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	01/29/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 10770 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed to self-administer medications and had Physician's Orders to self-administer for 1 of 1 resident reviewed for self-administration of medication. (Resident G) Finding includes: During random observations on 1/21/25 at 11:28 a.m. and 2:56 p.m., on 1/22/25 at 9:45 a.m., 1:31 p.m. and 3:10 p.m., and on 1/23/25 at 5:45 a.m., an Albuterol hand-held inhaler was observed on Resident G's over bed table. During an interview on 1/21/25 at 11:30 a.m., the resident indicated she used the inhaler for rescue breathing at least daily. The record for Resident G was reviewed on 1/22/25 at 4:23 p.m. Diagnoses included, but were not limited to COPD (Chronic Obstructive Pulmonary Disease), acute respiratory failure, Alzheimer's disease, anxiety disorder, high blood pressure, and bipolar disorder. The 11/14/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident's vision was adequate and she wore glasses. A Care Plan, revised on 5/14/24, indicated the resident was at risk for complications including shortness of breath experienced while lying flat and upon exertion secondary to COPD. The approaches were to administer aerosol or bronchodilators as ordered. A Physician's Order, dated 8/19/24, indicated Albuterol Sulfate HFA Inhalation Aerosol Solution 108, administer inhale one puff orally every 6 hours as needed for wheezing. There was no self-administration assessment or a physician's order for the resident to self-administer her own inhaler. During an interview on 1/23/25 at 10:05 a.m., the Director of Nursing had no additional information to provide. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current 2/15/21 Self-Administration of Medications-Clinically Appropriate policy, provided by Nurse Consultant 1 on 1/23/25 at 11:45 a.m., indicated a resident may only self-administer medications after the IDT has determined which medications may be self-administered. The IDT will determine at a minimum if the resident had the capacity to follow directions, the resident's cognitive status was evaluated, and the resident's ability to understand and store medication securely. 3.1-11(a)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 10770 Based on observation and interview, the facility failed to ensure a resident's privacy was maintained related to a Nurse Practitioner (NP) completing an assessment of a peg tube (a tube inserted directly into the stomach for nutrition) in a common area for 1 of 1 resident reviewed for tube feeding. (Resident C) Finding includes: During a random observation on 1/28/25 at 11:34 a.m., a CNA removed Resident C from the dining room when the lunch trays had arrived, due to the resident being NPO (nothing my mouth). The resident was placed in the hallway right outside of the room. At that time, an NP entered the memory care unit and asked the Infection Prevention Nurse for a pair of gloves. The NP donned the pair of gloves and lifted up the resident's shirt to observe the peg tube (a tube inserted directly into the stomach for nutrition) in the middle of the hallway. She did not take the resident to a private area to make her assessments. The resident's stomach and peg tube were exposed for all to see. The record for Resident C was reviewed on 1/27/25 at 2:03 p.m Diagnoses included, but were not limited to, peg tube, falls, dysphagia (difficulty swallowing), type 2 diabetes, palliative care, Parkinson's disease, psychotic disorder, severe dementia with agitation, high blood pressure, restlessness and agitation. The 12/24/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and was dependent on staff for most of his activities of daily living, including bathing. The resident had a feeding tube and received 51% or more of his nutrition through the tube and 501 cubic centimeters (cc) of fluids through the tube. During an interview on 1/28/25 at 11:50 a.m., the NP had no additional information to provide. During an interview on 1/28/25 at 4:15 p.m., the Director of Nursing indicated she had called the NP's physician supervisor and informed him of her concerns. She had no additional information to provide. 3.1-3(p)(4)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48383 Based on record review, and interview, the facility failed to file a grievance form, thoroughly investigate, and resolve grievances for missing personal items that were reported to staff for 1 of 1 resident reviewed for grievances. (Resident 23) Finding includes: During an interview on 1/21/25 at 9:52 a.m., Resident 23 indicated she was missing a teal blue outfit and had told many people about the issue. The outfit had been missing for over 2 months and nothing was done about it. On 1/27/25 at 10:23 a.m., The resident was observed in her wheelchair watching she television. She indicated she had not filed a grievance for the missing clothing. She indicated she spoke with laundry staff and she had no follow up. The record for Resident 23 was reviewed on 1/27/25 at 10:00 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body), hypertension (high blood pressure), depression, anemia (low iron), and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 10/27/24, indicated the resident was cognitively intact. The resident had impairment on one side of the upper and lower extremity and used a wheelchair. There was no grievance/concern form filed for the resident's first missing clothing. During an interview on 1/27/25 at 2:48 p.m., Laundry Aide 1 indicated she was aware of the missing teal outfit. She indicated she had personally labeled the outfit and knew exactly what was missing. She had not been able to locate the clothing for a while and had not filed a grievance to replace the resident's personal belongings. During an interview on 1/28/25 at 9:51 a.m., the Director of Nursing (DON) indicated she understood a grievance should have been filed for the missing items. 3.1-7(a)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 10770 Based on record review and interview, the facility failed to ensure residents were involved in decisions about their care related to informing them of new medications for 1 of 7 residents reviewed for participation in care planning. (Resident D) Finding includes: During an interview on 1/21/25 at 2:49 p.m., Resident D indicated the staff did not always tell or inform him of new medications or new physician's orders. The record for Resident D was reviewed on 1/22/25 at 4:10 p.m. Diagnoses included, but were not limited to, acute respiratory failure, COPD (Chronic Obstructive Pulmonary Disease) type 2 diabetes mellitus (DM), heart failure, high blood pressure, chronic kidney disease, osteoarthritis, and depression. The 12/2/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed substantial to maximal assistance with bathing and/or showering. A Physician's Order, dated 12/4/24, indicated Amlodipine 10 milligrams (mg), give one tablet in the morning for high blood pressure. Physician's Orders, dated 1/9/25, indicated Losartan Potassium Oral Tablet 100 mg, give one tablet in the morning for high blood pressure and Tamiflu Oral Capsule 75 mg, give one capsule one time a day for 14 days for prophylactic for the flu. There was no documentation in the clinical record the resident was made aware of the new medication regime for his high blood pressure and for the flu. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager indicated the resident was to be made aware of new medications. During an interview on 1/28/25 at 4:00 p.m., the Director of Nursing indicated there was no documentation the resident was made aware of the newly ordered medications. 3.1-35(d)(2)(B)

