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	08/15/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 10326 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. 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). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48055 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. 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)

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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. 10326 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 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 facility would also provide care and services for toileting/elimination. This citation relates to Complaints IN00438030 and IN00438757. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-38(a)(3)(A)

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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. 10326 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. 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)

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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 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. 10326 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 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. This citation relates to Complaint IN00440433. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 10326 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. 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 10326 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 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)