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	07/02/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 20580 Based on record review and interview, the facility failed to ensure employees (Confidential Interview 2 and Terminated Employee 6) reported allegations of abuse by an employee (Employee 7) toward residents of the Memory Care Unit to the Administrator. This had the potential to affect 18 residents who resided on the Memory Care Unit. Finding includes: During an interview, Confidential Interview 5 indicated Employee 7 would make fun of the residents and would call the residents by derogatory names. They had never seen physical harm done to the residents. They indicated this had been going on but it had not been reported. They felt when abuse was reported nothing was ever done and the facility didn't care. The Administrator was immediately notified and indicated this was the first time she had been made aware of this allegation. During an interview on 7/2/24 at 11:51 a.m., Terminated Employee 6 indicated Employee 7 had told her she would hit the resident when no one could see her. Terminated Employee 6 was unable to provide names of residents. Employee 7 would threaten other staff if they reported her, she would get them all fired. Terminated Employee 6 indicated Employee 7 would use foul language, call residents names and tell them their family members did not like them. She would cuss in front of the residents and would refuse to provide care to the residents. Terminated Employee 6 indicated she reported this to the DON, her hours were cut and the facility took away her holiday pay. She indicated when she attempted to tell the Administrator she was told to report it to the DON. During an interview with the DON on 7/2/24 at 1:53 p.m., she indicated Terminated Employee 6 had never reported allegations of abuse and her hours had never been decreased. She indicated when abuse was reported to her, the allegations would have been reported to the Administrator, the Indiana Department of Health and an investigation would have been initiated. During an interview with the Administrator on 7/2/24 at 2:24 p.m., she indicated Terminated Employee 6 had just reported the allegation and a full investigation had been initiated. She had not been informed of the allegation at any prior time from the employee. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Corporate Regional [NAME] President and Corporate Nurse Consultant were made aware of the allegations from Terminated Employee 6 on 7/2/24 at 2:56 p.m. The facility abuse policy, dated 9/1/20, and received as current from the Administrator, indicated employees were required to report any incident, allegation or suspicion of abuse to the administrator immediately. The employees, without fear of retaliation, may also independently report the abuse to the state survey agency. This citation relates to Complaints IN00437067, IN00437119, and IN00437564. 3.1-28(c)

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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 falls were in place, related to anti-roll brakes not initiated in a timely manner for 1 of 4 residents reviewed for falls and accidents. (Resident D) Finding includes: During an observation on 7/1/24 at 3 p.m., Resident D was sitting in her wheelchair in activities. There were no anti-roll back brakes on the wheelchair. During an observation on 7/2/24 at 5:04 a.m., the resident was in bed. The wheelchair was beside the bed and there were no anti-roll back brakes on the wheelchair. During an observation on 7/2/24 at 6:13 a.m., there were no anti-roll back brakes on the wheelchair. RN 8 was in the room and acknowledged the anti-roll back brakes were not on the wheelchair. During an interview on 7/2/24 at 6:15 a.m., the Director of Nursing (DON) indicated the Fall Care Plan indicated the anti-roll back brakes would be used when available and they had been ordered. She presented an e-mail, dated 6/26/24 that indicated the brakes had been requested. The e-mail, dated 7/1/24 indicated the facility was to call the Supplier. The invoice had not indicated the anti-roll back brakes had been ordered. Resident D's record was reviewed on 7/1/24 at 1:14 p.m. The diagnoses included, but were not limited to, fracture of the left femur. An Annual Minimum Data Set assessment, dated 5/28/24, indicated an intact cognitive status, no impairment of the upper and lower extremities, was independent with wheelchair mobility, required moderate assistance with bed mobility and transfers, and had no falls. A Nurse's Progress Note, dated 6/14/24 at 7:32 a.m., indicated the resident was found on the floor between the two nightstands in the room. She was unsure how she had ended up on the floor. She denied pain or injury and was assisted into the wheelchair. A Nurse's Progress Note, dated 6/14/24 at 6:09 p.m., indicated the resident complained of left hip and leg pain. The Nurse Practitioner was notified and an X-ray of the left hip was ordered. The X-ray of the left hip and pelvis, dated 6/14/24 at 10:06 p.m., indicated the bones were osteopenic with degenerative changes of the lower lumbar spine and sacroiliac joint. No acute fractures or dislocations seen. The left leg X-ray indicated mildly osteopenic bones and no fractures were seen. A Care Plan, dated 8/25/2, indicated the resident was a risk for falls. The interventions included a fall occurred on 6/14/24 and the intervention of anti-roll back brakes would be applied when available was added on 6/15/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Interdisciplinary Team Progress Note,dated 6/17/24 at 10:41 a.m., indicated the wheelchair not locked prior to a transfer was the root cause of the fall. The intervention and care plan updated, indicated anti-roll back brakes were put into place. A Nurse's Progress Note, dated 6/18/24 at 9:21 a.m., indicated the resident continued to complain of pain to the left hip. A Nurse's Progress Note, dated 6/18/24 at 9:38 a.m., indicated a Physician's Order to transfer the resident to the emergency room was obtained. A hospital X-ray of the left hip, dated 6/18/24, indicated a left femoral neck fracture. A Nurse's Progress Note, dated 6/25/24 at 6:51 p.m., indicated the resident returned to the facility post surgical repair of the left femoral neck fracture. During an interview on 7/2/24 at 2 p.m., the DON indicated the facility was able to get the anti-roll back brakes from another facility and they were now on the resident's wheelchair. This citation relates to Complaints IN00437100 and IN00437564. 