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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. 10770 Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to receiving showers and assistance with eating for 3 of 9 residents reviewed for ADLs. (Residents D, C, and E) Findings include: 1. During an interview on 1/21/25 at 2:44 p.m., Resident D indicated he was not getting showers on Saturdays. He indicated his showers were supposed to be Wednesdays and Saturdays in the evening time. The record for Resident D was reviewed on 1/22/25 at 4:10 p.m. Diagnoses included, but were not limited to, acute respiratory failure, COPD (Chronic Obstructive Pulmonary Disease) type 2 dm, heart failure, high blood pressure, chronic kidney disease, osteoarthritis, and depression. The 12/2/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed substantial to maximal assistance with bathing and/or showering. The resident did not receive a shower at least two times a week for the months of 10/2024, 11/2024, and 1/2025. There was no shower or completed bed bath documented on 10/1/24, 11/20/24, 1/4/25, 1/8/25, 1/15/25, and 1/25/25. During an interview on 1/28/25 at 4:15 p.m., the Unit Manager indicated the resident should have a shower at least two times a week. 2. The record for Resident C was reviewed on 1/27/25 at 2:03 p.m Diagnoses included, but were not limited to, peg tube, falls, dysphagia (difficulty swallowing), type 2 diabetes, palliative care, Parkinson's disease, psychotic disorder, severe dementia with agitation, high blood pressure, restlessness and agitation. The 12/24/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and was dependent on staff for most of his activities of daily living, including bathing. A Care Plan, revised on 1/14/25, indicated the resident required assistance with ADLs due to dementia. The resident was to receive a shower on Wednesdays and Saturdays evenings. There was no shower documented at least 2 times a week on 11/2, 11/9, 11/13, and 1/22/25 During an interview on 1/28/25 at 4:15 p.m., the Assistant Director of Nursing indicated the resident should have least two showers a week. 48383 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 1/23/25 at 8:30 a.m. and 8:48 a.m., Resident E was observed sitting up in bed and eating a bowl of cereal. The bowl was tipped in the opposite direction of the resident and milk was dripping out of the bowl onto her gown. The resident had a plastic spoon positioned backwards in her mouth and was making a gagging noise. The restorative nursing aide was walking by the resident's room and was immediately notified. During an interview at the time, Restorative CNA 1 indicated the resident was normally a set up for meals and that something must be wrong with the resident. The record was reviewed for Resident E on 1/23/25 at 10:04 a.m. Diagnoses included but were not limited to, depression, muscle weakness, age related cataract, and encephalopathy. A Quarterly Minimum Data Set (MDS) assessment, dated 10/20/24, indicated the resident was cognitively intact for daily decision making. The resident required supervision/touching assistance for eating . Oral hygiene required partial to moderate assistance, and toileting hygiene, shower/bathing, upper and lower body dressing required substantial/maximum assistance. A Care Plan, revised on 1/20/24, indicated the resident had impaired visual function related to cataracts and glaucoma. A Care Plan, revised on 1/20/24, indicated the resident required assistance with Activities of Daily Living (ADLs) including bed mobility, eating, transfers, toileting and bathing related to weakness and diagnosis of osteoarthritis. Interventions were to assist with meal consumption, eating and drinking as needed, and assist with oral and personal hygiene as needed. A Physician's Order, dated 1/22/25, indicated to administer 1 gram of Ceftriaxone (antibiotic) intravenously (IV) daily for a Urinary Tract Infection (UTI) for 10 days. Nurses' Notes, dated 1/22/2025 at 10:08 a.m., indicated the resident was experiencing increased confusion. Nurses' Notes, dated 1/21/2025 at 9:00 p.m., indicated the resident had spit out medication, had been yelling and screaming, refused meals, and refused care. The Physician was notified and new orders were received for a midline IV (intravenous) access and IV antibiotic. During an interview on 1/24/25 at 11:12 a.m., the Director of Nursing indicated the resident should have had supervised meal consumption. This citation relates to Complaints IN00450254 and IN00451800. 3.1-38(a)(3)

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F 0679 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48383 Based on observation, record review, and interview, the facility failed to provide a personalized activity program for cognitively impaired and dependent residents related to ongoing stimulation and being invited to activities for 1 of 1 resident reviewed for activities. (Resident 81) Finding includes: On 1/21/25 at 10:13 a.m., Resident 81 was observed sitting in her wheelchair. She was crying and rocking herself back and forth in her chair. There was no television on or music playing. On 1/21/25 at 3:50 p.m., the resident was observed awake in her wheelchair with her head down. The television was not on. During a family interview on 1/22/24 at 9:49 a.m., the resident's niece indicated she walked in and her aunt was screaming and hollering out. She indicated the television was not on when she got there. On 1/22/25 at 1:35 p.m. and 2:51 p.m., the resident was observed lying awake in bed. The television was not on and there was no music playing. On 1/23/25 at 8:30 a.m. and at 8:48 a.m., the resident was observed sitting up in bed, the television was not on. On 1/24/25 at 8:39 a.m., the resident was observed in her room. She was awake lying in bed staring straight ahead at the television. The television was off and there was no music playing. On 1/24/25 at 9:00 a.m., the Activity Director was observed delivering the daily chronicle to the resident. She placed the chronicle on her bedside table and walked back out. During an interview at the time, the Activity Director [NAME] indicated the resident receives one on ones. She indicated she had had only been in her role for 1 month and would try and locate documentation. On 1/24/25 at 9:03 a.m., the Activity Director went to check if the resident had her television on, and asked the resident if she would like the daily chronicle read for her, or if she wanted music played. The record for Resident 81 was reviewed on 1/23/25 at 10:04 a.m. Diagnoses included, but were not limited to, depression, muscle weakness, age related cataract, and encephalopathy. A Quarterly Minimum Data Set (MDS) assessment, dated 10/20/24, indicated the resident was cognitively intact for daily decision making. The resident required supervision/touching assistance for eating . Oral hygiene required partial to moderate assistance, and toileting hygiene, shower/bathing, upper and lower body dressing required substantial/maximum assistance. (continued on next page)

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F 0679 Level of Harm - Potential for minimal harm Residents Affected - Many	A Care Plan, revised on 1/20/24, indicated the resident had impaired visual function related to cataracts and glaucoma. There was no activity care plan. Activity one-on-one documentation indicated the last one-on-one visit for the resident was on 1/18/25. During an interview on 1/27/25 at 2:11 p.m., the Director of Nursing indicated she understood the concern and music or the television should have been on for the resident. 3.1-33(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure non-pressure areas were monitored, assessed, and bandages were changed for 1 of 1 resident reviewed for skin conditions non-pressure related, blood pressure parameters were followed for 1 of 1 resident reviewed for dialysis, and a resident was assessed and monitored post cataract surgery for 1 of 1 resident reviewed for vision and hearing. (Residents G and 82) Findings include: 1. During an interview 1/21/25 at 11:28 a.m., Resident G indicated her double vision was back and she had told the staff about it. She indicated she had cataract surgery a couple of months prior and was afraid something else was wrong. The record for Resident G was reviewed on 1/22/25 at 4:23 p.m. