., and 4/8/24 at 4:04 a.m., indicated there was no signs or symptoms of injury such as swelling or bruising, no change the activities of daily living status, and no change in the resident's mental status. A Nurse's Progress Note, dated 4/8/24 at 5:10 a.m., indicated the resident complained of pain to the left hip during incontinent care by the CNA. The Physician was notified and orders were received to X-Ray the left hip and leg. The X-Ray of the left hip was completed on 4/8/24 and indicated an acute impacted left hip fracture. A Nurse's Progress Note, dated 4/8/24 at 1:06 p.m., indicated the resident was transferred to the hospital due to the left hip fracture. A CT scan (Computerized Tomography - medical imaging technique used to obtain detailed internal images of the body) report of the left hip from the hospital indicated an impacted fracture of the intertrochanteric region of the left femur, osteopenia, and moderate to severe osteoarthritis of both hips. The hospital left hip X-Ray indicated a left hip fracture and osteopenia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/24 at 10:53 a.m., the Administrator indicated the fracture was from the fall on 4/4/24. She acknowledged the X-Ray on 4/5/24 was negative for a hip fracture and had not completed a further investigation to rule out other causes of injury or to support the finding of the fall causing the fracture after the X-Ray on 4/8/24 indicated a fractured left hip. A facility fall prevention policy, dated 9/1/20 and identified as current by the Director of Nursing, indicated a resident would be assessed for the risk of falls and appropriate interventions to provide necessary assistive devices would be implemented. This citation relates to Complaints IN00432283 and IN00434490. 3.1-37

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 20580 Based on observation, interview, and record review, the facility failed to ensure care planned interventions to prevent injuries due to a fall were in place, related to floor mats not in place next to the bed and anti-roll brakes not on the wheelchair. The facility also failed to ensure an intervention initiated to prevent further falls was completed related to a urinalysis not obtained, for 2 of 3 residents reviewed for falls. (Residents D and E) Findings include: 1. During observations on 5/28/24 at 8:27 a.m. and 1:25 p.m., Resident D was lying in bed with the head of the bed elevated. The bed was elevated approximately two and a half feet off the ground. There was no mat on floor next to the bed. Resident D's record was reviewed on 5/28/24 at 12:19 p.m. The diagnoses included, but were not limited to, vascular dementia and bilateral above the knee amputations. A fall risk assessment, dated 4/3/24, indicated a high risk for falls. A Quarterly Minimum Data Set (MDS) assessment, dated 4/8/24, indicated an intact cognition, no behaviors, impairment of the bilateral lower extremities, dependent for transfers and wheelchair mobility, and had no falls since the last assessment was completed. A Care Plan, revised on 1/22/24, indicated the resident has had falls and there was a risk for future falls. The interventions included, anti-roll back brakes were to be used on the wheelchair and on 5/2/24, a floor mat was to be placed on the open side of the bed due to a fall on 5/1/24. A Nurse's Progress Note, dated 5/1/24 at 3:31 a.m., indicated the resident was found sitting on the floor next to her bed. The resident indicated she thought it was 6 a.m. and had rolled out of bed to use the bathroom. An Interdisciplinary Team (IDT) Progress Note, dated 5/1/24 at 2:05 p.m., indicated the resident had intermittent confusion and had attempted to take herself to the bathroom. The root cause of the fall was due to a roll from the bed. The intervention initiated was a floor mat to be placed next to the bed. During an observation on 5/29/24 at 8:07 a.m., Resident D was sitting in a wheelchair in the Dining Room. There were no anti-roll brakes on the wheelchair. During an interview on 5/29/24 at 8:11 a.m., CNA 1 indicated there were no anti-roll brakes on the wheelchair. 2. Resident E's record was reviewed on 5/29/24 at 8:39 a.m. The diagnoses included, but were not limited to fractured left femur 4/11/24 and falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Significant Change MDS assessment, dated 4/18/24, indicated a severely impaired cognitive status, required moderate assistance with bed mobility and maximum assistance with transfers, and had no falls since re-admission into the facility. A Care Plan, revised on 4/26/24, indicated she was a risk for future falls. An intervention was added on 4/4/24 and indicated a urinalysis (UA) and culture and sensitivity (C&S) was to be obtained. A Post Fall Observation form, dated 4/4/24 at 10:30 p.m., indicated the resident had fallen from the wheelchair in her room. She indicated she had fallen asleep. An IDT Progress Note, dated 4/5/24 at 11:46 a.m., indicated the resident had fallen asleep in her chair and slid to the floor from the wheelchair. The intervention initiated indicated an urinalysis would be obtained. There was no documentation that indicated the UA had been obtained or ordered. There was no UA result located in the record. During an interview on 5/29/24 at 10 a.m., the Director of Nursing (DON) and the Corporate Nurse Consultant indicated the UA had not been completed. This citation relates to Complaints IN00432283 and IN00434490. 3.1-45(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 20580 Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (CNA 1 and Wound Nurse), when providing care to a resident who was in Enhanced Barrier Precautions (EBP), and failed to remove soiled gloves before touching clean surfaces for 1 of 1 random observations for infection control. (Resident D) This had the potential to affect the residents on 4 of 5 Units (Cherry, Blueberry, Apple, and Cherry Lane) and 18 residents who received wound care where staff should use EBP. Finding includes: During an observation on 5/28/24 at 8:27 a.m., Resident D had a sign on the outside of the entry door to her room, which indicated Enhanced Barrier Precautions (EBP) were to be used when providing care. The sign indicated the EBP was to be used for Bed 1 and 2. There was a storage cart with the PPE in the hallway outside of the entry door. Resident D's record was reviewed on 5/28/24 at 12:19 p.m. The diagnoses included, but were not limited to, end stage kidney disease with hemodialysis. A Quarterly Minimum Data Set (MDS) assessment, dated 4/8/24, indicated an intact cognition, no behaviors, impairment of the bilateral lower extremities, dependent for transfers, required maximum assistance for toileting, showers, hygiene, and was always incontinent of bowel and bladder. A Care Plan, revised on 1/22/24, indicated assistance was required for bed mobility, transfers, toileting, and bathing. The interventions indicated the staff would assist with all activities of daily living. During an observation and interview on 5/28/24 at 1:33 p.m., The Wound Nurse and CNA 1 donned gloves and were starting incontinent care. They were stopped prior to care beginning and asked about EBP precautions and the sign on the door. CNA 1 indicated a gown was required. CNA 1 and the Wound Nurse then donned a gown to provide care to the resident. The resident had been incontinent of bowel movement and had menstrual/uterine bleeding. CNA provided incontinent care. While still wearing the gloves used for the incontinent care, he began looking for a bottom sheet in the room and opened and closed the resident's closet, drawers, and touched the wheelchair handle with the soiled gloves. He then entered the roommate's area and was stopped before he touched any surface. He then doffed the gloves and gown, completed hand hygiene and exited the room to obtain linens for the bed change. During an interview on 5/28/24 at 2:10 p.m., the Director of Nursing (DON) indicated they room would be wiped down with disinfectant. She also indicated the staff had all been trained in EBP requirements. Review of the in-house trainings for EBP, dated 5/9/24 and 5/17/24 and received from the DON on 5/29/24 at 8:30 a.m., indicated the staff were educated on EBP, which included a gown and gloves were to be used during high-contact resident care activities. Signage would be on the door with the number of the bed who required EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated facility's EBP Guidelines, received as current from the DON on 5/29/24 at 8:30 a.m., indicated the use of gown and gloves during high-contact resident care activities was required. EBP was to be used with transfers or during bathing assistance and when close physical contact is present. 3.1-18(b)