3.1-45(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 20580 Based on record review and interview, the facility failed to ensure a resident who was admitted with a urinary catheter had a correct assessment of the catheter, physician orders for the catheter, and a documented reason for the catheter. The facility failed to ensure urinary catheter care was completed and the urinary catheter was monitored, for 1 of 2 residents reviewed for urinary catheter care. (Resident G) Finding includes: Resident G's closed record was reviewed on 7/1/24 at 3:12 p.m. The diagnoses included, but were not limited to, cellulitis of the left lower limb and benign prostatic hyperplasia (BPH). A Hospital Discharge Summary, dated 6/5/24, indicated the resident would be discharged with a urinary catheter. An Admission Nursing Assessment, dated 6/5/24 at 10:55 p.m., completed by LPN 1, indicated the resident was continent of urine and a toilet and incontinent briefs were used. The resident's urine was clear and the resident did not have a urinary catheter. The Baseline Care Plan, dated 6/5/24, indicated one person assistance was required for toileting. There was no care plan that indicated the resident had an urinary catheter. The Admission Nurse's Progress Note, dated 6/5/24 at 5:29 p.m., and completed by LPN 1 indicated the Physician had been notified of the admission and the medication orders from the hospital were to be continued. There was no documentation that indicated the resident had a urinary catheter. The Physician's Orders, dated 6/5/24 through 6/11/24, indicated there were no Physician's Orders for the urinary catheter, the reason for the urinary catheter, or the care of the urinary catheter. There were no Nursing Progress Notes from 6/5/24 to 6/11/24 at 1:27 p.m., that indicated the resident had a urinary catheter or the urine and catheter was being monitored. A Nurse's Progress Note, dated 6/11/24 at 1:27 p.m., indicated a family member requested the resident be transferred to the hospital due to blood being present in the urine on 6/10/24. The Nurse indicated the urine was yellow and without blood on 6/11/24. There was no documentation that indicated a urinary catheter was present. A Physician's Order, dated 6/11/24, indicated the resident was to be transferred to the Hospital emergency room for an evaluation and treatment. The CNA urinary status documentation indicated: On 6/6/24 the day and night shift indicated there was a urinary catheter present (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/24, the night shift indicated a urinary catheter was present. On day shift the resident was incontinent and on evening shift the resident continent. On 6/8/24 the day shift indicated a condom urinary catheter was used, the evening and night shift indicated the resident was continent. On 6/9/24 the day shift indicated a urinary catheter was present and on the night shift the resident was continent. On 6/10/24 the night and day shift indicated the resident was continent and the evening shift indicated a urinary catheter was present. On 6/11/24 the night and day shift indicated the resident had a urinary catheter. The resident was no longer in the facility on evening shift. During an interview on 7/2/24 at 11 a.m., the Director of Nursing (DON) indicated she was unable to determine if the resident had a urinary catheter. During an interview on 7/2/24 at 11:09 a.m., LPN 2 indicated he was pretty sure a urinary catheter was present. During an interview on 7/2/24 at 11:13 a.m., LPN 3 (discharging nurse) indicated she could not remember if a urinary catheter was present. During an interview on 7/2/24 at 11:15 a.m., LPN 4 indicated a urinary catheter was present and she had removed the leg bag due to the urine flowed back into the bladder and placed a regular drainage bag on the tubing. During an interview on 7/2/24 at 11:31 a.m., LPN 1 (admission nurse) indicated the resident had a urinary catheter. She acknowledged she had not documented the catheter on the Admission Assessment. She indicated the CNA's completed rounds every two hours and should know when they see the urinary catheter that the bag should be emptied and catheter care needed completed. During an interview on 7/2/24 at 11:35 a.m., the DON indicated output is not completed on the residents with urinary catheters. A facility policy for urinary catheter care, dated 9/1/20, and received from the DON as current, indicated catheter drainage bags would be emptied one time on each shift or as needed. This citation relates to Complaint IN00437524. 3.1-41(a)(1)

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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 a staff members (RN 8), when providing care to a resident (Resident D) who was in Enhanced Barrier Precautions (EBP). This had the potential to affect 21 residents who reside on the Blueberry Lane Unit (1 of 5 Units) Finding includes: During an observation on 7/1/24 at 10:02 a.m., Resident D was observed lying in bed #2 in the room. The resident had an indwelling urinary catheter and the drainage bag was covered. There was a sign on the door that indicated the resident was in EBP and PPE was to be worn during care. There was PPE located next to the door outside of the room. Resident D's record was reviewed on 7/1/24 at 1:14 p.m. The diagnoses included, but were not limited to, fracture of the left femur. A Physician's Order, dated 6/28/24 at 4:24 p.m., indicated a urinary catheter was present and was to be changed every month and as needed for leakage or blockage. During an observation on 7/2/24 at 6:13 a.m., RN 8 was standing next to the resident's bed. She was holding a clear garbage bag. The bag contained the indwelling urinary catheter and drainage bag. RN 8 indicated she had just taken the urinary catheter out. She indicated she wore gloves but not a gown because the resident was not in isolation. RN 8 then acknowledged the EBP sign on the resident's door. A Physician's Order, dated 7/2/24, indicated the urinary catheter was to be discontinued. The facility policy for EBP, dated 3/20/24 and received from the Administrator as current, indicated EPB (gown and gloves) was to be used if the resident had an indwelling medical device (urinary catheters). 3.1-18(b)