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), acute respiratory failure, Alzheimer's disease, anxiety disorder, high blood pressure, and bipolar disorder. The 11/14/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident's vision was adequate and she wore glasses. There was no Care Plan for vision. A referral, dated 7/11/24, indicated the resident was to schedule for cataract surgery. The appointments were made for the right eye on 8/26/24 at 12:30 p.m. and the left eye on 9/17/24 at 10:30 a.m. There was no documentation in the clinical record the resident had the cataract surgery. There were Physician's Orders, dated 9/11/24, for Prednisone eye drops and for Polytrim antibiotic eye drops post cataract surgery. There was no assessment or monitoring of the resident documented after she returned from having cataract eye surgery on 9/11/24. Physician's Orders, dated 9/18/24, indicated orders for Prednisone and Polytrim eye drops again for post cataract surgery. There was no documentation in the clinical record the resident left the facility to have cataract surgery for the other eye, nor was there an assessment or any kind of monitoring when the resident returned. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager, indicated she would expect nursing staff to document in the clinical record when a resident left for an appointment and compete an assessment after the resident returned from having cataract surgery. (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 1/28/25 at 4:15 p.m., the Unit Manager had no additional information to provide The current 10/1/2020 Change in Condition Assessment policy provided by the Director of Nursing (DON) on 1/29/25 at 10:45 a.m., indicated resident assessment was to be completed upon admission, re-admission, and with change in condition. When a change in resident condition was identified, the RN/LPN must complete an assessment including vital signs and any complaints of pain. Resident assessment was to documented in the resident's medical record. 2. During an observation on 1/23/25 at 6:52 a.m., Resident 82 was sitting on the side of the bed with his shirt off. There was a soiled, foul smelling bandage located on his lower back. The bandage had dried brown drainage noted and was crinkled and rolling down. There was also another clear bandage with a gauze observed just above the soiled one. There was a drainage bag filled with liquid coming from a drain under the foul smelling and soiled bandage. On 1/23/25 at 2:40 p.m., the Unit Manager was observed in the resident's room and was asked to look at the bandages on his back. She was able to lift the bandage with the drain and observed the area. There was a very strong, foul smelling odor coming from the bandage. During an interview at that time, she indicated the bandage was dirty and there was a strong odor coming from it. She was unsure if the bandage had ever been changed since he had returned with the drain. At 2:45 p.m., the Wound Nurse removed the bandage from the drain site. At that time, there was a white flange and drain observed. There was a large amount of dried brown drainage on the flange and drain. The Wound Nurse had to use several normal saline pouches and gauze pads to remove the substance that was adhered to the flange and drainage tube. The soiled gauze pad was rank and had a large amount of dried brown drainage noted. The Wound Nurse then attempted to remove the clear bandage and it took several attempts because it was adhered to the resident's back. During an interview with the Wound Nurse at that time, indicated he had never changed either one of the bandages prior to 1/23/25. The treatment was scheduled prn (as needed), so it was not on his list to do. The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis, anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making and had an indwelling Foley catheter. A Care Plan, dated 12/9/24, indicated the resident had a drain in place due to a renal abscess. A Physician's Order, dated 1/7/25, indicated to monitor the renal abscess drain site (right accordion drain site) every shift and report any abnormalities to the doctor. May cleanse with wound cleanser or normal saline and cover the drainage site with gauze island with border. May change if soiled or may be removed as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Records (MAR), dated 12/2024 and 1/2025, indicated the right accordion drain site (renal abscess) was not signed out as being monitored on the following days: - Day shift: 12/26 and 12/27, 1/1, 1/4, 1/5, 1/6, 1/8, 1/9, 1/10, 1/12, 1/13, and 1/20/25 - Evening shift: 12/27 and 12/29, 1/7, 1/8, 1/10, 1/16, 1/18, 1/21, 1/22/25 The right accordion drain site bandage to be changed prn was not signed out at all on the 1/2025 MAR/TAR. A Physician's Order, dated 12/10/24, indicated Midodrine (a medication to raise the blood pressure) 10 milligrams (mg), give two tablets by mouth three times a day for hypotension. Hold if systolic (top number) blood pressure was greater than 140 or Diastolic (bottom number) blood pressure was greater than 80. The 1/2025 MAR indicated the Midodrine was administered on the following days: 1/2/25 a.m. dose and the blood pressure was 128/87 1/2/25 mid day dose and the blood pressure was 145/76 1/2/25 hs (bedtime) dose and the blood pressure was 113/83 1/18/25 hs dose and the blood pressure was 127/89 1/20/25 a.m. dose and the blood pressure was 122/81 During an interview on 1/23/25 at 3:00 p.m., the Director of Nursing (DON) was made aware of the condition of the foul smelling bandage over the renal abscess area. During an interview on 1/28/24 at 4:00 p.m., the Unit Manager had no additional information to provide regarding the blood pressure medication administration. The current 9/1/2020 Skin Condition Assessment and Monitoring Pressure and Non-Pressure policy, provided by the DON as current on 1/28/25 at 5:00 p.m., indicated non-pressure skin conditions will be assessed for healing progress and signs of complications or infection weekly. Dressings which were applied to pressure ulcers, skin tears, wounds, lesions, or incisions shall include the date of the licensed nurse who performed the procedure. The dressing will be checked daily for placement, cleanliness, and signs and symptoms of infection. 3.1-37(a)

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	155469	A. Building B. Wing	01/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to ensure pressure ulcer treatments were completed as ordered and IV (intravenous) antibiotics for a wound infection were administered as ordered for 1 of 1 resident reviewed for pressure ulcers. (Resident F) Finding includes: On 1/21/25 at 10:15 a.m., Resident F was observed lying in bed. At that time, he was observed with a PICC (peripherally inserted central catheter) in his right upper arm. There were no IV antibiotics infusing at that time. From 10:15 a.m. until 11:40 a.m., there was no IV antibiotic administered to the resident. On 1/22/25 at 9:45 .a.m., the resident was observed in bed. At that time, there was an IV antibiotic bag hanging on the pole that had already infused. The medication was Meropenem with 1/22/25 at 5:00 a.m. handwritten on the label. During a random observation on 1/23/25 at 6:55 a.m. of the medication room on the main station, there were 2 IV antibiotic bags of Vancomycin in one plastic bag that had arrived to the facility on [DATE]. The record for Resident F was reviewed on 1/22/25 at 1:35 p.m. Diagnoses included, but were not limited to, sepsis, osteomyelitis, arthritis, anxiety, major depressive disorder, pressure ulcer, paraplegia, schizophrenia, and neuromuscular of the bladder. The 10/10/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a Foley (urinary) catheter. The resident had one stage 3 (full-thickness skin loss where the underlying fatty tissue (subcutaneous fat) was visible within the wound, but the bone, tendon, or muscle was not exposed) pressure ulcer and one stage 4 pressure ulcer that were present on admission. The Care Plan, revised on 1/22/25, indicated the resident had actual skin impairments to the right and left hips and the right ischium. The approaches were to administer treatments as ordered and monitor for effectiveness. The Care Plan, dated 1/22/25, indicated the resident required IV medication and had a PICC line. The approaches were to administer IV antibiotics as ordered by the physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Physician Notes, dated 1/20/25, indicated the resident had a Stage 3 pressure ulcer to the right hip that measured 7.5 centimeters (cm) in length by 4.7 cm in width by 0.6 in depth that was 100% granulation tissue (a new, pink or red, moist tissue that forms at the site of a wound as it heals) with undermining (a condition where tissue damage creates a pocket under the wound surface, making the wound appear larger than it actually was) of 6 cm at 3 o'clock. There was another Stage 3 pressure ulcer to the left hip that measured 10.5 cm in length by 6.2 cm in width by 4.5 cm depth with 100% granulation tissue. There was undermining of 2.5 cm at 9 o'clock. There was a Stage 3 pressure ulcer to the right ischium that measured 5.5 cm in length by 5.7 cm in width by 1 3 cm in depth. There was 100% granulation tissue with undermining at 3 o'clock. All three wounds were present on admission but just had not healed. The resident was admitted to the hospital on 12/20/24 with septic shock and returned back to the facility on [DATE] with IV antibiotics for a wound infection. Physician's Orders, dated 11/24/24, indicated to cleanse the right and left hips with normal saline, pat dry, apply Dakin's moistened kerlix to the wound bed, cover with an ABD pad and secure with tape two times a day every a.m. and hs (bedtime). The Treatment Administration Record (TAR) for the month of 11/2024 indicated the treatment for the right and left hips were blank for the hs shift on 11/1, 11/2, 11/4, 11/6, 11/17, 11/18, and 11/24/24. Physician's Orders, dated 12/23/24, indicated to cleanse the right and left hips with normal saline, pat dry, apply gauze roll kerlix moistened with 0.9 saline to the wound bed with alginate calcium with sliver, cover with ABD pad and secure with tape every day and evening shifts. The right ischium was to be cleansed with normal saline, pat dry, apply gauze roll kerlix with sodium hypochlorite gel (anasept) to the wound bed, cover with an ABD pad and secure with tape every day and evening shift. The 12/2024 TAR indicated the treatment for the left and right hips were not signed out as being completed for the evening shift on 12/26, 12/27 and 12/30/24. The 12/2024 TAR indicated the right ischium treatment was not signed out as being completed on 12/26 and 12/27/24 for the evening shift. Physician's Orders, dated 1/9/25, indicated to cleanse the left and right hips with normal saline, pat dry, and apply gauze roll kerlix moistened with 0.9 saline to the wound bed with alginate calcium with sliver, cover with an ABD pad and secure with tape every day and evening shift. The 1/2025 TAR indicated the treatments for the left and right hips were not signed out as being completed on 1/10/25 for the day shift and on 1/9, 1/10, and 1/11/25 for the evening shift. A Physician's Order, dated 1/10/24, indicated Vancomycin HCl Intravenous Solution Reconstituted 1 gram infuse two times a day every a.m., and hs. The Medication Administration Record (MAR) for 1/2025 indicated the Vancomycin was not signed out as being administered on 1/10/25 for both a.m. and hs, and on 1/12/25 for the hs dose. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 1/13/25, indicated Vancomycin HCl Intravenous Solution Reconstituted 1 gram, infuse two times a day at 8:00 a.m. and 8:00 p.m. A Physician's Order, dated 1/13/25, indicated Meropenem Intravenous Solution Reconstituted 1 gram infuse three times a day. The 1/2025 MAR indicated the Vancomycin was not signed out as being administered on 1/18/25 for the 8:00 p.m. dose and 1/20/25 for the 8:00 a.m. dose. The Meropenem was not signed out as being administered on 1/13 at 5 a.m., 1/17 and 1/18 at 9:00 p.m., 1/20 at 1:00 p.m. and 9:00 p.m., and 1/21/24 at 5:00 a.m. and 9:00 p.m. A Physician's Order, dated 1/20/25, indicated Vancomycin HCl Intravenous Solution (Vancomycin HCl) 750 mg intravenously every 12 hours for wound infection. The 1/2025 MAR indicated the Vancomycin was not signed out as being administered on 1/20 and 1/21/25 for the 9:00 p.m. dose. During an interview on 1/23/25 10:37 a.m., the Wound Nurse indicated treatments were to be completed as ordered by the doctor. He worked from 5:00 a.m. until 3:00 p.m., and was not in the facility during the evening times. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager, indicated the treatments were to completed as ordered and IV antibiotics were to be administered as ordered by the physician. The current 9/1/2020 Skin Condition Assessment and Monitoring Pressure and Non-Pressure policy, provided by the DON as current on 1/28/25 at 5:00 p.m., indicated physician-ordered treatments shall be initialed by the staff on the electronic TAR after each administration. This citation relates to Complaint IN00450254. 3.1-40(a)(2)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 48055 Based on observation, record review, and interview, the facility failed to ensure the resident received the necessary treatment and foot care related to podiatry visits for 1 of 1 resident reviewed for podiatry care. (Resident 69) Finding includes: On 1/22/25 at 2:37 p.m., Resident 69 indicated he wanted his toe nails cut down and they were too long. He had told every staff member who entered his room this request multiple times. On 1/23/25 at 2:30 p.m., Resident 69 was observed lying in bed watching television. He indicated again that he wanted his toes nails cut and felt his request was going unheard. He indicated he was not senile, his mind was sharp, and he knew what he needed and wanted. Resident 69's toe nails were observed to be long and unkempt looking. He indicated the podiatrist had not cut his nails in months and the staff would not cut his toe nails either. The record for Resident 69 was reviewed on 1/23/25 at 1:39 p.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus with diabetic nephropathy. The Quarterly Minimum Data Set (MDS) assessment, dated 1/4/25, indicated the resident was cognitively intact for daily decision making. The Care Plan, dated 1/4/25, indicated to avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. The last Podiatry Assessment, dated 9/20/24 indicated Resident's 69's toenail length was 2 mm (millimeters). The podiatrist performed a comprehensive pedal exam, reviewed the medical history, and trimmed and debrided the toe nails to the resident's tolerance. There were no signs of infection and the note indicated non-professional treatment would be hazardous to the patient. Recall as medically necessary, but no sooner than 60 days. There were no visits from the podiatrist in January 2025 for Resident 69. During an interview on 1/24/25 at 9:56 a.m., the Social Service Consultant indicated she had no documentation of a missed podiatry appointment in January of 2025 or a rescheduled appointment noted. They would make sure to rescheduled the resident for podiatry services for 2/4/25. 3.1-47(a)(7)

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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. 10770 Based on observation, record review, and interview, the facility failed to ensure smoking materials were locked in a safe place and not in the residents' rooms for 2 of 2 residents reviewed for smoking and halos were on a resident's bed as ordered for 1 of 1 resident reviewed for falls. (Residents G, F and H) Findings include: 1. During a random observation on 1/21/25 at 11:18 a.m., Resident G was sitting on the side of the bed. At that time, there was a vape (electronic cigarette) laying on the bed next to her. During an interview at that time, the resident indicated she kept the vape with her at all times, but only used it when she went outside to smoke. The record for Resident G was reviewed on 1/22/25 at 4:23 p.m. Diagnoses included, but were not limited to COPD (Chronic Obstructive Pulmonary Disease), acute respiratory failure, Alzheimer's disease, anxiety disorder, high blood pressure, and bipolar disorder. The 11/14/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A Care Plan, revised on 10/23/23, indicated the resident was a smoker. The approaches were to explain the consequences outlined in the policy for smoking and noncompliance. The 10/3/24 Smoking Risk Assessment indicated the resident actively smoked and preferred to continue. The facility needed to store the resident's cigarettes and lighter. During an interview on 1/23/25 at 9:45 a.m., the Unit Manager indicated the vape should not be in the resident's room During an interview on 1/23/24 at 10:30 a.m., the Director of Nursing had no further information to provide. 2. During random observations on 1/21/25 at 10:47 a.m., 1:23 p.m. and 3:10 p.m., Resident F was observed in bed. At those times, the top drawer to his night stand was open. There were two vapes, three packs of cigarettes and two lighters inside the drawer. During an interview at that time, the resident indicated he was not currently smoking because it was too cold outside. The record for Resident F was reviewed on 1/22/25 at 1:35 p.m. Diagnoses included, but were not limited to, sepsis, osteomyelitis, arthritis, anxiety, major depressive disorder, pressure ulcer, paraplegia, schizophrenia, and neuromuscular of the bladder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/10/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no Care Plan regarding smoking. A 10/4/24 Smoking Risk Assessment indicated the resident actively smoked and preferred to continue. The resident needed the facility to store the lighter and cigarettes. A 10/30/24 Smoking Risk Assessment, indicated the resident actively smoked and preferred to continue. The resident needed the facility to store the lighter and cigarettes. A 1/9/25 Smoking Risk Assessment indicated the resident did not smoke currently. During an interview on 1/23/25 at 9:45 a.m., the Unit Manager indicated the cigarettes, lighters, and vapes should not be stored in the resident's room. During an interview on 1/23/24 at 10:30 a.m., the Director of Nursing had no further information to provide. The current 9/2022 Resident Smoking policy, provided by Nurse Consultant 1, indicated possessing, carrying, or holding materials used to smoke (including, but not limited to, cigarettes, cigars, loose tobacco, pipes, lighters, and matches) by residents who required supervision was prohibited inside the building. Residents must give smoking materials to staff when they enter the building even if the resident has been assessed to be independent in carrying such materials when off the premises. 48055 3. On 1/22/25 at 2:42 p.m., Resident H was in the bathroom. The resident's bed was observed in the low position and there were no halos (bed mobility assist device) on the resident's bed. On 1/24/25 at 9:26 a.m., Resident H was lying in bed watching television. The bed was in the low position. No bed halos were observed on the resident's bed. The resident indicated he had slid out of the bed several times. Resident H's record was reviewed on 1/22/25 at 3:10 p.m. Diagnoses included, but were not limited to, repeated falls, vascular dementia, moderate without behavioral distance, psychotic disturbance, mood disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/17/24, indicated the resident was cognitively intact. A Progress Note, dated 1/22/25, indicated the interdisciplinary team (IDT) met to review the incident that occurred on 1/2/2025. The root cause of the fall was the resident slid out of the bed. Interventions and the care plan were updated. All care planned interventions were in place at time of the incident. New interventions, dated 1/22/25, included implementing halos bilaterally. During an Interview with the Director of Nursing on 1/24/25 at 11:25 a.m., she indicated the intervention of halos to the bed should have been in place for the resident to prevent falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaint IN00450652. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure Foley catheter bags and tubing were kept off of the floor, Enhanced Barrier Precautions (EBP) were maintained and suprapubic catheter site care was completed for 2 of 2 residents reviewed for catheters. (Residents 82 and 49) Findings include: 1. During random observations on 1/22/25 at 9:44 a.m., 1:25 p.m., and 2:06 p.m., and on 1/27/25 at 9:49 a.m. , Resident 82 was observed sitting in his wheelchair with a Foley catheter bag hooked on the arm of the wheelchair, making the bag above the resident's waist. During a random observation on 1/23/25 at 6:52 a.m., the resident was sitting on the side of the bed, and the indwelling Foley catheter tubing was on the floor and the drainage bag was hanging on the trash can. CNA 1 was in the resident's room and was going to empty the Foley catheter. The CNA donned a pair of clean gloves to both hands and started to look for the urinal to empty the urine, she could not find one, so she removed the gloves and left the room. She came back to the room with a pink wash basin, and indicated she could not find anymore urinals so she grabbed the basin and was going to empty the urine into it. She donned a pair of clean gloves to both hands, without performing hand hygiene and placed a paper towel on the floor and put the pink wash basin on top of the towel. She picked up the resident's Foley catheter and emptied the urine into the basin. She took the basin into the bathroom and emptied the contents into the toilet. She rinsed out the basin in the sink and with a paper towel she begun to dry the inside. After drying the basin, she opened the resident's drawer and put the basin into the closet. She removed her gloves and left the room. During an interview at that time, CNA 1 indicated she was not aware she was supposed to wear an isolation gown when emptying the urinal. The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis, anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making and had an indwelling Foley catheter. A Care Plan, dated 1/22/25, indicated the resident required contact isolation precautions due to ESBL (Extended-Spectrum Beta-Lactamase) in the urine. The approaches were to provide proper PPE and maintain contact isolation precautions. A Care Plan, revised on 1/12/25, indicated the resident was at risk for complications secondary to a Foley catheter. The resident preferred to position the Foley drainage bag on wheelchair arm rest at times. The approaches were to maintain enhanced barrier precautions, and educate the resident on the risks of not following the catheter drainage bag recommendations related to the positioning. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Order, dated 12/9/24, indicated Foley catheter, size 16 French with a balloon size of 10 milliliters (ml) for neurogenic bladder. A Physician Order, date 12/18/24, indicated Enhanced Barrier Precautions (EBP) for infection control intervention to reduce transmission of multi drug resistant organisms (MDROs). Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices.). A Physician Order, dated 1/22/25, indicated contact isolation related to ESBL in the urine. An urinalysis with a culture and sensitivity, dated 1/22/25, indicated the resident had an urinary tract infection with Klebsiella Pneumoniae (ESBL) that was greater than 100,000 colonies. A Physician Order, dated 1/22/25, indicated Invanz injection solution reconstituted 1 gram. Use 500 milligrams (mg) intravenously every evening shift for an UTI for 10 days. During an interview on 1/23/25 at 7:09 a.m., the Director of Nursing indicated an isolation gown was to be worn due to the resident being in contact isolation because he had ESBL in the urine. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager, indicated the resident had a care plan that he preferred the Foley catheter on the arm rest of the wheelchair. The catheter bag and tubing should not have been on the floor. The current 9/1/2020 Urinary Catheter Care policy, provided by Nurse Consultant 2, indicated catheters shall be positioned to maintain a downhill flow of urine to prevent back flow of urine into the bladder or tubing, during transfer, ambulation and body positioning. Urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly. The current 9/1/2020 Infection Prevention and Control Program provided by Nurse Consultant 2 on 1/23/25 at 1:30 p.m., indicated the facility followed CDC protocols for transmission based precautions (TBP). Residents with known or suspected infections were placed on appropriate TBP. 48383 2. During an interview on 1/21/25 at 2:23 p.m., Resident 49 indicated the staff does not drain his catheter bag all night or day, he had to call 911 to get his catheter exchanged, and they do not flush or clean his catheter. On 1/21/25 at 3:39 p.m., the resident had lifted his shirt to show his stomas site and catheter. The catheter was dirty and dried crusted blood around insertion site. On 1/22/25 at 2:58 p.m., the resident indicated no one had cleaned his catheter site today, and they did not flush his catheter yet. The resident lifted his shirt to show his catheter. The catheter was dirty and dried crusted blood remained around the insertion site. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record was reviewed for Resident 49 on 1/22/24 at 2:11 p.m. Diagnoses included, but were not limited to, depression, chronic obstructive pulmonary disease (COPD), quadriplegia, muscle wasting and anxiety. The Quarterly (MDS) assessment, dated 12/18/24, indicated the resident was cognitively intact for daily decision making. Resident had an indwelling catheter. The resident required supervision or touching assistance with toileting hygiene and shower and bathing. A Care Plan dated 7/9/24, indicated the resident required assistance with ADLs including bed mobility, eating, transfers, toileting and bathing related to decreased mobility and weakness. Interventions were to assist with personal hygiene as needed and assist with toileting care as needed. A Care plan dated 7/9/24 indicated the resident was at risk for complications secondary to requiring use of a suprapubic catheter. Interventions were to, check tubing for kinks routinely each shift, monitor for pain, and signs and symptoms of a urinary tract infection. A Physician's Order, dated 10/18/24, indicated to perform catheter care every shift. A Physician's Order, dated 10/18/24, indicated the resident had a 16 fr (French) suprapubic catheter with a balloon size of 10 ml (milliliters) and to change every ____ and as needed for dislodgement, leaking or blockage. A Physician's Progress, note dated 1/14/25 indicated the resident called 911 last week due to bladder pain. The resident was sent out to the hospital and returned few hours later. His catheter was exchanged due to obstruction. The Treatment Administration Record (TAR) indicated the order to clean the insertion site was signed out on the TAR as completed on 1/21/25 and 1/22/25. During an interview on 1/22/24 at 3:39 p.m., the Director of Nursing (DON) indicated she understood the concern that the resident's insertion site should be cleaned as ordered and the physician's order should be clear regarding catheter exchange. No further information was provided. 3.1-41(a)(1)

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	155469	A. Building B. Wing	01/29/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review and interview, the facility failed to ensure food consumption logs and supplements were completed for residents with a history of weight loss for 2 of 3 residents reviewed for nutrition. (Residents F and 82) Findings include: 1. During an interview on 1/21/25 at 10:51 a.m., Resident F indicated he had lost a lot of weight. He was supposed to receive double portions for all the meals, but breakfast was skimpy at times. He had only received 1 serving of scrambled eggs for breakfast that morning. The record for Resident F was reviewed on 1/22/25 at 1:35 p.m. Diagnoses included, but were not limited to, sepsis, osteomyelitis, arthritis, anxiety, major depressive disorder, pressure ulcer, paraplegia, schizophrenia, and neuromuscular of the bladder. The 10/10/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a Foley (urinary) catheter. The resident had no oral problems, weighed 118 pounds with no significant weight loss. The resident had one stage 3 pressure ulcer and one stage 4 pressure ulcer that were present on admission. The Care Plan, revised on 1/14/25, indicated the resident was at risk for impaired nutritional status. The approaches were to provide diet and supplements as ordered. The Care Plan, revised on 1/22/25, indicated the resident had actual skin impairments to the right and left hips and the right ischium. The approaches were to monitor nutritional status, serve diet as ordered, monitor intake and record. The resident weighed 112 pounds on 12/2/24 and weighed 92 pounds on 1/20/25. A Physician Order, dated 1/15/25, indicated double portions at meals. The meal consumption logs indicated there was no breakfast documented on 11/12, 11/28, 12/7, 12/8, 12/29/24, 1/12, and 1/14/25. There was no lunch documented on 10/6, 12/29 , 10/9, 10/11, 10/15, 10/18, 10/19, 10/20, 10/27, 10/30, 11/2,11/3, 11/4, 11/10, 11/12, 11/13, 11/16, 11/18, 11/19, 11/22, 11/23, 11/24, 11/27, 11/28, 11/29, 12/2, 12/4, 12/7, 12/8, 12/19, 12/20, 12/28, 12/29/24, 1/12, 1/14, and 1/15/25. There was no dinner documented on 10/6, 10/8, 10/10, 10/11, 10/12, 10/14, 10/21, 10/25, 12/18, 12/29/24, 1/9, 1/11, 1/18/25. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager indicated meal consumptions should be documented after every meal. 2. During an observation on 1/23/25 at 2:10 p.m., Resident 82 was observed in his room. At that time, his lunch tray was observed on the dresser covered and untouched. He was served meat, potatoes, vegetable and dessert. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis, anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and weighed 161 pounds. The resident received a therapeutic diet. A Care Plan, revised on 12/10/24, indicated the resident was at risk for impaired nutritional status due to dialysis. The approaches were to provide the diet and supplements as ordered. A Physician Order, dated 12/11/24, indicated liberal renal diet and a renal liquid supplement in the morning, give one can of Nepro every day. The resident weighed 160 pounds on 12/9/24 and 163 pounds on 1/7/25. The meal consumption logs indicated there was no breakfast documented on 12/7, 12/8/24, 1/12, and 1/14/25. There was no lunch documented on 12/7, 12/8, 12/19, 12/28, 12/31/24, 1/1, 1/12, 1/14, 1/15, 1/19, and 1/23/25. There was no dinner documented on 11/1, 11/4, 11/6, 12/18, 12/28/24, 1/2, 1/12, 1/14, 1/18, 1/25, and 1/27/25 The Medication Administration Record (MAR) for 12/2024 and 1/2025 indicated the renal liquid supplement was signed out as being administered, but lacked documentation of how much was consumed by the resident. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager indicated food consumptions were to be documented after every meal and the amount of renal supplement should also have documented in the clinical record. The current and revised 1/13/25 Nutritional Monitoring policy, provided by Nurse Consultant 2 on 1/29/25 at 9:35 a.m., indicated monitor each meal intake to include food, hydration, and supplement consumption. Record the intake as follows on the medical records: 100%, 75% or more, between 50-75%, between 25-50% and less than 25% 3.1-46(a)(1)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to monitor a fluid restriction for 1 of 1 resident reviewed for dialysis. (Resident 82) Finding includes: The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis, anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. He had an indwelling Foley catheter and received dialysis on admission and while a resident. A Care Plan, revised on 12/18/24, indicated the resident was at risk for altered fluid balance related to dialysis and fluid restriction. A Physician Order, dated 12/8/24, indicated for the resident to only have 1200 cubic centimeters (cc) of fluids per day for chronic kidney disease: dietary 780 cc and nursing 420 cc every shift. There was no documentation on the 12/2024 and 1/2025 Medication Administration or Treatment Administration Records to indicate the fluid restriction was being monitored or accounted for by nursing staff. During an interview on 1/29/25 at 10:45 a.m., the Director of Nursing indicated there was no documentation in the clinical record regarding for any monitoring of the fluid restriction. The 10/7/2020 Fluid Restriction policy indicated management of fluid intake was critical to specific residents, therefore a physician order for fluid restriction would be maintained. Dietary and other departments would be notified of the fluid restriction so they can communicate any fluid given. 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 10770 Based on observation, record review and interview, the facility failed to ensure proper medication storage related to medications prepared in advance, pre-filled saline syringes used to flush PICC (peripherally inserted central catheter) lines and not stored securely, medications and keys left unattended, insulin pens not labeled when opened, and loose pills observed in the medication carts for 1 of 2 units (The Main Station Unit) This had the potential to affect all residents receiving medications from LPN 2. Findings include: 1. During a random observation on 1/23/25 at 5:29 a.m., an unattended medication cart was observed on the Main Station unit. There were seven pre-poured medications in plastic cups on the top of the medication cart with the resident's first name on each of the cups. The medication cart keys were on top of the cart, as well as a box of Ciprofloxacin eye drops, and two bingo (punch out) cards of 30 pills each of Losartan (a medication used to lower the blood pressure) and Finasteride (a medication used for prostate enlargement). During an interview on 1/23/25 at 5:34 a.m., LPN 2 indicated he was in the bathroom and left the items on top of the cart because he was going to put them away, but just had not done that yet. The LPN stated, I know better not to pre-pour the resident's medications. During an interview on 1/23/25 at 10:00 a.m., the Director of Nursing indicated the nurse was not allowed to pre-pour resident medication. 2. During random observations on 1/21/25 at 10:57 a.m. and 3:01 p.m., on 1/22/25 at 9:45 a.m., 1:23 p.m., and 3:10 p.m., and on 1/23/24 at 6:39 a.m., there was a bag full of pre-filled saline syringes hanging on the IV pole in Resident F's room. During an interview on 1/23/25 at 9:10 a.m., the Director of Nursing indicated the pre-filled saline syringes should not have been stored in the resident's room. The current 9/1/2020 Medication Storage policy provided by Nurse Consultant 1 on 1/23/25 at 11:45 a.m., indicated the facility should ensure all medications were stored in a locked cart. 3. During an observation of the medication cart for Apple Lane on 1/28/25 at 9:10 a.m. with the Wound Nurse, the following was observed: - There were five pills in a medication cup with a first name written on it. - A Lovenox syringe with no resident label was loose in the top drawer. - There were 2 Lantus Insulin pens with no resident label or date when opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There was a Basaglar insulin pen that was opened with no date. - There were seven loose pills in the second drawer and six loose pills as well as two plastic vials of Refresh eye drops that had no resident name on it in the third drawer. During an interview on 1/28/25 at 9:20 a.m., the Director of Nursing (DON) indicated all loose pills/unlabeled injectables found needed to be disposed of. Insulin pens should be labeled with the resident name and date opened. The current 9/1/2020 Medication Storage policy provided by Nurse Consultant 1 on 1/23/25 at 11:45 a.m., indicated once a medication was opened, the facility should follow manufacture guidelines with respect to expiration dates. Facility staff should record the date opened on the medication container. The facility should ensure that all medications were each resident were stored in the containers in which they were originally received. 3.1-25(j) 3.1-25(k)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 48383 Based on observation, record review, and interview, the facility failed to ensure a resident received routine dental services related to decayed and broken teeth for 1 of 3 residents reviewed for dental services. (Resident 73) Finding includes: During an interview on 1/21/25 at 2:57 p.m., Resident 73 indicated the facility was supposed to follow up with the dentist after she cracked her tooth. She had seen a dentist over a year ago and he indicated she needed an extraction. There had been no follow up since. The record for Resident 73 was reviewed on 1/22/25 at 1:55 p.m. Diagnoses included, but were not limited to, anxiety disorder, depression, kidney failure, and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 12/24/24, indicated the resident was cognitively intact. The resident had no cracked, loosed, or chipped teeth. There was no dental care plan. A Dental Note, dated 11/22/23, indicated the resident required an oral surgeon for extraction of #14 and #16 root tips. A Social Service Note, dated 12/7/2023 at 11:59 a.m., indicated the writer was waiting to hear back from the Oral Surgeon regarding the resident's appointment. During an interview on 1/23/25 at 3:18 p.m., the Social Service Director indicated she did not find any documentation that the resident had seen the dentist or had a follow up appointment with the oral surgeon for 2024. During an interview on 1/23/25 at 3:48 p.m., the Director of Nursing indicated she understood the concern and had no additional information to provide. 3.1-24(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to a Nurse Practitioner (NP) failing to perform hand hygiene after glove removal, enhanced barrier precautions (EBP) not followed while emptying an indwelling Foley catheter and for a resident with a peripherally inserted central catheter (PICC), disposal of a lancet in the garbage can, and glove use in the hallway during random infection control observations. (Residents 82, C, 12, and F) Findings include: 1. During a random observation on 1/22/25 at 1:25 p.m., Resident 82 was observed in his room getting dressed. At 1:30 p.m., an Intravenous (IV) nurse entered the room to insert a PICC line so the resident could start his IV antibiotic therapy for an Urinary Tract Infection. At 1:33 p.m., the IV nurse walked out of the room wearing gloves to both of his hands and continued to walk all the way down the hallway to the nurses' station. At 1:35 p.m., he walked back into the room wearing the same gloves to both hands. At 2:03 p.m., the IV nurse walked out of the room wearing soiled bloody gloves to both hands. He walked all the way down to the nurses' station and then he removed his gloves and threw them away in the garbage can. During an interview on 1/22/25 at 2:04 p.m., Restorative CNA 1 indicated, He can't do that, referring to the gloves in the hallway, and she was going to let the Unit Manager know right away. The record for Resident 82 was reviewed on 1/23/25 at 6:17 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute myocardial infarction, renal and perinephric abscess, renal dialysis, anemia, chronic kidney disease, depression, and, end stage renal disease. The 12/24/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and had an indwelling Foley (urinary) catheter. A Care Plan, dated 1/22/25, indicated the resident required contact isolation precautions due to ESBL (Extended-Spectrum Beta-Lactamase) in the urine. The approaches were to provide proper PPE and maintain contact isolation precautions. A Physician Order, dated 1/22/25, indicated contact isolation related to ESBL in the urine. An urinalysis with a culture and sensitivity, dated 1/22/25, indicated the resident had an urinary tract infection with Klebsiella Pneumoniae (ESBL) that was greater than 100,000 colonies. During an interview on 1/28/25 at 10:00 a.m., the Director of Nursing indicated she was made aware from her staff of the nurse leaving the resident's room with the soiled gloves. The current 9/1/2020 Infection Prevention and Control Program provided by Nurse Consultant 2 on 1/23/25 at 1:30 p.m., indicated personal protective equipment was appropriately discarded after resident care prior to leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a random observation on 1/28/25 at 11:34 a.m., a CNA removed Resident C from the dining room when the lunch trays had arrived, due to the resident was NPO (nothing my mouth). The resident was placed in the hallway right outside of the room. At that time, an NP entered the memory care unit and asked the Infection Prevention Nurse for a pair of gloves. The NP donned the pair of gloves, without performing hand hygiene, and lifted up the resident's shirt to observe the peg tube (a tube inserted directly into the stomach for nutrition). She touched the peg tube with her gloved hands and then pulled down his shirt, removed the gloves and threw them away on the side of the medication cart. She then asked the Infection Prevention Nurse some questions about the resident as well as other residents. She did not perform hand hygiene after glove removal. During an interview at that time, the NP indicated she could not find any hand sanitizer to perform hand hygiene and had no additional information to provide. During an interview on 1/28/25 at 3:30 p.m., the Director of Nursing had no additional information to provide. The current 9/1/2020 Infection Prevention and Control Program policy, provided by Nurse Consultant 2 on 1/23/25 at 1:30 p.m., indicated gloves were to be changed and hand hygiene performed before moving from a contaminated body site to a clean site. 3. During medication pass on 1/23/25 at 11:34 a.m., LPN 1 was preparing to check Resident 12's blood sugar with a glucometer. The LPN gathered the supplies and entered the resident's room. She washed her hands with soap and water, donned a pair of gloves to both hands, and wiped the resident's finger with an alcohol pad. She pricked the resident's finger with a blue lancet, obtained the blood and placed it on the strip that was inside the glucometer. After checking the blood sugar level, she placed the used lancet, the alcohol pad and the used bloody test strip into one of her gloved hands and removed the glove with all of the supplies inside, removed the other glove and rolled them into a ball and threw everything away into the garbage can inside the resident's room. She walked out of the room and performed hand hygiene at the medication cart. She drew up the resident's scheduled insulin and administered it in her abdomen. Before leaving the room, the LPN was asked where she disposed of the used lancet, she indicated she put it in the sharp's container on the side of the medication. She was then asked to look into the garbage can in the resident's room, where the blue lancet could be visibly seen inside the rolled glove in the trash can. During an interview at that time, the LPN indicated she was aware used lancets should be disposed of into the sharp's container. During an interview on 1/23/25 at 11:45 a.m., the Director of Nursing (DON) indicated the used lancet should have been disposed of in the sharp's container. The current 10/25/2014 Syringe and Needle Disposal policy provided by the DON on 1/28/25 at 2:00 p.m., indicated, immediately after use, syringes and needles will be placed into a puncture resistant one way container (sharps) specifically designed for that purpose. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a random observation on 1/23/25 at 6:39 a.m., LPN 2 entered Resident F's room to disconnect the intravenous (IV) antibiotic from the resident's PICC line. The LPN donned clean gloves to both hands and did not perform hand hygiene first, disconnected the IV from the PICC line, and flushed the port of the PICC line with a saline flush. The LPN removed his gloves and left the room. CNA 1 entered the room shortly thereafter to empty the resident's Foley catheter. She donned a clean mask over her mouth and gloves to both hands. She did not put on an isolation gown. She removed the urinal from the bathroom and emptied the urine from the catheter bag into the urinal. Afterwards she poured the urine into the toilet, removed her gloves and performed hand hygiene. The record for Resident F was reviewed on 1/22/25 at 1:35 p.m. Diagnoses included, but were not limited to, sepsis, osteomyelitis, arthritis, anxiety, major depressive disorder, pressure ulcer, paraplegia, schizophrenia, and neuromuscular of the bladder. The 10/10/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a Foley (urinary) catheter. The resident had no oral problems, weighed 118 pounds with no significant weight loss. The resident had one stage 3 pressure ulcer and one stage 4 pressure ulcer that were present on admission. A Care Plan, dated 1/22/25, indicated the resident was in contact isolation. A Care Plan, dated 1/22/25, indicated the resident required IV medication and had a PICC line. A Physician Order, dated 1/9/25, indicated Enhanced Barrier Precautions (EBP) for infection control intervention to reduce transmission of multi drug resistant organisms (MDROs). Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices.). A Physician Order, dated 1/2025, indicated Vancomycin 750 milligrams (mg) IV for a wound infection. During an interview on 1/23/25 at 7:09 a.m., the Director of Nursing indicated an isolation gown was to be worn due to the resident being on EBP for the wounds, PICC line and Foley catheter. During an interview on 1/27/25 at 3:30 p.m., the Unit Manager indicated the resident was in EBP and proper precautions should be followed. 3.1-18(b)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48055 Based on observation and interview, the facility failed to keep the resident's environment clean and in good repair related to marred walls, marred and dirty floors, marred and dirty heat registers, missing toilet paper holders, feces on bed linen, feces on a shared room divider, cracked ceiling tile, a call light not working, and hot water temperatures above 120 degrees on 5 of 5 units throughout the facility. (Cherry Lane, Cherry Court, Blueberry Lane, Apple Lane and Bakersfield Lane). Findings include: During the Environmental tour with the Maintenence Director on 1/29/25, the following was observed: 1. Cherry Lane a. room [ROOM NUMBER]: The room divider between the resident beds had smeared feces on it. The divider was shared between 2 residents. b. room [ROOM NUMBER]-2: The residents bed linen had visible feces stains on them. The resident asked multiple times for clean bed linen and was not granted clean bed linen. Two residents shared this room. c. room [ROOM NUMBER]-2: The room had marred walls along the bed. 2. Cherry Court a. room [ROOM NUMBER]-1: The wardrobe closet was marred and the bathroom walls were marred. 3. Apple Lane a. room [ROOM NUMBER]: On 1/21/25 at 2:53 p.m., the hot water temperature was checked by the Maintenence Director and registered 122 degrees in the resident's bathroom. b. room [ROOM NUMBER]: On 1/21/25 at 2:53 p.m., the hot water temperature was checked by the Maintenence Director and registered 122 degrees in the resident's bathroom. The Maintenence Director indicated at that time, the hot water heater was set at 118 and he was going to turn it down now. The day before, a pipe burst in the kitchen and they had turned up the boosters. 4. Blueberry Lane a. room [ROOM NUMBER]: On 1/21/25 at 2:30 p.m., the hot water temperature was checked by the Maintenence Director and registered 123 degrees in the resident's bathroom. (continued on next page)

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	01/29/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. room [ROOM NUMBER]-1: There were marred walls in the resident's room. c. room [ROOM NUMBER] -2: There were marred walls in the resident's bathroom. d. room [ROOM NUMBER]-1-2: The wall behind the head of beds 1 and 2 were scratched and marred, the front of the heat register was discolored with a black substance at the base, the walls were marred in the room and the bathroom. 5. Bakersfield Lane a. room [ROOM NUMBER]: The heat register was marred in the bathroom. b. room [ROOM NUMBER]-2: There were marred walls and cracked ceiling tile outside of the bathroom door. The bathroom walls were marred and there was no toilet paper holder. One resident use this bathroom. c. room [ROOM NUMBER]-2: The heat register was marred, the wall behind the head of the bed was marred, and there was no toilet paper holder in the bathroom. Two residents shared the room and four residents used the bathroom. d. room [ROOM NUMBER]-1: The walls were marred next to the bed. The call light was not working. The heat register was marred. There were no toilet paper holder in the bathroom. The wall underneath the mirror by sink was marred. One resident resided in the room and used the bathroom. e. room [ROOM NUMBER]-1: The toilet paper holder was broken in the bathroom. The nuns cap (urine collection cup) laying on the heat register in bathroom was not contained. There was debris behind the bed and dirt against the wall behind the bed. Three residents shared the bathroom. During an interview with the Maintenance Director on 1/29/25 at 9:31 a.m., he indicated the areas of concern should have been cleaned and/or repaired and he would take care of it. This citation tag relates to Complaint IN00450254 and IN00451800. 3.1-19(f)